HEALTH AUTHORITIES ACT
S.N.S. 2014, c. 32
MEDIATION-ARBITRATION DECISION

CANADIAN UNION OF PUBLIC EMPLOYEES, Local Unions 835, 1933, 2431, 2525, 4150
NOVA SCOTIA GOVERNMENT AND GENERAL EMPLOYEES UNION
NOVA SCOTIA NURSES' UNION
UNIFOR, Local Unions 4600, 4603 and 4606

UNIONS

SOUTH SHORE DISTRICT HEALTH AUTHORITY
SOUTH WEST NOVA DISTRICT HEALTH AUTHORITY
ANNAPOLIS VALLEY DISTRICT HEALTH AUTHORITY
COLCHESTER EAST HANTS HEALTH AUTHORITY
CUMBERLAND HEALTH AUTHORITY
PICTOU COUNTY HEALTH AUTHORITY
GUYSBOROUGH ANTIGONISH STRAIT HEALTH AUTHORITY
CAPE BRETON DISTRICT HEALTH AUTHORITY
CAPITAL HEALTH AUTHORITY
IZAAK WALTON KILLAM HEALTH CENTRE

EMPLOYERS

ATTORNEY GENERAL OF NOVA SCOTIA

ATTORNEY GENERAL

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Dates of Mediation:	November 6 to 17, 2014
Location of Mediation:	Dartmouth, Nova Scotia
Dates of Arbitration Hearing:	December 9 to 13, 2014
Location of Arbitration Hearing:	Goffs, Nova Scotia
Dates of Written Submissions:	December 22, 2014; January 5 and 12, 2015
Date of Decision:	January 17, 2015

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1. ACUTE CARE CONSOLIDATION AND STREAMLINING PROMISED IN 2013

[1] A headline promise in the 2013 election platform of the Liberal Party of Nova Scotia was to spend health care dollars in emergency rooms not boardrooms. The promise was to "do what it takes so that our health care system puts patients first." Nova Scotians elected a majority of Liberal members to the 62nd General Assembly, which formed government October 22, 2013.

1.1 Consolidating Acute Care Health Program Management for April 1, 2015

[2] The new government immediately said it would streamline acute care service delivery by replacing nine district health authority service deliverers with one provincial health authority.

[3] The nine district authorities established by legislation in 2000[1] had replaced four regional service delivery agents established in 1994.[2]

[4] This course of action was affirmed by the Minister of Health and Wellness in February 2014.

> Our ability to pay for health services is becoming even more challenging as the federal government changes how it funds health services across the country, moving to a per capita funding formula. Nova Scotia's demographics and burden of illness are not considered. It means we will receive $23 million dollars less from the federal government next year, and about $1 billion less over the next ten years. Clearly, our approach must change. Duplication must be eliminated. Service delivery must be as efficient as it can be, resources must be used to promote better health, improve quality and outcomes and target top priorities.
>
> Fewer health authorities will allow for a streamlined, more efficient system and will enable a provincial planning approach. This will allow us to integrate services where it makes sense, providing more equitable access to specialized services with a focus on quality-patient-centered, culturally competent care. Information can be shared across the province more easily, with more consistent approaches to everything from data collection to service delivery. There will no longer be ten different interpretations of programs, policies and services. Health assets will be used as efficiently and effectively as possible for the benefit of the patient and front line care.[3]

[5] The goal is to improve health outcomes for Nova Scotians by maximizing benefits from every dollar spent. "With a more coordinated approach to service

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[1] *Health Authorities Act*, S.N.S. 2000, c. 6
[2] *Regional Health Boards Act*, S.N.S. 1994, c.12
[3] *Health Care Conversations: What We Heard*, Nova Scotia, June 2014, p. 2

delivery, we can enhance front-line patient care and care that is delivered in communities."[4]

[6] On increased efficiency, the Minister reported there had to be more shared corporate services across the province, less duplication and fewer resources spent on negotiating multiple collective agreements.

[7] Implementing and managing service change is always challenging. Making sweeping change without compromising ongoing service is more challenging. The Minister identified the challenge, the extent to which its success depends on the people providing the service and the need for their involvement:

> Those working within the system are compassionate, dedicated and above all, resourceful. The ingenuity they display is surpassed only by their passion for the job and their patients. These qualities were evident at discussions that were held in every region of the province regarding the plan to restructure Nova Scotia's health care delivery system. The plan will consolidate the nine existing district health authorities into one provincial authority, the IWK will continue as a separate entity. Change of this magnitude must be done carefully, and cannot be done successfully unless those who work within the system are engaged and involved.[5]

[8] The Department of Health and Wellness announced a team to coordinate planning to implement the change effective April 1, 2015. "The messages heard on tour and relayed in the What We Heard report, along with the themes identified by the Department, will help guide the work of the Transition and Design Team."[6]

[9] In a June 2014 report explaining the Minister's "Listening and Learning Tour", the Department underscored the importance of health care workers in the change process.

> What will [be] the most important thing to consider as you merge the health authorities?
>
> The strength of any system is the people who are part of it and their strengths, skills, resourcefulness and commitment. As we consolidate the health authorities we will want to maintain our focus on what is best for patients and how we can best support those who we rely on to provide and support care and focus on service, teaching and research.[7]

[10] The failings of the current structure were listed June 25th as follows:

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[4] *Health Care Conversations 2014 – What We Heard*, p. 8
[5] *Health Care Conversations: What We Heard*, Nova Scotia, June 2014, p. 1
[6] *District Health Authority Consolidation What We Heard Report - Listening & Learning Tour Frequently Asked Questions*, June 3, 2014, Summary
[7] *District Health Authority Consolidation What We Heard Report - Listening & Learning Tour Frequently Asked Questions*, June 3, 2014.

- Lack of singular purpose, direction, culture and accountability leading to variable care and outcomes
  – 10 different strategic plans, vision statements and operational goals
- Technological barriers remain despite best efforts to consolidate
  – SAP system was intended to standardize approaches – still considerable variation
- Resource capacity in the smaller DHAs creates gaps and risks
  – Single incumbent positions (e.g. legal counsel, internal medicine)
- Current structure leads to inter-district competition for health professionals and resources
- 10 structures for approximately 900,000 residents
- Limited coordination and standardization (administrative and clinical) results in inefficiencies[8]

[11] The boards of the nine district health authorities were disbanded effective July 1st. An administrator was appointed to oversee management of the districts until April 1, 2015.

[12] The Department published "Transition News" to communicate and explain the change process. In the first issue in July, one of the "fast facts" was: "Staff who are impacted by the consolidation and ongoing transition will be treated fairly with terms and conditions of employment and collective agreement provisions honoured."[9]

[13] In September, the Minister named the Chief Executive Officer for the consolidated provincial health authority. She joined the Transition and Design Team working with principles intended to reflect seven quality components – safety; population focus; accessibility; supportive of healthy workplace culture; people centered; continuity of service; and effectiveness, efficiency and sustainability.[10]

[14] In October, the legislature enacted new health authority governance and structural change effective April 1, 2015.[11] The existing nine district health authorities will become one as yet unnamed provincial health authority with a mandate to "provide health services to the entire Province, except for those health services provided by the IWK Health Centre."[12] The provincial health authority will partner or align with IWK Health Centre, which continues as a separate corporate body with its own board of

[8] *People Centered Health Care* Transition Planning for DHA Consolidation, June 25, 2014
[9] *Transition News*, Issue #1, July 15, 2014. p. 4
[10] *Info, Design Principles*, September 22, 2014
[11] *Health Authorities Act*, S.N.S. 2014, c. 36
[12] Section 49(1)

directors and a mandate to "operate a health centre and to provide health services and programs for children, youth, women and families."[13] The IWK Health Centre has an Atlantic province mandate and receives funding from other provinces. The provincial health authority and IWK Health Centre are each a "health authority."[14]

[15] While there is recurring reference to the current structure of acute health care service delivery as a "system", an identified problem is that the structure does not act with enough integration and consistency. The consolidation of the nine district health authorities aligned with the IWK Health Centre is to overcome "ten different interpretations of programs, policies and services" and, perhaps, health outcomes.

[16] Some of the goals of this restructuring and realignment are: to use limited resources more efficiently and effectively; to foster and support collaborative practice among health care professionals; to ensure they can practice to their full scope; to diminish competition among communities in recruiting and retaining health care providers; and to promote innovative service delivery.

[17] The Minister recognized employee anxiety over the impact of restructuring.

> Uncertainty increases anxiety and staff need to know as soon as possible how they will be affected by restructuring. Concerns were shared regarding the time, effort and resources spent negotiating 215 separate health contracts, noting that perpetual negotiations for a province of this size is simply not sustainable. As one health professional noted, "That's a lot of time in hotel rooms".
>
> Concerns focused on how local unions will be impacted. A strong desire to avoid run-off votes and the resulting impact on the workplace was consistently shared.
>
> Anxiety around job losses or possible job relocation is surfacing. Many stressed the need for a robust change-management process as part of the way forward.[15]

[18] One part of the vision is: "The labour relations environment is less complex than it is now."[16] The plan moving forward was to:

> Work with union leaders and their members to ensure that the transition is as smooth as possible. Listen to their ideas. Provide regular, factual and timely information to outline the progress being made and the potential impact on the workplace. We will look for cooperation from unions in an effort to avoid run-off votes. We are committed to change that is respectful, collaborative and transparent.[17]

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[13] Section 43(2)
[14] *Health Authorities Act*, S.N.S. 2014, c. 36, s. 2(1)(o)
[15] *Health Care Conversations 2014 – What We Heard*, p. 12
[16] *Transition News*, Issue #3, September 25, 2014, p. 3
[17] *Health Care Conversations 2014 – What We Heard*, p. 12

The subsequent discussion with the unions is reviewed later.

1.2 Community Health Boards and Regional Management Zones

[19] With a history of community based hospitals having been regionalised and then devolved to nine districts, there was concern about centralization in the Halifax Regional Municipality. The longer name of the legislation is *An Act to provide for Health Authorities and Community Health Boards*.

[20] The two health authorities must prepare annual business plans that include a public engagement plan.[18] Community health boards, whose boundaries can be altered by the provincial health authority, continue.

> The objects of a community health board are to advise the provincial health authority on local perspectives, trends, issues and priorities, and to contribute to health-system accountability by facilitating an exchange of information and feedback between the community and the provincial health authority.[19]

[21] Regulations may establish regional management zones within the provincial health authority.

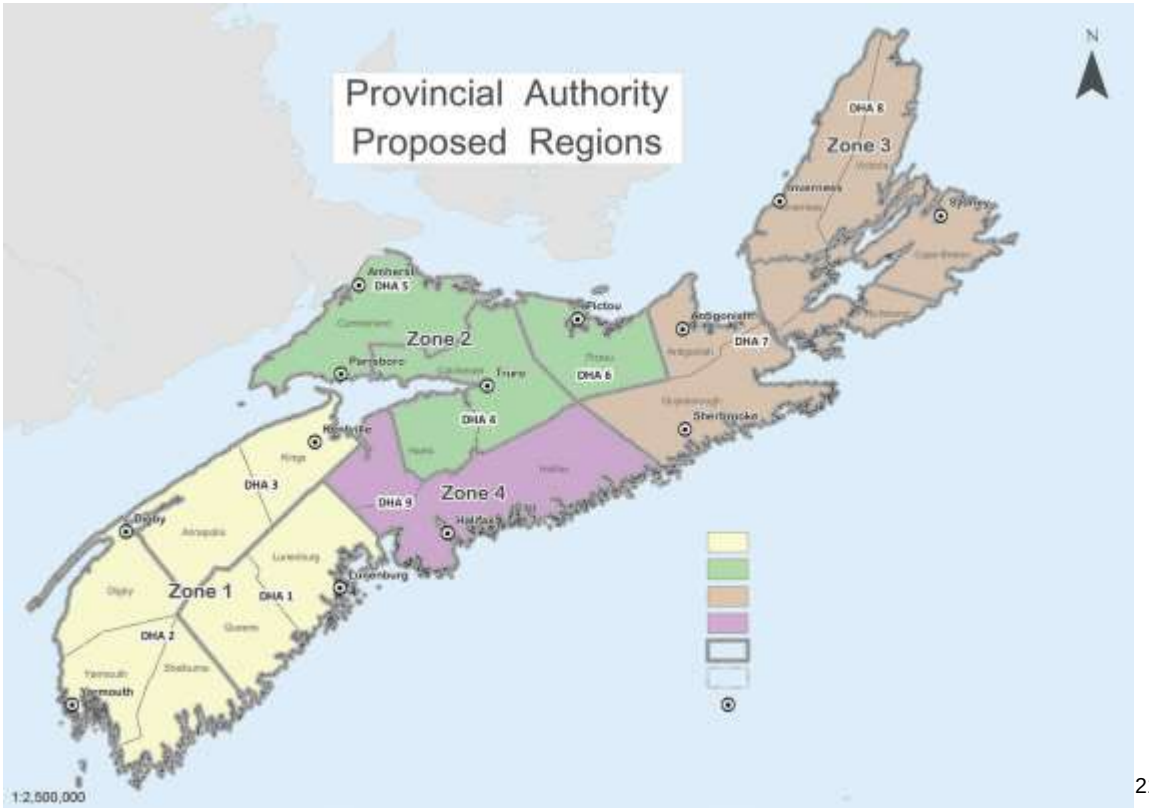
> (1) Management zones within the Province may be established by the regulations for the purpose of delivering and managing health services on a regional level at the direction of the provincial health authority.
>
> (2) Subject to clause 9(a), the provincial health authority shall determine the uses of management zones in the delivery and management of health services by the provincial health authority.[20]

[22] Regulations have not been made, but the Department has identified there will be four zones. The zone coverage of the nine district health authorities is:

Zones	**District Health Authorities**
Western	South Shore District Health Authority
	South West Nova Health Authority
	Annapolis Valley District Health Authority
Northern	Colchester East Hants Health Authority
	Cumberland Health Authority
	Pictou County Health Authority
Eastern	Guysborough Antigonish-Strait Health Authority
	Cape Breton District Health Authority
Central	Capital District Health Authority

[18] *Health Authorities Act*, S.N.S. 2014, c. 36, s. 40(6)
[19] *Health Authorities Act*, S.N.S. 2014, c. 36, s. 62
[20] *Health Authorities Act*, S.N.S. 2014, c. 36, s. 60

Map: Four Regional Management Zones



[21]

[23] County-based zone boundaries were determined by service, staffing and program delivery considerations:

- where Nova Scotians typically access services
- traditional community affiliations and medical staff relationships (e.g. referral patterns)
- recent/concurrent planning processes that address/consider boundary issues
- the impact of geographic boundaries as an enabler/barrier to future clinical services planning, and
- the geographic boundaries used by other connected services such as Community Services.

This is a logical grouping of counties and the health facilities and services within them. It will help optimize collaboration and integration as part of our new health authority structure. In its design recommendations the DHA Consolidation Transition & Design team will include advice on how services and staff can be structured by management zones that are part of the provincial health authority, as well as the operations offices for the zones.[22]

[24] The Transition and Design Team has recommended leadership structure for the provincial health authority and its four management zones. Seven vice-presidents have

[21] *Transition News*, Issue #2, September 8, 2014, p. 3
[22] *Info, Management Zones*, September 2, 2014

been named. Each zone will have two Executive Directors – one Operations and one Medical. The four Medical Executive Directors will report to one V.P. Medicine and Integrated Health Services. The four Operations Executive Directors will each report to four Vice Presidents with different program responsibilities. The role of each management zone Operations Executive Director is:

- Creates integrated networks within the Management Zone
- Works with Management Zone leadership to identify and recommend safe and quality health services by location and facility
- Engages the public, patients and families and other stakeholders in the identification and planning of priorities for health services
- Leads a healthy, safe, diverse and respectful workplace by championing and practicing sound human resources management
- Supports the transition and alignment of services and programs across zones
- Cultivates relationships with CHBs, [Community Health Boards] foundations, auxiliaries and local leaders[23]

[25] The locations of the corporate and zone offices have been determined:

- Corporate Office:
  - Will be located in Halifax Area (specific location to be determined)
  - Will be separate from Central Zone leadership office
- Zone leadership office locations:
  - Western – Kentville (15 Chipman Drive offices)
  - Northern – Truro (Colchester East Hants Health Centre)
  - Eastern – Sydney (Cape Breton Regional Hospital)
  - Central – Halifax (to be determined)
- Rationale:
  - Minimal travel distance between zone office and other main facilities within the zone
  - Proximity to major system partners
  - Technology largely available to support communication across NS[24]

How were the zone office locations established?

The transition team researched and ranked zone office locations based on a number of factors. The selected locations include the following advantages:

- Minimum travel distance between zone office and other main facilities within the zone.

[23] *District Health Authority Consolidation Provincial Health Authority Executive Structure*, October 30, 2014, slide 21

[24] *DHA Consolidation – Transition and Design People Centred Care Provincial Health Authority Executive Structure and Accountabilities*, October 30, 2014, slide 25

- Proximity to major system stakeholders – reducing travel time for system leaders to interact with Government, IWK Health Centre, academic institutions and provincial bodies, such as regulatory colleges.
- Technology is largely available to support communication across the province.[25]

[26] The Transition and Design Team's planning assumptions are:

- People centred and focus on quality and patient safety
- Focus for April 1 on executive (CEOs, VPs, administrative assistants) and zone leadership
- Clear links between zone management and provincial leadership
- Mission encompasses service delivery, academic and research mandates
- Explore administrative alignment opportunities with IWK as Provincial Shared Services evolves (in addition to current shared VP Research and Academic)
- Savings in administration on April 1, and thereafter[26]

1.3 Health Authority Collaboration and Provincial Shared Services

[27] Collaboration between the provincial health authority and IWK Health Centre is expected: "Where directed to do so by the Minister, the health authorities shall collaborate with each other on all or part of their health-services business plans."[27]

[28] The Transition and Design Team will "also identify priorities and suggest approaches for sharing or merging services with the IWK."[28]

[29] Initiatives to share corporate and targeted services that began before 2014 are to continue – human resources, information technology, procurement, finance, laboratory service and diagnostic imaging. Some services will be provided outside the provincial health authority and IWK Health Centre.[29]

[30] A *Shared Services Act* with scope beyond health care was enacted in November.[30] The current and future approach to human resource shared services is summarized as follows:

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[25] District Health Authority Consolidation Executive Structure / Recruitment Process / Zone Offices *Questions & Answers – October 2014*, p. 3
[26] *DHA Consolidation – Transition and Design People Centred Care Provincial Health Authority Executive Structure and Accountabilities*, October 30, 2014, slide 3
[27] *Health Authorities Act*, S.N.S. 2014, c. 36, s. 40(3)
[28] *Transition News*, Issue #2, September 8, 2014. p. 2; see also *Update Shared Services*, October 20, 2014
[29] *Transition News*, Issue #4, October 20, 2014, pp. 4-5
[30] S.N.S. 2014, c. 38

> Given that organizations such as nursing homes and home care agencies rely heavily on these services [labour relations, compensation analysis and group benefits administration] to support their operations, the proposed model will recommend a continued role for the association [Health Association Nova Scotia] in delivering labour relations and compensation analysis and group benefits administration services.
>
> A suggested model for human resources will be finalized in the coming months and submitted to government for their consideration. Among other things, this work will identify the extent to which these services will be offered by Health Association Nova Scotia and the degree to which human resources functions will be centralized or decentralized.
>
> The full implementation of the redesigned human resources model will occur over the next two years and will depend on technology to maximize the potential benefits.[31]

[31] One impact of shared services will be the transfer of some employees of district health authorities and the work they do to the provincial government shared services provider. They will become employees of the provincial government covered by collective agreements in bargaining units represented by the Nova Scotia Government and General Employees Union (NSGEU). The current estimate is 150 to 200 employees. The projected implementation of all shared services across the provincial public sector is five years.[32]

2. A THIRD RESTRUCTURING – 4 REGIONS ► 9 DISTRICTS ► 1 PROVINCIAL

[32] This province-wide restructuring happens against a backdrop of previous restructurings that apparently failed to achieve their goals.

> Fears of a centralized approach are rooted in history. The past saw communities feeling neglected, needs overlooked and those close to the decision makers holding the greatest influence. Boundaries became the lines of isolation. Local voices were lost and urban areas were favoured over rural.[33]

[33] Tension between rural and urban interests or local and remote control are evident in the debate about the current restructuring, as in previous centralizing restructuring.

[34] In July 1999, a Ministerial Task Force made recommendations to strengthen and complete regionalization and to minimize “the potential chaos of further organizational

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[31] *Update Shared Services*, October 20, 2014
[32] Department of Internal Services, *Shared Services Project - Fact Sheet October 2014*
[33] *Health Care Conversations 2014 – What We Heard*, p. 8

change."[34] Then in October 1999, the Minister of Health of a new government with an election platform "to replace the existing RHBs [Regional Health Boards] with nine boards that are based on the catchment areas of the nine regional hospitals"[35] announced the disbandment of Regional Health Boards.

> This decision is the Government of Nova Scotia's first step towards establishing a more community-responsive health care system that will see District Health Authorities established in the province. District Health Authorities will be smaller than the current Regional Health Boards, and they will have formal links to Community Health Boards. [36]

[35] Service integration goals for both the 1994 and 1999 restructurings were similar to the goals of the current restructuring.

> There will be nine (9) DHAs that will be aligned, in general, along county lines. The DHAs will be based in the areas primarily served by existing regional hospitals, and they will enjoy the same historical relationships, catchment areas, and referral patterns.
>
> *********
>
> There will be nine District Health Authorities serving geographic areas smaller than the previous regions. These new structures will make the system more responsive to the needs of Nova Scotians and enhance the efforts that are already under way to better integrate the province's health care services.[37]

[36] The regional boundaries that were erased were similar to the new management zone boundaries replacing the boundaries of the district health authorities.

[37] The 1999 policy on labour relations restructuring was succinct and in keeping with existing labour relations legislation – "Unions will be kept informed and provincial succession rights legislation will guide migration to the new structure."[38]

[38] Since 1994, the restructuring path has been from community-based to regional management to smaller, more local district/county management to central provincial management with regional zone management.

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[34] Minister's Task Force on Regionalized Health Care in Nova Scotia, *Final Report and Recommendations July 1999*, Letter of Transmittal
[35] Nova Scotia Department of Health, *Future Direction of the Health care System …establishing District Health Authorities*, November 1, 1999, p. 19
[36] Nova Scotia Department of Health, *Future Direction of the Health care System …establishing District Health Authorities*, November 1, 1999, p. 1
[37] Nova Scotia Department of Health, *Future Direction of the Health care System …establishing District Health Authorities*, November 1, 1999, p. 2; 4
[38] Nova Scotia Department of Health, *Future Direction of the Health care System …establishing District Health Authorities*, November 1, 1999, p. 22

[39] In the current restructuring, smaller geographic areas of common interest are recognized in the continuation of 37 community health boards across the province.

[40] However, historic and geographic trade union representation of acute care employees generally tied to regional, now zone, management is not explicitly recognized in acute care labour relations restructuring in the transitional sections of the *Health Authorities Act*.

[41] Each restructuring required accompanying labour relations restructuring for the new employer structure. In this restructuring, existing collective bargaining relationships are not being modified. They are being swept away. As a consequence, potential operational and organizational chaos is a recurring forecast for this restructuring by the unions that lived through past restructurings.

3. LABOUR LANDSCAPE – LEGACY OF DECISIONS AND EVOLUTION

[42] Union resistance to this centralizing labour relations restructuring is rooted in history and local union loyalties. To understand this resistance, it is necessary to review how the current landscape evolved.

[43] It begins with employees of community-based hospital employers choosing representation by unions active in their community. The first appears to have been in 1955 when the Canadian Hospital Employees Union, Local Union No. 324 was certified by the Labour Relations Board to represent groups of employees of the Aberdeen Hospital Commission in New Glasgow and the City of Sydney Hospital.[39]

[44] A 1962 fact finding inquiry into labour legislation reported a tension at hospital collective bargaining tables between local hospital autonomy and central funding by the new provincial Hospital Commission. Unions wanted to negotiate with the central payer. The Hospital Commission advocated local bargaining.

> The Commission also contended, and in our view with justification, that every effort should be made to see that local hospitals retain the measure of autonomy which they now have. Any lessening of that autonomy might seriously impair the great degree of responsibility which local hospital areas now exercise towards these institutions.

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[39] *The Aberdeen Hospital Commission*, October 27, 1955, LRB #377. An earlier application was dismissed September 13, 1955, LRB #366. See also *City of Sydney* Hospital, December 21, 1995, LRB #402.

> Collective bargaining, as an important factor in the matter of autonomy, should remain at the local hospital level. It was pointed out to us that the Hospital Commission encourages fund-raising by means of local campaigns and the imposition of extra charges for semi-private and private rooms, and that some hospitals have realized extra revenue through this means.
>
> It is suggested that this complaint may be remedied by the union and hospital boards negotiating new agreements early in the year but not finalizing the same until after the Government has ruled on the hospital budgets presented to it by the Commission. By this method the Commission would be aware of the terms agreed to by the hospital boards and, presumably, would so provide accordingly in the budget presented to the Government for approval. When that information became available, the agreement could be finalized.[40]

[45] In the 1960's, employees in Cape Breton chose to be represented by the Eastern Institutional Workers Union, which later became a local union of the Canadian Brotherhood of Railway Employees and General Workers Union (CBRT), which merged with the National Automobile, Aerospace, Transportation and General Workers Union of Canada that became the Canadian Auto Workers (CAW), which is now Unifor after a 2013 merger.

[46] At the same time, Yarmouth employees chose the National Union of Public Employees, Local 835 that is now the Canadian Union of Public Employees, Local 835. Other CUPE local unions were selected by employees at hospitals across the province outside the Halifax area.

[47] Through employee choice verified by the Labour Relations Board these unions acquired exclusive rights to represent all classifications of employees in community hospitals except Registered Nurses. They represented Certified Nursing Assistants, the predecessor classification to Licensed Practical Nurses.

[48] Exclusive trade union representation is based on verified or agreed majority support among a group or unit of employees for whom the union negotiates a collective agreement and enforces employer compliance with the agreement. The *Trade Union Act* defines a "unit" as:

> "unit" means a group of two or more employees and "appropriate for collective bargaining" with reference to a unit, means a unit that is appropriate for such purposes whether it be an employer unit, craft unit, technical unit, plant unit or

[40] Judge Alexander H. MacKinnon, *Report of Fact-Finding Body Re: Labour Legislation*, February 1, 1962, p.43

> any other unit and whether or not the employees therein are employed by one or more employers[41]

[49] A group of employees appropriate for collective bargaining does not have to be the most or ideal grouping of employees. As unions applied and gained certification to represent bargaining units of hospital employees, the Labour Relations Board, like other North American boards, certified various employee groupings.

[50] In the early days of organization and representation in an industry or industrial sector, labour relations boards followed a building block approach in setting bargaining structures. The boards balanced short term employee access to collective bargaining against long term industrial stability. Various factors influenced the shaping of units. One of many statements of these factors is the following from a decision involving a hospital by the Ontario board:

> . . . [W]hat then is the purpose of the concept of the "appropriate bargaining unit"? Quite simply, 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. . . . It is, as we have noted, a matter of balancing competing considerations, including such factors as: whether the employees have a community of interest having regard to the nature of the work performed, the conditions of employment, and their skills; the employer's administrative structures; the geographic circumstances; the employees' functional coherence, or interdependence or interchange with other employees; the centralization of management authority; the economic advantages to the employer of one unit versus another; the source of work; the right of employees to a measure of self-determination; the degree of employee organization and whether a proposed unit would impede such organization; any likely adverse effects to the parties and the public that might flow from a proposed unit, or from fragmentation of employees into several units, and so on.[42]

[51] Labour relations boards also deferred to bargaining unit boundaries agreed between a union and employer.

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[41] *Trade Union Act*, s. 2(1)(x)

[42] *Hospital for Sick Children*, 1985 CanLII 899 (ON LRB), ¶ 17. See also Adams, *Canadian Labour Law*, loose-leaf, Chapter 7 para 7.30-7.262; ***University of King's College Teachers' Association v. University of King's College***, 2011 NSLB 61 (CanLII),¶ 47, 56 - 60; *National Automobile Aerospace, Transportation and General Workers Union of Canada (CAW-Canada) v LeHave Manor Corporation*, 2012 NSLB 181 (CanLII).¶ 1; *Canadian Union of Public Employees Local 2330 v Highcrest Place Ltd*, 2012 NSLB 109 (CanLII), ¶ 18 - 19

3.1 Four Standard Hospital Bargaining Units is Labour Board Policy

[52] The result is it was a combination of decisions by the Nova Scotia Labour Relations Board and private agreements between unions, employers and governments that created the current landscape of hospital bargaining units and union representation in acute health care.

[53] On October 29, 1973, the Labour Relations Board moved to standardize future hospital bargaining units. This was also happening in other North American jurisdictions.

> The Labour Relations Board (Nova Scotia) wishes to announce guidelines in the determination of appropriate units for applications for certification in hospitals. The guidelines, set out below, are for the convenience of all parties concerned in applications for certification. They in no way affect existing bargaining units except, possibly, on an application to amend a Board Certification Order.
>
> The Board will continue to exercise its discretion in considering appropriateness of the bargaining unit in every individual application by a union for certification as bargaining agent on behalf of hospital employees. However, if a union applies for a bargaining unit that departs from the guidelines, it will be called upon to satisfy the Board that, under the circumstances, the unit requested is appropriate. In a small hospital or nursing home, for instance, the Board might conclude that a broader unit, or even an all employee unit, is appropriate.
>
> Employees excluded by Section 1(2) of the *Trade Union Act* of Nova Scotia will of course, not be included in any unit.
>
> In the absence of grounds which lead the Board to conclude otherwise the following hospital bargaining units will be considered appropriate:
>
> 1. Nurses - all registered or graduate nurses and specialized nurses, such as psychiatric nurses, working in their speciality.
> 2. Health Care Employees - all employees directly concerned with the treatment of patients.
>
>   Without limiting the generality of the foregoing, specifically included are certified nursing assistants, nursing assistants, nurses' aides, orderlies, technicians, dieticians, pharmacy clerks, medical records staff, and therapists.
> 3. Office Employees - all employees performing duties of a primarily clerical, bookkeeping or secretarial nature.
>
>   Where employees are performing clerical, bookkeeping or secretarial duties in particular departments of the hospital under circumstances which demonstrate a community of interest with other employees in those departments, the Board may find them to be appropriately included in a unit other than a unit of office employees.
> 4. Residual - all other employees working in or out of the hospital.

> Without limiting the generality of the foregoing, specifically included are the kitchen, housekeeping and dietary staff.[43]

[54] Today, there are no registered psychiatric nurses in Nova Scotia. Consistent with the practice at the time elsewhere in Canada, the Nurses unit did not include certified or other nursing assistants. Nursing assistants were included in the Health Care unit.

[55] The distinct character of the Health Care unit is that it is a grouping of employees "directly concerned with the treatment of patients." This group of non-nursing clinical employees is not limited to the twenty self-regulating health care occupations in Nova Scotia.[44] It is not limited to what is referred to as "allied health professionals." It is not a unit of all professionals except doctors and nurses, sometimes called a paramedical professional unit. It includes technicians, which in some jurisdictions are in a separate unit of technician or paramedical technicians. The Health Care unit includes orderlies and medical records staff.

[56] Being "directly concerned with the treatment of patients" has been broadly construed. It includes all health care employees with hands on patients, such as orderlies, and members of the team two or three steps removed from hands on patient care, such as pharmacy clerks and medical records staff.

[57] Other provincial labour relations boards took other approaches. To varying degrees multiple hospital craft units were initially certified and then later not allowed in an effort to limit the proliferation of bargaining units and to rationalize collective bargaining structures. Some non-standard and anomalous units eventually disappeared with health care regionalization and restructuring.

[58] In some jurisdictions, increased credentialization of technical occupations and professionalization of proliferating health occupations created occupational convergence and conflict over the boundaries between paramedical professionals and paramedical technicians and the proper grouping assignment for individual occupations. This was avoided in some provinces, like Nova Scotia, which had adopted four or fewer standard units.

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[43] *Hospital Bargaining Units*, LRB Policy and Procedure Statement # 023-001-073, October 29, 1973
[44] See the list and statutes in *Regulated Health Professions Network Act*, S.N.S. 2012, c. 48

[59] The Nova Scotia Board's approach made Health Care the principal unit after nurses and included, in some circumstances, employees performing clerical, secretarial and bookkeeping duties, who were regarded not as "clerical", but as administrative employees or professionals.

[60] The third unit of Office employees was a grouping of employees outside clinical departments. Over time, the parties have called this unit the Clerical unit. The NSGEU collective agreements referred to the unit as "Office / Administrative Professional."

[61] The fourth Residual unit was for the remaining employees. On November 17, 1997, the Board changed the name of this bargaining unit to "Service Support."[45] Kitchen, housekeeping and facility maintenance employees are in this unit.

[62] The four hospital unit approach was fashioned within the Board's jurisdiction under the *Trade Union Act* when the affected facilities were primarily in smaller communities. However, it was easily adaptable to regional hospitals.

[63] When describing some of the North American experience in defining bargaining unit groupings of employees for restructuring in Saskatchewan in 1997, I began with Nova Scotia.

> The models for appropriate bargaining unit configurations in health in Canada and the United States are varied. In 1973 the Nova Scotia Board adopted four standard units for hospital - nurses, health care employees directly concerned with patient treatment, office, and all others. The 1974 *Ontario Report of Hospital Inquiry Commission* recommended that future certifications recognize only three units for employees in public hospitals - service, nursing and paramedical. It also recommended that the existing craft units of operating engineers be eliminated. In Alberta, initial organizing was on craft lines. The Board moved to broader units and finally in 1976 to five standard units - direct nursing care, auxiliary nursing care, paramedical professional, paramedical technical and general support services. In community health units it limited the bargaining units to three - nursing, professional and support.
>
> In Newfoundland there are four units - nurses, allied health professionals, laboratory and x-ray technicians and support staff. In New Brunswick the units were legislated and there are eight - technical/paramedical, scientific and professional, three groups of administrative, administrative support, patient services and institutional services. The British Columbia Labour Relations Board adopted a practice in the 1970's of three units - nurses, paramedical professionals and all other employees.
>
> In the U.S. a special rulemaking process in 1989 determined eight units for hospitals - registered nurses, physicians, professionals except nurses and

[45] *Queen Elizabeth II Health Sciences Centre*, LRB #4453 Interim II,

> physicians, technical, skilled maintenance, business office clerical, guards and all other non-professional.
>
> In jurisdictions where it was adopted, a policy of standard or predictable unit configuration has generally facilitated organizing by enabling unions to know which employees to organize. It has facilitated collective bargaining because the uniformity fosters province-wide agreements.[46]

[64] When the Nova Scotia Board was pioneering standardized units for hospitals, there continued to be union acquisition of bargaining rights by employer voluntary recognition. As a consequence, the scope of some voluntarily recognized hospital bargaining units varied from standard units. This happened across the province in 1997. A fifth, non-standard bargaining unit was agreed without reference to the Board when the provincial government devolved programs to district health authorities.

[65] The presumptively appropriate bargaining units did not prevent the Board from making variations in some situations. However, after a public meeting in January 1981 to discuss hospital units, the Board reaffirmed the guidelines as the preferred but not inflexible bargaining units.

> The Labour Relations Board (Nova Scotia) wishes to announce two matters of general policy following its study of its guidelines for hospital bargaining units of October 29, 1973.
>
> 1. The Board has considered the guidelines for dealing with Hospital Bargaining Units issued by it on October 29, 1973, and has decided not to alter them.
> 2. The Board, in determining who are regular part-time employees to be included in a hospital bargaining unit, shall have regard to the special skills required, the shift requirements, the regularity of shifts worked and the hours worked during a significant test period. If the hours worked average two shifts or more per week during the test period, the Board will normally include such employees in the unit.[47]

[66] Some Canadian legislation expressly allowed labour relations boards to determine whether one classification of employees would be in one of two units on the basis of the majority of the employees' wishes as expressed in a vote among the employees in the classification.[48]

[67] Some Nova Scotia unit boundary decisions were based on Board directed or agreed representation votes among employees in merged bargaining units. For example, in 1996 on application to the Board to declare the Western Regional Health

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[46] James E. Dorsey, Health Labour Relations Reorganization Commission, *Reorganization of Saskatchewan`s Health Labour Relations*, January 15, 1997, pp. 61 - 62
[47] *Hospital Bargaining Units*, LRB Policy and Procedure Statement # 023-002-081, February 28, 1981
[48] E.g., *Labour Relations Act,1995*, S.O. 1995, c. 1, s. 9(1)

Board a successor employer to the Health Services Association of the South Shore, Yarmouth Regional Hospital and Valley Regional Health Board, it was agreed there would be four bargaining units and representation votes by employees choosing among unions representing employees. It was also agreed by the employer and unions that Licensed Practical Nurses at ten acute care facilities would have a separate vote to choose to be included in a bargaining unit with Nurses or in a Health Care unit.[49] They voted to remain with the Health Care unit and be represented by a CUPE local union.

3.2 Licensed Practical Nurses in both Health Care and Nurses Units

[68] Not all Licensed Practical Nurses made this choice before and since 1996. One inconsistent result is varied inclusion or exclusion of Licensed Practical Nurses, previously Certified Nursing Assistants, from Nurses units. Then as now, the *Trade Union Act* provided: "The Board in determining the appropriate unit shall have regard to the community of interest among the employees in the proposed unit in such matters as work location, hours of work, working conditions and methods of remuneration."[50]

[69] The Nova Scotia Nurses' Union (NSNU) was founded in 1976 to represent Registered and Graduate Nurses. Formerly, it was a component of the Registered Nurses Association of Nova Scotia negotiating terms and conditions of employment. In June 1980, the NSNU changed its constitution to include representation of Certified Nursing Assistants. In 2005, the NSNU extended representation to Nurse Practitioners.

[70] This was in contrast to what was happening in Ontario and other provinces.

> . . . [F]or the purposes of collective bargaining, RNA's [Registered Nursing Assistants] have regularly and routinely been included in the service bargaining unit, even though there might be a plausible claim to group them together with RN's or perhaps with paramedical/technical employees.
>
> The precise rationale for this established practice is not entirely clear, and may have more to do with the historical evolution of collective bargaining in the health care sector than any calculated assessment of what would ultimately be the most rational "shape" for the collective bargaining structure. Registered nurses had an early and active appetite for collective bargaining through an organization (the Ontario Nurses' Association – "ONA") which catered exclusively to the interests and concerns of their own professional group. ONA was not interested in, or able under its constitution, to represent anyone other than registered nurses,

[49] *News Release To The Western Region*, November 26, 1996
[50] Section 25(14)

> and, at the time, the role of the RNA may not have been as developed, defined, or regulated as it is today.[51]

[71] The NSNU change to its constitution initiated Licensed Practical Nurse bargaining unit inconsistency. It began in April 1981 when a four member majority of a five member Labour Relations Board panel acceded to the wishes of a group of previously unrepresented Certified Nursing Assistants at the Highland View Regional Hospital (founded in 1903 on donated land after a typhoid outbreak in the Amherst area) to be added to an existing Nurses unit. The Board included the Certified Nursing Assistants without holding a vote among them and against the Board's preference. Notice the union composition of the unit represented by CUPE, Local 920.

> The Board would have preferred that the Certified Nursing Assistants should join the CUPE unit, Local 920, which was a bargaining agent at the hospital for five full-time and four part-time nursing assistants, twelve laboratory technicians, four X-Ray technicians, two respiratory technicians, a health record technician, seventeen clerk-typists, three full-time and three part-time P.B.X. Operators, three cooks, twenty full-time and four part-time general workers, nine full-time and two part-time utility workers, five engine operators and four general maintenance tradesmen, in late November, 1980.
>
> The CNA's however, showed no preference to join the CUPE local. Their wish was to join the Registered Nurses' Union. The latter had altered its constitution to admit of such membership and by a majority vote indicated it would accept CNA's. There was no evidence to indicate that the CUPE local had tried to sign up the CNA's. …
>
> In considering whether there is a community of interest, the Board has examined: (1) the seven departments within the 113-bed hospital; (2) the participation on a "team unit" basis of CNA's except in one of those seven departments, that of intensive care; (3) the similarities in work assignments and the differences; (4) the lines of authority; (5) the growing assumption of responsibilities by and the job functions of CNA's; (6) the common factors of their working conditions including location and hours and benefits; (7) the professional standards for RN's and CNA's.
>
> Having weighed the pros and cons of all these factors, the majority of the Board finds that there is a community of interest between the RN's and the CNA's at this hospital, and that it is appropriate to include the CNA's in the Nurses' local.
>
> A caveat. This decision is not to be construed as in any sense supporting the breaking up of existing units in the Group 2 category.[52]

[72] The dissenting employer member of the Board was unwilling to create a precedent and deviate from the hospital unit guidelines.

> It is the community of interest theme which is the chief criteria adopted by most Labour Relations Boards in Canada when using any guideline to determine the

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[51] *Hospital for Sick Children*, 1985 CanLII 899 (ON LRB), ¶ 36 - 37
[52] *Highland View Regional Hospital*, April 14, 1981, LRB #2719

appropriateness of the bargaining unit. The Labour Relations Law Casebook, Queens University, breaks down community of interest into the following sub-headings: (a) Nature of Work Performed, job description. (b) Conditions of Employment. (c) Skills of Employees, education, training. (d) Administration Responsibilities. (e) Geographic Circumstances. (f) Functional Coherence and Interdependence.

The statutory admonishment in Sec. 24 (14) apparently adds several more examples to the above list. (See also test criteria in *Health Services Association* (1975) 1 C.L.R.B.R. 82 attached).

In responding to the above six criteria only (b) conditions of employment and (e) geographic circumstances are fundamentally the same for Registered Nurses and Certified Nursing Assistants in this case. Evidence introduced at the hearing indicates a lack of community of interest in the other four headings.

The formal job descriptions introduced at the hearing by the hospital were not challenged by the solicitor for the Nurses' Union and must therefore be assumed to be accurate. There are major differences in those job descriptions. Evidence from witnesses supported the argument of the differences in work performed as between Registered Nurses and Certified Nursing Assistants and I believe that the case cannot withstand this test.

In considering the skills of employees, education, and training, the expert witness presented by the solicitor for the Nurses' Union indicated that training for Certified Nursing Assistants has just been reduced to a ten-month program while the nurses' training is a full two-year program. This expert witness also indicated in testimony that a trend is developing for registered nurses to continue to a Baccalaureate Degree. In other words the formal training program for nurses is being expanded by the registered nurses themselves. It is therefore obvious that there is no community of interest between Certified Nursing Assistants and Registered Nurses in the area of skills, education and training and in fact there is a widening of this training gap.

In consideration of administration responsibilities, evidence introduced in the case indicated that Certified Nursing Assistants are subservient to Registered Nurses. Certified Nursing Assistants have no opportunity for promotion at any level while Registered Nurses, on the other hand, not only are able to supervise Certified Nursing Assistants in the normal daily functioning of the hospital but have opportunities for advancement into a number of supervisory positions.

It was obvious from the testimony presented at the hearing that there is not really functional coherence and interdependence between Registered Nurses and Certified Nursing Assistants. While both work together in a number of areas throughout the hospital in a team approach to nursing care it was obvious from the evidence that Certified Nursing Assistants do not and cannot replace Registered Nurses in the health delivery system. Registered Nurses however may and do replace Certified Nursing Assistants. Again I find there is no community of interest.

In the matter of precedents of the Nova Scotia Labour Relations Board this is the first case where Certified Nursing Assistants and Registered Nurses are being allowed to form into a single bargaining unit. (There may have been cases of all employee units prior to 1973.) In the history of Registered Nurses appearing before the Labour Relations Board of Nova Scotia since the late 1950's first as an Association and since 1976 as a Union, this is the first time that Registered Nurses have requested that Certified Nursing Assistants be brought into their

> bargaining unit. The evidence indicated that until June, 1980 the Nurses' Union under the terms of their own constitution could not request this action.
>
> The Health Care Guidelines established in 1973 by this Board and reaffirmed in March, 1981 were developed in recognition of the need to create a harmonious environment in the health care field and part of that harmonious environment was the recognition that Registered Nurses considered themselves to be professional and should not be considered as appropriate members of a bargaining unit with other workers in the health care field.
>
> Evidence from the expert witness of the Nurses' Union indicated that professionalism came as a result of formal training programs and the same witness indicated a widening of the gap in the formal training programs between Registered Nurses and Certified Nursing Assistants. No Evidence was introduced to indicate that Registered Nurses now consider themselves to be less professional or that Certified Nursing Assistants consider themselves to be more professional than they were in prior hearings before this Board. The only evidence in this area was the indication that the Constitution of the Nurses' Union had been changed in June, 1980.
>
> It would seem that in order to deviate from the guidelines which have been in place for almost a decade there would need to be stronger evidence of community of interest before Certified Nursing Assistants should be considered as members of the same unit for bargaining purposes.[53]

[73] The employer applied to the Nova Scotia Supreme Court to quash the Board's decision. Its application was dismissed. The employer appealed. The Court of Appeal dismissed its appeal. The Court of Appeal found the Board knew the employees' wishes and was not required to conduct a vote among the Certified Nursing Assistants to determine whether they wished to be added to the Nurses unit.

> This does not mean that a vote may never be taken on an application to amend certification, but rather that the Board under the authority vested in it under Regulation 20 may direct a vote where there is doubt that the wishes of the employees is to have the applicant trade union certified as their bargaining agent. The Board in this case made no such direction as it was apparent from the record that the employees wished to join the Registered Nurses' Union.[54]

[74] Today, Regulation 20(2) states:

> An application to amend a certification order to include specific additional classifications of employees in the unit or to combine previous certification orders into one order shall be made in a form approved by the Board and verified by statutory declaration, and, subject to the direction of the Board, shall be processed as an Application for Certification.[55]

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[53] *Highland View Regional Hospital*, April 14, 1981, LRB #2719 (Supplementary)
[54] *Highland View Regional Hospital v. Highland View Regional Local of the NS, Nurses' Union* [1982] N.S.J. No. 419, ¶ 23
[55] *Trade Union Procedure Regulations* made under Sections 18 and 94 O.I.C. 72-933 (August 29, 1972), N.S. Reg. 101/72 as amended up to O.I.C. 2010-359 (September 28, 2010), N.S. Reg. 148/2010

[75] The inclusion of Licensed Practical Nurses in either of two bargaining units became enshrined. In 1995, the Board amended its hospital bargaining unit policy.

> An amendment is required in the 1973 Guidelines to reflect the change to the Nurses constitution to include Certified Nursing Assistants. As a result C.N.A.'s are considered appropriately included in any certification application by the Nova Scotia Nurses Union. This, however, does not exclude C.N.A.'s from the Health Unit or from being represented by another union.[56]

If Licensed Practical Nurses were appropriately included in either of two units, then the best way to determine which unit in any situation was to ask Licensed Practical Nurses their wishes through a representation vote.

[76] Today, the NSNU represents one-quarter (572) of the Licensed Practical Nurses (2,217) in acute care. Over time, the NSNU negotiated a single collective agreement with all district health authority employers and the IWK Health Centre covering the Registered and Licensed Practical Nurses it represents.

[77] Licensed Practical Nurses are in Nurses and Health Care bargaining units in all nine district health authorities. They are in the Health Care unit at IWK Health Centre. Registered and Licensed Practical Nurses are also in the fifth non-standard bargaining unit in eight district health authorities and a sixth non-standard bargaining unit in one district health authority.

3.3 Government Creates Public Health and Addiction Services Unit in 1997

[78] In 1997, the provincial government devolved drug dependency and public health services from the Department of Health to regional health boards. Provincial civil service employee members of NSGEU providing the services became regional health board employees.

[79] There were no successor rights provisions in the *Trade Union Act* governing devolution of a service from the provincial government as employer. The NSGEU, the provincial government and regional health boards agreed to the devolution and each regional health boards entered into a voluntary recognition agreement with NSGEU.

[80] These agreements created a fifth bargaining unit outside the scope of the four standard units under the Labour Relations Board’s guidelines.

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[56] *Hospital Bargaining Units*, LRB Policy and Procedure Statement # 023-003-095

[81] When the regional health boards were replaced by district health authorities, eight districts inherited this fifth bargaining unit, which includes both Registered and Licensed Practical Nurses represented by NSGEU.

[82] In 1997, CUPE Local 2611 was certified to represent a unit of employees of the South Shore Drug Dependency program.[57] By 2003, the program had been absorbed by the South Shore District Health Authority and the union was CUPE, Local 1933.

[83] By this route, the South Shore District Health Authority became the only district health authority with six bargaining units of employees. CUPE, Local 1933 represents both Registered and Licensed Practical Nurses.

3.4 Halifax Regional Municipality: Four Standard Units with More Employees

[84] From 1973 to 2000 in the geographic areas of eight district health authorities where community hospital employers were replaced by regional boards and then district health authorities, there evolved relatively consistent trade union representation and bargaining unit composition around the four standard hospital units. The notable exception was the inclusion of Licensed Practical Nurses in Health Care and Nurses units and the fifth Public Health and Addiction Services units created in 1997.

[85] In this rural labour relations landscape NSNU represented Registered Nurses and a minority of Licensed Practical Nurses. CUPE local unions represented employees in Health Care, Office (Clerical) and Service Support units. Unifor local unions represented employees in the Service Support unit in the Guysborough Antigonish Strait district and employees in both Health Care and Service Support units in Cape Breton.

[86] In South Shore, South West Nova and Annapolis Valley districts, the NSGEU represents the three Office units. This anomaly in the rural landscape is the result of employee choice in a representation vote when the three districts were the Western Regional Health Board. The employees chose the NSGEU instead of a local of CUPE or the International Union of Operating Engineers.[58]

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[57] *South Shore Drug Dependency Program*, February 5, 1997, LRB # 4469
[58] *Western Regional Health Board*, November 14, 1997, LRB #4453 Interim Order II

[87] In the Halifax Regional Municipality the route to the current urban landscape was consolidation of community based and devolved provincial government facilities.

- **Capital District Health Authority**

[88] The Nova Scotia Civil Service Association, the predecessor to the NSGEU, was founded in 1958. In time, legislation formalized the relationship between the government and the union and established a closed collective bargaining system between the union and provincial government employer with some unique characteristics. The legislation includes statutory certification of the NSGEU as the exclusive bargaining agent for civil service employees.

[89] Similar legislated formalization of relationships happened for teachers[59] and highway[60] workers. These collective bargaining schemes are outside the *Trade Union Act* processes for employee choice, selection of a bargaining agent and impartial and independent certification by a tribunal guarding against employer interference or participation in employees' exercise of their rights.[61] As an aside, it has not been argues this legislation formalizing an existing relations is state creation of a monopoly union contrary to the employees' freedom of association.

[90] The provincial government bargaining units were civil servant occupations grouped by classifications and pay plans. In the past, there were nine units. Currently there are eight in Schedule A to the *Civil Service Collective Bargaining Act*.

1. Health Services Classification and Pay Plan - (HSA)
2. Health Services Classification and Pay Plan - (HSB)
3. Health Services Classification and Pay Plan — Nursing Services Personnel (HSN)
4. Education Classification and Pay Plan - (EDA-EDB)
5. Service Classification and Pay Plan - (SE)
6. Maintenance and Operational Services Classification and Pay Plan - (MOS)
7. Technical Classification and Pay Plan - (TE)
8. Professional Classification and Pay Plan - (PR)
9. Clerical and Related Classification and Pay Plan - (CL)

[59] Teachers Collective Bargaining Act, R.S.N.S. 1989, c. 460
[60] *Highway Workers Collective Bargaining Act*, S.N.S. 1997, c. 1 (since 1973)
[61] See *Nova Scotia Government Employees Association et al. v. Civil Service Commission of Nova Scotia et al.*, [1981] 1 S.C.R. 211; *Nova Scotia Government Employees' Union Act* S.N.S. 1973, c.136; *Civil Service Collective Bargaining Act*, R.S.N.S. 1989, c.71

[91] The NSGEU's representation of civil servants at Victoria General Hospital, Nova Scotia Hospital and the Department of Health Drug Dependency and Public Health Program conformed to these groupings, not the Labour Relations Board's four standard hospital bargaining units. At the Nova Scotia Foundation for Cancer Treatment the NSGEU represented an all employee unit.

[92] When the provincial government acquired and devolved facilities bargaining unit composition was a mix of the standard hospital units and civil service unit configuration.

1978

- Camp Hill Hospital was created to take over a federal government facility.[62] The Public Service Alliance of Canada (PSAC) followed its members and became an active union in the provincial sector.[63] The NSNU represented the Registered Nurses. PSAC represented employees in the other three standard bargaining units.

1982

- Camp Hill Hospital amalgamated with Abbey J. Lane Memorial Hospital, which the province purchased in 1981. Following Board supervised votes, PSAC and NSNU were certified to represent groups of employees. Locals of the International Union of Operating Engineers and CUPE were displaced.[64]

1989

- Camp Hill Hospital amalgamated with Halifax Infirmary. After employee representation votes, the Labour Relations Board certified the NSNU, NSGEU and CBRT&GW to represent employees of Camp Hill Medical Centre in the four standard hospital bargaining units.[65]

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[62] *Camp Hill Hospital Act,* S.N.S. 1978
[63] LRB #2455, 2456 and 2457
[64] *Camp Hill Hospital*, LRB #2835, January 19, 1982
[65] *Camp Hill Medical Centre*, LRB #3500, April 1, 1989

1996

- Queen Elizabeth II Health Sciences Centre was established by legislation[66] which merged Victoria General Hospital, Camp Hill Medical Centre, Cancer Treatment and Research Foundation of Nova Scotia and the Nova Scotia Rehabilitation Centre. Queen Elizabeth ll Health Sciences Centre is the largest provider of acute care health services in Nova Scotia. It provides specialized tertiary and quaternary care and primary care to a third of the population of Nova Scotia. It is a referral centre for Atlantic Canada. The employer and union agreed to include the Technical, Professional and Health Service Classifications and Pay Plans in the Civil Service into the Health Care unit, which they treated as a catch all or residual unit. That agreement and its effects reverberate in this mediation-arbitration.

- Certified Nursing Assistants voted to be included in the Health Care unit where the NSGEU had overwhelming support. Employees selected the NSGEU in votes in each of the four standard units. It was certified as bargaining agent for each of the four. Several secretary positions were included in the Office unit.[67]

1997

- The Dartmouth General Hospital and Community Health Centre, Eastern Shore Memorial Hospital, Hants Community Hospital, Twin Oaks Memorial Hospital, Musquodobit Valley Memorial Hospital and Cobequid Multi Service Centre merged to form the Central Regional Health Board. The NSNU represented Registered Nurses and Licensed Practical Nurses at each and continued to represent them without a vote. After two votes, the Board certified a local of the Canadian Auto Workers for the Service Support unit and no union for the two other units.[68] A year later, the NSGEU organized the employees in the unrepresented Health Care and Office units. The Board supervised votes and certified the NSGEU for both two units.[69]

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[66] *Queen Elizabeth II Health Sciences Centre Act S.N.S. 1995-96, c. 15*
[67] *Queen Elizabeth II Health Sciences Centre*, January 30, 1998 and October 11, 1998, LRB #4580 (Interim 1 and 2)
[68] *Central Regional Health Board*, February 23, 1998, LRB #4586 (Interim 1)
[69] *Central Regional Health Board*, January 21, 1999, LRB # 4678 and LRB #4679

- The Province devolved drug dependency and public health services from the Department of Health to regional health boards. Provincial civil service employees providing the services became regional health board employees. Voluntary recognition agreements created a fifth bargaining unit in all of the boards outside the scope of the four standard hospital units.

2000 - 2003

- The four regional boards were restructured as nine district health authorities.[70] The Northern, Western and Eastern regional health boards were divided into eight district health authorities, which inherited the existing five bargaining units from the boards. Generally, employees retained their representation and membership in the same unions. With the split of the Eastern Regional Health Board into three district authorities, CUPE and CAW and the Cape Breton District Health Authority entered a transfer agreement which transferred Health Care unit employees from a CUPE local union to what is now a Unifor local union.[71] CUPE also transferred Clerical union employees between Locals 2525 and 2431.
- The Central Regional Health Board was merged with the Queen Elizabeth II Health Sciences Centre and the Nova Scotia Hospital to form the Capital District Health Authority. The Capital District Health Authority and NSGEU had 15 collective agreements for 15 bargaining units, which they agreed to merge by expanding the four units at the Queen Elizabeth ll Health Sciences Centre. The expansion maintained the anomalous nature of the Health Care unit. The CAW Local and NSGEU agreed to merge the Service Support units of the Queen Elizabeth ll Health Sciences Centre and former Central Regional Health Board and have the Board hold a representation vote. The employees chose the NSGEU.[72] The Board ordered dovetailing of seniority.[73] The NSGEU withdrew its application to have all nurses in a single bargaining unit.[74] The result is the Capital District Health Authority has five bargaining units. The NSGEU

[70] *The Health Authorities Act,* S.N.S. 2000, c. 6
[71] Wayne Thomas Affidavit, December 5, 2014, Exhibit B
[72] *Capital District Health Authority*, February 7, 2003, LRB #5034, Interim 1
[73] *Capital District Health Authority*, March 1, 2003, LRB #5034, Amended
[74] *Capital District Health Authority*, September 24, 2003, LRB #5034, Final Order

represents employees in the four standard units. The NSNU represents employee in a fifth unit of Registered Nurses in hospitals formerly part of the Central Regional Health Board.

- **IWK Health Centre**

[93] In 1995, the Izaak Walton Killam Hospital for Children and the Salvation Army's Grace Maternity Hospital merged to create the Izaak Walton Killam - Grace Health Centre for Children, Women and Families. After holding representation votes among employees, the Labour Relations Board certified the NSNU to represent a unit of Registered Nurses. Licensed Practical Nurses were given a choice to be in the Nurses unit represented by the NSNU or the Health Care unit represented by the NSGEU. A majority who voted chose to be in the Health Care unit. The Board certified the NSGEU for the Health Care and Office units and the CBRT&GW (now Unifor) for the Service Support unit.[75]

3.5 Current Representation Landscape: Bargaining Units and Employees

[94] The resulting bargaining unit and trade union representation characterised as complex, inefficient, costly and an impediment to effective acute health care service delivery is depicted in the following table using employer supplied employee data at November 25, 2014. This is the most current, reliable employee data available.

[95] The NSNU has as members a majority of the Registered and Licensed Practical Nurses in the ten Nurses bargaining units.

[96] Because of the number of employees in the Capital District Health Authority, the NSGEU has as members a majority of employees in the ten Health Care and Clerical units. It has as members a majority of the employees in the Public Health and Addictions Services units. No union has as members a majority of the employees in the Service Support unit.

[97] This landscape of employee groupings into bargaining units and representation in the nine district health authorities is to be streamlined with consolidation into a single provincial health authority employer.

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[75] *Izaak Walton Killam-Grace Health Centre for Children Women & Families*, September 16 and November 5, 1996; February 27, 2990 LRB #4405 (Interim 1, 2 and 3) and April 19, 1999, LRB #4712

[98] A central focus of the labour relations restructuring legislation and the mediation-arbitration process concerns Registered and Licensed Practical Nurses. Their combined total is over 40% of the total unionized employees.[76]

[99] Including all Registered and Licensed Practical Nurses from existing bargaining units into one unit impacts all units they leave.

[76] "unionized employee" is defined in s. 2(1)(zl) as "an employee who is represented by a union"

Table 1: DHA Units – Approx. Employee Numbers – November 25, 2014

Employer	SSDHA	SWNDHA	AVDHA	CEHDHA	CHA	PCHA	GASHA	CBDHA	CDHA	Total by Union	Total by Group
Nurses	297 NSNU	295 NSNU	428 NSNU	343 NSNU	299 NSNU	357 NSNU	396 NSNU	1,081 NSNU	683 NSNU*	4,179 NSNU	6,726
									2,547 NSGEU	2,547 NSGEU	
Health Care	452 CUPE	519 CUPE	593 CUPE	300 CUPE	190 CUPE	253 CUPE	292 CUPE		3,904 NSGEU	3,904 NSGEU	7,761
										2,599 CUPE	
								1,258 Unifor		1,258 Unifor	
Clerical	152 NSGEU	192 NSGEU	237 NSGEU						1,449 NSGEU	2,030 NSGEU	3,096
				151 CUPE	131 CUPE	122 CUPE	149 CUPE	513 CUPE		1,066 CUPE	
Service	176 CUPE	233 CUPE	206 CUPE	120 CUPE	133 CUPE	127 CUPE			1,216 NSGEU	1,216 NSGEU	2,966
										995 CUPE	
							210 Unifor	545 Unifor		755 Unifor	
Public Health / Addiction Services	64 NSGEU	93 NSGEU	102 NSGEU	93 NSGEU	78 NSGEU	83 NSGEU	153 NSGEU	255 NSGEU		921 NSGEU	973
	52 CUPE									52 CUPE	
Totals	1,193	1,332	1,565	1,000	831	939	1,197	3,653	9,821		21,522
	NSGEU 10,618 49.34%			CUPE 4,712 21.89%			NSNU 4,179 19.42%			Unifor 2,013 9.35%	

* NSNU represents employees at Cobequid Multi-Service Centre, Dartmouth General Hospital, Eastern Shore Memorial Hospital, Hants Community Hospital, Musquodobit Memorial Hospital, and Twin Oaks Memorial Hospital

3.6 Current Collective Agreements: Number, Coverage and Expiration

[100] The current district health authority bargaining unit configuration of 46 bargaining plus four units at IWK Health Centre could, but does not, have 50 collective agreements. Over the years, the unions and employers recognized it was redundant and wasteful to have concurrent or sequential collective bargaining at separate bargaining sessions for each district health authority. [77]

[101] NSNU, NSGEU and CUPE and Unifor local unions are the trade unions under the *Trade Union Act* that are the certified and voluntarily recognized bargaining agent parties to the collective agreements. NSNU has one province-wide agreement with all ten employers. Some locals collaborate to negotiate one collective agreement with several employers.

Table 2: Collective Agreement Distribution

Bargaining Units	Unions	Employers	Agreements	Expiry
Nurses (2)	NSNU	9 DHAs & IWK	1	31-Oct-14
	NSGEU	1 DHA	1	31-Oct-14
Health Care (4)	NSGEU	1 DHA	1	31-Oct-14
		IWK	1	31-Oct-14
	CUPE Locals 835,1933, 2525 and 4150	7 DHAs	1	31-Oct-14
	Unifor Local 4600	1 DHA	1	31-Oct-14
Clerical (3)	NSGEU	4 DHAs	4	31-Oct-14
		IWK	1	31-Oct-14
	CUPE Locals 2525 and 2431	5 DHAs	1	31-Oct-14
Service Support (4)	NSGEU	1 DHA	1	31-Oct-14
	CUPE Locals 1933, 835, 2525 and 4150	6 DHAs	1	31-Oct-14
	Unifor Local 4603	2 DHAs	2	31-Oct-14
	Unifor Local 4606	IWK	1	31-Oct-14
Public Health & Addiction Services (2)	NSGEU	8 DHAs	1	31-Mar-15
	CUPE Local 1933	1 DHA	1	31-Mar-15

[77] The 215 contracts referred to at page 12 of the *Health Care Conversations 2014 – What We Heard* report must include contracts other than collective agreements

[102] For the nine district health authority employers, there are twelve collective agreements. On average, this is one for every 1,800 employees. The number of rounds of collective bargaining is fewer. CUPE locals negotiate their Health Care, Clerical and Service Support agreements at one table and Unifor locals bargain their Health Care and Service Support agreements at one tale. The labour relations restructuring contemplates reducing the instances of collective bargaining to four. On average, one for every 5,400 employees.

[103] For IWK Health Centre there will continue to be four bargaining units and four collective agreements. It will be negotiating all four jointly with the provincial health authority – "The health authorities shall engage in multi-employer collective bargaining when negotiating collective agreements with bargaining agents in respect of bargaining units of the same type for each health authority."[78]

[104] There could be minimal restructuring and collective bargaining at five or six tables with a solution for representation of Nurses units in the Capital District Health Authority (Capital Management Zone) and Health Care units in the Eastern Management Zone. However, there would continue to be collective bargaining for the same classification positions at more than one table. Some wonder if it will transpire that zone management is the true functioning employer.[79] Or perhaps, events will unfold so that both health authorities become, in fact, a common employer.[80]

[105] CUPE's proposed zone-based, multi-union representation and bargaining by three unions in one zone, two unions in two zones and three unions in one zone has not gained traction.

[106] By April 1, 2015 all existing collective agreements will have expired. Collective bargaining is legislatively suspended until then by the *Health Authorities Act*.[81]

[107] In the interim, the possibility of a change in union representation of bargaining units was eliminated by suspending the operation of *Trade Union Act* provisions on

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[78] s. 26
[79] For details of this approach and question see Wayne Thomas Affidavit, December 5, 2014
[80] *Trade Union Act*, s. 21
[81] ss. 98 - 102

acquiring, amending and revoking certification and voluntary recognition during this labour relations restructuring. Section 83(1) of the *Health Authorities Act* states:

> Sections 23 to 26, clauses 28(1)(b) to (d) and Sections 29 to 32, 40A and 40B of the *Trade Union Act* do not apply in respect of labour relations between a district health authority, its unionized employees and the bargaining agents for those unionized employees.

[108] The inoperable sections also cover employer and union successorship. It is unclear why section 26 dealing with bargaining units at interdependent manufacturing locations was included.[82]

3.7 Arbitrated Bargaining Impasses since 2000: NSGEU and CDHA

[109] Before 2000, when employees of the Victoria General and Nova Scotia Hospitals were part of the provincial civil service and employees of the IWK Health Centre were not represented by a union, there were few incidences of work stoppages.

[110] An exception was the 1981 common front strike in which the NSNU did not participate.

> Hospital unions initiated a "Common Front" in 1981 to develop a co-operative approach to negotiations for classifications including clerks, technicians, certified nursing assistants, general workers in 36 unionized hospitals in the province. It was agreed that no local would sign an agreement until all groups were satisfied with the offer.
>
> The nurses in the province were in contract negotiations while discussions to form a Common Front were underway. They subsequently accepted the government's offer resulting in the Common Front losing some of its bargaining power.[83]

[111] A Cape Breton hospital strike in 1990 lasted ten weeks. A one day strike in 2001 by 1,200 or so Nurses and Health Care employees precipitated the introduction of legislation.[84] The NSNU had been given a strike mandate after its members rejected a tentative agreement with the employers. Its members joined the strike begun by members of the NSGEU. Many employees represented by NSGEU in the Nurses and Health Care units were not in favour of striking and submitted membership resignations to the NSGEU.

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[82] See Brian Langille, "The Michelin Amendment in Context", (1980-81) 6 Dalhousie Law Journal 523
[83] Nova Scotia Environment and Labour, *Dispute Resolution in Healthcare and Community Services Collective Bargaining*, Discussion Paper June 2007, p. 5
http://novascotia.ca/lae/unionworkplaces/docs/DiscussionPaperHealthcare.pdf
[84] *Health Care Continuation (2001) Act*, Bill 68

[112] Both the NSGEU and NSNU agreed with the government as agent for the employers to settle the bargaining impasse by final offer selection (FOS) interest arbitration. CUPE signed the FOS agreement but did not participate in the arbitration.

[113] To address circumstances unique to Licensed Practical Nurses', they were separated from other Health Care unit employee groups in the impasse resolution process. Arbitrator Susan Ashley selected the unions' final wage offer for Registered Nurses and the employers' final offer for Licensed Practical Nurses. Her decision reports recurring issues about the role and relationship between Registered and Licensed Practical Nurses.

> The Union's main argument justifying a 13.5% wage increase for the Licensed Practical Nurses is that the role of the LPN has changed significantly, with increased responsibilities resulting from performing many duties that were formerly done by Registered Nurses. This is due to the changes in the health care system, the reduction in number of acute care beds, the increase in patient acuity, the implementation of limited hospital stays, and the shortage of Registered Nurses. As recognition of this changing role, there is a growing professionalism to the role of the LPN, evidenced by recent legislative changes, by licensing, and by more stringent education and examination requirements. The Union argues that these factors justify a one-time adjustment to the LPN wage rate to reflect the recent significant increase in skill, effort and responsibility and the Employer's policy of full utilization of LPN's within their scope of practice.
>
> At the same time, according to "*Nursing Strategy in Nova Scotia: Strengthening the Foundation*" (*supra*), many LPN's feel that they are underutilized, and working below their competency level. Hopefully the policy of "full utilization" will address these concerns. In any event, it is clear that the role of the LPN is evolving to a more highly skilled and highly professional one, in which the LPN works together with other members of the health care team in providing the highest quality care to the patient. LPN's are an invaluable part of the health care system.
>
> There is no evidence that there are any recruitment and retention problems with LPN's at this time. While it has been suggested in the hearings that there may be a supply problem in a few years, the Union's supporting documents ("*'Nursing in Nova Scotia: Strengthening the Foundation*"(*supra*)) indicate that there was, at the date of that document (August 1999) an oversupply of LPN's in the province. Because there are no current recruitment and retention concerns for LPN's in Nova Scotia, it is more difficult to argue that comparability, especially on a national scale, should be a significant factor.
>
> The Employer accepts, as do I, that LPN's perform indispensable work. However, they suggest that, if the new job responsibilities of LPN's require wage adjustments, this can be dealt with through other means in the collective agreement, such as job evaluation and classification review. In the Union's view, the classification process holds little hope for LPN's to resolve their concerns about getting a wage rate to match their responsibilities during the life of the collective agreement.

> The parties are far apart in their Final Offers, and I have no authority to find the middle (or other) ground. While the Employer has added only an additional $750.00 lump sum to its final pre-FOS offer, the Union's Final Offer is significantly higher than the offers they accepted in the two Tentative Agreements. While not too much emphasis should be placed on these agreements (they were, indeed, tentative), they do represent the best judgement of the Union negotiators at the time as to what they could bargain from the Employer, on wages as well as other issues. I agree with the negotiators that the Tentative Agreement mediated by Mr. Outhouse represented a reasonable deal in the circumstances. This second Tentative Agreement was rejected by the membership on June 16.
>
> The movement on both sides from that Tentative Agreement is discouraging. The FOS process has not operated to bring the parties closer together in dealing with the LPN's or with the Health Care unit. The Employer increased its offer by just $750. On the other hand, the Unions increased the wage demand from what they would have accepted in the Tentative Agreements to thirteen point five percent (13.5%). While I anticipate that the Unions would never have accepted the Employer's Final Offer if it had been presented in free collective bargaining, I am equally confident that the Employer would never have agreed to pay the LPN's thirteen point five percent (13.5%) to resolve this impasse.
>
> In these unusual circumstances, I find that I must accept the Employer's Final Offer. It offers a higher percentage increase to the LPN's than has been given to other public sector employees in the province, and it places them in a competitive wage position at fifth or sixth in the country, leading in Atlantic Canada based on current figures. Overall, it should match the forecasted yearly inflation rate. The LPN's are not now experiencing recruitment or retention problems. I am reinforced in my view that the Employer's Final Offer is fair and reasonable in the circumstances by knowledge that this was the agreement that was accepted not once, but twice by the Union negotiators, and topped up by a further $750 payment.
>
> I recognize that this result will further widen the wage gap between the RN's and LPN's (as would have been the case under either the Employer's or the Unions' Final Offer). I recognize too the danger that this could tempt cash-strapped health care institutions to seek to download duties of RN's to lower-paid LPN's. Such a result, should it come about, would be most regrettable.
>
> LPN's are being called upon to play an expanding role in the delivery of vital health care services, and have met these new demands with professionalism and dedication. The Employer will have to be increasingly aware of the contribution they make and be responsive to the higher expectations placed upon them, both through the mechanisms provided in the collective agreement and in other ways.
>
> I accept the Final Offer of the Employer in relation to the Licensed Practical Nurses.[85]

[114] In 2003, the Capital District Health Authority and NSGEU reviewed all classifications in the Health Care, Clerical, and Service units under an agreed job evaluation process. The outcome has province-wide application for classifications in

[85] *Nova Scotia Government and General Employees' Union v. Nova Scotia (Final Offer Selection) [2001] N.S.L.A.A. No. 13 (Ashley), ¶ 51 - 60*

other employer bargaining units. This was an indirect form of what the union advocated at the 1962 fact finding inquiry. There was no review of classifications in the Nurses unit. Its collective agreement has a classification appeal process.

[115] In November 2003, the NSGEU and Capital Health District Authority agreed to voluntary interest arbitration held in May and June 2004 to settle the unresolved terms of the Health Care collective agreement. The unit covered 170 classifications and approximately 3,000 employees, of which Licensed Practical Nurses were approximately 15%. The main issue was the amount of a wage increase. The recent classification review and diversity of classifications in the unit was a factor influencing the outcome. The board majority described the employer and unit.

> The CDHA is the largest, the leading, and the most advanced health care institution in Atlantic Canada. It provides core health services for approximately 40% of the population of Nova Scotia and high level tertiary and quaternary acute care services for people throughout Atlantic Canada. The CDHA is also the largest academic health sciences centre in Atlantic Canada, affiliated with the Faculty of Medicine and Health Professions at Dalhousie University. The CDHA was created as a result of passage of legislation effective January 1, 2001, amalgamating a number of different health care institutions and numerous bargaining units.
>
> The bargaining unit in this case is the largest at the CDHA covering, broadly speaking, health care employees. There are professional groups such as pharmacists and social workers. There are highly trained technologists operating sophisticated diagnostic and therapeutic systems, technologist assistants, licensed practical nurses and employees such as ward aides. There are a large number of classifications (albeit many with only one or two incumbents) and over 3100 employees in this bargaining unit.[86]

[116] The majority rejected both the union and employer proposals. “We do not accept that a "below market" increase, requested by the employer, is appropriate nor do we accept the optimistic and rather extraordinary claims advanced by the union.”[87]

> As previously stated, we have attempted to take into account the existence of the recently concluded classification review and the historical practice of the parties themselves, and previous arbitration boards, which have preferred to award "across the board" increases. There are other factors as well which should disincline an interest board of arbitration to presume to fashion a compensation award which requires widely varying wage increases for numerous classifications across a large bargaining unit. …
>
> To state the point again, this Board accepts that the claim to first in Atlantic Canada has more than arguable legitimacy given both the value of the work, as

[86] *Capital District Health Authority* [2004] N.S.L.L.A. No. 16 (Kaplan), ¶ 2 - 3
[87] *Capital District Health Authority* [2004] N.S.L.L.A. No. 16 (Kaplan), ¶ 8

> reflected in comparable collective bargaining outcomes in the region and the country, and the institution where that work is being performed. However, in addition to classifications requiring large adjustments, there are also classifications which would require no adjustments, classifications requiring small adjustment and those in-between (and classifications where comparisons would be, at best, problematic). On the data made available to us, it appears that the weighted average increase for the group as a whole which would be necessary to achieve this objective would be in excess of what is actually being awarded. Simply put, the end result must be and has been tempered by an appreciation of fiscal realities in Nova Scotia, Atlantic Canada and the rest of the country.[88]

[117] Minority Member John Plowman described past collective bargaining that produced provincial classification benchmarks and wage parity.

> Since 1997, there has been "wage parity" in the health care sector throughout the Province, that is, persons in the same classification receive the same rate of pay wherever they work in the health care system, whether the person is a nurse, a cook or a social worker. In many cases, this meant "levelling-up" to rates established for former civil service employees at the former VG Hospital.
>
> The concept of wage parity was developed with strong support from all the health care unions, including the NSGEU, and at a considerable cost to the Province. It was developed in acute care and then was extended to continuing care. From the Province's perspective, wage parity was recognition that in a small province like Nova Scotia, the existence of different wage rates for equivalent classifications created significant difficulties. Wage parity was intended to end the "catch-up" syndrome which was prevalent among different groups of employees and their bargaining agents and also reduced the movement of employees among health care employers based on a search for higher wages.
>
> In the 2000/01 round of bargaining, there was further integration of pay rates. In the bargaining at CDHA for the three non-nurse bargaining units, the parties negotiated terms under which a review of all positions in those bargaining units would take place. The CDHA made a specific monetary commitment in the amount of $3.5 million or approximately 2% of the total payroll for the three groups, to fund increases in the wage rates that would arise from the process. Non-nurse bargaining units outside of CDHA incorporated specific provisions tying each group into the results of the classification review process at CDHA. Positions in those organizations were to be matched to their counterparts at CDHA. A classification review process was subsequently initiated at CDHA and an agreement between CDHA and the NSGEU establishing a new pay plan for the health care, support and clerical bargaining units was reached in November 2003.
>
> In summary, the 1997/98 round of bargaining brought in the era of "wage parity" and this was further solidified in the 2000/01 round with implementation of parity maintenance agreements tying wages throughout the Province to the outcome of the classification review process at CDHA. Although a very costly exercise in the short-term, this was expected to enhance the overall labour relations stability by promoting consistency in the use of provincially recognized benchmarks.[89]

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[88] *Capital District Health Authority* [2004] N.S.L.L.A. No. 16 (Kaplan), ¶ 12 - 13
[89] *Capital District Health Authority* [2004] N.S.L.L.A. No. 16 (Kaplan), ¶ 48 - 51

[118] Member Plowman disagreed with the increase awarded by the majority.

> The Majority Award states that "these bargaining unit employees employed by the leading health care employer in Atlantic Canada could reasonably expect in free collective bargaining that their compensation should be located in the forefront of wages paid for equivalent work performed in Atlantic Canada and in the middle of the Canadian 'pack'." I firmly disagree. CDHA may be the leading health care institution in Atlantic Canada, but I do not believe that free collective bargaining would result in special treatment for the health care bargaining unit at CDHA as compared to other DHAs. It would certainly not result in all of the approximately 170 classifications in the bargaining unit being eligible for a catch-up based on the top wage rate in the Atlantic Provinces - whether the classification is for skilled or relatively unskilled work, whether the labour market for the classification is local or regional, whether there are any recruitment and retention issues.[90]

[119] He concluded the majority award destroyed wage parity across the province with special focus on Licensed Practical Nurses and undid what had been accomplished since 1997.

> The Majority Award destroys the principle of wage parity which has been established in the Province during the past two rounds of bargaining. At present, employees in the same classification receive the same pay rate everywhere within the Nova Scotia health care system, irrespective of region or entry point into the health care system (acute care or continuing care). As noted earlier, this was developed with the strong support of all the health care unions, including the NSGEU.
>
> With the CDHA health care bargaining unit now treated differently, labour relations in the health care sector will be reversing the direction in which it has moved since 1997.
>
> The immediate effect of the Majority Award is that it destroys wage parity for the LPN position, both within CDHA's own organization, as well as among other health care employers in the Province. The LPNs at CDHA in the NSGEU bargaining unit will now receive more than LPNs at CDHA in the NSNU bargaining unit and more than other LPNs in the Province. This is a significant break from the past in that LPNs within NSGEU and NSNU have received and maintained the same rates for the past three rounds of negotiations. The two unions, health care employers and the Government had recognized and addressed the need for LPNs within both unions to be paid the same. Notably, in the process for final offer selection in the last round of bargaining, there was agreement to treat the LPNs as a distinct group so as to ensure parity between LPNs represented by the NSNU and those represented by NSGEU.
>
> Wage parity for other classifications in health care bargaining units will also be destroyed unless the increases in the CDHA wage rates cascade throughout the other health care bargaining units - and both scenarios have very serious consequences.

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[90] *Capital Health District Authority* [2004] N.S.L.L.A. No. 16 (Kaplan), ¶ 77

> The parties have put major efforts into the classification review which covered not just the health care bargaining unit, but the support and clerical bargaining units. Superimposing the concept of "top in Atlantic Canada" on the present pay plan for the health care unit will have a significant impact on the relativities in the present pay plan.
>
> The submissions of both parties clearly show that they attach great importance to maintaining the integrity of the classification relativities which have been established through the classification review. Nevertheless, the Majority Award, based on the approach of "top in Atlantic" undermines that classification review and flies in the face of those submissions.[91]

[120] In 2005, Arbitrator Innis Christie established wage rates for Queen Elizabeth II Registered Nurses for the collective agreement from November 1, 2003 to October 31, 2006. The supply of Registered Nurses was a matter of concern to the employer and NSGEU. The focus of the wage increase was to ensure QE II Registered Nurses received the same wage increases as the NSNU Registered Nurses employed by the employer.[92]

[121] Wages for Registered Nurses and the term of the collective agreement were the issues submitted to arbitration in 2011 by the NSGEU and Capital Health District Authority. The genesis of the dispute was a provincial government request for wage restraint. The union and employer were apart 3% per year in wages and one year in the term of the agreement.

> Specifically, the provincial government called for restraint in the form of a maximum 1% across-the-board wage increase in each of the two years. This is the only significant health care sector unit whose wage adjustment in this round has not already been determined. All the other bargaining units in the health care sector have settled for 1% and 1% wage increases for the period November 1, 2009 to October 31, 2011 under contracts with either two or three-year terms ending on or about October 31, 2011. As the Employer emphasizes, the 1% and 1% annual increases were recommended by the various bargaining agents (CUPE, NSNU, CAW, IUOE, SEIU, CUPW, UFCW and this bargaining agent in respect of its other health care units) and accepted by the affected bargaining unit employees. Of particular importance are the settlements involving this Employer and the NSNU and this Employer and this Union (NSGEU) involving its health care unit. The NSNU collective agreement covering 541 RNs and 189 LPNs provided for 1% and 1% wage increases over the November 1, 2009 to October 31, 2011 term. The NSGEU health care unit collective agreement covering 3,896 employees, including a range of professional classifications, also

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[91] *Capital District Health Authority* [2004] N.S.L.L.A. No. 16 (Kaplan), ¶ 93 - 98
[92] *Capital District Health Authority*, unreported, September 27, 2005 (Christie)

> provided for 1% and 1% wage increases over the same November 1, 2009 to October 31, 2011 term.[93]

[122] Arbitrator Kevin Burkett described the composition of the employees covered by the dispute and the terms of the previously negotiated collective agreement.

> There are just over 2,500 nurses in the Union bargaining unit and about 90% of them work at the QEII. Bargaining unit nurses are assigned to all the specialized areas of the QEII with about 85% of the bargaining unit in the "staff nurse" classification. Eighty-three percent of the nurses in this bargaining unit are regular employees working on a full or part-time basis. The remainder are casual employees.[94]
>
> **********
>
> The 2006-2009 collective agreement, the predecessor to the instant collective agreement, was freely negotiated. The parties agreed to increases totalling just under 11% over three years with a 2.1% increase effective April 1, 2009, breaking a public sector pattern for the term. The parties also agreed to a new step on the grid for nurses with 25 years' service worth 3.5%. In addition, the parties agreed on a 2% bonus for nurses who remained at work even though eligible to retire on an unreduced pension. This settlement maintained these nurses as the highest paid in Atlantic Canada and restored them to middle of the Canadian pack (fifth).[95]

[123] A majority awarded 1% for each of the first two years, 1.6% for a third year term and:

> A grid adjustment effective November 1, 2011 as follows: The bottom step of each pay grid is to be removed and a new step inserted at the top of each pay grid with a differential of 3.5% between the top two steps of each pay grid exclusive of the 25 year rate. The 25 year rate is to be maintained at 3.5% above the top step of each pay grid. For purposes of clarity the differential between step 5 and step 6 of the adjusted grid for the staff nurse is to be 3.5% and the differential between step 6 and the 25 year rate is to be maintained at 3.5%.
>
> Each nurse is to be placed at the same step on the adjusted grid as she/he was on the prior grid.[96]

[124] Dissenting Member Brian Johnston would not have awarded a three year term or the 25 year service increase awarded by the majority.

[125] In 2012, the final settlement for the Health Care unit at Capital Health District Authority was resolved by interest arbitration following strike notice and a mediated impasse resolution agreement. Under the expired collective agreement, approximately

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[93] *Capital District Health Authority* [2011] N.S.L.L.A. No. 9 (Burkett), ¶ 9
[94] *Capital District Health Authority* [2011] N.S.L.L.A. No. 9 (Burkett), ¶ 3
[95] *Capital District Health Authority* [2011] N.S.L.L.A. No. 9 (Burkett), ¶ 10
[96] *Capital District Health Authority* [2011] N.S.L.L.A. No. 9 (Burkett), ¶ 18

30% of the employees would have continued to provide essential service throughout a strike. Other collective agreements were settled during the time in mediation and arbitration period.

> Eight sister District Health Authorities across the Province, which had been engaged in bargaining within the same time-frame as the parties here, reached a common settlement but with a different bargaining agent - the Canadian Union of Public Employees, which represents employees in health care bargaining units within those Districts engaged for the most part in identical or nearly identical job classifications as those here. By the terms of the common settlement, Renewal Collective Agreements covering 2,455 employees in seven healthcare bargaining units were penned, each for a three-year term commencing 01 November 2011 and terminating 31 October 2014, with wage increases totaling 7.5% :
>
> 2% effective 01 November 2011;
>
> 2.5% effective 01 November 2012; and
>
> 3.0% effective 01 November 2013.
>
> Identical wage terms covering 2,025 employees in five clerical and six service units in those District Health Authorities were reached with CUPE in that settlement.
>
> That cluster of settlements was reached in early May, prior to the date set by the parties for the filing of their written submissions, and so addressed by each of them in those submissions as well as orally at the 02-03 June hearing. In late May, the Canadian Auto Workers reached a common settlement on the same terms with three more Health Authorities: three renewal Collective Agreements, each of a three-year term covering *inter alia,* bargaining units of health care employees engaged in identical or nearly identical job classifications as those here, with wage increases identical to those in the CUPE settlement totaling *7.5%.*[97]

The annual increases awarded for a three year term were the same as the negotiated agreements – 2%, 2.5% and 3%.

[126] Against this background, NSGEU summarizes its leadership place and role in health care collective bargaining as follows:

> NSGEU is the largest Union in Atlantic Canada. More than 12,500 of our 30,000 members are affected by Bill 1. Two of our leading locals Local 97 and Local 42, work at the largest quaternary and tertiary care hospital east of Montreal.
>
> NSGEU Nurses at Capital Health (Local 97) and Health Care Workers (Local 42) have almost exclusively established wage patterns in Nova Scotia for the last fifteen years ….
>
> These two groups set wage patterns in this province because bargaining and arbitration history has established that they have a national wage standing, because they are historically willing to take job action to support that standing and because they have the consistent backing of the NSGEU to pursue

[97] *Capital District Health Authority*, unreported, June 15, 2012 (Kutter), ¶ 9 - 10

> appropriate wage settlements. The wage patterns set by Locals 97 and 42 are followed by employees in the remaining healthcare unions and in the broader public sector.[98]

[127] The Registered Nurses collective agreement between NSGEU and Capital District Health Authority expired October 31, 2012. Collective bargaining continued into 2014. In March 2014, the Registered Nurses were on the verge of strike and anticipating legislation. The *Essential Health and Community Services* Act[99] was introduced March 31st and passed April 4th ending a one-day April 3rd strike. A collective agreement was concluded in October after enactment of the *Health Authorities Act*.

3.8 Rivalry and Recent Instances of Union Collaboration

[128] Trade unions, like self-regulating health care professionals, can be fiercely autonomous and jealously protect their jurisdiction. They compete in achieving increased and new benefits for their members. They are proud of what they have achieved and quick to praise their choice in matter like job evaluation or service portability in crediting seniority as better than another union's choice.

[129] In acute health care, this is most prominent in the NSGEU and NSNU rivaling praise for the benefits achieved, approaches chosen and provisions incorporated in their collective agreements on behalf of Registered and Licensed Practical Nurses. Merging bargaining units will eventually result in one approach on the many issues covered by collective agreements prevailing.

[130] For example, the NSNU has pride in the provision allowing nurses to use seniority as a member union of the Canadian Federation of Nurses Union outside Nova Scotia to establish seniority in Nova Scotia under its collective agreement.

> In the event that an Employer hires a Nurse to a regular position to commence work within six (6) months of the Nurse leaving employment from a position in any other bargaining unit represented by a member of the Canadian Federation of Nurses Unions (CFNU), the Nurse shall be credited with equivalent Seniority as at the time of termination from the other bargaining unit.[100]

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[98] *Summary*, Tab 11 – NSGEU Documents, October 17, 2014
[99] S.N.S. 2014, c. 2
[100] Article 21.01 "Canadian Nurse Portability"

The NSGEU has not chosen to have any of its nurse members' seniority ranking lowered by a newly hired nurse from another province and, in this process, resists having its current members' seniority ranking in a province-wide unit changed by the NSNU approach when integrating seniority among nurses.

[131] It is axiomatic that collaborative health care is better care. Health care professional collaboration is legislated in Nova Scotia.[101] Many trade union leaders and activists know from experience that collaboration with employers advances common workplace and social interests. They also know union collaboration is necessary to address common issues.

[132] Standard bargaining units provided a basis for multi-employer negotiations resulting in common terms and conditions of employment across multiple bargaining units. At times, perhaps for perceived tactical or strategic advantage, unions and employers disagreed over the extent to which collaboration crossed employer and bargaining unit boundaries.[102]

[133] CUPE and Unifor have collaborated in workplace and community surveys to identify collective bargaining priorities. Locals of each of these national unions prepare, prioritize and ratify a set of common proposals to be advanced in a round of collective bargaining with district health authority employers at a common provincial table.

[134] With CUPE taking the lead, the health care unions identified the employers were not paying the full service costs to the employees' pension plan established in 1960. In effect, the employers were taking a contribution holiday. In 2006, the Labour Relations Board dismissed an employers' complaint the issue could not be the subject of collective bargaining.[103] Subsequently, there was a union public awareness campaign and strike threat before a multi-union and multi-employer settlement described as follows:

> By the end of a final negotiation session, attended by representatives of all of the unions, the Government and the Employers agreed to end their now-acknowledged contribution holiday, returned $10,611,000 to the NSAHO [Nova

[101] *Regulated Health Professions Network Act*, S.N.S. 2012, c. 48
[102] One instance was the subject of 2009 CUPE complaints. *South Shore District Health Authority*, LRB #6280, May 19, 2009 and *Annapolis Valley District Health Authority*, May 19, 2009, LRB #6287
[103] *South Shore District Health Authority*, September 6, 2006, LRB #6067

> Scotia Association of Health Organizations] Pension Plan for fiscal 2006 to 2007, and permanently increase Employer contributions by 1.4% and freeze any future use of Plan Surplus. The unions estimated that this change would "return" the amount of contribution holiday to the plan that had been taken within approximately 10 years. Secondarily, the Memorandum of Agreement that was signed committed the NSAHO to engage in a good faith negotiation to discuss a comprehensive change to the governance structure of the plan on the basis of equal Union and Employer representation. In the result, this discussion evolved into a lengthy but ultimately successful process that restructured the plan's governing board into a genuinely 50-50 joint decision making structure. This process was concluded on June 4, 2012, some six years after the beginning of the process.[104]

[135] In another collaborative union endeavour after the scope of practice for Licensed Practical Nurses was changed in 2006, unions representing Licensed Practical Nurses in both Nurses and Health Care bargaining units formed a joint committee with the employers to examine compensation for Licensed Practical Nurses. This issue was enduring from previous rounds of collective bargaining and interest arbitration. The 2008 – 2009 Joint Committee recommended an adjustment in addition to any other economic based increases and made recommendations “to advance the recognition of the knowledge, skills and duties” of Licensed Practical Nurses.[105]

[136] Last year, the unions collaborated in anticipation of district health authority consolidation.

4. UNIONS AND EMPLOYERS DISAGREE HOW TO RESTRUCTURE

[137] In early 2014, with the Minister on his Listening and Learning Tour across the province, it appeared inevitable that district health authority employers would be consolidated by the spring of 2015 under legislation to be introduced in the fall of 2014.

> Between January and May, the Minister and members of the Department of Health and Wellness visited every health authority in the province and the IWK Health Centre. This involved more than a dozen stops at hospitals and health centres across Nova Scotia.
>
> The Minister also discussed health issues with members of First Nation, African Nova Scotian and Acadian communities.[106]

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[104] Kevin Skerrett Affidavit, December 5, 2014, ¶ 22
[105] Maria Langille Affidavit, December 1, 2014, ¶ 22 - 28
[106] *District Health Authority Consolidation What We Heard Report - Listening & Learning Tour Frequently Asked Questions*, June 3, 2014, p. 2

[138] CUPE local unions 835, 1933, 2431, 2525 and 4150 began discussions to consider what district health authority consolidation and a province-wide bargaining unit meant for them. Their exclusive bargaining agency and collective agreements are:

- Local 835 Health Care and Support in South West Nova Health Authority
- Local 1933 Health Care and Support in South Shore District Health Authority
- Local 2431 Clerical collective agreement in Cape Breton Health Authority
- Local 2525 4 Clerical, 4 Health Care and 3 Service in Colchester East Hants, Cumberland, Pictou County and Guysborough Antigonish Strait Health Authorities.
- Local 4150 Health Care and Support Collective Agreement in Annapolis Valley District Health Authority

They began discussing consolidation into a new provincial acute care local based on a regional structure that would mirror what emerged as employer management zones.[107]

[139] In February 2014, the NSNU commissioned a survey telephone poll conducted between February 10th and 28th among its Registered and Licensed Practical Nurse members to determine their opinions on the importance of being represented by a u exclusively representing nurses. The results of this poll among its members were favourable for the NSNU. In contrast, the NSGEU prides itself in its diversity of membership in diverse workplaces and believes it derives strength to represent nurses and all its members from this diversity.

[140] On February 14, 2014, the Nova Scotia Federation of Labour on behalf of unions representing acute care employees wrote the Premier and Minister proposing union successorship representation of employees of the consolidated health authority be determined in accordance with the *Trade Union Act*, as in past restructuring, with an interim freeze on certification amending applications.

> We are writing to propose a straight forward approach to the labour relations aspects of your plan to create a single Provincial Health Authority to replace the present District Health Authorities. This approach will permit a smooth transition to a single health authority while minimizing disruption of the employment rights of front line employees who provide acute health care services to Nova Scotians.

[107] Wayne Thomas Affidavit, December 10, 2014

From previous discussions with the Minister of Health and Wellness we understand that your government will bring forward legislation in the fall which would create a Provincial Health Authority. Reorganizations in public services since 1994 have all included protections for employees to preserve their employment rights as they transition to a new organization. One of the clauses which is usually included in legislation reorganizing public services is a provision that the new entity is a successor employer to the present employers under Section 31 of the *Trade Union Act*. We expect that any legislation creating a Provincial Health Authority will include these standard provisions.

In order to avoid the disruption of employee rights in their workplaces because of creation of the Provincial Health Authority, we propose that the merger legislation also include a provision that neither the Authority nor any of the Unions representing its employees may apply to the Labour Board to modify the existing bargaining units without the consent of all parties.

This approach would facilitate the reorganization of the District Health Authorities, but avoids the reorganization of bargaining units and the disruption of the collective agreement rights of the employees delivering front line services. The Unions representing bargaining units would continue to represent their members in bargaining with the Provincial Health Authority.

Although there are presently 49 bargaining units of employees of the District Health Authorities, the Authorities and the Unions involved do not bargain 49 separate agreements.

The Canadian Union of Public Employees, the Nova Scotia Nurses Union and Unifor each bargain at a single provincial table for their members employed by the District Health Authorities other than Capital Health. NSGEU bargains at a single table for employees of the District Health Authorities engaged in public health, drug addiction and continuing care outside the Capital District. There are four bargaining units represented by the NSGEU at Capital Health. As a result, there are actually less than ten agreements covering employees of the nine District Health Authorities.

This approach to bargaining has consistently generated collective agreements for the employees who provide services in our hospitals. While it preserves the right to strike, strikes have been extremely rare and very brief. This approach to labour relations would provide the Provincial Health Authority with the ability to predict and plan for labour relations and collective bargaining based on the experience since the District Health Authorities were created. In contrast, a reorganization of labour relations has the likelihood of not only creating turmoil during the transition but a potential for eventual province wide strikes. You have championed the right to strike for health care employees in the past. We are asking you to maintain a system which preserves it.

As the heads of all the public sector health care unions in Nova Scotia, NSGEU, CUPE, NSNU and Unifor represent more than 20,000 health care members. Our members - nurses, health care workers, clerical and support staff - want to focus their efforts on delivering front line health care. They do not want to enter into a protracted battle over benefits and the provisions of collective agreements that they have negotiated over several decades.

We believe that our approach to the organization of labour relations in the new Provincial Health Authority will provide security to employees in the acute care sector and make the merger of the District Health Authorities smooth and

> successful at the front line of delivering care to Nova Scotians and we anxiously await your response to this positive approach.
>
> As reflected in our approach, we take this matter very seriously and in fact are scheduled to meet again on the 24th of February on this matter. A response to this approach for that meeting would be very positive and greatly appreciated.

[141] The unions representing acute health care employees had been through restructuring and devolution before. If employee choices in past votes are a predictor of the present, two likelihoods emerge. First, a majority of employees will select the NSGEU to represent them in a vote between it and other unions. Second, a majority of Licensed Practical Nurses will vote to be in a Health Care, not a Nurses, unit.

[142] However, in March 2014, there were reports the Minister preferred to have all nurses in one unit represented by one union. On April 29th, the Minister spoke at the NSNU annual general meeting. It was reported he mused the next day that he liked a model of nurses being represented by a nurse leader.[108] This would eliminate rivalry between the NSNU and NSGEU in representing, speaking and advocating on behalf of Registered Nurses.

[143] There is no report the Minister spoke about the unit placement of Licensed Practical Nurses or was contemplating including them in a Nurses unit. It was reported he preferred not having representation votes and fall legislation could determine the unions representing units of employees. He would meet with the unions.

4.1 Broad Union Perspective on Restructuring

[144] Previous restructuring had generated disputes before the Labour Relations Board, representation votes among employees, competition between unions for employee support and loss of bargaining rights to other unions.

[145] Was the process this time to be similar or a dedicated process specifically designed for the restructuring as had been adopted in some other provinces?

[146] Was it to be mediation similar to the process in Prince Edward Island that avoided votes among all employees except Licensed Practical Nurses represented by

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[108] Brian Flinn, *Leo Glavine Wants Single Nurses' Union*, Holly Fraughton Affidavit, November 28, 2014, Exhibit "A", Tab 1

several unions? Was it to be an appointed commissioner recommending or making regulations as in British Columbia and Saskatchewan?

[147] The choice has process, policy and legal implications. In 1994, British Columbia chose to appoint a Health Sector Labour Relations Commissioner under amendments to its *Health Authorities Act*[109] who made recommendations to the Lieutenant Governor in Council, which could make regulations. This approach was chosen when labour relations restructuring became bogged in multiple successorship proceedings before the Labour Relations Board. It side-stepped lengthy, complex and costly Board hearings and adjudication subject to judicial review.

[148] The Health Sector Labour Relations Commissioner appointed March 8, 1995 delivered recommendations in the form of regulations June 30, 1995 reducing the number of bargaining units from 888 to 10 with only a 5% change in union membership of the 96,700 employees represented by 19 unions and reducing the incidents of collective bargaining and the number of collective agreements from 200 to 5.[110]

[149] In Saskatchewan, the Health Labour Relations Reorganization Commissioner under *The Health Labour Relations Reorganization Act*[111] made regulations submitted to the Minister subject to approval, but not amendment, by the Lieutenant Governor in Council. The Commissioner appointed July 15, 1996 issued an interim reorganization proposal November 28, 1996 for consultation and delivered regulations January 15, 1997.[112] The regulations reduced the number of bargaining units from 538 to 45. The incidence of collective bargaining was reduced from 25 to 9 or 10 depending on the outcome of a representation vote in one unit. The bargaining agents for 43 units were determined. The Labour Relations Board supervised representation votes in the other two units.

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[109] S.B.C. 1993, c. 47

[110] James E. Dorsey, Health Sector Labour Relations Commissioner, *Reshaping B.C. Health Care Appropriate Bargaining Units*, June 30, 1995 (see also “B.C.'s Health Sector Collective Bargaining Restructuring: An Unfolding Story", address to Alberta Labour Relations Board Conference, Issues in the New Health Care Environment, Edmonton, Alberta, September 24, 1996 published in (1997), *5 Canadian Labour & Employment Law Journal* 85)

[111] S.S. 1996, c. H-0.03

[112] James E. Dorsey, Health Labour Relations Reorganization Commission, *Reorganization of Saskatchewan`s Health Labour Relations*, January 15, 1997 (see also *Health Labour Relations Reorganization (Commissioner) Regulations*, RRS c.H-0.03, Reg 1)

[150] Alberta gave regulation making authority to the Lieutenant Governor in Council through amendments to its *Labour Relations Code* that bypassed many processes. The Alberta Labour Relations Board describes the four bargaining unit configuration and composition for the provincial health authority as follows:

> The basis of these unit descriptions is job function. The Board's assignment of an employee to a bargaining unit depends upon the person's actual function, not upon occupational title. …
>
> Boundaries of the Unit
>
> The Regulation requires all units to be province-wide. …
>
> *Direct Nursing Care or Nursing Instruction*
>
> "All employees when employed in direct nursing care or nursing instruction."
>
> This unit includes all those employees for whom nursing training is a prerequisite. It applies to those employed in nursing care or instruction in nursing care. The unit could contain graduate and registered nurses, psychiatric nurses and nursing instructors when instructing.
>
> *Auxiliary Nursing Care*
>
> "All employees when employed in auxiliary nursing care."
>
> This unit includes all those employees providing nursing care but not to the level of registered or graduate nurses. Persons employed as licensed practical nurses, registered nursing assistants, nursing assistants, and nursing aides are within this unit. It also includes people working in such categories as nursing orderlies.
>
> *Paramedical Professional or Technical Services*
>
> "All employees when employed in a paramedical professional or technical capacity."
>
> This unit includes all employees providing professional paramedical services. Persons working as dietitians, pharmacists, social workers, physiotherapists, occupational therapists, laboratory scientists, and psychologists fall within this unit. This unit also includes all employees directly related to or engaged in providing qualified technical services. Persons working as combined laboratory and x-ray technologists, dietary technologists, cardiology technicians, ophthalmic technicians, and pharmacy technicians are within this unit. Administrative employees such as health information management professionals and medical photographers are also included. This unit also includes technologist categories. Some of these are medical radiation technologists, medical laboratory technologists, respiratory therapists and e.g. technologists.
>
> *General Support Services*
>
> "All employees when employed in general support services."
>
> This unit includes all employees whose prime function is general support activities. Persons employed in activities such as clerical, office administration,

> trades, food services, housekeeping, laundry and custodial services are in this unit.[113]

[151] In Quebec, there are four legislated units with occupations defined.[114]

1. Nursing and cardio-respiratory care personnel;
2. Paratechnical, auxiliary services and trades;
3. Office, administrative technician and professionals; and
4. Health and social services technicians and professionals

[152] In Nova Scotia, the unions representing employees of the nine district health authorities decided to get ahead of the government process choice of Labour Board, regulation, commissioner or any other, and explore options to support transition of representation and collective bargaining rights and collective agreements to a single consolidated provincial health authority employer.

[153] Apprehension, scepticism and, perhaps, attributing less than altruistic motivations are common union reactions to organizational change that portends diminished bargaining power. An accompanying loss of membership and representational rights strikes at the core of a union as a mutual support organization for employees with common interests and history.

[154] Trade unions are not simply service providers for a fee. They are communities of employees who focus on employment, health and safety, equality and other workplace issues and broader community and social interests. As CUPE submits, union membership helps protect against the "vulnerability of isolation" in ways beyond the economic sphere.[115] Employees active in unions contribute time and invest a part of their personal identity in their union activism.

[155] Unions provide members opportunities for education and self-improvement. Licensed Practical Nurse Dianne Frittenburg, CUPE Local 1933 President, describes her experience.

> My seniority date is 1985: 28 years.

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[113] Alberta Labour Relations Board, Information Bulletin #10, *Bargaining Units for Hospitals and Nursing Homes* – Effective: December 1, 2011 (see also *Regional Health Authority Collective Bargaining Regulation,* Alta Reg. 80/2003 as amended)
[114] *An Act respecting Bargaining Units in the Social Affairs Sector*, CQLR, c. U-0.1
[115] CUPE Submission, November 27, 2014, ¶ 6

I was hired as CUPE Local 1933 with regionalization in 1998 and went to Local 4150, then back to Local 1933 in 2003.

I am President of Local 1933. I have been President for six years. Prior to that I was Vice President for eight years. I have been Secretary Treasurer for CUPE NS for 9 years, on CUPE National Health Care Committee last 2 years, on CUPE National Women's Committee for 2 years, Human Rights Committee CUPE NS.

I've acted as Executive Liaison CUPE NS to the Human Rights Committee, the Women's Committee and the Global Justice Committee. Previously I was Secretary-Treasurer for Local 4150. …

I sit in NSCHC network, which is a Board that advocates for Public Health Care and a non-profit organization, a Multi board with community members from various sectors and non-union. …

****

I became more involved in CUPE because of the opportunities, stewarding, committee work, sitting on various working groups, and organizing social events.

It's our autonomous structure that I love: representing the members, giving back to the members.

Being a CUPE activist has given me the ability for personal growth: I attended Labour College in Port Elgin, Ontario.

I was selected to be part of a delegation to travel to Honduras to learn about women working in the Maquill and the health and safety issues they face. Few other unions offer this kind of opportunity. From what I've seen, CUPE works on women's equality and human rights more than other unions. We have an Equality Rep and an OHS Rep at the Atlantic Regional Office in Dartmouth.

I've sat on the CUPE national resolutions committee and the national constitutional amendments committee, where I've gained a detailed understanding of parliamentary procedure.

The greatest thing is the huge opportunity for educational growth that CUPE has for every member, locally, provincially, nationally, and even internationally. CUPE provides a wide variety of educational activities for all its members.

Because of our local autonomy and our union dues staying mostly with our Local, we've held community events like BBQs with entertainment at the shipyard's landing in Bridgewater -- a celebration of May Day. We give bursaries to members' children that are going to universities (6) in Liverpool, Bridgewater, and Lunenburg. We participate in Labour Day events and December 6th Memorial Services with the South Shore District Labour Council. We make donations to Harbor House Women's Shelter each year. This isn't just about money, it's about being a real part of our communities.

Regarding the Health Accord renewal campaigns, as a CUPE member I sit on the Nova Scotia Citizens' Healthcare Network. Their main objective is to raise awareness about the need for a renewed health accord. I believe that having LPNs in CUPE actually helps public health care.

I was one of the coordinators for this health accord campaign. Our local embraced it as concerned healthcare workers from the summer through the fall of 2014, holding community events, such as the Exhibition Parade in July for the South Shore, and in New Germany's parade Celebrating Canada Day. We handed out free hand sanitizers and info about the health accord. We raised public awareness about healthcare.

> This year we held a big town hall meeting in Bridgewater where close to 300 people attended. CUPE President Paul Moist and Maude Barlow spoke about the 902 million dollars lost out of healthcare in NS starting in 2017.
>
> This year our local held lunch and learns about health care, across the south shore to hospital and LTC [long term care] workers and interested community groups. And we campaigned door to door.[116]

[156] Residential Care Worker John Deveau, CUPE Local 385 President, describes his union's community work:

> My local 835 has been extremely busy forever. We had a very proud history: at our last CUPE National Convention in Quebec, our local won a national award for literacy. We financially assisted members wishing to advance their education. In 2014 we still have members who can't read or write. Our CUPE local paid the cost for their GED exams and books.
>
> Local 835 donates annually to two different adult learning centres, one in Yarmouth and one in Digby. The more literate our members are, the more empowered they are. The more empowered they are the more likely they are to participate in CUPE educationals, conferences and conventions, and in our communities. Our local's leadership takes pride in being part of that.
>
> Part of our history is Labour Day events with other unions. When four years ago I became a CUPE NS Vice President, we began celebrating Labour Day with a family picnic, bouncy castles, and BBQs in the centre of downtown Yarmouth.
>
> Our local donates annually to a Transition Home, Juniper House a place where women can go to get away from their abusing spouses in Yarmouth.
>
> The CUPE educationals, through Union Development, and the strong CUPE Equality Branch, helps CUPE members develop their sense of community. It also helps that CUPE has area offices, as in Yarmouth, and specialized staff in the regions, for instance, an Education Rep and an Equality Rep located in the Atlantic Regional Office in Dartmouth.
>
> In the Acute Care sector in Nova Scotia, with the coordination with Wayne Thomas and Communications Rep John McCracken, we organized the HAIS campaign that went from Yarmouth to Sydney. CUPE provincially came up with an idea for a hand sanitizer campaign and how to prevent Hospital Acquired Infections. It was a public health campaign really explaining the importance of proper hand-washing. We were educating the public about MRSA C-Dif, VRE. One of the faces of CUPE was an environmental service worker because they are *the* front-line, they are our defense. CUPE National funded this. CUPE understood the importance of educating the public and workers about the importance of HAIS prevention. I don't believe that other Unions match CUPE's commitment to this kind of public education.[117]

[157] Trade unions have different constitutions and bylaws, organizational structures, cultures and capacities. Some are more rooted in some communities, workplaces and occupations than others. Some are more socially and politically active than others.

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[116] Dianne Frittenburg Affidavit, November 28, 2014, ¶ 3 - 5; 8; 28 - 38
[117] John Deveau Affidavit, November 28, 2014, ¶ 12 - 17

Some are more collaborative, practical and pragmatic than others. Not unlike provincial tables in the Canadian federation, a union's membership size will direct its place, and perhaps its voice and vote, at local, provincial and national labour councils and federation of unions. And like some provinces, some unions have an influence above their size.

[158] Employees more active in a union's affairs are more aware of the differences between their union and others; are proud of their union; and can have a deep antipathy to being forced to leave their union for another. Staffing Clerk Tammy Provost, CUPE Local 2431 President, speaks of forced movement between union representation:

> I use a religious analogy to explain what the change could mean for me. All of my life I've been a Catholic; now I'm being told you must convert - I'm being told I have to be a Protestant. Bill 1 is taking away everything I've believed in my entire working life, and now I have to believe something else. Not to mention the complete upheaval. If I have to go to a union I don't want to belong to and vice versa, I won't be able to go quietly. I believe the negative consequences of the upheaval would be long-lasting, and are completely avoidable.[118]

[159] Another analogy, despite commonality of services, is some credit union members would deeply resent being forced to change to a chartered bank even if it is just across the street from the credit union location where they have been a member all their life. The resentment might run deeper if, over the years, they had contributed and devoted volunteer hours and effort to their credit union. Similarly, despite general commonality of political viewpoint and common opposition to other points of view, political party members might strongly oppose coalitions or mergers between their party and another with a similar, but not the same, viewpoint. They might oppose and resist being forced to join or support the other party. And they might view with suspicion and resentment constituency boundary changes that diminish their party's local chance of success and increase the chances of an opponent party.

[160] Membership is its main lifeblood and asset of unions. It is the pool from which leadership, staff and activists are drawn. Membership composition and complexion will shape and direct the priorities and culture of the organization. Membership size will determine organizational viability and the resources available for training, leadership

[118] Tammy Provost Affidavit, November 28, 2014, ¶ 10

development, research and social and political activism. This was expressed by Unifor as follows:

> Unity is the process of transforming individual aspirations into collective interests and action. It is based on equality. It is forged in diversity. It is strengthened by solidarity. As we overcome the divides of geography, the barriers of separate workplaces and occupations, and the differences of race and gender, age and background, we build a unified working class organization.
>
> An engaged membership is critical to Unifor's success. Engagement happens when ideas are welcome, involvement is encouraged and when the union actively develops the skills and understanding of its members. In our efforts to be inclusive, we open the union to new members and a broader definition of membership, and we ensure that our union reflects the diversity of our membership and communities.
>
> Unifor is more than an aggregate of individual members. The union is shaped by our relationships, by how we treat and care for each other. Our commitment to solidarity speaks to the significance of the language of "union sister" and "union brother". It is evident in the day-to-day bonds of fellowship and friendship, it is found in the expressions of respect and mutual support, and it is witnessed in the acts of cooperation and interdependence, and by our commitment to anti-harassment.
>
> Unifor is committed to good governance, fair representation and clear rules and practices. The principle of accountability will be apparent in all our decision making and actions. And the practice of transparency will be evident in our procedures. Our reporting, financial and otherwise, will be timely and reliable and our decision making will be clear and relevant.
>
> Unifor is fully committed to equity and inclusion. Women, Racialized and Aboriginal Workers, Lesbian, Gay, Bisexual and Transgendered Workers, Young Workers, Workers with Disabilities and other Equity seeking groups, will be represented in the structures of the union at all levels. In certain articles the constitution provides specific provisions which detail how women and equity groups participate in the leadership structures of the union. Elsewhere the commitment is expressed as a more general one. Where the commitment is a general one it requires those with the necessary authority and responsibility to address the issue. When By-Laws of all bodies in the unions are submitted to the National Executive Board for approval they will be viewed through this gender and equity lens.[119]

[161] Unifor expressed the role of local leadership in maintaining harmonious and stable labour relations and its view of the future effect of the approach being taken to acute health care labour relations restructuring.

> Stable and harmonious labour relations are based not only on trust between unions and employers, but also between the union and its membership. The development of this relationship of trust creates an environment in which resolutions can be found without unnecessary conflict.

[119] *Submissions of Unifor Locals 4600, 4603 and 4605*, December 8, 2014, ¶ 4

> The ability to lead and resolve issues in a manner satisfactory to union membership requires that the members accept the guidance of the leadership. This has nothing to do with majoritarian determinations of bargaining agency. It takes time, education, the development of a culture and the time-tested demonstration that the union's leaders have and will continue to act in the best interests of the membership. Without this, members will not follow the guidance of the union's leadership resulting in a greater number of arbitrations because settlements cannot be had, - leading to anything but harmonious and stable labour relations. As such, the manner in which the government has chosen to have a bargaining agent determined will inevitably result in increased conflict, instability and potential harm to the delivery of health care services.
>
> Adding to the difficulties engendered by a lack of trust given the new "labour landscape", the local leadership in most of the districts and at each facility will not know or be familiar with the people and culture of the union they will become a part of. They may not want to become part of the administration of the new union; certainly they will not hold any elected positions in their new union on April 1, 2015. The loss of those people at a crucial time will create the real difficulty in representing members during the transition period, whatever length it turns out to be. This is not like a single entity transfer of a single entity bargaining unit with a single collective agreement. This is a province wide, multi-location; simultaneous transfer of bargaining agents and collective agreements. There is no need for precedential case law, even if there were any, to demonstrate that the administration of the bargaining units could become unmanageable without the machinery to represent the members, who are entitled to fair representation by statute.[120]

[162] These characteristics of unions and other factors shaped the unions' proposal to the Minister and Premier on February 14, 2014. The Premier replied February 21st, in part, as follows:

> Planning for the reorganization is in the early stages at this time. You are aware the Minister of Health and Wellness is currently embarking on a tour of all districts including the IWK. The purpose of the tour is to engage stakeholders in a discussion of how to improve the health system. Union leaders at the local level have been invited to attend these sessions. As well, there is a commitment to meet with all of you, as the provincial union leaders, as part of the tour.
>
> Government has not made any decisions on the issues you have raised. It is currently assessing the many complex elements of the current health system. As we consider and reach conclusions on these and many other issues, your proposal will be considered."

[163] The Nova Scotia Federation of Labour responded April 9th with concerns.

> … the Minister has been quoted in several of the media and related comments that he intended to meet with the leadership within the next six months. Clearly given the importance and profile of this matter; these comments or overtures do not reflect a serious desire or intent to have open and constructive discussions with those who represent the thousands of workers in the Health Care system.

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[120] *Submissions of Unifor Locals 4600, 4603 and 4605*, December 8, 2014, ¶ 93 - 95

> We believe this meeting needs to be arranged sooner rather than later if we are to have or hope to instill confidence in the process.

4.2 Health Care Unions Propose Multi-union Bargaining Association

[164] The February proposal by the Nova Scotia Federation of Labour was not accepted. The Minister's subsequent musing created union concern future rights would not be determined in accordance with successorship principles or processes in the *Trade Union Act*. However, on May 1, 2014, the Minister of Labour and Advanced Education stated in the House of Assembly: "The government will respect the desires of the health care union members in which union they want to belong." The context was as follows:[121]

> **NURSES UNIONS: AMALGAMATION - LEGISLATION**
>
> HON. FRANK CORBETT: Mr. Speaker, my question is for the Minister of Labour and Advanced Education. Earlier this week the Minister of Health and Wellness told reporters that his preference is to have one union representing all nurses in this province. The Minister of Health and Wellness went a little further saying he would prefer health care workers not vote on which union should represent them - no he wouldn't want to have that democratic right. What he would prefer is that government introduce legislation this Fall to decide which union represents each health care worker. I will table that story.
>
> Mr. Speaker, through you to the Minister of Labour and Advanced Education, when does she plan to introduce such legislation dictating which union will represent which health care worker?
>
> HON. KELLY REGAN: Mr. Speaker, I thank the honourable member for the question, I think. Just to be clear, I have had no conversations with the Minister of Health and Wellness on this particular subject and I have no plans to introduce any such legislation. Thank you.
>
> **********
>
> MR. CORBETT: Mr. Speaker, they're not only rudderless on the Bluenose II but they're rudderless on the labour issues. The Minister of Health and Wellness has some odd ideas about labour relations. Taking away the right to choose which union represents you in the workplace is another one of these musings by the ne'er-do-well minister. What this does is it really destabilizes the workforce within the health care system.
>
> I want to ask the minister once again, through you Mr. Speaker. If the minister shares the views of the Minister of Health and Wellness and should they decide which union should represent which health care workers at the bargaining table, then when will these public consultations begin?
>
> MS. REGAN: Mr. Speaker, there are no consultations planned because there is no legislation of this kind planned either. Thank you.

[121] Nova Scotia House of Assembly, *Hansard Debates and Proceedings*, Assembly 62, Session 1, May 1, 2014, pp. 2639 - 2641

> MR. CORBETT: Well Mr. Speaker, we have a lone ranger apparently in that cabinet, who is making musings and he's making it up as he goes apparently.
>
> Now look, Mr. Speaker, these are not things that this caucus is saying. We've tabled the musings, if you will, of the minister and it's not like someone on the backbench had said this. This is someone that's a member of the Executive Council. That should carry a fair amount of weight, even with that government.
>
> Mr. Speaker, the last time the Liberals amalgamated district health authorities there were runoff elections, health care sector unions were left in flux, labour (interruption) was broken up . . .
>
> MR. CORBETT: … Mr. Speaker, I'm going to ask just a very simple question. Why would the Minister of Health and Wellness say this if he wasn't contemplating it? And why would this government then not respect the rights of health care workers to choose which union they want to belong to?
>
> MS. REGAN: This government will respect the desires of the health care union members in which union they want to belong, thank you.

[165] The unions met May 29th and agreed they should continue to represent their current members in collective bargaining with the new employer. At the same time, because public statements suggested the government wanted reconfigured province-wide bargaining units they rejected the prospect of competing in representation votes for employee support beyond their members.

[166] While the unions had worked collaboratively for common cause, there was some residual sentiments from past representation votes. Because the district health authority employers had pursued a provincial collective bargaining agenda since 1998, the unions knew the struggle they had cooperating to avoid one agreeing to an employer proposal that others would not. The unions had leapfrogged one another to achieve economic benefits and wage gains ahead of inflation. A single collective bargaining table for each unit diminished that tactic for the future. Recent essential services legislation weakened a future strike threat in collective bargaining.

[167] The unions decided the goal of maintaining representation of existing members in province-wide units required they agree on a structure for joint union bargaining. Construction industry provisions in the *Trade Union Act* provide for representation and bargaining by a council of trade unions. Could there be a council of health care unions?

[168] An alternative to councils of trade unions was health care union bargaining associations created in British Columbia as a solution to similar circumstances. A lead union in each association conducts collective bargaining for province-wide collective

agreements. The associations have proportional representation on the negotiating committee. Ratification and strike votes are province-wide.

[169] Whatever the approach, there were challenges and risks: accepting loss of autonomy; overcoming cultural differences, rivalries and personality conflicts; and foregoing opportunities to grow at another's loss by going it alone. There were risks to not collaborating: potential loss of members; costs to fight to keep or gain members; splits in labour unity that would last into the future; and weakened survivors having to deal with weakened strike threat bargaining with a strengthened employer.

[170] In June, the Minister reported during his tour: "A strong desire to avoid run-off votes and the resulting impact on the workplace was consistently shared."[122]

[171] The union leadership met in June and July and agreed to a framework for a bargaining association structure fashioned on the British Columbia approach.

[172] They knew the government had a preference to eliminate the fifth unit. They agreed there would be four, not five, bargaining units with one association and one collective agreement for each unit. The four units were: (1) Registered Nurses and Nurse Practitioners; (2) Health Care; (3) Administrative Support; and (4) Service Support. Employees in the Public Health and Addiction Services units would be integrated into these four units. This could be a loss for the NSGEU.

[173] They recognized there would be consistency in unit composition at both the consolidated provincial health authority and IWK Health Centre. To create classification consistency and to avoid representation votes, they agreed:

> Because the make-up of the present Nursing, Health Care, Administrative Support and Service Support bargaining units is not consistent in all District Health Authorities and the IWK Health Centre, there are employees in some classifications that are included in different standard bargaining units depending on the location; these employees should be included in the provincial bargaining unit that corresponds to the present standard unit in which a majority of those employees are included province-wide;
>
> Where there are inconsistencies between the scope of the present bargaining units, the inclusion of any particular classification in a provincial bargaining unit should not depend on a vote of the employees or other preferences; rather,

[122] *Health Care Conversations 2014 – What We Heard*, p. 12

> inclusion should depend on the type of standard bargaining unit in which the majority of employees in that classification in the province are included;[123]

[174] This was consistent with labour relations board practice that newly organized or currently represented numerical minorities of employees can be added to or reassigned to a bargaining unit without giving those employees a choice by representation vote. The current majority placement, not some other criteria or preference, would be the determining factor for classifications in two or more units.

[175] This meant Licensed Practical Nurses, currently evenly distributed for representation among the four unions, would be in the Health Care unit. There would be no vote or "other preferences" directing them to be in another standard unit or a separate auxiliary nursing unit as in Alberta. As identified in the table below, only 26.8% of the Licensed Practical Nurses employed by the nine district health employers are in the Nurses unit and represented by the NSNU.

[176] While the leadership understood the government's preference was to have Licensed Practical Nurses and Registered Nurses at the same bargaining table, in subsequent discussion they learned this preference could be overcome and the Licensed Practical Nurses could remain in the Health Care unit if other matters were satisfactorily resolved.[124] They also learned the government wanted to reduce the diversity of classifications in the Health Care unit, which they did not address.

[177] They proposed multi-employer bargaining by the consolidated provincial health authority and IWK Health Centre, which would reduce the incidence of collective bargaining to four sets of provincial negotiations.

[178] The overarching Framework Agreement the unions made includes the following principles.

> 1. We believe that our members employed by the District Health Authorities will be best served by each Union continuing to represent its own members in dealings with the Provincial Health Authority;
>
> 2. We are not interested in a contest for membership between the Unions and do not seek to take over the members of other Unions;

---

[123] Framework Agreement, August 5, 2014, ¶ 7 - 8

[124] Email exchange July 15, 2015 between Raymond Larkin, Q.C. and Executive Director Public Sector Labour Relations Roland B. King

> 3. We accept that the merger of the District Health Authorities will result in provincial bargaining units;
>
> 4. We support a new model of collective bargaining in which the Provincial Health Authority and the IWK Health Centre (together "the Employers") bargain with an association of bargaining agents in each of four provincial bargaining units;
>
> 5. The features of the new model of collective bargaining include:
>
> a. The Unions which have been certified or recognized to represent employees of the District Health Authorities or the IWK Health Centre will continue to be the certified bargaining agents for those employees;
>
> b. Collective bargaining in each of the four provincial bargaining units will be conducted between the Employers and a Bargaining Association formed by the Unions representing the employees included the provincial bargaining units;
>
> c. The Unions certified or recognized to represent employees who are included in a provincial bargaining unit will continue to perform all of the usual functions of a certified bargaining agent under the *Trade Union Act* except collective bargaining;
>
> d. Collective bargaining on behalf of employees in each of the four provincial bargaining units will be conducted exclusively by the Bargaining Association of the Unions representing employees in that provincial bargaining unit;[125]

[179] The agreement contained provisions on bargaining units, four bargaining associations, collective bargaining, bargaining principles and administration of collective agreements.

[180] The approach separated collective agreement negotiation from local collective agreement administration and enforcement through grievance and arbitration. There would be transition issues to be resolved.

[125] Framework Agreement signed August 5, 2014

Table 3: DHA Units – Approximate Number of LPNs – November 25, 2014

Employer	SSDHA	SWNDHA	AVDHA	CEHDHA	CHA	PCHA	GASHA	CBDHA	CDHA	Total by Union	Total by Group
Nurses				91 NSNU	91 NSNU	108 NSNU	96 NSNU		186 NSNU	572 NSNU	572
Health Care	151 CUPE	163 CUPE	162 CUPE					471 Unifor	523 NSGEU	523 NSGEU 476 CUPE 471 Unifor	1,470
Public Health / Addiction Services	5 NSGEU	13 NSGEU	5 NSGEU	2 NSGEU		1 NSGEU	26 NSGEU	39 NSGEU		91 NSGEU	91
Total	150	176	167	93	92	109	123	505	709	2,133	

NSGEU 614 28.8%	NSNU 572 26.8%	CUPE 476 22.3%	Unifor 471 22.1%

4.3 Employers Reject Unions' Proposal as Fundamentally Flawed

[181] On August 5th, the unions and Nova Scotia Federation of Labour (NSFL) met with Patrick Lee, Pictou County Health Authority Chief Executive Officer who had been appointed in April to lead the Transition and Design Team reporting to the Deputy Minister; Bob Dunn, Director of Labour Relations and Compensation Analysis, Health Association Nova Scotia; and Rolland B. King, Executive Director, Public Sector Labour Relations, who had facilitated the meeting and continued after the meeting to facilitate discussions.

[182] On August 22nd, the employers responded to the unions' proposal. At that time, the IWK Health Centre had a board of directors and Chief Executive Officer and the nine district health authorities had a single administrator. The response in an unsigned and unattributed document - "Employer Comments: August 20, 2014" - said the unions' proposal was "flawed in five fundamental ways." The reply states, in part:

> It is important at the outset to emphasize, as we did in our meeting of August 5, that our role in these discussions is not to make a decision about the proposed structure being put forward by the unions. Ultimately, this will be a decision for government to make; however, government will likely seek the input of the employers regarding the unions' proposals. Therefore, it is in the spirit of transparency that we will provide you with the input we would also provide government, if it is to ask for our opinion on the Framework Agreement of August 5. ….
>
> By concentrating on creating a proposed structure in which each union would continue to represent its current constituency, the unions may have failed to consider potential solutions to the current health sector bargaining structure.
>
> From the employers' perspective, the proposal is flawed in five fundamental ways:
>
> 1. **The question of the appropriate bargaining unit for LPNs.** From our perspective, the question is with which bargaining unit the LPNs have the greatest community of interest. We see the greatest community of interest lying with the RNs in the Nursing unit. Best practice would suggest that the LPNs should be placed in the appropriate bargaining unit, rather than simply placing them in the unit which currently contains the greatest proportion of LPNs (Framework Agreement, paras. 7 and 8).
> 2. **Bargaining unit composition generally.** Although the LPNs are the most obvious problem regarding the composition of the four health sector bargaining units, we generally disagree with the process proposed in paras. 7 and 8 of placing classifications in bargaining units based on current majority placement. We feel that the bargaining units should be defined and composed of classifications based on their community of interest, not on accidents of history (which would simply enshrine existing problems).

3. **Enshrining current collective agreements.** Paragraphs 24, 32 and 41 all suggest that the unions' collective goal is to enshrine the current differences between their collective agreements with the new provincial employer. Therefore, while there would only be one collective agreement, it would comprise substantially different terms relating to different employees based on prior collective agreements. In other words, while there may only be one cover, it would, for all intents and purposes, remain multiple collective agreements. Moreover, there are fundamentally different ways of dealing with issues in the collective agreements that would become nonsensical in one collective agreement (e.g., security against lay-offs vs no contracting out that would lead to lay-offs, education premiums vs. special unit premiums, STI vs. accrued sick leave, the Long Assignment/Short Assignment, etc.).
4. **Dysfunctional bargaining.** Paragraphs 24 and 32 also signal that the bargaining process itself would become dysfunctional. Each union may see its own approach to hot button topics as correct, and the other unions' approaches as concessionary. These provisions would require the employer to engage, by default, in multi-party bargaining (albeit, at one table). Although para. 31 of the Framework Agreement provides that majority rule will prevail for the bargaining association, there is no way to trigger a vote or require the association to take a "majority position." Moreover, in the Service bargaining unit, the three unions currently have close to an equal three way representation of members. The potential for deadlock is even greater in that unit. Finally, while para. 33 requires members of the bargaining committee to support and not undermine decisions made in bargaining, there is nothing to hold union leadership accountable.
5. **Mobility issues.** Paras. 37 through 42 address some issues arising from mobility of work in a new, single employer. The document does not address the temporary, short-term, even day to day movement of employees between facilities. Para. 41, however, suggests a strong impediment to mobility.

[183] On August 22nd, NSFL Counsel wrote the Minister of Health and Wellness, in part:

> The development of the bargaining association model has provided a unique opportunity to bring the IWK into the province-wide system of collective bargaining.
>
> In order to implement this new model, legislation would be required. The *Trade Union Act* does not provide for multi-employer bargaining units or bargaining associations of Unions. Further consultation and discussion is required to discuss the legislative framework in Nova Scotia for this bargaining association model.

[184] On placement of Licensed Practical Nurses and inconsistency in bargaining unit composition as a result of accidents of history, he wrote: “the Unions recognize the harmonization of bargaining units is a necessary part of the creation of a province-wide bargaining structure. We are prepared to engage in further discussions about how this can be achieved.”

[185] On continuing existing collective agreements: “There is nothing in the Framework Agreement that suggests the Unions plan to bargain multiple collective agreements under a single cover. The Employers will presumably have their own objectives which they will seek to advance in collective bargaining.”

[186] On collective bargaining and province-wide employee mobility:

> In item number four, the Employers argue that the bargaining process under the bargaining association model could become dysfunctional. Dysfunctional bargaining can happen, regardless of the structure of the bargaining parties. The Framework Agreement contains a number of provisions that are designed to insure that collective bargaining with the bargaining association will work. Decisions by the negotiating committees are majority decisions. All members of the committees are bound to those decisions. Communication strategies are controlled by the negotiation committees.
>
> The suggestion that there is no way in the agreement to "trigger a vote or require the association to take a majority position" ignores the plain language of the agreement, particularly paragraphs 25 through 33.
>
> All bargaining agents must contend with tensions arising from competing interests among their members. The clear, transparent structure of the bargaining association will make it less likely that those tensions will impede the collective bargaining process. Maintaining current relationships between members and their Union will promote stability.
>
> In item number five, the Employers ignore one of the fundamental aspects of the Framework Agreement. The Unions are committed to full, province-wide mobility within the merged bargaining units. They are saying that union membership will not be a barrier to that mobility, whether the movement is temporary or permanent. This is expressed in clear, unambiguous terms in the Framework Agreement. How mobility is achieved throughout the geographic scope of the province-wide bargaining units will be a matter for collective bargaining, as it will be regardless of the structure of the bargaining association.

[187] The letter concludes:

> The Unions believe that their proposal is responsive to the objectives of Government. It is a plan that has been developed by the leadership of the health care unions and their senior staff. They are all invested in making the Health Association model work. It is their sincere hope that the Government will work cooperatively to develop a labour relations system for the new Health Authority.
>
> In achieving the Framework Agreement, the unions have been able to overcome some old rivalries and abandon positions based on past conflicts. We trust that in time, the Employers and their representatives will be able to do the same thing.
>
> If you are receptive to the proposed bargaining association model, the Unions and your officials can move forward and make necessary refinements. We look forward to receiving your response.

[188] NSFL Counsel was told on August 25th there would be legislation in the fall to consolidate and create the provincial health authority, but not necessarily legislation on labour relations restructuring. Discussions should continue. The Minister wrote, in part, on August 28th:

> I have instructed the employer representatives to schedule further meetings in order to engage in further discussions to determine whether a model that addresses the needs of all stakeholders can be supported. Recognizing that there is little time remaining I have asked the committee to conclude these continued discussions within two weeks.

Two weeks was September 11th.

[189] The union leadership met on September 4th and 9th. On September 10th the unions released their proposal in an update to members, which included:

> We've met with government and employers. We've addressed their key questions (see the attached Executive Summary on coloured paper for these details). The Minister will be briefed this week and Cabinet will review the proposal soon. We are waiting for their response. It's now up to them whether they accept, amend, or reject our proposal. The House of Assembly (Legislature) opens on September 25th, which means legislation regarding the healthcare restructuring and labour representation could be introduced any time after that date.

[190] There was no proposal from the employers or government. On September 11th, the unions were informed the government had not made a decision on their proposal. The press reported a decision would not be made until the Premier returned from an international trade mission.[126]

5. GOVERNMENT LEGISLATES NEW LABOUR RELATIONS STRUCTURE

[191] On September 18th, the Minister wrote the unions, in part:

> We appreciate the work and effort that you have devoted to resolving the structural and representation issues. Your efforts have demonstrated a desire to work *cooperatively.* However, we believe that it has not adequately addressed valid and significant concerns articulated by the employer representatives, nor has it resolved all of the issues of interest for this government. It has always been the desire of government to have a more streamlined and efficient health labour structure that supports the transformative changes required to improve health services for Nova Scotians.
>
> In your letter of August 22, 2014 you correctly pointed out that legislation will be required to address the labour structure. It is my intention to introduce legislation dealing with the labour structure during the fall session of the House of

[126] Michael Gorman, The Chronicle Herald, September 11, 2014, *Nova Scotia healthcare unions call for province-wide contracts*

> Assembly. The efforts and genuine dialogue of the parties is acknowledged with thanks. In recognition of these efforts, the legislation will include an option for mediation with a neutral third party, in another effort to allow the parties to reach a negotiated solution to the challenges of the current system in a more structured way.

[192] Concrete characteristics of intended transformative changes rather than organizational changes, if any have been approved by government, had not been articulated. What was clear was that nine would become one and no longer would there be nine "different interpretations of programs, policies and services"[127] and there would be more efficient and effective use of assets and resources.

[193] Will the nature, specifics and timing of the transformative changes be decided by the Minister or the leadership of the new provincial health authority? Is the new structure to be built on a concrete plan or higher level vision?

[194] What was to be mediated was not stated. Would there be a role for the Labour Board (formerly the Labour Relations Board)? Could the government negotiators be persuaded during mediation to agree to some form of multi-union structure? Would the government insist on Licensed Practical Nurses being in the same bargaining unit as Registered Nurses? What else was to be legislated, perhaps multi-employer bargaining?

5.1 Seizing the Opportunity to Streamline the Labour Relations Structure

[195] As discussions proceeded over the summer, there was a shift in focus in communications from the Department of Health and Wellness away from celebrating the value of staff and their contributions towards the opportunity consolidation provided to streamline the acute care labour relations landscape.

[196] The issues of the same classification of employees in multiple bargaining units, multiple union representation of the same classification of employees and multiple rounds of collective bargaining were identified September 25th in the third issue of *Transition News*:

> With consolidation comes an opportunity to improve the labour relations structure and representation for unionized employees. The opportunity is to have more timely settlements and more efficient collective bargaining if we reduce the number of bargaining processes and the number of collective agreements. This

[127] *Health Care Conversations: What We Heard*, Nova Scotia, June 2014, p. 2

> will also benefit employees through fair and consistent practices across bargaining units.
>
> Government and employer representatives have met with the unions representing health care providers. There were discussions around options for a new labour relations structure. However after a review, the government and employers feel a union proposal for a joint union bargaining association does not address all the concerns of government. This fall, government will introduce legislation to deal with the labour structure. That legislation will include mediation with a neutral third party, so employers and government can continue to work with unions to address these challenges. More information will be shared as this evolves.[128]

Who would represent government in the mediation?

[197] The same day, the Throne Speech announced the government's future approach to collective bargaining: "…this government will take a more deliberate and careful approach to labour relations in Nova Scotia. There will be no improvised and ad hoc decisions that ultimately cost taxpayers hundreds of millions of dollars."[129]

[198] On acute care restructuring, the Throne Speech was harshly critical of the management of the nine district health authorities and their failure to collaborate.

> Consider the reality of Nova Scotia's health delivery system: nine health authorities with nine different business plans, nine different visions and missions, nine strategies — all competing for equipment, staff, and doctors.
>
> That is the past.
>
> On April 1, 2015, Nova Scotia will launch a new structure to create the foundation for a health system that thinks and acts as one. Nine current district health authorities will be consolidated into one provincial authority, partnering with the IWK Health Centre — acting and caring as one for Nova Scotians.[130]

The legislative agenda included the *Health Authorities Act*. No second health care labour relations statute was identified.

[199] Department of Health and Wellness comments posted on its website on September 29th said the unions' proposed bargaining association model did not go far enough and restated the fundamental flaws as challenges:

> Health care unions proposed a "bargaining association" model, which would see all four health care unions bargain together at the same table.

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[128] *Transition News*, Issue #3, September 25, 2014, p. 4
[129] Nova Scotia House of Assembly, *Hansard Debates and Proceedings*, Assembly 62, Session 2, September 25, 2014, p. 3
[130] Nova Scotia House of Assembly, *Hansard Debates and Proceedings*, Assembly 62, Session 2, September 25, 2014, p. 11

> Government seriously considered this model, but it didn't go far enough in establishing a fair and practical labour relations structure for the health system moving forward.
>
> **Challenges with the bargaining association model**
>
> Health care workers who do the same job could still be represented by different unions.
>
> Different rules around scheduling and overtime could apply to the same employees, working side-by-side.
>
> If unions do not agree among themselves, there is no way to guarantee they will make a decision. This could result in longer rounds of bargaining.
>
> Each union would keep its original members, which would be confusing as people change jobs in the provincial system.
>
> Unclear whether staff could fill in when they are needed at another facility on short notice.[131]

[200] The next day, September 30th, the press reported:

> Health and Wellness Minister Leo Glavine has mused that a compromise could be unions keeping their members with only one union going to the bargaining table.
>
> Although that possibility isn't in the bill, Glavine said Wednesday all options would be on the table. "I believe there's some interpretation within the bill (for) the mediator. We have said all options are available for the mediator to consider, and we will respect the decisions of the mediator."[132]

[201] This appeared to be a retrenchment by government opening the possibility a bargaining association approach could be accepted in mediation. The Minister wrote the unions on September 30th:

> I am writing in response to your letter of today regarding Bill 1. This letter will serve to clarify my comments on the legislation that was introduced last night.
>
> As you are aware, I met with the unions in December and again in June. Departmental staff met with the unions throughout the summer. I have previously outlined our reservations in regard to the Bargaining Association, and those reservations are as relevant today as when I first expressed them.
>
> That said, we have introduced the bill now, and it lays out a process for mediation in another effort to find a negotiated resolution to the structural issues that currently exist. All parties are free to bring forward proposals for discussion and consideration in mediation. I remain hopeful that the mediator will be successful in helping the parties to find creative solutions.
>
> As Minister, I will not be a party at that table. It's not my suggestions that are important. The ones that matter are the unions' and the employers'.
>
> I will not be in a position to meet with you to discuss further at this time.

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[131] *Fact Sheet Health Labour Landscape in Nova Scotia*, September 29, 2014, http://novascotia.ca/dhw/PeopleCentredHealthCare/health-authorities-act.asp

[132] Michael Gorman, *The Chronicle Herald*, *Glavine skips debate, won't meet with unions on merger bill*, September 30, 2014

[202] The mediation would be between the unions and the current employers, all of whom except IWK Health Centre would be disbanded and not have to live with whatever was agreed.

[203] In the House of Assembly, the Premier spoke about the legislation:

> The arbitrator will determine who is in the four categories, which the union leaders agreed upon. Anything else will happen at the bargaining table. No health care worker in this province is losing anything associated with this piece of legislation.[133]

[204] Within a week, the *Health Authorities Act* passed from First Reading September 29th to Royal Assent October 3rd. A proposal at the Law Amendment Committee to amend the bill as follows was defeated:

> The unions that represent the unionized employees in a bargaining unit constitute a bargaining association that shall act as the bargaining agent for that bargaining unit and is deemed, for the purpose of collective bargaining, to be the certified bargaining agent for that bargaining unit.[134]

[205] Within a second week, the unions and employers informed the Minister on October 9th they had agreed to have me appointed Mediator-Arbitrator. The Minister appointed me October 9th.

[206] The streamlined collective bargaining process was explained October 20th by the Department of Health and Wellness:

> The government's passing of the new *Health Authorities Act* enables the provincial district consolidation. In addition to elements of governance, structure and regulations for the health authorities and clarity around the role of Community Health Boards; the bill also allows for the creation of a revised labour relations model for both the provincial health authority and the IWK. There is a mechanism to identify which employee classifications should be in each bargaining unit and a mediation/arbitration process to help guide the discussion and decisions around union representation.
>
> **Key labour relations elements in the new legislation:**
>
> Defines four types of bargaining units for employee classifications: nursing, health care, clerical, support services.
>
> - Existing unions to remain.
> - Legislation contains mediation/arbitration process. Mediation will attempt to find a negotiated solution to current structural issues, including union representation.

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[133] Nova Scotia House of Assembly, *Hansard Debates and Proceedings*, Assembly 62, Session 2, September 30, 2014, p. 105

[134] Unifor Book of Documents, Volume IV, Tab 67

- Arbitrator will make decisions on matters that are not resolved by mediation.
- Wages, benefits and pensions will not change as a result of the new Act. These are already standard across the health care system.
- Retirement allowances will not change as a result of the new Act.
- Service is protected.
- Freeze on strikes, lockouts and collective bargaining until April 1, 2015, when new authority is in place.

Currently there are about 21,000 unionized health care providers represented by four health care unions (CUPE, NSGEU, NSNU, Unifor) across the nine district health authorities and the IWK, with 50 separate bargaining units. There is inconsistency among terms and conditions of employment for people who do the same types of jobs. Equally challenging is the fact that four different unions may represent people in the same classification doing the same type of work. This means that a nurse at the Dartmouth General can't walk across the street to cover a shift at the Nova Scotia Hospital because their nurses are represented by a different union.

The legislation is designed to change a structure that is fragmented and complex. It has often taken many months and sometimes years after a contract has expired to reach negotiated settlements. There is a need to have: more efficient collective bargaining, more timely settlements and one shared set of rules/contracts that apply to all unionized health care employees. Employees will benefit through fair and consistent practices across the province, including the ability to apply for and move more easily to jobs within the new structure.

Our acute health sector needs to be less complicated and as efficient and responsive as possible. That includes a more practical labour relations model with streamlined union representation. It doesn't make sense to be signing contracts many months or even years after the original contracts have expired. This does not make sense and is not fair to employees or to the public who depend on health programs and services.[135]

5.2 Process Choice Implications for Labour Relations Restructuring

[207] Mediation-arbitration is common when resolving disputes over the terms of a new or renewed collective agreement. It is becoming more common in resolving rights disputes under a collective agreement either at the initiative of the parties or the grievance arbitrator.

[208] Mediation involves private communication between the arbitrator and each party. Although this is inconsistent with traditional legal standards for a fair hearing, it does not disqualify the arbitrator from adjudicating the dispute if a settlement is not achieved. As the *Canada Labour Code* states for the federal jurisdiction, mediation is "without

[135] *Transition News*, Issue #4, October 20, 2014, pp. 4-5

prejudice to the power of the arbitrator or arbitration board to continue the arbitration with respect to the issues that have not been resolved."[136]

[209] The *Health Authorities Act* choice of mediated negotiations followed by arbitration, if necessary, does not include at the table the most critical decision-maker, the government. The mediation challenges were obvious.

[210] The process concludes with adjudication orders, not recommendations. Arbitration orders are registered in the Nova Scotia Supreme Court "enforceable in the same manner as a judgment of that Court."[137]

[211] This process choice has a risk the Court will be guarded about embracing and enforcing orders as its own if the Court concludes the Mediator-Arbitrator failed in some manner to respect all parties' right to a fair hearing. A final order might be subject to judicial scrutiny for error in interpreting legislation, including challenges the Mediator-Arbitrator did not interpret, apply and administer statutory authority in a manner consistent with the *Canadian Charter of Rights and Freedoms*.

[212] To guard against judicial review risks for failure to provide a fair hearing to all or interpretation errors under this statutory scheme, mediation-arbitration required more time, process, attention and resources devoted to legal concerns and issues than other process choices would.

[213] A commissioner process is not entirely directed or dependant on the unions and employer or confined to their sources of information. A commission team can initiate research, challenge commissioner's ideas and have access to government background policy discussion papers and their authors. Because it is not an adjudicative process, the written report and recommendations does not have to adhere to the standard or structure courts expect from tribunal decision-makers or demonstrate all parties' submissions have been heard and considered. Draft reports or preliminary ideas can be circulated for comment and consultation. Recommended solutions are not limited by the constraints of precedents and legislative language. They are reviewed and

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[136] s. 60(1.2). See also Michel Picher, "The Arbitrator as Grievance Mediator: A Growing Trend" in Allen Ponak, Jeffrey Sack and Brian Burkett eds. *Labour Arbitration Yearbook Second Series 2012-2013*, p. 9

[137] s. 95(2)

evaluated in a labour relations and political context, not by the courts. Litigation over *Canadian Charter of Rights and Freedoms* questions arise after not within the process.

[214] In contrast, the mediation-arbitration process under the *Health Authorities Act* is designed to be responsive to the unions and employers with no direct role for the government, which pays fees and expenses of the Mediator-Arbitrator.[138] The parameters of mediated negotiations and arbitration are constrained by negotiating limitations the unions and employers cannot ignore or place on themselves or one another in light of their anticipated outcomes at arbitration. The only forum for the Mediator-Arbitrator to explore ideas for resolution of issues not resolved in mediation is during the adversarial arbitration hearing.

[215] It is wishful to contemplate and, perhaps, fanciful to expect unions, under threat with the most at stake, will join with employers, destined to vanish and perhaps with little to lose, to find and agree to long term creative solutions in 45 days that will apply to an employer not yet in existence to be managed by a senior executive not yet in place that will oversee a service delivery system not yet designed in accordance with a business plan not yet fashioned.[139]

[216] Labour relations board restructuring of bargaining unit composition and bargaining agent representation usually follows corporate restructuring. If it precedes the corporate restructuring there is a great risk the employer's restructuring plans will change. It is a classic horses and carts situation. In some situations, boards will act on an anticipatory restructuring.

[217] For this restructuring, the future governance is legislated. The Transition and Design Team are planning for the future. The current employers cannot state the ways service delivery will change or if any plans will change.

[218] Under the *Trade Union Act*, the Labour Board has ability to act in anticipation of a successorship or proactively.[140] There is no general Nova Scotia public sector

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[138] s. 84(4)
[139] s. 86(3)(d)
[140] *Izaak Walton Killam-Grace Health Centre for Children, Women and Families*, LRB # 4550, November 5, 1996

restructuring legislation as elsewhere.[141] The *Trade Union Act* and Labour Board have been bypassed in favour of an expedited process, despite the scale of the undertaking.

[219] Providing a fair hearing to all parties and achieving a final arbitrated order in a further 45 days after mediated negotiations presents unique challenges when the employer parties cannot speak to the business plan not yet formulated or future models of care and service delivery not yet adopted. The Minister allowed a requested 19 day extension.[142]

[220] In this context, an important mechanism to manage the process and timeline that all parties invoked is the Mediator-Arbitrator's retained jurisdiction.

> In respect of each bargaining unit, the mediator-arbitrator retains jurisdiction over the implementation of any order issued under subsection 87(1) or Section 93 until such time on or after April 1, 2015, that the health authority and the bargaining agent enter into a new collective agreement.[143]

The approach taken was to address some issues in generalities and leave unresolved, matters to be addressed in future retained jurisdiction proceedings.

5.3 Mediated Negotiations: Seeking Creative Solutions

[221] In mediated negotiations the employers and unions bargain in "good faith and make every reasonable effort to reach an agreement" on some or all of the matters to be determined.[144]

[222] Mediated negotiations were time limited to November 17th, which is 45 days after October 3rd, the date of Royal assent, or an earlier date if there was an impasse. After November 17th, mediated negotiations can be conducted with the consent of the employer and unions.[145] There has been none to date.

[223] How far could the current employers and the unions agree to deviate from four, province-wide bargaining units with a Nursing unit including Licensed Practical Nurses harmonised at both the future provincial health authority and IWK Health Centre with one union representing employees in each of the four units? What collective

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[141] E.g., *Public Sector Labour Relations Transition Act*, S.O. 1997, c. 1
[142] s. 94(1)(a)
[143] s. 97
[144] s. 86(2)
[145] s.92(1)

agreements are to apply in bargaining units after April 1st that will have deemed status for future collective bargaining under section 104 of the *Health Authorities Act*?

> For the purpose of concluding a new collective agreement in respect of a bargaining unit, where an order issued under subsection 87(1) or Section 93 provides that, in respect of that bargaining unit, all of the collective agreements pertaining to the unionized employees within the bargaining unit are to remain in force, the collective agreement to which the bargaining agent that represents the bargaining unit is a party is deemed to be the expiring collective agreement.

[224] Some mediated negotiation tasks and outcomes were clear:

- Agreeing to have any representation votes among employees was remote.
- Bargaining unit placement of Licensed Practical Nurses was going to be especially challenging.
- Agreeing to an alternative to single union representation of employees in a single bargaining unit was problematic.
- Inconsistent inclusion of job classifications in multiple bargaining units covered by multiple collective agreements across the province would have to be addressed.
- Employee seniority had to be integrated in each province-wide bargaining unit.
- Over 950 employees in the Public Health and Addictions Services units are to be integrated by classification into the four units.

[225] Mediated negotiations were further complicated by constitutional challenges to the legislation, which, by their nature, cannot be resolved through mediation.

6. NSGEU CHARTER OF RIGHTS AND FREEDOMS CHALLENGE

[226] Some unions representing acute health care workers believe what this legislation without representation votes to create a revised labour relations landscape is unconstitutional. The NSGEU regards it as a thinly veiled attack to reduce its power as an assertive and successful bargaining agent for acute care health workers.

[227] It was clear from the first organizational meeting on October 17th that one or more of the unions would raise a challenge to the constitutionality of provisions of the

Health Authorities Act. Notice was given by the NSGEU on October 23, 2014. CUPE made a separate application based on the constitution the next day.

[228] I requested written submissions on the NSGEU application to be filed on or before Friday, November 15th, the last business day before the legislated time for mediation. I issued a decision on November 19th dismissing this application for a general declaration of invalidity.[146]

[229] The application by CUPE and a second application the NSGEU made November 21st were heard during the arbitration hearing and in subsequent written submissions. They are addressed below.

7. BARGAINING UNIT BOUNDARIES AND CLASSIFICATION GROUPINGS

[230] A central determination to be made under the *Health Authorities Act* is the "appropriate bargaining units for each health authority, including the appropriate composition of each bargaining unit." This is to be determined "from among the unionized employees of the district health authorities."[147]

[231] The legislation directs "there must be four bargaining units of unionized employees for each health authority, namely, a nursing bargaining unit, a health care bargaining unit, a clerical bargaining unit and a support bargaining unit."[148]

[232] Further, "all unionized employees who occupy positions that must be occupied by a registered nurse or a licensed practical nurse must be included in the nursing bargaining unit for the health authority that employs those employees."[149]

[233] Apart from this specific direction, the general direction in determining the composition of each of the four units is:

> In determining the appropriate composition of the bargaining units for each health authority, the mediator-arbitrator shall consider the community of interest among the unionized employees in each proposed bargaining unit in respect of the nature of the work being done, such that

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[146] *Canadian Union of Public Employees, Local 835 v. South Shore District Health Authority (Acute Health Care Restructuring Jurisdiction – Canadian Charter of Rights and Freedoms*) [2014] N.S.L.A.A. No. 10 (Dorsey)
[147] s. 86(1)(a)
[148] s. 89(1)(a)
[149] s. 89(1)(b)

(a) the nursing bargaining unit is composed of all unionized employees who occupy positions that must be occupied by a registered nurse or a licensed practical nurse;
(b) the health care bargaining unit is composed of all unionized employees who
    (i) occupy positions that require them to be engaged primarily in a clinical capacity to provide patient care, and
    (ii) are not included in the nursing bargaining unit;
(c) the clerical bargaining unit is composed of all unionized employees who occupy positions that require them to be engaged primarily in a non-clinical capacity to perform functions that are predominantly clerical or administrative; and
(d) the support bargaining unit is composed of all unionized employees who
    (i) occupy positions that require them to be engaged primarily in a non-clinical capacity to provide operational support in respect of the provision of health services, and
    (ii) are not included in the clerical bargaining unit.[150]

[234] There are differences over the bargaining units into which some classifications and employees currently in the fifth and sixth Public Health and Addiction Services units are to be placed.

[235] There are differences over whether Licensed Practical Nurses should remain in the Health Care unit and whether Registered and Licensed Practical Nurses in some classification positions should be in the Nursing unit.

[236] There are differences over whether classifications and employees in existing Health Care units should remain in the Health Care unit or be included in the Clerical or Support unit.

7.1 Nursing Unit Composition – Registered and Licensed Practical Nurses

A. "Generic" Classification Positions

[237] Some classifications in the Health Care and Public Health and Addiction Services units have qualifications that include, but are not exclusive to, being a Registered or Licensed Practical Nurse. These are referred to as "generic" classification positions because they can be occupied by employees other than Registered or Licensed Practical Nurses.

[150] s. 90(1)

Submissions by NSNU, Employers and Other Unions

[238] The NSNU submits whenever a nurse is in a classification, that position is appropriately included in the Nursing unit. It noted on December 4th:

> The NSNU has been unable to ascertain the qualifications of certain classifications as job descriptions were missing or titles were missing. The NSNU requested further disclosure regarding the qualifications and incumbency from the Employer in respect of these positions and this request was not fulfilled.

Consequently, all the generic positions with nurse incumbents have not been identified.[151] The unions are familiar with the classifications and employees in the bargaining units they represent, but not those in other bargaining units.

[239] The NSNU approach is that inclusion in the Nursing unit should be determined by objective factors that include "current incumbency for the classification; the historic incumbency for the classification; the duties and responsibilities of the position; the education and the registration as well as the position description for the classification."[152]

[240] This is the approach the NSNU has taken in the past with Coordinator positions. Examples are Infection Control, Geriatric Resources and Palliative Care. If the successful applicant was a nurse, the position was in the Nurses unit because it should be presumed the nurse will be using knowledge and skills acquired through nursing education and experience to fulfill the duties of the position.[153] If the successful candidate was not a nurse, the position was in the Health Care unit.

> In NSNU's submission, the current process regarding generic positions is one that should be maintained and explicitly applied to the new province wide health authority. It provided the parties with an opportunity to grieve and to make submissions to an arbitrator in respect of any disputes regarding the allocation of a position deemed to be in the bargaining unit.
>
> In the submission of NSNU this best recognizes the community of interest of the professional employees who occupy the generic positions. Depending on their education and background their "community" lies either with the Nurses unit or with the Health [Care] Unit.
>
> It is also the submission of NSNU that you have the jurisdiction under the Act to include in the nurses unit not only those who "must" be licenced as nurses but

[151] Some potential ones are listed in Grant Vaughan Affidavit, November 28, 2014, ¶ 77
[152] NSNU, Final Argument, ¶ 230
[153] See *Pembroke Civic Hospital* [1993] OLRB Rep. October 995; *Victorian Order of Nurses* [1984] OLRB Rep. Feb. 395

> also those who "are" licenced as nurses. We note that the language of s. 90 (1) (b) is not the same mandatory language of s. 90 (1) (a), this jurisdiction comes from discretion given to the arbitrator under the Act.[154]

[241] By legislation, classifications with the designation “nurse” or any derivative or abbreviation in their title must be occupied by a Registered or Licensed Practical Nurse or a licensed Nurse Practitioner or other person qualified to describe their activity as nursing.[155] All the classifications currently in the Nurses unit are not exclusively those with “nurse” or any derivative or abbreviation in their title.

[242] Any that are generic classifications have not been identified. In selecting classification placement, the employers presumed all positions currently in the Nurses unit, whether represented by the NSNU or NSGEU, require a nursing certificate.

> Roles currently in Nursing bargaining units (both NSNU and NSGEU) were presumed to require an RN or LPN certification, and, therefore, were not considered for movement into other groups. Roles in other bargaining units that were found to require an LPN designation (e.g., OR Technicians) were recommended to move into the Nursing bargaining unit.[156]

[243] In light of the joint job evaluation process completed in March 2010 on the classifications within the Nurses unit,[157] this might be an accurate presumption, but it needs to be confirmed in this process.

[244] The NSNU identified generic positions in the Capital Health District Authority Health Care unit occupied by 25 employees and in the Public Health and Addiction Services units occupied by 311 employees. It identified positions in Health Care units in the nine district health authorities’ occupied by 436 employees and in the Public Health and Addiction Services units occupied by 69 employees for which it did not have access to job descriptions.[158] The result is there are 841 unionized employees of district health authorities whose bargaining unit placement is potentially in dispute. There are positions at IWK Health Centre occupied by 217 unionized employees for which the NSNU did not have access to job descriptions.

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[154] NSNU, Final Argument, ¶ 239 - 241
[155] *Registered Nurses Act* S.N.S. 2006, c. 21, s. 19(2)
[156] Employer Criteria for Determining Bargaining Unit Placement, November 26, 2014, p.1
[157] NSNU Submission November 4, 2014
[158] NSNU Appendix A, Positions and Classifications in Dispute, as of December 4, 2014

[245] The employers and other unions disagree with the NSNU's position on generic classifications for two reasons. First, the positions are not ones that "must be occupied by a registered or licensed practical nurse"[159] and, therefore, do not have to be included in the Nursing unit.

[246] Second, having the unit assignment of such a position determined by the status of the incumbent will result in employees in the same classification, perhaps working together, in separate units covered by separate collective agreements. The goal is to eliminate, not perpetuate, this situation.

[247] The employers submit:

> In relation to the so-called "generic positions" (positions for which more than one health professional qualification is accepted), the employers argue that it is the qualifications required by the job and the primary job functions, not the incumbent or applicant, that should determine bargaining unit placement. Such positions should be governed by the same terms and conditions regardless of the incumbent's qualifications. It would be less efficient, more time-consuming, and confusing to manage, or work as, a group of professionals doing the same job according to different collective agreements depending on the incumbent's qualifications.[160]

[248] Unifor submits:

> Unifor is also of the position that with respect to the "generic" classifications, where there is a requirement that the employee be a nurse or have another designation, such position should not automatically be included in the Nursing Bargaining Unit. Historical filling of positions with a certain type of employee should not be the determining factor. The determination should be based on where the classification has normally been aligned in terms of a bargaining unit, and the language of s. 90(1)(a) should be given meaning, with respect to the words "must be occupied" by a Nurse or LPN.
>
> A determination that a classification will be included in the Nursing Bargaining Unit because it "should" be staffed by a nurse or is "usually" staffed by a nurse is not in keeping with a focus on least disruption, historical alignment, normal labour relations practice, or the provisions of the *Act*.[161]

Discussion, Analysis and Decision

[249] Like some other bargaining unit composition issues, there is incomplete information to make a full and final determination on classification positions. This is a

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[159] s. 90(1)(a)
[160] Final Submissions of the Employers, ¶ 89
[161] Submissions of Unifor Locals 4600, 4603 and 4606, ¶ 75 - 76

function of both the available time and resources for the arbitration process and limitations in the employers' data systems. As the employers observe:

> While the employers have attempted to sort through the classifications and match them according to the criteria, there are undoubtedly some that have been missed, and new ones will be created in the future. A clear definition will assist the parties in sorting out any that come to light subsequent to your Order, and give guidance where new classifications are created.[162]

[250] Both "registered nurse" and "licensed practical nurse" are defined in the *Health Authorities Act* as having the same meaning as in their regulating statutes.[163] Simply stating the Nursing bargaining unit is composed of all Registered and Licensed Practical Nurses would achieve the result in other provinces to which the NSNU refers, namely a nursing bargaining unit including all nurses regardless of their occupational classifications. This was an option available to the House of Assembly. It could have chosen less qualifying language than "occupy positions that must be occupied by a registered nurse or a licensed practical nurse."

[251] Non-nurses cannot occupy a nursing position. Nurses can occupy positions that are not required to be occupied by a nurse. Those positions are not ones that "must" be occupied by a nurse. They are not positions that the legislation directs must be included in the Nursing bargaining unit.

[252] The NSNU submits nurses in the generic positions do have a community of interest with employees in the Nursing bargaining unit and should be included in the Nursing unit. The challenge with this approach is that the legislation states the Nursing unit "is composed" of all unionized employees who occupy positions that must be occupied by a nurse. It does not speak of the unit "including" nurses or employees in generic positions simply because they have nurse qualifications.

[253] An overriding concern of the legislation is to correct and avoid future classification and position duplication in more than one bargaining unit covered by more than one collective agreement. This directed the legislative choice to describe the Nursing unit as encompassing all unionized employees who occupy positions "that must be occupied by a registered nurse or a licensed practical nurse" and not all unionized

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[162] Final Submissions of the Employers, ¶ 88
[163] s. 2(1)

employees who are nurses, regardless of the positions they occupy. Neither does it speak of positions frequently, normally, usually, historically or otherwise occupied by a Registered Nurse or Licensed Practical Nurse. Mandatory occupation by a Registered Nurse or Licensed Practical Nurse is the ordinary sense of the words read in harmony with the scheme, object and intention of the *Health Authorities Act*.[164]

[254] Therefore, I determine unionized employees who occupy "generic" positions are not intended to be included and, on any determination of their community of interest, should not be included, in the Nursing bargaining unit.

[255] After April 1, 2015, the two health authority employer will decide whether a future created position "must" or "may" be occupied by a nurse. If nursing registration or licensure, education, knowledge and experience are optional, even if desirable to have, the position will not be in the Nursing unit.

[256] This will require collaboration between the two after April 1st to avoid establishing the same classification position in two bargaining units. A current example is the classification "Crisis Intervener" in both the Nurses and Health Care units at IWK Health Centre and in the Health Care unit at Capital District Health Authority. Another is "Patient Navigator Cancer Care" in some Nurses units and one Health Care unit.

[257] There has been no opportunity to question or test the employer's assumption about classifications currently in the Nurses unit. Consequently, no union and the employers did not propose any position currently in the Nurses unit be moved to the Health Care or another unit at April 1st.

[258] Based on the NSNU submission, it appears some positions currently in the Nurses unit are generic positions and only in the Nurses unit because the incumbent is a nurse. If this is correct, to avoid future disputes for both health authorities, these positions will have to be identified and moved to another unit at April 1, 2015.

[259] The identification of these positions and the placement of the unionized employees for whom the NSNU did not have position descriptions will be on the agenda for the continuation of this arbitration.

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[164] See *Rizzo & Rizzo Shoes Ltd. (Re)* [1998] 1 S.C.R. 27, ¶ 21

B. Distribution of Registered Nurses in Province-wide Unit

[260] The Registered Nurses to be included in the province-wide Nursing unit employed by the new provincial health authority are the Registered Nurses employed by the nine district health authorities in ten Nurses units (two at Capital Health District Authority); in nine Public Health and Addiction Services units (two at South Shore District Health Authority); and, perhaps, in any non-generic positons in the nine Health Care units which have not been identified.

[261] The employers propose eight classification positions in the Public Health and Addictions Services be included in the Nursing unit. Licensed Practical Nurses in two classification positions with titles containing “Licensed Practical Nurse” are addressed later.

[262] It appears the employees in the remaining six classification positions, of which four have “nurse” in their title, are Registered Nurses. Further inquiry might reveal some of the 237 nurses in these classification positions are Licensed Practical Nurses. However, for now, assuming all 237 are Registered Nurses, the following table contains the Registered Nurse distribution at November 25, 2014.

Table 4: RNs in Public Health and Addictions Services Units

Classification		SSDHA	SWNDHA	AVDHA	CEHHA	CHA	PCHA	GASHA	CBDHA	Totals
1.	Public Health Nurse	11	8	14	15	7	9	18	30	112
2.	Nurse Rehabilitation Counsellor	8			3	11	13	11	25	71
3.	Staff Nurse Continuing Care							26	22	48
4.	Detox/Inpatient Team Leader					1	2			3
5.	Communicable Disease & Prevention Team Lead				1			1		2
6.	Youth Health Centre Nurse							1		1
Totals		**19**	**8**	**14**	**19**	**19**	**24**	**57**	**77**	**237**

[263] Again, assuming all these employees are Registered Nurses properly included in the Nursing unit and that no Registered Nurse currently in the Nurses unit is to be reassigned out of the Nursing unit, the following table contains the distribution, current union membership and representation of Registered Nurses employed by the nine

district health authorities to be consolidated into the provincial health authority as well as the separate group of Registered Nurses employed by IWK Health Centre.

[264] The table contains totals for each health authority, a provincial total for both health authorities and union membership totals and percentages.

Table 5: RNs - District Health Authorities & IWK – November 25, 2014														Provincial	
Employer	SSDHA	SWNDHA	AVDHA	CEHDHA	CHA	PCHA	GASHA	CBDHA	CDHA	Totals	Union Totals	Union %	IWK	Union Totals	Union %
Nurses Unit															
NSNU	297	295	428	252	208	249	300	1,081	497	3,607	3,607	56.43%	987	4,594	62.26%
NSGEU									2,548	2,548					
PH&AS Unit											2,777	43.44%		2,777	37.63%
NSGEU	11	8	14	19	19	24	57	77	0	229					
CUPE	8									8	8	0.13%		8	0.11%
	316	303	442	271	227	273	357	1,158	3,045	6,392			987	7,379	

C. Licensed Practical Nurses

[265] Including Licensed Practical Nurses in the Nursing unit at April 1, 2015 is one of the most contentious issues. Section 90(1)(a) of the *Health Authorities Act* states:

> In determining the appropriate composition of the bargaining units for each health authority, the mediator-arbitrator shall consider the community of interest among the unionized employees in each proposed bargaining unit in respect of the nature of the work being done, such that
>
> (a) the nursing bargaining unit is composed of all unionized employees who occupy positions that must be occupied by a registered nurse or a licensed practical nurse;

[266] Licensed Practical Nurses are currently in two of the Nurses and Health Care standard hospital units and the fifth non-standard unit. CUPE, Unifor and NSGEU submit consideration of community of interest requires they remain in the Health Care unit.

Elsewhere in Canada and Recent Developments in Nova Scotia

[267] While Alberta legislatively directed Licensed Practical Nurses to be in an auxiliary nursing unit, in 1998 the Manitoba Labour Relations Board included them in a nursing unit in acute care. That board also addressed "generic" units.

> As in rural determination, classifications which do not specifically require that the incumbent be a nurse, i.e. a classification which provides that a number of disciplines, including a person holding the designation of a nurse, would be eligible to apply for and obtain that position and would fall within the scope of the technical/professional paramedical unit. The parties would still have the opportunity to deal with specific situations pursuant to the Board ruling provisions of *The Labour Relations Act*. An additional classification, which may be the subject of such a ruling, would be that of an operating room technician.[165]

[268] In a 2013 amendment in British Columbia, "nurse" now includes a licensed practical nurse with the consequence that Licensed Practical Nurses are included in the statutory nurse bargaining unit.[166]

[269] Elsewhere Licensed Practical Nurses in acute care are variously included in nursing and other bargaining units. They are not in nursing units in Saskatchewan, New Brunswick, Prince Edward Island and Newfoundland and Labrador. It is difficult to

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[165] Manitoba Labour Relations Board, *Review of Bargaining Unit Appropriateness in Manitoba's Urban Health Care Sector*, December 22, 1998, p. 3

[166] *Health Authorities Act*, RSBC 1996, c. 180, ss.19.1 and 19.4. See also *Health Employers' Association of British Columbia* [2013] B.C.L.R.B.D. No. 157

identify the basis for the “best practice” including Licensed Practical Nurses in a nursing bargaining unit as characterized in the employers’ August 20th summary of five fundamental flaws with the unions’ bargaining association model.

[270] In 2007, a consultant team reviewing the delivery of health care in Nova Scotia concluded:

> … despite the relentless pressures to deliver increasingly complex care, models of care in Nova Scotia have not changed appreciably over the last two decades. Nova Scotia, like most jurisdictions in Canada, has significant opportunities to redesign how work is done as well as where work is done. “If we maintain current delivery models and levels of demand, then the shortage of nurses, physicians and other professionals being experienced in 2006 [is] unsolvable.” Model of care redesign is intended [to] address this issue and start to solve the problem by establishing new roles and processes that can anticipate and meet the changing demands for care, helping to reduce the cost of delivering care while improving the health status of the Province’s population. [167]

[271] Dr. Kathleen MacMillan, Registered Nurse, Professor and Director of the School of Nursing at Dalhousie University describes a subsequent new model of care initiative:

> In and around 2009, Ministry of Health in Nova Scotia introduced the "Model of Care Initiative", where all nurses have been encouraged to optimize their roles and practice to the full level of their individual competency, based upon their education and competency.
>
> Canadian Nurses' Associations literature reviews highlight that the changing model of care was a result of nursing shortages, and increased patient acuity and complexity, which caused many health-care systems to re-evaluate and redesign staff mix.
>
> > See: Canadian Nurses Association, Staffing Decisions for the Delivery of Safe Nursing Care, June 2003, Canadian Nurses Association, Evidence to Inform Staff Mix Decision-making: A Focused Literature Review, March 2012
>
> Since the introduction of the new model, and as cited above, the College of Registered Nurses of Nova Scotia and the College of Licensed Practical Nurses have worked closely together to produce significant joint Guidelines and documents for both memberships to assist their membership in appreciating the impact of the new model of care on their member's scope of practice.
>
> Both Colleges held numerous joint workshops on the scope of practice and leadership to assist nurses with their interpretation and understanding of their scope [of] practice in the context of the new model of care. The Colleges also produced a joint information sheet for managers.
>
> According to both Colleges, the new model of care requires that nurses work collaboratively with each other and in partnership with their client/patient within the discipline of nursing.

[167] Corpus Sanchez, *Changing Nova Scotia’s Healthcare System: Creating Sustainability Through Transformation*, December 2007, p. 34

> Within the collaborative practice model, the assignment of work is a dynamic process. Nurses are assigned according to:
>
> i. the client's condition (complexity, variability and acuity)
> ii. the scope of practice
> iii. the individual's scope and competence
> iv. the scope of the employment/agency policy
> v. context of practice
>
> Within the new model of care, the major focus of the Registered Nurse is the completion of the comprehensive nursing assessment of their assigned client. RNs are accountable to ensure that each client has a nursing care plan. Registered Nurses manage and coordinate care, evaluate health outcomes, educate, counsel and advocate for clients. Many duties, responsibilities, and the effort of the nurses overlap.
>
> To assist with the new model of care, the Colleges provide a framework to identify and describe the factors to consider in the most effective utilization of RNs and LPNs: the client, the nurse and environmental factors. Overall the care requirements are influenced by the client's complexity of care needs, predictability of health outcomes and the risk of negative outcomes.
>
> The Colleges also produce a joint Guideline specifically dealing with the "Assignment and Delegation for Registered Nurses and Licensed Practical Nurses" (as cited above). This Guideline provides both RNs and LPNs, as autonomous professionals, with a framework when delegating or assigning responsibilities to Continuing Care Assistants (or as referred to by the Colleges, unregulated care providers, "UCP", such as Personal Support Workers).
>
> The Colleges' Guideline specifies that both the RN and LPN are recognized as having similar responsibility as autonomous care providers who are responsible for their own practice. It is the nurse who determines the most appropriate care provider to be "assigned" to perform a specific intervention for a client.
>
> What the new model of care requires in a nursing setting is careful attention to the environment of the client and the condition of the client. Without a doubt, there may be environments where it is not appropriate to assign an LPN due to the on-going complexity of the clients. In such complex environments, the LPN would not be working to their full scope of practice as they would be required to transfer care to RNs.[168]

[272] Currently, Registered and Licensed Practical Nurses are in Nurses unit represented by the NSNU in four district health authorities and several facilities in the Capital District Health Authority. Elsewhere they are in Health Care and Public Health and Addiction Services units. While some placements could be characterized as accidents of history, most were a deliberate choice or agreement of employers and government or a choice of Licensed Practical Nurses through a representation vote.

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[168] Kathleen MacMillan Affidavit, December 1, 2014, ¶ 43 – 53. See also *Model of Care Initiative in Nova Scotia (MOCINS) Final Evaluation Report,* October 21, 2010 (https://novascotia.ca/dhw/mocins)

[273] The Canadian Federation of Nurses Unions (CFNU) promotes evidence-based staffing practices. Linda Silas, its President since 2003, deposed that 85% of Registered Nurses are in direct care classifications and, in 2013, Licensed Practical Nurses constitute 25% of the combined Registered and Licensed Practical Nurse population in Canada. [169]

[274] It is interesting that, with the exception of the Cumberland and Pictou County Health Authorities, there are higher proportions of Licensed Practical Nurses in the nursing mix in district health authorities where Licensed Practical Nurses are in Health Care units represented by CUPE and Unifor local unions, which do not represent Registered Nurses.

Table 6: Nurse Staffing Mix in District Health Authorities

Employer	RNs	LPNs	Total	LPNs as % of Mix	Variation from Average
SSDHA	316	150	466	32.19%	7.77%
SWNDHA	303	176	479	36.74%	12.33%
AVDHA	442	167	609	27.42%	3.01%
CEDHA	271	93	364	25.55%	1.13%
CHA	227	92	319	28.84%	4.42%
PCHA	273	109	382	28.53%	4.12%
GASHA	357	123	480	25.63%	1.21%
CBDHA	1,158	505	1,663	30.37%	5.95%
CDHA	497	186	683	27.23%	2.82%
CDHA	2,548	523	3,071	17.03%	-7.38%
Totals/Av	6,591	2,129	8,720	**24.42%**	

[275] There is no information in this arbitration which district health authorities or facilities have better health outcomes than others; which mix is more economical and efficient; or the mix intended for the provincial health authority.

[276] While it is commonly accepted organizational factors can affect quality of care, there is no empirical study of the impact of bargaining unit composition on the nurse staffing mix or the quality of patient care in acute care. It is also commonly accepted money can be saved by replacing Registered Nurses with Licensed Practical Nurses.

[169] Linda Silas Affidavit, December 10, 2014

There is no evidence of the circumstances or extent to which decisions are made to replace a Registered Nurse with a Licensed Practical Nurse.

Union and Employer Submissions

[277] The NSNU submits:

> Even without the clear statutory direction that the nurse unit must include both registered nurse and licensed practical nurse, consideration of the community of interest factors supports a combined unit of registered and licensed practical nurses. Not only has the NSNU represented both registered and licensed practical nurses in the same bargaining units for almost 35 years, RNs and LPNs are of the same discipline, study from the same body of knowledge, and have scopes of practices which overlap and work together in intra-discipline collaborative teams. In the NSNU's submissions, a reliance on community of interest factors leads to a conclusion that the LPNs and RNs have a strong community of interest and fully constitute an appropriate bargaining unit.[170]

The NSNU draws on the language of the *Trade Union Act* to submit a Nursing unit of Registered and Licensed Practical Nurses is a "craft" or quasi-craft unit which it is uniquely qualified to represent.[171]

[278] The employers submit all Licensed Practical Nurses should be in the same unit. They agree with the legislated choice of the Nursing unit.

> Section 89(1)(b) & 90(1)(a) of the *HAA* restrict your jurisdiction in relation to the definition and makeup of the nursing bargaining unit, requiring inclusion of all unionized employees who occupy positions that must be occupied by a registered nurse or licensed practical nurse.
>
> Aside from being mandated by the *HAA*, a bargaining unit of RNs and LPNs fits within a community of interest analysis. As illustrated by documents on record, RNs and LPNs have complimentary and largely overlapping scopes of practice. They are often assigned to work in teams and scheduled as such. Often the staffing mix of RNs and LPNs on some units fluctuates based on factors such as census, acuity, and skills.
>
> As the materials show, LPNs are already in the Nursing bargaining unit in some DHAs, and in the Health Care bargaining unit in others. The *HAA* requires that positions which require an LPN or RN be placed in the same bargaining unit. Regardless, the terms and conditions of LPNs should be the same throughout the province. If this were a typical merger of employers with a merging of bargaining units, it is certain the LPNs would be placed in one bargaining unit. If they will be in the same bargaining unit, they will have to be taken out of the

[170] NSNU Final Argument, ¶ 49 iv

[171] *Trade Union Act*, R.S.N.S. 1989, c. 475, ss. 2(1)(x) and 25. See also *Ontario Nurses' Association v. Pembroke Civic Hospital*, 1993 CanLII 7911 (ON LRB), ¶ 55 – 56; *Hospital for Sick Children*, 1985 CanLII 899 (ON LRB), ¶ 17

> Nursing unit, or taken out of the Health Care unit. The *HAA* resolves the question of which one.
>
> Aside from the legislative direction, the Employers state that because of the strong community of interest between LPNs and RNs it would be more appropriate to put the LPNs in the Nursing unit than pull them out of it. Although the number of LPNs in Health Care makes this a contentious issue, it is submitted that that is the only factor that does.
>
> The employers seek a definition of the Nursing bargaining unit that reflects the wording in the *HAA*. While the employers have attempted to sort through the classifications and match them according to the criteria, there are undoubtedly some that have been missed, and new ones will be created in the future. A clear definition will assist the parties in sorting out any that come to light subsequent to your Order, and give guidance where new classifications are created.[172]

[279] Unifor has represented Licensed Practical Nurses in Nova Scotia and Ontario.

> In Ontario, Unifor represents RPNs (LPNs), as well as other employees in health care-related bargaining units, including those in service/support, clerical and para-medical bargaining units. [Vol. II, Tab 5] These units include over 8,000 employees in approximately 35 Ontario hospitals. [Vol. II, Tab 3] Part of the collective bargaining process with these hospitals includes a process by which the hospitals and other health care facility providers, including those in personal, long-term and after care facilities, collectively engage in bargaining with Unifor. [Vol. II, Tab 6] The process provides one central table, where eight unrelated employers and multiple bargaining units negotiate issues common to all of the collective agreements.[173]

[280] Unifor submits the role of Licensed Practical Nurses is primarily clinical. It is "of or relating to the observation and treatment of actual patients rather than theoretical or laboratory studies."[174] It submits the legislated assignment of Licensed Practical Nurses to the Nursing unit is an infringement of its members' rights and will be detrimental to the delivery of health care services.

> With respect to the alignment of LPNs with the Nursing Bargaining Unit, post-April 1, 2015, Unifor takes the position that such a step is detrimental not only to the LPN members of Unifor, but to the delivery of health care services by a cohesive and dedicated workplace team who are bound together by their shared trade union values. In terms of the usual factors considered in bargaining unit delineation, a strong community of interest exists between the LPNs and the current Health Care Group classifications they work with, have bargained alongside of, and have with whom they have struggled for recognition and respect as workers.
>
> The LPNs represented by Unifor have a long history with our union and its predecessor, CAW-Canada. Their "community of interest" is in part historical, in part operational, being that the members of the current CBDHA [Cape Breton

[172] Final Submission of the Employers, ¶ 84 - 88
[173] Submissions of Unifor Locals 4600, 4603 and 4606, ¶ 31
[174] Submissions of Unifor Locals 4600, 4603 and 4606, ¶ 58

> District Health Authority] Health Care Group aid each other in the delivery of health care, but also as a result of being regionalized in Cape Breton.
>
> The government's objective of reducing the number of bargaining units and collective agreements can be met without infringing upon the associational rights of these members. The union proposed bargaining association, regarding which the government has never provided an adequate explanation for dismissing, is a far less disruptive and intrusive means of accomplishing its publicly stated goals.[175]

[281] The NSGEU views the removal of Licensed Practical Nurses, a strong and vocal group among its membership, from bargaining units it represents as an effort to lessen its effectiveness. It submits Licensed Practical Nurses efforts for a wage increase through job evaluation under its collective agreement will be thwarted.

> The community of interest of the LPNs lies with the health care unit. The LPNs should be able to choose if they wish to be part of the nursing health care unit or the health care bargaining unit. Further, there should be a vote to determine which union will represent the nursing bargaining unit as should be the case with the other three bargaining units. It is submitted democratic and *Charter* principles demand there be no presumptions. Further to force the LPNs into a nurse only bargaining unit is not only contrary to good labour relations policy but also will have a negative effect on delivery of health care.
>
> If the LPNs are taken into a nursing unit and lose the benefit of coverage by the NSGEU collective agreement they will lose significant protection in relation to the job evaluation process. The Arbitrator has heard considerable evidence concerning the expanded scope of practice of the LPN. The NSGEU has a third-party dispute resolution process with the Joint Job Evaluation process built into its collective bargaining agreement (Unifor and CUPE have "me too" clauses concerning this issue as well). The NSNU does not have a third-party dispute resolution job evaluation process. The NSNU appeal is made to HANS. The employer has already indicated it does not agree to a change of pay. The independent appeal will be lost if the LPN does not stay in the NSGEU bargaining unit.[176]

[282] This is consistent with NSGEU's view of the "true purpose" of the *Health Authorities Act* to lessen its role and achieve wage restraint.

> The NSGEU has taken a strong leadership role in representation of health care workers in the province. It is submitted the purpose of the *Act* is to lessen the membership and effectiveness of the NSGEU in protecting workers' rights in acute care in the province. At present the union represents approximately one half of acute care workers in Nova Scotia. The provisions of the *Act* restricting a union to representing only one of the four bargaining units is intended to restrict the representation of the NSGEU as it is likely if workers were allowed to choose their collective bargaining representative the NSGEU would be the choice of three and perhaps all four of the to-be-formed collective bargaining units.

[175] Submissions of Unifor Locals 4600, 4603 and 4606, ¶ 79 - 81
[176] NSGEU Final Submission, ¶ 33 – 34

> Further, the proposed interpretation would see both LPNs and RNs removed from representation by the NSGEU against their wishes. The NSGEU represents a large number of RNs and LPNs. These members tend to be active, vocal, valuable and strong union members. This is an effort to lessen the effectiveness of the union.
>
> The purpose of the legislation is also to put NSGEU at a disadvantage compared to the other unions representing acute care workers and removing its collective bargaining rights and its members' rights to be represented by the NSGEU.
>
> Further, it is submitted an oblique purpose of the *Act* is to achieve wage restraint in the public sector, by reducing the bargaining power of the NSGEU.[177]

[283] The NSGEU advocates a vote among Licensed Practical Nurses to choose the union in which they wish to be included.

> There should be a vote amongst the LPNs to determine if they wish to be part of the nursing bargaining unit. Further, there should then be a vote amongst those employees in the nursing unit to determine which union should represent them.
>
> **********
>
> There should be no presumptions in either case. *Charter* protected freedom of association is implicated in determining bargaining units. In this case, the existing bargaining unit structures are also the product of employee collective action and choice. In 1996 and 1997, Licensed Practical Nurses voted to be included in the Health Care bargaining unit, and some Licensed Practical Nurses have voted to be included in the Nursing bargaining unit. …
>
> Because of this unique history of collective action being directly involved in the bargaining unit composition of LPNs, NSGEU says that to place all LPNs in the Nursing bargaining unit without further consideration of employees' choice is comparable to nullifying collective agreements. In redefining the bargaining units in this way, the government renders meaningless past exercises of collective action. Furthermore, because of the indefinite freeze on revisiting the representation question under the *Trade Union Act,* future exercises of freedom of association of LPNs is also infringed. NSGEU therefore submits that respect for freedom of association requires LPNs vote on what bargaining unit they will belong in for collective bargaining processes.[178]

[284] The NSNU submits having Registered and Licensed Practical Nurses in the same bargaining unit will result in more collaboration, less conflict and fewer disputes over ownership of work.

> The Province's new model of care does not align with the bargaining unit structure in those four DHA's where the nursing work of the LPNs is within the health care units and the nursing work of RNs is in the Nurse bargaining units.
>
> Because of the overlapping role description between RNs and LPNs, it is in those DHA's where the nurses are not together in one bargaining unit that jurisdictional questions as to which unit "owns" the work are more likely to arise. This in turn can lead to labour relations conflict.

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[177] NSGEU Final Submission, ¶ 10 – 12
[178] NSGEU Final Submission, ¶ 36; 88 – 89

> The NSNU has filed grievances in three of the District Health Authorities where NSNU does not represent the LPNs, alleging that a LPN may be performing the work of the NSNU bargaining unit. These grievances arose where it was perceived that the Hospital was assigning the nurses' bargaining unit work out of the nurses' bargaining unit to the health care unit.
>
> This labour relations conflictual environment does not exist in those bargaining units were the NSNU represents both RNs and LPNs in the nurse bargaining unit. Here when there are issues in respect of the appropriate assignment of work, and based upon the scope of practice of either the LPN and/or the RN's in the nurse bargaining unit, the NSNU discusses the issues with the Employer at the joint labour management meeting. The matters are usually resolved after a fulsome discussion of the nurses' scope of practice.179

[285] The motto “nurses led by nurses” does not resonate with CUPE. It submits the real world workplace motto is “nurses led by Registered nurses,” which does not resonate with Licensed Practical Nurses. CUPE submits, as a minority in a Nursing bargaining unit, Licensed Practical Nurse issues would not receive the attention and priority they deserve. Registered Nurses earn a higher salary and have a vested interest in protecting their work from being eroded by assignment to Licensed Practical Nurses. This happened in 2014 when nurses represented by the NSGEU struck for a nurse-to-patient ratio that did not include Licensed Practical Nurses.

[286] In contrast, CUPE submits Licensed Practical Nurses, as the classification with the most employees in the Health Care unit, make a significant contribution and have a significant impact on collective bargaining and union priorities.

[287] CUPE submits because of the combination of an enlarged scope of practice for Licensed Practical Nurses and stagnating government funding for health care creating pressure for administrators to become more efficient, the number of Licensed Practical Nurses has grown faster than the number of Registered Nurses. The resulting change in nurse staffing mix creates workplace tensions with Registered Nurses as administrators seek to have Licensed Practical Nurses work the full scope of their practice.

[288] In Manitoba, where a nurses’ union has represented Licensed Practical Nurses for decades, there is the lowest utilization of Licensed Practical Nurses. The 2013 Licensed Practical and Registered Nurse ratio is the lowest in the country at 15.51%,

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[179] NSNU Final Argument, ¶ 188 - 191

lower that it was in 2010. In the same period it rose in Nova Scotia from 23.26% to 30.99%, the third highest after Quebec and Prince Edward Island. CUPE submits this is the underlying reason nurses' unions are moving to include Licensed Practical Nurses, where they will be a minority in internal union democratic processes. Some CUPE Licensed Practical Nurse leaders resent the prospect of being a minority in a union dominated by a majority that views itself as "real nurses."[180]

[289] CUPE submits including Licensed Practical Nurses in a Nursing unit will hinder government's "ability to plan an effective nursing workforce" and the ability of Licensed Practical Nurses "to find an effective advocate for their desire to work to their full scope of practice."[181]

[290] CUPE submits nursing collaboration is a laudable goal, but advocacy is needed to produce change. Doug Allan, a CUPE senior national officer with health research experience, deposes:

> Health employers constantly seek to restructure the health care team in the context of financial constraints, worker shortages and a highly complex and rapidly evolving sector.
>
> They've steadily changed the roles of nurses, care aides, paraprofessionals, support workers and other team members, in part to deal with changing health system and patient care needs.
>
> The continuum of care model stands in contrast to the hierarchical and rigid primary nursing model favoured by most Registered Nurses. Moving away from a fluid teamwork model would seriously constrain health care planners and providers and seriously harm patients and residents.
>
> I believe that if LPNs are moved into the same bargaining unit as Registered Nurses, their profession will shrink, leaving health employers and their government funders and regulators with much less room to innovate in terms of teamwork, skill mix and human resources more generally.[182]

[291] CUPE submits there will be structural inequities between Registered and Licensed Practical Nurses. Registered Nurses can displace Licensed Practical Nurses, who cannot replace Registered Nurses. In the event of layoffs, Licensed Practical Nurses in a bargaining unit with only one other classification will lose the broader displacement and recall options they have in Health Care units. Similarly, their

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[180] Dianne Frittenburg Affidavit, November 28, 2014
[181] Doug Allan Affidavit, December 8, 2014, Exhibit D. See also Cheryl Burbidge Affidavit, November 28, 2014
[182] Irene Jansen Affidavit, December 8, 2014, ¶ 14 - 16

promotion opportunities in Health Care units will disappear. For some local CUPE leaders opportunities for regional or national roles and positions within CUPE will be lost.

[292] Despite all the talk, plans and dreams, CUPE submits nothing has really changed on the front line to warrant moving Licensed Practical Nurses from the Health Care to the Nursing unit. Licensed Practical Nurses, who suffer more work-related injuries in Nova Scotia than Registered Nurses and who require workplace accommodation due to disability, will have fewer options in the Nursing unit than in the Health Care unit. There will be more barriers to employer accommodation if the accommodation has to be in another bargaining unit.

[293] CUPE submits Licensed Practical Nurses, aware of a broader picture than the one portrayed by policy advocates, understand their community of interest is in a Health Care unit. This is where they have in the past and recently overwhelmingly chosen to be, rather than be with a nurses union promoted as a professional body.[183] They understand that mobility rates are lower and retention rates are higher for Licensed Practical Nurses than Registered Nurses. Consequently, Licensed Practical Nurses are less attracted by the promise of provincial or national mobility.

Discussion, Analysis and Decision

[294] This arbitration cannot address whether turf protection or collaboration will prevail in nursing services and whether inclusion of Licensed Practical Nurses in the Nursing unit will provide them less voice and influence and fewer professional, social, democratic, promotional, accommodation, job security and other opportunities and benefits. These are issues for campaigns and future research.

[295] Perhaps, after expiration on the current freeze on certification under the *Trade Union Act* first proposed by the unions through the Nova Scotia Federation of Labour, the Labour Board will have occasion to revisit its past decisions that Licensed Practical Nurses are appropriate for inclusion in either the Health Care or Nursing unit. At this time, I accept that Licensed Practical Nurses can have a community of interest with

[183] *See Miner's Memorial Manor* 2010 CanLII 23555 (NSLRB)

employees in both the Nursing and Health Care units and are appropriately included in either.

[296] In this arbitration, CUPE, Unifor and NSGEU confront two insurmountable obstacles to their submissions to maintain the *status quo*. First, the Labour Board has determined the community of interest of Licensed Practical Nurses can be with Registered Nurses. Secondly, the House of Assembly has pre-empted this decision and directed the composition of the Nursing unit leaving no discretion to the Mediator-Arbitrator.

[297] Consequently, I have determined all unionized Licensed Practical Nurses who occupy positions that must be occupied by a Licensed Practical Nurse are to be included in the Nursing unit at the provincial health authority and IWK Health Centre at April 1, 2015.

[298] Currently, there are 572 Licensed Practical Nurses in the Nurses unit with 3,607 Registered Nurses. For them, unless they occupy a generic position, there will be no bargaining unit change and no violation of any of their associational or other rights.

[299] Under the *Health Authorities Act*, there is no provision for a determination of the separate or combined wishes of the Licensed Practical Nurses and Registered Nurses in Public Health and Addiction Services. The movement of the Registered and Licensed Practical Nurses from these existing non-standard bargaining units to the Nursing unit is by legislative direction. And no one submits that the abolishment of the fifth bargaining unit and reassignment of all the employees to one of the four units infringes their associational or other rights.

[300] In some circumstances, employees are included in a bargaining unit with other classifications of employees without canvassing their wishes or over their objections. This might be the approach a labour relations board would take at IWK Health Centre where there is a small number of Licensed Practical Nurses (87) and the Licensed Practical Nurse proportion of the nursing mix is the lowest of the ten employers (87 LPNs/1,074 RNs = 8.1%).

[301] When a large number of employees are added to an existing bargaining unit, labour relations boards under general collective bargaining legislation inquire to determine the wishes of the employees to be included in the unit and represented by the union that will become their certified exclusive bargaining agent. At times, the inquiry will include holding a supervised representation vote among the employees. As addressed later, this is not an option.

[302] There are no Licensed Practical Nurses in the Clerical or Service Support units. No generic classification positions occupied by Licensed Practical Nurses were identified. There was mention of the Infection Control Practitioner, Infection Control Technician and Infection Prevention and Control Co-ordinator, but the information is not complete on whether any Licensed Practical Nurses (or Registered Nurses) occupy any of these classification positions.

[303] Across eight district health authorities, the first group of unionized Licensed Practical Nurses to be moved to the Nursing unit are those occupying positions in two classifications in the nine Public Health and Addiction Services units. The second group is unionized Licensed Practical Nurses occupying two positions in two classifications in the Health Care units.

[304] The following table contains the distribution and classification positions of the 1,583 unionized Licensed Practical Nurses of the nine district health authorities at November 25, 2014 who are to be moved from existing Public Health and Addiction Services and Health Care units to the provincial health authority Nursing unit on April 1, 2015.

Table 7: Distribution of LPNs for Inclusion in Nursing Unit

Unit and Classification	SSDHA	SWNDHA	AVDHA	CEHHA	CHA	PCHA	GASHA	CBDHA	CDHA	Totals
PH&SA										
LPN	5	13	5	2		1		39		65
LPN Continuing Care Referral Assistant							26			26
Health Care										0
LPN	151	163	162					471	523	1,470
OR Technician								2	19	21
Totals	**156**	**176**	**167**	**2**	**-**	**1**	**27**	**512**	**542**	**1,583**

7.2 Health Care Unit Composition

[305] Licensed Practical Nurse is the classification with positions in three bargaining units - Public Health and Addictions Services, Health Care and Nurses – represented by the most unions and covered by the most collective agreements.

[306] In the standard hospital units, there are many classifications in the same unit in different geographic locations across the province employed by different district health authority employers represented by different unions and covered by different collective agreements. A single province-wide unit for the consolidated provincial health authority will bring all of the classification positions into one unit eventually covered by one collective agreement with one employer.

A. Twenty Unopposed PH&AS Classifications to Health Care

[307] Some classification positions are in the Public Health and Addictions Services units and one of the standard hospital units. Examples are Secretary 2 (Clerical unit), Community Outreach Worker (Health Care unit) and Cook (Service Support unit). Some classifications are unique to the Public Health and Addictions Services unit. Examples are “Coordinator Prevention & Health Promotion” and “Counsellor.”

[308] In the dissolution of the Public Health and Addictions Services units the classification positions in these units will be included in a standard unit as was done with Registered and Licensed Practical Nurses.

[309] The employers propose and the unions do not oppose assigning to the Health Care unit twenty Public Health and Addictions Services classifications with positions occupied by 448 unionized employees.

Table 8: 20 Classifications (448 employees) from PH&AS to Health Care

	Classification	SSDHA	SWNDHA	AVDHA	CEHHA	CHA	PCHA	GASHA	CBDHA	Totals
1	Care Coordinator				25			18		43
2	Care Coordinator Continuing Care	25	25	22					40	112
3	Clinical Therapist		6	9	6	5	4	5	16	51
4	Clinical Therapist B/Problem Gambling Specialist	11								11
5	Community Health Worker	9	3	6	1		1	2	2	24
6	Community Home Visitor	3	4	7	4	4	2			24
7	Community Outreach Worker	2	3	7	4	2	2	7	19	46
8	Continuing Care Coordinator Team Lead							1		1
9	Continuing Care Referral Assistant		6		4					10
10	Coordinator Community Health Project					1				1
11	Coordinator Continuing Care					17	17			34
12	Coordinator Placement			2	1	1	1	1		6
13	Coordinator Youth Wellness					3				3
14	Coordinator Youth Wellness				1					1
15	Counsellor	10		10		9	5	6	3	43
16	Dental Hygienist	2	2	2	2	1	1	1	3	14
17	Nutritionist	2	4	2	3	1	2	2	2	18
18	Placement Officer								2	2
19	Recreation Therapist	1							2	3
20	Team Coordinator			1						1
	Totals	65	53	68	51	44	35	43	89	**448**

B. Classifications and Associated Classifications in Two Standard Units

[310] Unlike the Nursing unit, the composition of the Health Care unit is not specifically prescribed. It is one of the four "types"[184] of units described as:

> In determining the appropriate composition of the bargaining units for each health authority, the mediator-arbitrator shall consider the community of interest among the unionized employees in each proposed bargaining unit in respect of the nature of the work being done, such that …
>
> (b) the health care bargaining unit is composed of all unionized employees who
>
> (i) occupy positions that require them to be engaged primarily in a clinical capacity to provide patient care, and
>
> (ii) are not included in the nursing bargaining unit;[185]

[311] Past Labour Board decisions and employer and union agreements are one factor in assessing the community of interest a group of employees in the same or similar classification positions have with groups of employees in other classification positions. As with Licensed Practical Nurses, there are groups of employees who will have a community of interest with employees in more than one unit and their inclusion in or exclusion from either will not affect the appropriateness of the composition of either unit.

[312] The employer identified classifications, other than Registered and Licensed Practical Nurses, in two or more of the standard hospital units. It did so with the following methodology and limitation:

> In many cases, job titles are recorded in SAP using differing spellings, abbreviations, and/or numbers across DHAs. For instance, a Medical Laboratory Technologist may appear as a Lab Tech, Lab Technologist, or Medical Lab Tech 1. For this reason, a common title was assigned to each job to the extent possible based on the job title from SAP and pay grade. It was not always possible to identify whether jobs with similar titles referred to the same role, therefore, it is possible that jobs may be duplicated or omitted from this list. It is likely, however, that these duplications or omissions are minimal.[186]

[313] SAP is the information technology system the Nova Scotia government uses for financial management and business functions like payroll, recording and tracking leaves, etc. The district health authorities have used SAP since 2009. Variation in the SAP program across district health authorities is an example of the failure to attain a

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[184] s. 2(1)(zj)
[185] s. 90(1)(b)
[186] HANS, *List of Classifications by DHA and Union with Proposed Redistribution*, November 25, 2015, "Notes"

standardized information technology approach referred to by the Transition and Design Team.[187]

[314] During the process leading to arbitration, CUPE identified the positions Custodial Care, Patient Sitter and Maintenance Planner / Safety which are not in the employers' classification lists. These and any others identified will be addressed in continuation proceedings of this arbitration.

Medical Transcriptionist C (Clerical)

[315] One of ten identified positions in this classification is in a Health Care unit. The others are in Clerical units. All other 91 positions in the Medical Transcriptionist and Transcriptionist classifications are in Clerical units. CUPE identified there is a Medical Transcriptionist classification in the Clerical unit at Guysborough Antigonish Strait Health Authority. The employer does not list one. CUPE also identified several classifications in this and other Clerical units that the employers did not list.

[316] The unionized employees in these classification positions will be included in the Clerical unit for each health authority at April 1, 2015.

Porters (Support)

[317] The district health authorities have 237 employees in Porter positions. Thirty one are in Health Care units. The reminder is in Service units. Among other things, these employees are responsible for the safe transport of patients between areas within hospitals.

[318] Locals of CUPE represent Porters in both Health Care and Service units in different district health authorities. CUPE agrees with the employer that all Porter positions are appropriately included in the Support unit at April 1, 2015.

[319] The unionized employees in Porter and Senior Porter classification positions will be included in the Support unit for the provincial health authority at April 1, 2015. The IWK Health Centre does not employ porters.

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[187] *People Centered Health Care* Transition Planning for DHA Consolidation, June 25, 2014

Dietetic Technician (Health Care)

[320] Seven of the nine positions in four district health authorities in this classification are in Health Care units. Two are in Service units. The employers and CUPE local unions representing these employees agreed the positions should be in the Health Care unit.

[321] The unionized employees in these classification positions will be included in the Health Care unit for each health authority at April 1, 2015.

Ward Aide and Orderly (Health Care)

[322] The Colchester East Hants District Health Authority lists 14 Ward Aide classification positions in its Health Care unit and two in its Service unit. There is no explanation why the same classification is in two bargaining units with the same employer.

[323] Two other district health authorities have 36 Ward Aide positions in their Health Care units. Of these, the Cape Breton District Health Authority employs 29. It also employs two orderlies in its Health Care unit, for which no position description was provided. Orderly is one of the classifications of employees the Labour Relations Board specifically identified in 1973 for inclusion in the Health Care unit. CUPE identified its local union represents Ward Aides employed by the Pictou County Health Authority, which does not list any.

[324] The employers propose Ward Aide and Orderly positions are to be included in the provincial health authority Support unit. CUPE disagrees.

[325] The Cape Breton District Health Authority position description describes the position purpose and responsibilities.

> **PURPOSE OF POSITION**
>
> A ward aide assists nursing staff in their care of patients and family. They work cooperatively and effectively with all members of the nursing team maintaining good communication. Reporting to the Unit Manager or delegate, the Unit Aide completes their work assignment under the direction of the nursing staff.
>
> **RESPONSIBILITIES**
>
> - Assists as directed by nursing staff with patient transfer and hydration.
> - Assists with distribution of supplies and replenishing work areas.
> - Does errands for patients.

- Tidies patient bedside area
- Delivers flowers, newspapers to patient rooms.
- Retrieves trays from dietary lift.
- Set up and assists with feeding patients.
- Make un-occupied beds.
- Any other duties as may be assigned.

[326] As part of the nursing team, Ward Aides are "engaged primarily in a clinical capacity to provide patient care, and are not included in the nursing bargaining unit." Unionized employees in Ward Aide classification positions are appropriately included in the Health Care unit of the provincial health authority.

[327] Assuming Orderlies, for which no position description was provided, similarly assist nursing or medical staff in patient care, unionized employees in Orderly positions are appropriately included in the Health Care unit of the provincial health authority.

[328] There is no dispute over where unionized employees in positions in the Renal Dialysis Aide classification, described in the job position description as Renal Dialysis Ward Aide, are to remain in the Health Care unit.

[329] The unionized employees in Ward Aide and Orderly classification positions will be included in the Health Care unit for the provincial health authority at April 1, 2015.

Patient Attendants (reserved for continuation)

[330] Two district health authorities employ Patient Attendants. The Capital District Health Authority employs 101 Patient Attendants in its Health Care unit. The Colchester East Hans District Health Authority employs 5 in its Service unit. The IWK Health Centre does not employ Patient Attendants.

[331] The employer proposes these classification positions be included in the Support unit at April 1, 2015.

[332] The classification position description at the Capital District Health Authority states Patient Attendants are responsible, among other things, for transporting patients to and from operating and holding rooms.

[333] The NSGEU submits the employees' "functions are directly related to the assessment and treatment of patients and they provide service unique to health care and therefore should be included in the Provincial Health Care bargaining unit."[188]

[334] There has been no explanation by either the NSGEU or Capital District Health Authority of the critical difference between the function of Porter and Patient Attendant or the basis on which the Capital District Health Authority has Porters in one unit and Patient Attendants in another. Perhaps it is simply a legacy of the evolution of the district or perhaps there is a work organization and patient care basis for the distinction.

[335] Whether all Patient Attendants are more appropriately included in the Health Care or Support unit at April 1, 2015 is an issue that requires further attention. Consequently, I reserve jurisdiction on this issue to be addressed in the continuation of this arbitration.

Unit Aide and Lead Hand (reserved for continuation)

[336] The Capital District Health Authority employs 232 employees in positions in the Unit Aide classification. IWK Health Centre employs 118 and four lead hands in a classification with the same name in the Service unit.

[337] The Capital District Health Authority position description identifies 15% of the mix of responsibilities is to: "Assist with patient care (weigh patients, set patient up with basins, assist with patient baths, shaves, feeds, positioning, lifts and transfers, records Intake and output). Answer patient call bells. Make beds. Performs tasks only under the direction and supervision of the RN/LPN." The main job summary is:

> The Unit Aide has an important role within the health care team. Reporting directly to the Health Services Manager, the Unit Aide is responsible for ordering, stocking and maintaining all supplies and equipment to meet the needs of patients in their designated work area. An understanding of the basic principles of infection control is essential and key to providing a safe environment for patients and staff alike. This role also provides indirect and direct support for patient care under the direction and supervision of the RN/LPN.

[338] The employers summarize their role as follows:

> … unit aides may assist with patient care activities such as bathing, but these roles are primarily responsible for ordering, stocking, and maintaining supplies

[188] Grant Vaughan, Affidavit , November 28, 2014, ¶ 86

> and equipment. Only a small portion of the role relates to patient care activities, and is not engaged primarily in a clinical capacity to provide patient care.[189]

[339] The employers propose and the NSGEU opposes inclusion of the employees in these positions in the Support unit of the provincial health authority.

[340] Unlike Ward Aides, it appears the treatment or care of patients is not the primary responsibility for Unit Aides. No position description for Unit Aides employed by IWK Health Centre was supplied.

[341] Whether Unit Aides are more appropriately included in the Health Care or Support unit at April 1, 2015 is an issue that requires further attention. Consequently, I reserve jurisdiction on this issue to be addressed in a continuation of this arbitration.

Coordinator Information (reserved for continuation)

[342] Three unionized employees occupy positions in the Coordinator Information Systems classification in the Health Care units in Colchester East Hants, Cumberland and Pictou County health authorities.

[343] Two employees occupy positions in the Coordinator Information classification in Clerical unit in Guysborough Antigonish Strait Health Authority. Two employees occupy positions in this classification in the Health Care unit in the Cape Breton District Health Authority.

[344] Whether these positions are more appropriately included in the Health Care, Clerical or Support unit at April 1, 2015 is an issue that requires further attention. Consequently, I reserve jurisdiction on this issue to be addressed in a continuation of this arbitration.

Coordinator Telecommunications (reserved for continuation)

[345] Four unionized employees occupy positions in the Coordinator Telecommunications classification in the Health Care units in the Colchester East Hants and Pictou County health authorities and in the Clerical units in the Guysborough Antigonish Strait Health Authority and IWK Health Centre. The employers propose these positions be moved to the Support unit of the provincial health authority and IWK

[189] Mandy Proulx Affidavit, December 8, 2014, ¶ 24

Health Centre. CUPE disagrees. NSGEU has not made a submission on this classification position at IWK Health Centre.

[346] Whether these positions are more appropriately included in the Health Care, Clerical or Support unit at April 1, 2015 is an issue that requires further attention. Consequently, I reserve jurisdiction on this issue to be addressed in a continuation of this arbitration.

Health Care Equipment Maintenance (reserved for continuation)

[347] The employers propose unionized employees in several classification positions maintaining health care equipment be reassigned to the Support unit from the Health Care unit. Associated positions in the Service unit were not identified. The proposed positions are:

Classification	**Employer**	**Employees**
Biomedical Engineer	CBDHA	4
Biomedical Engineer Non-Certified	CBDHA	3
Biomedical Engineering Tech	CDHA	25
Biomedical Engineering Tech	IWK	11
Chief Dialysis Technologist	CDHA	1
Electronics Engineering Tech B	CDHA	1
Electronics Engineering Tech C	CDHA	2
Electronics Engineering Tech D	CDHA	5
Environmental Technologist	CDHA	4
Medical Physics Assistant 2	CDHA	1
Orthotic Technician	CDHA	1
Orthotics Prosthetics Tech	CDHA	9
Othotics/Prosthetics Technician 1 Unregistered	CDHA	1
Total		68

[348] Whether these positions are more appropriately included in the Health Care, Clerical or Support unit at April 1, 2015 is an issue that requires further attention. Consequently, I reserve jurisdiction on this issue to be addressed in a continuation of this arbitration.

Information Technology (reserved for continuation)

[349] The employers propose unionized employees in several classification positions providing information technology service in a following table be reassigned to the

Support unit from the Health Care unit. Associated positions in the Service unit were not identified.

[350] Whether these positions are more appropriately included in the Health Care or Support unit at April 1, 2015 is an issue that requires further attention. Consequently, I reserve jurisdiction on this issue to be addressed in a continuation of this arbitration.

Sterile Processing Positions (reserved for continuation)

[351] Unionized employees are employed by all employers in sterile processing functions necessary for the safe operation of a hospital, but not unique to hospitals. The classifications, employers and unit distribution of the employee positions are in a following table.

[352] There are employees in Health Care and Service units. As with other classifications, the Capital District Health Authority unit composition is somewhat anomalous, but for sterile processing it is not the only employer with employees in both units.

[353] There are no employees in the identified classifications at the Guysborough Antigonish Strait Health Authority. Perhaps some of its 194 employees in the Service unit in positions in the Utility Worker Environment classification are engaged in sterile processing.

[354] Whether these and any other sterile processing classifications and positions are more appropriately included in the Health Care or Support unit at April 1, 2015 is an issue that requires further attention. Consequently, I reserve jurisdiction on this issue to be addressed in a continuation of this arbitration.

Miscellaneous and Overlooked Positions (reserved for continuation)

[355] There are other classifications with positions occupied by unionized employees that have not been specifically addressed. Examples are Animal Quarters Technician and Medical Photographer. There are likely others, including any identified since the hearing or overlooked by me. There are classifications, like Wheelchair Service Technician and others identified above, which are not identified by the employers, but the unions propose for inclusion in their current units.

[356] The employers submit certain groupings of employees should be keep together. One the employers identify is Care Team Assistants, Personal Care Workers, Patient Support Workers, and Continuing Care Assistants, but it is unclear if each is a classification for which there are no current positions of if these are simply descriptive groupings.

[357] These and any others identified by a union or employer require further investigation and attention. I reserve jurisdiction on these issues to be addressed in a continuation of this arbitration.

Table 9: Distribution - Information Technology Classifications and Positions

	Classification	SSDHA	SWNDHA	AVDHA	CEHHA	CHA	PCHA	GASHA	CBDHA	CDHA	Totals
1	Collaboration & Desktop Security Administrator		1								1
2	Computer Services Officer 2C									8	8
3	Computer Services Officer B									6	6
4	Computer Services Officer C									1	1
5	Coordinator Application								1		1
6	Coordinator Information						2				2
7	Coordinator Information Systems				1	1	1				3
8	Data/Business Analyst - Pathology Informatics									2	2
9	Database Analyst					1					1
10	Information Processing Tech A									5	5
11	Information Processing Tech B									2	2
12	Information Processing Tech D									1	1
13	Information System Analyst				2	1					3
14	Information System Technician				4	1	1				6
15	Mechanical Tech 2									2	2
16	Network Analyst 2	1	1	1							3
17	Network Engineer		1								1
18	Senior Computer Operator									1	1
19	Senior Equipment Repair Tech 1									1	1
20	Systems Analyst 1	1		3							4
21	Systems Analyst 2	2	4	3							9
22	Systems Educator						2				2
23	Technical Analyst	3	3	1							7
24	Technical Support Representative Level 1									45	45
25	Technical Support Representative Level 2									3	3
26	Telehealth Analyst									1	1
27	Training & Productivity Analyst	1	1	1							3

Table 10: Distribution - Sterile Processing Classifications and Positions

	SSDHA			SWNDHA			AVDHA			CEHHA			CHA			PCHA			GASHA			CBDHA			CDHA			Total	IWK		
	Health Care	Clerical	Service	Health Care	Clerical	Service	Health Care	Clerical	Service	Health Care	Clerical	Service	Health Care	Clerical	Service	Health Care	Clerical	Service	Health Care	Clerical	Service	Health Care	Clerical	Service	Health Care	Clerical	Service		Health Care	Clerical	Service
Sterile Processing																															
SPD Aide	1		10			14	24																		6			55			
SPD Team Leader																									2			2			
CSPD Technician												10			6													16			
CSR Technician																						41									
OR SPD Liaison							4																					4			1
OR SPD Supply Tech																		1										1			
OR CSPD Technician										7			1					1										9			
Utility Worker SRD																											19	19			
SPD Team Lead																									2			2			
Sterile Processing Technician																									105			105			
Sterile Processing Technician (Training)																									15			15			
Sterile Processing Technician Staff Developer																									1			1			
Unit SPD Aide																												0			11

C. Other Health Care Proposed for Clerical (reserved for continuation)

[358] The employers submit the occasion of the district health authority consolidation is the opportunity to revise the composition of the Health Care unit and by consequence the composition of both the Clerical and Support units by applying more restrictive criteria for inclusion in the Health Care unit than fashioned and applied by the Labour Relations Board.

[359] In effect, the employers submit the legislative intention is not only to address and redress inconsistent inclusions of classification positions in multiple units, but also to trim the size and composition of the Health Care unit by generally revisiting bargaining unit composition as was stated in the second "fundamental flaw" in August in response to the unions' bargaining association proposal.

[360] On closer examination, the central thrust is to revisit the bargaining unit composition structure that emerged at the time of the creation of Queen Elizabeth II and treated the Health Care unit as a default or residual unit based on civil service classification and pay plans. Most of the classifications the employer proposes are in the Capital District Health Authority. Some include the same or similar classifications in the other district health authorities where the employees are represented by CUPE or Unifor local unions. None are represented by the NSNU.

[361] The history of the employers' concern is rooted in decisions made before the creation of the Capital District Health Authority and collective bargaining dispute resolution with the Capital District Health Authority since 2000. The beginnings of the background are summarized by NSGEU Servicing Coordinator Grant Vaughan.

> The creation of the Queen Elizabeth II Health Sciences Centre involved the devolution of the Victoria General Hospital employees from the Civil Service and the merger of the Victoria General Hospital with the Camp Hill Medical Centre, the Nova Scotia Cancer Treatment and Research Foundation and the Nova Scotia Rehabilitation Corporation.
>
> **********
>
> The employees of the Nova Scotia Cancer Treatment and Research Foundation were included in a single bargaining unit and the employees at the Camp Hill Medical Centre were divided into four bargaining units.
>
> The terms and conditions of employment for employees from the Civil Service were different from those that prevailed outside of the Civil Service; in particular, employees who came from the Civil Service generally had superior employment

> benefits and higher wages than the other groups; in a few instances positions from outside the Civil Service were higher paid.
>
> In 1998 NSGEU and the Queen Elizabeth II Health Sciences Centre negotiated a Master Agreement governing all unionized employees. The significant feature of the Master Agreement was the "leveling up" of the wages of all employees to the highest level.
>
> The leveling up exercise involved adopting the civil service classification system and applying it beyond the Victoria General Hospital to the other parts of the Queen Elizabeth II Health Sciences Centre.
>
> The adoption of the Master Agreement, for the most part, had the effect of establishing wage parity between the higher paid Civil Service positions for employees who had been employed in parts of the Queen Elizabeth ll Health Sciences Centre other than the Victoria General Hospital.
>
> One result of the leveling up exercise was that bargaining units represented by the NSGEU outside of the Queen Elizabeth II Health Sciences Centre were able to negotiate wage parity with the Queen Elizabeth II Health Sciences Centre.
>
> I was responsible for the implementation of wage parity for NSGEU bargaining units in acute care services outside of the Queen Elizabeth ll Health Sciences Centre; for example, working with the Nova Scotia Association of Health Organizations (the predecessor to the Health Association of Nova Scotia) at the IWK Health Centre, the classifications and wage rates from the Queen Elizabeth II Health Sciences Centre Master Agreement were extended to employees represented by NSGEU.
>
> The Capital District Health Authority was established in 2001 and involved the merger of the Queen Elizabeth ll Health Sciences Centre with several local hospitals previously operated by the Central Regional Health Board; NSGEU became the bargaining agent of all of the unionized employees of the Capital District Health Authority other than Registered Nurses at the several local hospitals.
>
> NSGEU and the Capital District Health Authority agreed to choose a new classification system to apply to all Capital District Health Authority unionized employees except Registered Nurses. The system was developed through a Joint Job Evaluation process.
>
> I led this Joint Job Evaluation process for NSGEU and participated with the Employer on a Joint Steering Committee applying the new classification system.
>
> The Joint Job Evaluation and classification process at the Capital District Health Authority resulted in standardized classifications and was the basis for the establishment of wage rates at the Capital District Health Authority.[190]

[362] The 2004 interest arbitration board underscored the challenge in fashioning "a compensation award which requires widely varying wage increases for numerous classifications across a large bargaining unit."[191]

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[190] Grant Vaughan Affidavit, November 28, 2014, ¶ 12; 15 - 25

[191] *Capital District Health Authority* [2004] N.S.L.L.A. No. 16 (Kaplan), ¶ 12

[363] The employers' submission to change the range, composition and size of the Health Care unit is explained in its statement on *Criteria for Determining Bargaining Unit Placement*, which begins:

> The definitions set forth in the *Health Authorities Act* were used as a basis for determining the appropriate bargaining Unit placement of classifications in the acute care sector. A key consideration in making these recommendations was the notion set out in the definitions that group composition should be based on the primary responsibilities of classifications included in the bargaining unit. Specifically, the core functions that formed the basis of each role, and the amount of time spent on these core functions, were considered when making recommendations for group placement. To aid in the placement of classifications, the criteria detailed below were developed. These criteria build upon the definitions outlined in the *Health Authorities Act* to create a framework for decision making.

[364] For the Health Care unit, the employers began with the premise that licensure or being one of the twenty regulated occupations is principally what determines whether an employee is "engaged primarily in a clinical capacity to provide patient care."

> The majority of classifications in this bargaining unit will be required to be licensed under a regulatory body or have certification in a specific health care field, including Allied Health professions (e.g., Physiotherapists and Occupational Therapists), as well as related assistive roles (e.g., Physiotherapy Aides and Occupational Therapy Assistants). Also included are Care Team Assistant, Personal Care Worker, and Acute Care Worker classifications, which are required to assist patients with personal care and may also perform basic nursing procedures, such as taking the patient's pulse. Certification and registration requirements ensure that clinical standards of care are upheld.
>
> This bargaining unit will also include classifications that may not have patient contact on a regular basis, but provide clinical care by performing functions that are critical to the clinical treatment of patients, and classifications that collaborate closely with other team members in providing patient care. This includes, for example, Medical Laboratory Technologists and Pharmacists, as well as related assistive roles (e.g., Medical Laboratory Assistant, Pharmacy Assistant).[192]

The criteria are providing patient care in a clinical capacity, but limited to those with a license or certificate plus others who collaborate in delivering "direct" patient care.

[365] The employer also applied operational considerations:

> … there are a small number of instances in which it is not apparent from the job descriptions that certain classifications should be placed in the group that is recommended. Additional information gathered from the employers revealed that, in some instances, these classifications perform work that is not specified in the job description that would support its placement in the bargaining unit.

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[192] *Criteria for Determining Bargaining Unit Placement*, p. 1

> In addition, it was identified that placing these roles in a bargaining unit separate from other related roles would have an impact on the day-to-day operations of a function. These roles are considered to function in a Models of Care capacity, such that the functions of each role are fully integrated to provide clinical care in a team setting. Within these Models of Care functions, roles are interdependent to the extent that one role cannot function effectively without the other. This interdependence creates a community of interest in respect of the nature of the work being done, and supports placing these classifications in the same bargaining unit. In these instances, it may be viewed as the Models of Care team that meets the definitions set forth in the *Health Authorities Act*.
>
> Furthermore, placing these roles in separate groups would create significant recruitment and retention challenges. There is a natural career progression among these related roles, and placing them in different bargaining units would have a negative impact on that progression. Placing these roles in different bargaining units may cause incumbents to choose to move into positions that would maintain their seniority and job security, which would result in a loss of knowledge and expertise as well as create instability within a function.
>
> Classifications that were placed in bargaining units in part based on these considerations include:
>
> - PACS Coordinator, DIIS Coordinator, DIS Technologist, and LIS Coordinator roles have been placed in the Healthcare group with Diagnostic Imaging Technologists, Radiology Technicians, and Medical Laboratory Technologists.
> - Professional Practice Coordinators and Clinical Educators have been placed in the Healthcare group with Allied Health professionals and other care providers.
> - Patient Navigator roles (e.g., Access Navigators, Wellness Navigators, and Rehabilitation Navigators, etc.) have been placed in the Healthcare group with Allied Health professionals and other care providers.
> - Radiographic Assistant roles have been placed in the Healthcare group with Diagnostic Imaging Technologists and Radiology Technicians.[193]

Several of the classifications listed were initially proposed by the employers for inclusion of the Clerical or Support units.

[366] Using this approach, the only unit classification positions the employers propose move to the Health Care unit are Dietetic Technicians. It does not propose any position movement from the Clerical unit or the Nurses unit. "Roles currently in Nursing bargaining units (both NSNU and NSGEU) were presumed to require an RN or LPN certification, and, therefore, were not considered for movement into other groups."[194]

[367] The third criteria the employer applied is to have related roles in the same unit.

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[193] *Criteria for Determining Bargaining Unit Placement*, pp. 3 - 4
[194] *Criteria for Determining Bargaining Unit Placement*, p. 1

In reviewing the classifications, it was identified that a number of roles should be placed in the same bargaining unit for similar reasons to those outlined above. In contrast to the roles identified above, job descriptions for these roles clearly indicate that they should be placed in the recommended bargaining units. It is also important for these roles to remain together for the team-based reasons identified above. Specifically, placing these roles in a bargaining unit separate from other related roles would have an impact on the ability to effectively carry out work functions as they collaborate in a team capacity.

Furthermore, placing these roles in separate bargaining units would result in recruitment and retention challenges.

Classifications that should be placed in the same bargaining unit include:

- Recreation Therapists, Recreation Therapy Aides, Recreation Therapy Assistants
- Physiotherapists, Physiotherapy Aides, Physiotherapy Assistants
- Occupational Therapists, Occupational Therapy Assistants
- Dental Hygienists, Dental Assistants
- Pharmacists, Pharmacy Technicians, Pharmacy Assistants
- Psychologists, Psychology Technicians
- Medical Laboratory Technologists, Medical Laboratory Assistants
- Diagnostic Imaging Technologists, Radiology Technicians, Diagnostic Imaging Tech Assistants,
- Radiographic Assistants
- Respiratory Therapists, Respiratory Therapy Aides
- All Information Technology roles
    - Application Analyst
    - Collaboration & Desktop Security Administrator
    - Computer Services Officers
    - Information Coordinators
    - Telecommunications Coordinators
    - Data/Business Analysts
    - Database Clerks
    - HASP Training Analyst
    - Information Processing Techs
    - Information Systems Analysts
    - Information Systems Technicians
    - Network Analysts
    - Senior Computer Operators
    - Systems Analysts
    - Systems Educators
    - Technical Analysts
    - Technical Support Representatives
    - Training & Productivity Analysts

It is also important to note that Care Team Assistants, Personal Care Workers, Patient Support Workers, and Continuing Care Assistants should be placed in the

> same bargaining unit, as they all perform the same functions. That is to say, the roles are the same but have different titles.[195]

[368] The employers submit the preferred approach is to direct union assignment based on criteria, not the majoritarian or plurality approach of the unions which places a classification in units where the largest number currently is and ignores the need to keep closely connected groups of employees together covered by one collective agreement.

[369] With this approach, the employers' propose employees in several classification positions be moved out of the Health Care unit and placed in the Clerical or Support units of the two health authorities. The initial proposed changes in the size of the units, including elimination of the Public Health and Addictions Services units and movement of Licensed Practical Nurses, was:

Units	**Before**	**After**
Nurses (to Nursing)	7,714	9,599
Health Care	8,715	6,317
Clerical	3,681	4,261
Service (to Support)	3,295	4,189
PH & AS	961	

[370] The employers' proposal changes the Health Care unit from the broad one fashioned by the Labour Relations Board in 1973 and reaffirmed in 1981 and agreed to over four decades into a modified allied health professional unit. The employers submit the result could be an easier path to finding compensation resolutions in collective bargaining by varying the range of circumstances to be addressed. With reference to the Capital District Health Authority, this is described as follows:

> Because there is no shared community of interest among all classifications within the Health Care bargaining unit at CDHA, I have been told by Dave Collins, Manager, Labour Relations at CDHA, and I believe that there have been challenges when bargaining new collective agreements. For example, a retention incentive of an additional 3.5% salary increment upon completion of 25 years of service was awarded to all classifications in the Health Care bargaining unit, regardless of whether there were retention challenges for each classification.

[195] *Criteria for Determining Bargaining Unit Placement*, pp. 4 - 5

> The *Health Authorities Act* has the potential to rectify some of the challenges that result from a variety of classifications being included in any bargaining unit, including the Health Care bargaining unit at CDHA, by creating bargaining units in which classifications share common interests.[196]

It also increases size, range, complexity and variation in the Clerical and Support units.

[371] The NSGEU submits it also diminishes the strength of the Health Care unit in collective bargaining and seeks to shift the existing countervailing balance of power away from the NSGEU, which has represented the Capital District Health Authority Health Care unit, in favour of the future provincial health authority employer after seeking to limit the NSGEU's representation of nurses. The NSGEU uses the Health Care unit at Capital District Health Authority as the as the model for its submissions on the provincial health authority Health Care unit.

> The Health Care bargaining unit at the Capital District Health Authority has two essential features; it includes the classifications that were included in the Technical Classification and Pay Plan, Professional Classification and Pay Plan and the Health Service Classification and Pay Plans (HSA) and (HSB) in the Civil Service and it performs the function of a residual bargaining unit.
>
> The broad scope of the Health Care bargaining unit reflects the unique nature of the Queen Elizabeth II Health Sciences Centre which provides health services which demand a high level of technical, professional employees and the employees other than Registered Nurses who are directly engaged in the care of patients.
>
> The classifications included in the Health Care bargaining unit at the Capital District Health Authority are those that perform functions that are directly or indirectly related to the assessment and treatment of patients, those whose functions involve regular collaboration with other team members in providing patient care, those who perform work which is unique to the assessment and treatment of patients in acute care facilities and, to a certain extent classifications which are not unique to the provision of health services but which are closely connected due to the nature of their work with the employees who are performing work which is unique to healthcare.[197]

[372] The NSGEU says it is a "residual" unit because the original residual unit, Service Support, is not a residual unit in the Capital District Health Authority.

> These unique features of the Queen Elizabeth II Health Sciences Centre resulted in a bargaining unit configuration at the Queen Elizabeth II Health Sciences Centre and the Capital District Health Authority which features three narrowly defined bargaining units and one large unit made up of technical and professional employees as well as employees who provide health care services directly or indirectly to patients.

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[196] Mandy Proulx Affidavit, December 8, 2014, ¶ 18 - 19
[197] Grant Vaughan Affidavit, November 28, 2014, 48 - 50

> Unlike the standard hospital bargaining units described in guidelines adopted by the Labour Relations Board, the Service Support bargaining unit at the Capital District Health Authority is comprised of employees directly involved in physical plant operation and maintenance, cleaning, food preparation and distribution and laundry services.
>
> The narrow scope of the Service Support bargaining unit reflects the initial decision by NSGEU and the Queen Elizabeth II Health Sciences Centre to combine the employees in the Maintenance and Operational Services Classification and Pay Plan and the Service Classification and Pay Plan in place at the Victoria General Hospital to form the Service Support bargaining unit.
>
> The Service Support bargaining unit did not function as a residual bargaining unit and specifically did not include classifications of employees who in the Civil Service would be classified in the Technical Classification and Pay Plan and the Professional Classification and Pay Plan.
>
> The classifications that have been included in the Service Support bargaining unit at the Capital District Health Authority have a strong community of interest as a result of the nature of their work and that bargaining unit had provided a stable and cohesive framework for effective collective bargaining over the last several rounds of bargaining.[198]

[373] The employers accept this characterization and reply:

> While these roles conduct work that is unique to the provision of health services, they do not fit within the criteria for the Health Care unit set forth in the *Health Authorities Act*, as the primary responsibility of these roles is to build and maintain equipment used in a health care setting.
>
> Instead, this work is a better fit for the Support bargaining unit. The criteria set forth for this bargaining unit in the Health Authorities Act state that roles are "engaged primarily in a non-clinical capacity to provide operational support in respect of the provision of health services".[199]

[374] Collectively, the unions submit the employers take too narrow an approach to what is clinical by limiting it to "direct" patient care not "primarily in a clinical capacity to provide patient care" ignoring broader based collaboration. They do so without being able to articulate the nature of what is referred to in generalist terms as "Models of Care." A model of care is the way health care services are organized and delivered. When asked, the current employers do not know what model of care for what services the future employer will embrace and posit that it will be years before whatever is envisioned will be implemented.

[375] Collectively, the unions submit this is too much on top of everything else and creating unnecessary turmoil – a new employer with new leadership; changes in

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[198] Grant Vaughan Affidavit, November 28, 2014, 40 - 44
[199] Mandy Proulx Affidavit, December 8, 2014, ¶ 26 - 27

bargaining agents; loss of local union leadership; realignment of classifications; and commencement on April 2, 2015 of province-wide collective bargaining for all four bargaining units for entirely new collective agreements in which the unions will seek to include the best of current collective agreements (leveling up); and anticipate the effects of shared service restructuring.

[376] The unions submit this is exacerbated by the fact change is not being imposed or managed "carefully" as was forecast in the Minister's report – "Change of this magnitude must be done carefully, and cannot be done successfully unless those who work within the system are engaged and involved."[200]

[377] Unifor submits:

> The employers' principles relating to classification realignment; as set out in its November 25, 2014, document entitled "Criteria for Determining Bargaining Unit Placement" includes a host of subjective concepts that are not in keeping with either the *Act* or with the concept of creating the least amount of disruption to workers in their provision of health care services.
>
> **********
>
> … the employer includes in the Health Care Bargaining Unit those employees that "may not have patient contact on a regular basis, but provide clinical care by performing functions that are critical to the clinical treatment of patients…." While this may be understandable, it is not in keeping with the structures of the *Act* or the historical bargaining unit alignment that some classifications have had with others. The employers' subjective elements create a situation where the movement, or non-movement, of classifications is determined not by negotiation between union and employer, not by historical alignment, and without regard to the express terms of the *Act*. More disturbing, in Section 2 of its document the employers introduce concepts of: related rules, recruitment and retention, career progression and team capacity; none of which relate to the term "clinical" or to any of the other factors by which classification determinations are made.[201]

[378] Unifor submits in determining community of interest for bargaining unit groupings in the context of restructuring the history of collective bargaining should be given greatest weight among the commonly accepted factors.

> In determining a community of interest, the Nova Scotia Labour Board has endorsed "the framework for analysis provided by George W. Adams in his text *Canadian Labour Law* (Aurora, Ont.: Canada Law Book, loose leaf). (*Acadia University Faculty Assn. v. Acadia University* [2003] N.S.L.R.B.D. No. 1) Those factors include: (1) similarity in the scale and manner of determining earnings; in employment benefits, hours of work and other terms and conditions of

[200] *Health Care Conversations: What We Heard*, Nova Scotia, June 2014, p. 1
[201] Submissions of Unifor Locals 4600, 4603 and 4606, ¶ 57; 59

> employment; in the kind of work performed; and in the qualifications, skills and training of employees; (2) the frequency of contact or interchange among employees and the geographic proximity of work places; (3) continuity or integration of production processes; (4) common supervision and determination of labour relations policy; (5) relationship to the administrative organization of the employer; (6) history of collective bargaining; and (7) desires of affected parties and employees.
>
> With respect to all of these, it is Unifor's position that what is being dealt with in this proceeding is a province wide health care reorganization and classifications which have been grouped together for many years in a regionally based structure where there has been significant interaction between unions during bargaining; therefore if there is to be any application of the Adams' factors the greatest weight should be given to adhering to the historical patterns and creating the least disruption possible for the employees.
>
> In keeping with the primary rule of "if it ain't broke, don't fix it", classifications should not be moved unless failing to would result in serious labour relations harm.[202]

[379] The unions submit the employers have not identified any "concrete, demonstrable problems" that will result from continuing to include in the Health Care units the groups of employees that have always been in the unit and are not in another bargaining unit.[203] The criteria the employer seeks to apply is "no more principled than retaining the *status quo* and is certainly more disruptive with respect to employees and the delivery of health care."[204]

[380] The unions submit the employers are looking to what they regard as their past problems in impasse resolution, such as the retention incentive in Health Care collective agreements – "Upon completion of twenty-five years of service with the Employer, all permanent employees will receive an additional salary increment of 3.5% greater than the highest rate in effect for the applicable classification."

[381] The unions submit the employers are not looking to the unknown future models of care or the problems being created for the successor provincial health authority, such as paying and costly tracking employees this retention incentive benefit some employees currently have and are promised they will not lose when they are moved to new bargaining units and given grandparent rights under new collective agreements.

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[202] Submissions of Unifor Locals 4600, 4603 and 4606, ¶ 65-67; See also *Cambridge Sydney Ltd*, 2011 NSLB 84 (CanLII). ¶ 23 (cited as "Cambridge Suites" in Submissions of the Employer, December 4, 2014, ¶ 125

[203] *Active Mold Plastic Products*, 1994 CanLII 9940 (ON LRB), ¶ 30

[204] Submissions of Unifor Locals 4600, 4603 and 4606, ¶ 77

Or the problems it will create when these employee are working with other employees in the new unit under the same collective agreement who do not have this benefit. Unless, of course, it is given to everyone, which the employer would not agree to in past collective bargaining.

[382] A compounding factor is the disclosed limitations of the SAP relational database management system that does payroll system and which optimistically will not be able to respond to organizational change until, at least, September 2015 when it is hoped there will be a unique identifier for the new provincial health authority embedded in the relational database.

> SAP is the system of record for all human resources employee data, and also processes the bi-weekly payroll on behalf of the Employers. It is used to generate seniority lists, provision group benefits (medical, pension, etc.), process scheduling system and other absence and attendance data, and payroll including generating an electronic pay advise, Electronic Funds Transfers to financial institutions, and more.
>
> SAP also interfaces directly with a number of third party software systems including staff scheduling interfaces, benefits providers, recruitment systems and pension providers. Employers identify and request changes to the system as required, and we work together to identify business impacts, system impacts and associated timelines to implement.
>
> SAP is currently set up with 10 unique SAP Company Codes, one for each of the Employers. Only the current collective agreements which are applicable to the current Employers are configured in SAP for that Employer. While some of the configuration is the same, much of it is different, and the same configuration does not exist in all 10 Company Codes.
>
> I, and the EBS [Enterprise Business Support] team, have worked with SAP Canada to determine the best approach to support the new Provincial Health Authority ("PHA") requirements, and have confirmed a new SAP Company Code is required. Setting up the PHA in SAP, and moving of all the employees into that new Company Code will be the final step in the process.
>
> Presently, when an employee working under a collective agreement takes a job under a different collective agreement with a different Employer, the employee is treated by the system as a new employee because of the different Company Codes. When an employee working under a collective agreement takes a job under a different collective agreement within an Employer, the terms and conditions configured for that collective agreement apply.
>
> We are limited in what SAP can support across collective agreements until the new Company Code is configured. The exception is where SAP has been configured to account for collective agreement provisions which apply already across these boundaries. These same boundaries will exist at the time of the DHA merger until such time as the new SAP Company Code configuration can be completed.

> The EBS implementation partner for the new SAP Company Code is CGI. Together, we have determined that within SAP it is not possible to have existing employees governed by a different collective agreement while maintaining the former provisions until the new Company Code is configured. Building the new Company Code requires a significant amount of technical effort and testing to ensure payroll is not negatively impacted. In order to do this we need to know the bargaining unit composition, bargaining agent for each, and the identity of any Operating Agreements, if they are used. We then need to build the Company Codes, move the employees into them, and complete the necessary testing (including payroll before and after comparisons). At the time of the merger of the DHAs, the new SAP Company Code will not be configured.
>
> Presently our operating assumption is that as of April 1, 2015 existing employees will continue to be set up in the SAP system under their current Company Codes with their former Employer under their present collective agreements. This will mean that all provisions currently configured in the SAP payroll system for these employees will remain the same April 1, 2015.
>
> While the maintenance of current provisions as configured in SAP as of April 1, 2015 is fully supportable, this is only to the extent that current employees stay within the areas in which those provisions are presently configured. Again, this is due to the system configuration of the present SAP Company Codes. Until the new company Code is configured, SAP will not be able to support the continued application of the former collective agreement provisions in relation to employees who take a job in an area in which their present collective agreement is not configured.
>
> SAP currently calculates union dues based on the SAP Company Code and associated collective agreement. SAP is able to continue to deduct union dues from employees, at the same rates as previously deducted, according to the provisions of their present collective agreements and remit them to whatever bargaining agent is applicable after April 1, 2015. Any changes requested to the rate of deduction however, would not be supported by SAP until the new Company Code is in place due to the fact the system is configured by collective agreement, not by employee.[205]

[383] The unions identify there are foreseeable problems with the provincial health authority employers deducting union dues from employees at a higher or lower rate than the one payable to the new union representing them at April 1, 2015.

[384] Individual local unions resent the disruption and threat to their continued existence and representation because neither they nor their members "are the cause of what the government says the legislation is designed to address."[206] These are past collective bargaining process delays, the number of collective agreements and having Licensed Practical Nurses outside the Nursing unit.

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[205] Jamey Martell Affidavit, December 1, 2015, ¶ 6 - 16
[206] Submissions of Unifor Locals 4600, 4603 and 4606, ¶ 55

> Bill 1 is apparently designed to "rationalize" the administration of the health care delivery system, including the Liberal Government's concerns about the process of collective bargaining in the health care sector.
>
> *********
>
> Throughout the time period between stating its intention to merge the Health Care Districts and its introduction of Bill 1, the unions tried to find a way of addressing the concerns of government while respecting the rights of workers to remain in the unions they had chosen and the collective agreements they had fought for. However, during this entire period the Government never really let it be known what "all the concerns of government" were. The unions were therefore at a complete disadvantage in trying to find a solution when every attempt was met with a flat rejection.[207]

[385] The Nova Scotia Labour Board guidelines establish a Health Care unit of employees who are "directly concerned with the treatment of patients." The legislation describes the unit as employees who "occupy positions that require them to be engaged primarily in a clinical capacity to provide patient care." A clinical capacity is being involved or concerned with the observation and treatment of living patients. This does not mean an employee must be at a bedside.

[386] The employers have recognized this to some extent in the application of its criteria "Collaborate with other team members in delivering direct patient care." How far the team extends and the extent to which the status quo should be maintained requires closer examination.

[387] The five groups of Health Care employees the employers propose moving to the two health authority Clerical units are in the following table. Two groups are exclusively in the Halifax Regional Municipality at the Capital District Health Authority and IWK Health Centre.

Table 11: 5 Groups; 92 Classifications; 250 Positions

Health Care Groups and Classifications Proposed for Clerical Unit		Employer	Union	# Employees
	Coordinate & Planning Function			
1	Advisor Patient & Public Engagement	CHDA	NSGEU	1
2	Childhood Educator	CHDA	NSGEU	1
3	Coordinator Affiliate Placement	CHDA	NSGEU	1
4	Coordinator Clinical Product	CHDA	NSGEU	1
5	Coordinator Community Health Board	CHDA	NSGEU	8

[207] Submissions of Unifor Locals 4600, 4603 and 4606, ¶ 37 – 38; 40

6	Coordinator Early Psychosis Education	CHDA	NSGEU	1
7	Coordinator Education & Advanced Trauma	CHDA	NSGEU	1
8	Coordinator Health Promotions	AVDHA	CUPE	1
9	Coordinator Palliative Care	CHDA	NSGEU	1
10	Coordinator PHC Connections	CHDA	NSGEU	1
11	Coordinator PHC Program	CHDA	CUPE	1
12	Coordinator Primary Health Care	PCHA	CUPE	1
13	Coordinator Primary Health Care Project	AVDHA	CUPE	1
14	Coordinator Simulation Services	CHDA	NSGEU	1
15	Coordinator Stroke Program	CHDA	NSGEU	1
16	Coordinator Trauma Registry	CHDA	NSGEU	1
17	Health Records Administrator	CBDHA	CUPE	2
18	Health Records Administrator	AVDHA	CUPE	1
19	Health Records Administrator	CHDA	NSGEU	5
20	Health Records Administrator	IWK	NSGEU	1
21	Health Records Administrator B	CHDA	NSGEU	2
22	Health Records Technician	SWNDHA	CUPE	7
23	Health Records Technician	CEHHA	CUPE	7
24	Health Records Technician	PCHA	CUPE	7
25	Health Records Technician	AVDHA	CUPE	5
26	Health Records Technician	CBDHA	CUPE	5
27	Health Records Technician	CHA	CUPE	3
28	Health Records Technician	CHDA	NSGEU	18
29	Health Records Technician	IWK	NSGEU	12
30	Health Records Technician	GASHA	Unifor	22
31	Health Records Technician B	CHDA	NSGEU	9
32	Health Records Technician in Training	GASHA	Unifor	2
33	Knowledge Exchange Facilitator	CHDA	NSGEU	1
34	Librarian Educator	CHDA	NSGEU	2
35	Program Admin Officer Cancer Care NS	CHDA	NSGEU	1
36	Project Coordinator	CHDA	NSGEU	2
37	Project Coordinator NSH	CHDA	NSGEU	1
38	Project Officer Education	CHDA	NSGEU	1
39	Project Officer Rehab	CHDA	NSGEU	1
40	Project Officer Research	CHDA	NSGEU	1
	Total			141
	Management of Data & Information			
41	Data Integrity Auditor	IWK	NSGEU	1
42	Data Integrity Officer	CDHA	NSGEU	5
43	Registry Assistant	CDHA	NSGEU	1
44	Research & Statistics Officer 1A	CDHA	NSGEU	1
45	Research & Statistics Officer 2	CDHA	NSGEU	1
46	Research & Statistics Officer A	CDHA	NSGEU	3

47	Research & Statistics Officer B	CDHA	NSGEU	2
48	Research & Statistics Officer C	CDHA	NSGEU	2
49	Tissue Bank Customer Service Representative	CDHA	NSGEU	1
	Total			17
	Closely Related to Included Classifications			
50	Architectural Assistant 2	CDHA	NSGEU	1
51	Audiovisual Technician B	CDHA	NSGEU	1
52	Community Development Advisor	CDHA	NSGEU	1
53	Coordinator Clinical Data	IWK	NSGEU	1
54	Coordinator Continuing Care Education	CDHA	NSGEU	1
55	Coordinator Diversity & Inclusion	CDHA	NSGEU	1
56	Coordinator French Language	CDHA	NSGEU	1
57	Coordinator Healthy Built Environment	CDHA	NSGEU	1
58	Coordinator Safety	CDHA	NSGEU	4
59	Coordinator Supported Work	CDHA	NSGEU	1
60	Coordinator Workplace Health Promotion	CDHA	NSGEU	1
61	Drafting & Illustration Tech	CDHA	NSGEU	1
62	Financial Services Officer A	CDHA	NSGEU	3
63	Funding Officer	CDHA	NSGEU	1
64	Graphic Designer	CDHA	NSGEU	1
65	Graphic Designer	IWK	NSGEU	1
66	Health Interpretation Officer	CDHA	NSGEU	1
67	Product Factor Utilization Officer	CDHA	NSGEU	1
68	Registry Assistant (above also?)	CDHA	NSGEU	1
69	Safety Response Officer	CDHA	NSGEU	1
70	Supply Technician A	CDHA	NSGEU	16
71	Supply Technician B	CDHA	NSGEU	1
72	Voice Analyst	CDHA	NSGEU	2
	Total			44
	Involved in or Essential to Treatment			
73	Coding Classification Specialist	SSDHA	CUPE	5
74	Coordinator Funding	IWK	NSGEU	2
75	Coordinator Funding Remedial Seating	IWK	NSGEU	2
76	Coordinator Volunteer Services	SWNDHA	CUPE	1
77	Coordinator Volunteer Services	CDHA	NSGEU	5
78	Coordinator Wellness Program	GASHA	CUPE	1
79	Health Educator	CDHA	NSGEU	1
80	Health Promotion Team Lead	CDHA	NSGEU	1
81	Quality Safety & Accountability Advisor	PCHA	CUPE	1
82	Quality Technician	CDHA	NSGEU	1
83	Resource Facilitator	PCHA	CUPE	9
84	Screening Access Officer	CDHA	NSGEU	1
	Total			30

	Library			
85	AV Library Technician	IWK	NSGEU	1
86	Health Sciences Librarian	CBDHA	Unifor	1
87	Librarian	CEHHA	CUPE	1
88	Librarian	PCHA	CUPE	1
89	Librarian 1	SWNDHA	CUPE	1
90	Library Assistant	SWNDHA	CUPE	1
91	Library Assistant	IWK	NSGEU	2
92	Library Technician	CDHA	NSGEU	10
	Total			18

[388] The accuracy and completeness of this list of classifications and groupings requires further review and discussion by the employers and unions. Consequently, I reserve jurisdiction on this issue to be addressed in a continuation of this arbitration.

7.3 Clerical Unit Composition

[389] Most of the classification positions the employers propose for inclusion in the Clerical unit have been addressed above.

Resource Facilitator (Clerical)

[390] Locals of CUPE represent 24 employees in Resource Facilitator classification positions employed by three district health authority employers in the planned Northern Management Zone of the provincial health authority. The employees are in Clerical units with two employers and the third employer's Health Care unit. The IWK Health Centre does not employ Resource Facilitators.

[391] CUPE agrees with the employers that Resource Facilitators should be in the Clerical unit of the provincial health authority.

[392] The unionized employees in this classification position will be included in the Clerical unit for the provincial health authority at April 1, 2015.

Buyers, Senior Buyers & Procurement Coordinators (Clerical)

[393] In the Capital District Health Authority, thirteen Senior Buyers are in the Health Care unit. In four other district health authorities, Buyers are in Clerical units. All these employees perform procurement functions.

[394] The Clerical bargaining unit is described as: “composed of all unionized employees who occupy positions that require them to be engaged primarily in a non-clinical capacity to perform functions that are predominantly clerical or administrative.”[208]

[395] The NSGEU submits the Senior Buyer is functionally tied to the positions in the Health Care unit. The related Coordinator Procurement position in the Procurement Department is responsible to ensure clinically acceptable products and services for patients are delivered at the best possible price.[209] The position is described:

> The Procurement Coordinator is responsible throughout CDHA for the effective and efficient procurement of all goods/services including Capital Equipment throughout the district. It is the responsibility of this position to manage a group of buyers and to ensure that clinically acceptable products and services are delivered at the best possible price. This position is also responsible for using the Public Tendering System to request process and information from companies worldwide to ensure best competitive bidding. It is also the responsibility of this position to ensure that buyers have the best possible direction to be able to do their jobs effectively and that through them, goods arrive at the various institutions in a timely manner and that the appropriate goods are purchased.

[396] While the Capital District Health Authority has a position description for a Material Management Department classification titled Medical/Surgical Products Coordinator in the Health Care bargaining unit, this position is not on the employers’ lists.

[397] Procurement positions have more community of interest with employees in the Clerical unit than the Health Care unit. The unionized employees in these classification positions will be included in the Clerical unit for each health authority at April 1, 2015.

Stores (Clerical)

[398] The following table contains the current distribution and bargaining unit assignment of employees in stores classifications. The employers propose and CUPE agrees the unionized employees in these positions should be included in the Clerical unit of the provincial health authority.

[399] The unionized employees in these classification positions will be included in the Clerical unit for the provincial health authority at April 1, 2015.

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[208] s. 90(1)(c)
[209] Grant Vaughan, Affidavit , November 28, 2014, ¶ 62(i)

Table 12: Distribution of Stores Classifications and Positions

	SSDHA			SWNDHA			AVDHA			CEHHA			CHA			PCHA			GASHA			CBDHA			CDHA			Total	IWK		
	Health Care	Clerical	Service	Health Care	Clerical	Service	Health Care	Clerical	Service	Health Care	Clerical	Service	Health Care	Clerical	Service	Health Care	Clerical	Service	Health Care	Clerical	Service	Health Care	Clerical	Service	Health Care	Clerical	Service		Health Care	Clerical	Service
Stores Clerk			11			7			13			9			4			6					19					69			
Senior Stores Clerk									1									1										2			
Stores Team Lead																									4			4			
Stores Clerk A																										38		38			
Stores Clerk B																										19		19			
Stores Clerk C																										2		2			
Stores Delivery Clerk																										1		1			
Clerk 2 - Stores																		5										5			
Order Clerk																												0			1
Shipping/Receiving Clerk																												0			4

Eight PH&AS Clerk and Secretarial Classifications (Clerical)

[400] The employers and NSGEU agree the following classifications and the unionized employees occupying positions in the Public Health and Addiction Services units are to be included in the provincial health authority Clerical unit.

	Classification	SSDHA	SWNDHA	AVDHA	CEHHA	CHA	PCHA	GASHA	CBDHA	Totals
1	Clerk 1								1	1
2	Clerk 2					2				2
3	Clerk 2 Continuing Care	2		1					1	4
4	Clerk 3 Financial Continuing Care	1					1		2	4
5	Clerk 3/Secretary 2	1	3	3	5			1	15	28
6	Secretary 1	5	5	2	1	3	2	4	7	29
7	Secretary 1 Continuing Care				2					2
8	Secretary 2	7	3	3	6	6	7	12	11	55
										125

[401] CUPE did not make submissions. A CUPE local union represents seven employees in Secretary 2 positions in this group.

[402] The unionized employees in these classification positions will be included in the Clerical unit for the provincial health authority at April 1, 2015.

Maintenance Planner (Support)

[403] Unionized employees occupy positions in this classification in the Clerical unit in the Cape Breton District Health Authority and the Service unit in the South Shore District Health Authority. The employers and CUPE agree these positions are to be in the Support unit of the provincial health authority.

[404] I agree. The unionized employees in these classification positions will be included in the Support unit for the provincial health authority at April 1, 2015.

Twenty Five PH&AS Classifications (reserved for continuation)

[405] The following table lists the classifications and positions the NSGEU submits should be in the provincial health authority Health Care unit. It applies the same

approach it takes for the classifications and occupied positions in the Capital District Health Authority Health Care unit.

Table 13: PH&AS Classifications Reserved for Continuation

	Classification	SSDHA	SWNDHA	AVDHA	CEHHA	CHA	PCHA	GASHA	CBDHA	Totals
1	Coordinator Education								1	1
2	Coordinator Prevention & Health Promotion	2	2	1						5
3	Coordinator Prevention Project						2			2
4	Coordinator Quality Management		2	2			1	1	1	7
5	Coordinator Social Marketing	2								2
6	Data & System Quality Leader	1								1
7	Financial Services Officer 2	1			1				1	3
8	Health Educator				1	1	1	2	2	7
9	Health Equity Promoter							1		1
10	Health Equity Team Lead							1		1
11	Health Promoter	4	4	2						10
12	Health Promotion & Prevention Team Lead			1					1	2
13	Health Promotion Specialist								6	6
14	Healthy Development Team Lead							1		1
15	Knowledge Exchange Facilitator	1								1
16	Planning & Development Officer						1			1
17	Prevention & Education Officer				3		1			4
18	Program Admin Officer Drug Addiction Health Promotion					1				1
19	Program Admin Officer Gambling Health Promotion					1				1
20	Program Admin Officer Gaming Strategy							1		1
21	Program Admin Officer Smoking Treatment/Cessation							2		2
22	Program Admin Officer Tobacco Reduction Health					1				1

	Promotion									
23	Program Administration Officer 4				1					1
24	Project Assistant				1					1
25	Research & Statistics Officer						1		1	2
										65

[406] Whether these classifications and positions are more appropriately included in the Clerical or Health Care unit at April 1, 2015 is an issue that requires further attention. Consequently, I reserve jurisdiction on this issue to be addressed in a continuation of this arbitration.

7.4 Support Unit Composition

[407] Two Coordinator classifications with positions in the Service unit and another unit which the employers propose for inclusion in the support unit have been addressed above.

Transportation Driver (Support)

[408] One employee in this classification position is in the Clerical unit employed by Guysborough Antigonish Strait Health Authority and a second employee is employed by the Cape Breton District Health Authority in the Health Care unit.

[409] CUPE agrees this classification position is appropriate for inclusion in the Support unit, which is described as:

> composed of all unionized employees who
> (i) occupy positions that require them to be engaged primarily in a non-clinical capacity to provide operational support in respect of the provision of health services, and
> (ii) are not included in the clerical bargaining unit.[210]

[410] The unionized employees in these classification positions will be included in the Support unit for the provincial health authority at April 1, 2015.

Three PH&AS Classifications (Support)

[411] The employer proposes three classifications – Cook, Housekeeping Aide and Maintenance Worker – with six positions occupied by unionized employees of the Pictou

[210] s. 90(1)(d)

County Health Authority in the Public Health and Addiction Services unit are to be included in the Support unit of the provincial health authority. The NSGEU agrees.

[412] The unionized employees in these classification positions will be included in the Support unit for the provincial health authority at April 1, 2015.

8. SENIORITY INTEGRATION

[413] The "integration of seniority of unionized employees in each bargaining unit" is to be determined.[211] With the exception of one issue, the unions and employer achieved agreement that meets the basic principle that each employee in a bargaining unit is given seniority of the same basis as other employees in the bargaining unit.

[414] The issue in dispute is whether the employers or individual regular employees should bear initial responsibility to identify when an employee's seniority date at April 1, 2015 with a health authority will be earlier than it currently is with a district health authority because the employee is entitled to an adjustment based on casual hours worked before becoming a regular employee for which the employee was not given credit previously in calculating seniority.

[415] The agreed credit entitlement and retroactive adjustment is to harmonize seniority among employees going into the same bargaining unit from disparate units covered by differing collective agreement seniority provisions.

[416] The employer submits:

> The employers accept the framework of the common proposal put forth by the Unions. However, paragraph 2 of the proposal requires the Employers to identify all employees who had casual hours back to January 1, 2008, determine the number of those hours, and adjust their seniority. The employers submit that the same end result can be accomplished by employees making a request to the employer to check the records. Only the records of those employees who believe they have such hours to be converted would need to be checked. The employers believe this would greatly reduce the volume of work.[212]

[417] The employers identified some of the challenges some employers will face retrieving records that pre-date their use of the SAP payroll system. One is that legacy data from a prior system is no longer accessible for reporting detailed historical data.[213]

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[211] Ss. 86(1)(d), 88 and 93.
[212] Final Submission of the Employers, ¶ 98
[213] E.g., Rick Wentzell Affidavit, December 1, 2014

[418] This restructuring is presenting challenges for both employers and unions, but it must be accomplished with minimal burden on individual employees. The seniority integration agreement is a fair approach for all employees and all must have the benefit of all its provisions. The unions will ensure their members are aware of this aspect of the restructuring process ahead. It is their responsibility to communicate to their members what will happen. Similarly, it is the employers' responsibility to communicate with their employees. In some instances, unions and employers might issue joint communications.

[419] Communication to employees explaining the entitlement to additional seniority credit will prompt some to inform their employer they believe they have an entitlement. This will assist the employers.

[420] Employees hired as regular employees before or after certain dates will have no entitlement. Some employees have been credited with this entitlement in the past under some collective agreements. They will not be eligible. There are parameters the employers can use to identify the cohort that potentially have an entitlement.

[421] There are employer costs with employer initiated restructuring. This will be one of them.

[422] I have determined the agreement signed by the unions will be the determination of seniority integration under the *Health Authorities Act* with date changes in paragraphs 10 and 11. These timeline changes account for the Minister's extension for making this decision from January 1st to 19th.

[423] I order that the determination of integration of seniority of unionized employees in each bargaining unit is in accordance with the terms in Schedule 1.

9. ALL COLLECTIVE AGREEMENTS REMAIN IN FORCE

[424] Reassigning groups of employees among bargaining units, extinguishing the Public Health and Addiction Services units, reducing the number of bargaining units and having changes in bargaining agents requires a decision on how existing collective agreements will apply after April 1, 2015 until new collective agreements based on the restructured labour relations landscape are negotiated.

[425] The *Health Authorities Act* requires these determinations:

> whether, in respect of each bargaining unit,
>
> (i) only a collective agreement to which the bargaining agent, as determined under clause (b), is a party is to remain in force and apply to all unionized employees within the bargaining unit, or
>
> (ii) all of the collective agreements pertaining to the unionized employees within the bargaining unit are to remain in force;[214]

[426] The choice is one or all for each bargaining unit. If the choice is all, then the Mediator-Arbitrator can segment application of agreements within a unit, modify or restrict the operation of provisions and interpret provisions of collective agreements.

> **(2)** Where the order provides that all of the collective agreements pertaining to the unionized employees within a particular bargaining unit are to remain in force, the order may
>
> (a) specify which unionized employees in the bargaining unit are to be covered by each collective agreement;
>
> (b) modify or restrict the operation or effect of any provision of any of the collective agreements and define the rights with respect to the collective agreement of any unionized employees affected by the determination of the matters referred to in subsection 86(1) or Section 88; and
>
> (c) interpret any provision of any of the collective agreements.[215]

[427] Discussions on a protocol to address this transitional period in the context of disputes over the precise composition of each of the eight bargaining units and the identity of bargaining agents continued among the unions and between them and the employers throughout and after the hearing.

[428] One of the many complicating factors is that when more than one current collective agreement applies to positions in the same classification and all classification positions are included in the same bargaining unit there will continue to be more than one current or "original collective agreement" for the classification applicable to different positions. If an employee moves from one position to another within a bargaining unit before a new collective agreement is achieved is there to be a change in the "original collective agreement" that applies to that employee? If the change in positions is from one bargaining unit to another and more than one "original collective agreement" is in place for classification positions in the new bargaining unit, which agreement will apply to the employee newly arriving in the unit?

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[214] s. 86(1)(d)
[215] s. 94(2)

[429] It is not possible to anticipate and make provision for all circumstances that will emerge. The extent of workplace complication is lessened by the fact current collective agreements are rooted in geographic areas and facilities so that movement within a facility or community outside the Halifax Regional Municipality area will likely present fewer conundrums for resolution. This highlights the reality that the identified problems that have driven this labour relations restructuring approach are problems in the Halifax Regional Municipality, not communities in rural Nova Scotia.

[430] Another challenge is envisioning and anticipating a landscape that has not been determined and for which each party has a different plan.

[431] After many iterations and building on the agreement on integration of seniority, the framework of a protocol gained general acceptance. The approach is that at April 1, 2015 current employees will continue to have the benefit and limitations of their current seniority pools and their current collective agreements under composite transitional collective agreements for the newly configured bargaining units until new agreements for the bargaining units are concluded.

[432] As the employer describe: “While employees in a hospital might change bargaining units, the employees would stay under the same collective agreements, with the same seniority pool.” And further: “In other words, no employee will have more than 1 collective agreement apply, even though there will be multiple collective agreements in a bargaining unit.” [216]

[433] This approach is consistent with the promise employees will not have employment benefits swept away by district health authority consolidation. It recognizes there will be changes, but they will be the result of future collective bargaining under restructured collective bargaining relationships.

[434] During the transition period, which will likely vary among the bargaining units, explaining and administering the transitional collective agreement will be challenging for both union representatives and local management.

[216] Final Submissions of the Employers, ¶ 97.a and 97.b

[435] The challenge will vary according to the extent there are common provisions among the current or “original” agreements forming one of the “composite” transitional agreements. There will be fewer current agreement components of the composite transitional agreements in the Clerical unit than the Nursing unit.

[436] It is envisioned newly negotiated collective agreements replacing transitional collective agreements will not be composite agreements with segmented application among groups of employees in a bargaining unit. Newly negotiated agreements will likely be an integrated amalgam of provisions from current collective agreements, but they will not be composite agreements.

[437] There was discussion and references to the interaction of this approach and section 104 of the *Health Authorities Act* in collective bargaining for collective agreements to replace the transitional collective agreement.

> For the purpose of concluding a new collective agreement in respect of a bargaining unit, where an order issued under subsection 87(1) or Section 93 provides that, in respect of that bargaining unit, all of the collective agreements pertaining to the unionized employees within the bargaining unit are to remain in force, the collective agreement to which the bargaining agent that represents the bargaining unit is a party is deemed to be the expiring collective agreement.

[438] The practical effect of this provision and its interaction with the freeze on collective bargaining imposed by sections 98 and 102 of the *Health Authorities Act* as it might affect the time at which collective bargaining can commence have not been explored.[217] Sections 98 and 102 state:

> 98 Before April 1, 2015, neither a district health authority nor a union may
>
> (a) give notice under Section 33 or 34 of the *Trade Union Act* requiring the other to commence collective bargaining;
>
> (b) commence or continue collective bargaining under Section 35 of that Act; or
>
> (c) notwithstanding Sections 5 to 7 of the *Essential Health and Community Services Act*, commence or continue negotiations for an essential health or community services agreement.
>
> 102 (1) Any lockout or strike between a district health authority and a union that is taking place at the time this Section comes into force must cease until April 1, 2015.
>
> (2) Where, on the coming into force of this Section, a conciliation officer has filed a report pursuant to subsection 38(1) of the *Trade Union Act*

[217] *Trade Union Act*, s. 34

> and the 14-day period provided for in subsection 47(1) of the *Trade Union Act* has begun, no further time of that period elapses until April 1, 2015.
>
> (3) Where, before April 1, 2015, a conciliation officer files a report pursuant to subsection 38(1) of the *Trade Union Act*, the 14-day period provided for in subsection 47(1) of the *Trade Union Act* does not begin until April 1, 2015.

[439] There is no real world foundation for interpreting section 104 until the bargaining agent for each bargaining unit is determined. For this reason, the protocol ordered in Schedule 2 contains no reference to section 104.

[440] Some protocol provisions were not agreed by all. Schedule 2 contains the protocol I order. It contains my decisions on differences and is an abridged text of the final iteration submitted by the unions and employer. A proposed provision relating only to the Nursing unit is a matter the bargaining agent and employers can address in anticipation of or after April 1, 2015.

[441] The combination of this protocol and the agreement on seniority integration are responsive to the concerns raised in August about employee mobility within the single provincial health authority employer.

[442] The protocol includes a procedure to resolve disputes of both a general nature and for individual employees. If this protocol overlooks a matter or the text is unclear, any proposed amendments can be an agenda item for the continuation of this arbitration.

10. BARGAINING AGENT CERTIFICATION

[443] Majoritarianism is a fundamental principle of western liberal democracies. A numerical majority in a group has the power to make decisions that bind all members of the group.

[444] Because group minorities accept decisions by a numerical majority made within accepted constraints or limitations, such as not being able to bind a future majority or exclude a minority, the democratic majoritarian principle is our most important means of peacefully resolving conflicts.

[445] The democratic majoritarian principle permeates our formal institutions from Parliament and the Supreme Court of Canada to the rules of order commonly used in

group decision making. It is the decision making principle at every level of elected government. It is the principle used in regular, annual, impromptu and extraordinary meetings of organized groups.

[446] It is the decision making method that permeates our society and is taught to children at an early age as the dominant accepted method of making group decisions. Informally, gatherings refer to it when deciding such mundane matters as whether to go here or there for a recreation event. Often, in some circumstances, perhaps at a family table, at a sports team practice or on the shop floor, it is said: "This is not a democracy. The decision has been made." This illustrates that exceptions, not the norm, only prevail in some circumstances where there are power and role imbalances.

[447] Whether by simple majority of those participating or the more onerous majority of those eligible to participate or a percentage higher than a simple majority, it is by the majoritarian principle that decisions are made to select leaders, choose among options, engage service providers, adopt plans of action and too many other types of decisions to enumerate.

[448] It is as a consequence of a majority choice that the Liberal Party as provincial government has the legitimacy to decide on acute health care restructuring in the manner it has and that the House of Assembly passed the *Health Authorities Act*. It is because of the majoritarian principle that the Lieutenant Governor as vice regal representative gave Royal assent.

[449] Majoritarianism is a fundamental principle and value of our collective bargaining system embedded in collective bargaining legislation. As the employers describe it: "Indeed, this concept of majoritarian exclusivity is pervasive throughout labour legislation across Canada."[218]

[450] The word "majority" is used twenty times in different contexts for employees and employers in the *Trade Union Act*. One context is that thorough majoritarian choice trade unions gain and lose status as exclusive bargaining agent for a group of employees with rights and responsibilities that accompany the status. Individual

[218] Submissions of the Employers, December 4, 2014, ¶10

employees in the group lose the right to make individual contracts with their employer and access to courts and others means to address their individual employment issues.

[451] The principle and value of majoritarian employee decision making in choosing to certify unions as exclusive bargaining agents for groups of employees is so embedded in Canadian labour relations that it did not need any more elaboration in a major national review in 1968 than the following:

> The principles which underlie the Canadian industrial relations system are reflected in Canada's heritage of fundamental western values, in the liberal democratic political system adopted in this country and in the modified capitalist or mixed enterprise economy that has developed.[219]

[452] There have been innumerable political and legal disputes over the method of determining union majority support; the eligibility for inclusion and the composition of the constituency or appropriate grouping of bargaining unit employees among whom a majority will be determined; whether an employee or employees in a classification or job position will or will not be included in the group; weighting the expressed wishes of employees opposing certification; the date at which the wishes of a majority is to be determined; and related constituency boundary and expression of employee wishes issues. This is daily grist for labour relations board decision making. On occasion the disputes have reached the Supreme Court of Canada.[220]

[453] Since the 1689 Bill of Rights limiting the power of the Crown and establishing the rights of Parliament and holding regular elections, the evolution of democracy has been founded on the majoritarian principle which itself evolved to be more inclusive. Like certain traditions and constitutional conventions, it is so embedded there is seldom need to reflect on how basic it is to the society we are.

[454] Democracy and enhancement of democracy are values underlying and inherent in our constitution. The right to engage in collective bargaining is supported by the value of enhancing democracy. Industrial democracy is one of the core objectives of the *Trade Union Act* and collective bargaining legislation across Canada modeled on

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[219] H.D. Woods and others, *Canadian Industrial Relations: The Report of the Task Force on Labour Relations* (December 1968), ¶ 22

[220] E,g., *Canada (Labour Relations Board) v. Transair Ltd.* [1977] 1 S.C.R. 722

the American *Wagner Act*. This is employees having the sense at work of "worth, freedom and participation that democratic government promises them as citizens."[221]

[455] While statutory recognition of the principles of majority representation may not be constitutionally required in all situations and for all industries,[222] I have concluded that such a marked departure in the *Health Authorities Act* from this fundamental principle of the *Trade Union Act* cannot be implied. This is not a conclusion based on constitutional law but from a purposeful and contextual interpretation of the *Health Authorities Act*.

[456] I make this conclusion because all but a few provisions of the *Trade Union Act* continue to apply to these collective bargaining relationships established under the *Trade Union Act* and which can be changed under the *Trade Union Act* both immediately after April 1, 2015 [223] and fundamentally when the Governor in Council repeals section 83(2).[224]

[457] The collective bargaining to commence after April 1, 2015 will be regulated under the *Trade Union Act*, which presumes the union bargaining agent engaging in collective bargaining has majority support for the proposals its advances in collective bargaining and majority support as the employees' agent able to make agreements and commitments binding on individual employees, classifications of employees, employees working at specific hospitals and in specific programs and all the employees in the unit across the province.

[458] The *Health Authorities Act* transitional provisions relating to restructuring labour relations because of the anticipated employer successorship are simply a parallel process to successorship provisions of the *Trade Union Act*. While this mediation-arbitration process is a dedicated expedited process fashioned for the unique circumstances of this restructuring, it is a brief interlude on a branch line parallel to the main line on which the unions and employer have travelled for decades under the *Trade Union Act* with the Labour Board, which is still engaged in other aspects of their

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221 *Health Services and Support - Facilities Subsector Bargaining Assn. v. British Columbia* [2007] 2 S.C.R. 391 ¶ 57 quoting K.E. Klare, *Judicial Deradicalization of the Wagner Act and the Origins of Modern Legal Consciousness, 1937-1941* (1978), 62 Minn. L. Rev. 265, at pp. 281-84

222 *(Attorney General) v. Fraser*, [2011] 2 S.C.R. 3, ¶ 47

223 s. 103

224 s. 155(2)

relationships and can be reengaged in bargaining unit composition issues as early as April 1, 2015.

[459] The principle of "majoritarianism/exclusivity" is a fundamental principle of the *Trade Union Act* and, I conclude, of the *Health Authorities Act*.

> Majoritarianism/exclusivity means that the association supported by the majority of employees in the bargaining unit was the exclusive right to bargain on behalf of all employees in the unit. In a Wagner labour regime, an association that represents a minority of the employees, as much as 49 per cent of them, has no right to collectively bargain with the employer. Once a bargaining agent is certified by the relevant labour board, no other association of employees has any officially recognized status. An uncertified association has no right to bargain on behalf of workers, or so much as meet with employers to discuss the views of the workers they claim to represent. Even individual employees cannot negotiate their own terms and conditions of employment but must deal with the employer through the certified union.
>
> In light of the exclusive status accorded to the certified bargaining agent, labour legislation usually imposes on the agent a duty of fair representation. The agent must represent all employees in the unit in a manner that is not arbitrary, discriminatory or in bad faith.
>
> It is an important feature of the Wagner model that the employees' bargaining representative be structurally autonomous and independent of the employer.[225]

[460] This is a fundamental principle that logically cannot be suspended for one step in continuing coverage under the *Trade Union Act* and then reengaged under the *Trade Union Act* as if it was always in place without suspension.

[461] How can a union be an exclusive bargaining agent or be held to a duty of fair representation if it does not have majority support among the employees for whom it has exclusive bargaining authority? Why can an employee covered by a transitional collective agreement be denied recourse to the court if the union certified as the employee's exclusive bargaining agent had as members a minority of membership support at the time the union was certified in the process to replace a union that had majority support? How can a transitional collective agreement be valid and enforceable

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[225] *Mounted Police Association of Ontario v. Canada (Attorney General)*, 2012 ONCA 363, ¶ 26 – 28; Leave to appeal to S.C.C. granted February 2014. This quotation and citation is not a reference to the Ont. C.A. ultimate judgment but simply a recent source for a succinct description of "majoritarianism/exclusivity." On January 12, 2015, I was informed the Supreme Court of Canada intended to release its judgment on January 16, 2015, the last business day before this decision was to be released, I decided no further submissions were invited, permitted or to be accepted. I was informed the S.C.C. judgment was released as scheduled and asked to seek an extension of time from the Minister. I declined.

if the union party does not represent a majority of the employees the agreement covers?

[462] The interconnected principles and foundation of our collective bargaining legislation, history and values cannot be compartmentalized. The whole cannot function and will become dysfunctional if the foundation is not built on basic principles and values.

[463] There is no other choice than the conclusion this fundamental principle of Nova Scotia's collective bargaining legislation, of which the transitional labour relations restructuring provisions of the *Health Authorities Act* is a situational interlude, is inherent in and applicable to the interpretation and administration of those transitional provisions.

A. Nursing Bargaining Units

[464] It is against this background and context that the NSNU reflexively claims the right to be certified as the bargaining agent for the Nursing unit. The term "bargaining agent" is not defined in the *Health Authorities Act*. Words and expressions not defined "have the same meaning as in Part I of the *Trade Union Act*,"[226] which defines the term:

> "bargaining agent" means a trade union that acts on behalf of employees
> (i) in collective bargaining,
> (ii) as a party to a recognition agreement with their employer, or
> (iii) as a party to a collective agreement with their employer;[227]

[465] A trade union does not act on behalf of a group of employees in collective bargaining unless it has been selected by the employees to be their certified or voluntarily recognized bargaining agent or is a successor union to the one selected.

[466] With voluntary recognition, the *Trade Union Act* provides a collective agreement between an employer and voluntarily recognized union is not valid if "the trade union does not represent a majority of the employees in the unit defined by the agreement."[228]

[467] There are processes by which a union can replace another union as the bargaining agent for a group of employees if it demonstrates majority support among the employees.[229]

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[226] s. 2(20
[227] *Trade Union Act*, s. 2(1)(a)
[228] *Trade Union Act*, s. 30(3)(c)

[468] The NSNU submits the provisions of the *Health Authorities Act* relating to the Nursing unit are consistent with the *Trade Union Act* and:

> Based upon the principles of majoritarianism, and the community of interest amongst the nurses, the bargaining agent for the nurse bargaining unit should be the Nova Scotia Nurses' Union. These outcomes would meet the Bill 1 [Health Authorities Act] criterion of stable and harmonious labour relations and the provision of effective and efficient health care.[230]

[469] By the NSNU's calculation it represents and has as members 5,738 of 10,049 nurses to be included in the Nursing unit. On this calculation (57.1%), it submits: "Most importantly, the NSNU currently represents the clear majority of the combined group of LPNs and RNs [in] the proposed nurse bargaining unit."[231] Further:

> … NSNU has a majority representation of registered nurses in the DHAs and IWK. Traditionally, Labour boards recognize the bargaining agent with the majority of unionized employees. Fifth, when one looks exclusively to the LPNs, no union has a clear majority of the representation of the LPNs. NSNU represents approximately 25% of all LPNs in in the province. In NSNU's submission, in the context of nature of the LPN and RN work and the apparent community of interest, these factors should weigh more heavily in favour of the bargaining agent that represents the majority of all employees in the overall discipline of nursing.[232]

NSNU Does Not Have Required Double Majority

[470] If these calculations were correct, the resulting decision would be a simple, foregone conclusion.

[471] The NSNU represents a majority of the Registered Nurses (and Nurse Practitioners) in the Nursing unit among the employees in a consolidated provincial health authority and at IWK Health Centre. As reported in a table above, the NSNU represents 100% of the Registered Nurses employed by IWK Health Centre and 56.43% employed by district health authorities consolidated as the provincial health authority. This is 62.26% for all the Registered Nurses in both health authorities.

[472] Because the NSNU represents a majority at November 25, 2014 of the combined 987 Registered and 87 Licensed Practical Nurses in the future Nursing unit at IWK Health Centre, it could be prospectively certified for that unit effective April 1, 2015.

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[229] *Trade Union Act*, ss. 23 and 25
[230] Final Argument Nova Scotia Nurses' Union, ¶ 9
[231] Final Argument Nova Scotia Nurses' Union, ¶ 20
[232] Final Argument Nova Scotia Nurses' Union, ¶ 253

[473] However, limitations in the *Health Authorities Act* require an eligible union to have a double majority because in order for a union to be certified for one health authority Nursing unit it must also be certified for the Nursing units of both health authorities. There is no provision for combining the numbers in both units to achieve an overall majority and be certified for both.

[474] The 57.1% majority based on the NSNU numbers is an aggregate or overall percentage calculated for both units combined. It does not appear to include Registered and Licensed Practical Nurses moved to the Nursing unit of the provincial health authority from the disbanded Public Health and Addiction Services units.

[475] As calculated in the following table, the NSNU does not represent or have as members a majority of unionized employees in the Nursing units employed by the district health authorities at November 25, 2014. It has 48.9%. The NSGEU has 39.91%.

[476] Nothing less than 50% plus one is a numeric majority in any circumstance. A plurality does not count. Unions only become certified as exclusive bargaining agent for all employees in a group of employees by demonstrating support based on an absolute majority.

[477] It is possible the NSNU represents a majority if there is a mistake in my calculations or there are enough Registered Nurses currently in generic positions in the Nurses units. What those positions are and the number of Registered Nurses occupying the positions are not known and have not been addressed. In the data provided, the employers simply presumed all positions currently in the Nurses unit require a nursing certificate. The NSNU did not identify generic classifications and positions. It did not intend for them to be excluded from the Nursing unit. The NSGEU does not know which classifications in the NSNU Nurses units will be reassigned to the two Nursing units at April 1, 2015.

[478] Perhaps there is another date at which it is appropriate to determine majority and the NSNU can demonstrate majority membership at that date.

[479] Without including Licensed Practical Nurses, the NSNU represented a majority of both Nursing units in August when it was willing to have Licensed Practical Nurses included in Health Care units and the government was also willing if all other matters were resolved. As discussed, I do not have the discretion to include the Licensed Practical Nurses in the Health Care unit to assure the NSNU a double majority in the Nursing units.

Table 14: Distribution of RN and LPN Positions in Two Nursing Units														IWK
Employer		**SSDHA**	**SWNDHA**	**AVDHA**	**CEHHA**	**CHA**	**PCHA**	**GASHA**	**CBDHA**	**CDHA**	**Totals**	**Union Totals**	**Union %**	
NSNU	**RN**	297	295	428	252	208	249	300	1,081	497	**3,607**	**4,179**	**48.90%**	**987 91.9%**
	LPN				91	91	108	96		186	**572**			
NSGEU	**RN**									2,548	**2,548**	**3,411**	**39.91%**	
	LPN									523	**523**			**87 8.1%**
	OR									19	**19**			
PH&AS	**RN**	5	8	14	19	19	25	58	116		**264**			
	LPN	11	13	5	2			26			**57**			
CUPE	**LPN**	150	163	162		1					**476**	**484**	**5.66%**	
PH&AS	**RN**	8									**8**			
Unifor	**LPN**								470		**470**	**472**	**5.52%**	
	OR								2		**2**			
Totals		**471**	**479**	**609**	**364**	**319**	**382**	**480**	**1,669**	**3,773**	8,546			**1,074**

No Authority to Conduct Representation Vote

[480] The NSGEU submits I can and should order that the Labour Board conduct a representation vote among all Registered and Licensed Practical Nurses.

> The *Interpretation Act,* RSNS 1989, c 235, applies to the *HAA.* Section 19 of the *Interpretation Act* provides for implied powers for public officers, which include administrative decision-makers such as the Arbitrator under the *HAA.* Where the Arbitrator has the power to do or enforce the doing of any act, then all necessary powers to enable this are implied into the *HAA* (s. 19(b)). Where the Arbitrator has express authorization in the *HAA* to do an act, and the expressly authorized act is dependent on doing another act, then the Arbitrator has the power to do the other act (s. 19(c)). By virtue of the *Interpretation Act,* the Arbitrator has the authority and power to do whatever is necessary to achieve the goals of the Arbitrator's express mandate. NSGEU submits that the implied power includes the power to consider the wishes of employees and to require representation or run-off votes.[233]
>
> *********
>
> Consideration of the wishes of employees can also be arrived at pursuant to administrative law principles. The Arbitrator has the authority, under s.91(2) to determine procedures. Common law administrative law principles requires those procedures to be fair. The common law principle of *audi alteram partem,* or the right to be heard, is often implied where legislation does not specify all procedures to be used by an administrative decision-maker. Employees are directly affected by the choice of their bargaining agent. As such, employees have a right to be heard. Regardless of whether it is thought of as reading in a *Charter* remedy, or implying employees' common law right to be heard in decisions that affect them directly, NSGEU submits employees have the right to choose their bargaining agent. A vote process gives employees the opportunity to be heard and is required for the procedures pursuant to the *HAA* Transitional provisions to be fair.[234]
>
> *********
>
> As set out later in this argument, these votes could be conducted by the Labour Board or such other person or agency as the Arbitrator sees fit. As stated above, the Arbitrator's jurisdiction extends to any act necessary to do the express duties under the Act (ie., the selection of bargaining agent).
>
> If the Transitional provisions are applied in a manner that requires changes to union membership, the provisions must be applied in a manner that considers employees' wishes through a vote process.[235]

[481] The NSGEU submits a public opinion poll it conducted concluded a majority of Nova Scotians strongly supported this right voting for acute health care employees.[236] "Further, there should be a vote to determine which union will represent the nursing

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[233] Final Submission on Behalf of NSGEU, ¶ 38
[234] Final Submission on Behalf of NSGEU, ¶ 100
[235] Final Submission on Behalf of NSGEU, ¶ 111 - 112
[236] Robin MacLean Affidavit, November 28, 2014, Exhibit "D"

bargaining unit as should be the case with the other three bargaining units. It is submitted democratic and *Charter* principles demand there be no presumptions."[237]

[482] The NSGEU submits majority support for a bargaining agent is essential to meet the long range goals as directed in section 90(2):

> In determining the bargaining agent that is to represent each bargaining unit, the mediator-arbitrator shall consider whether the selection of the proposed bargaining agent will
>
> (a) be conducive to achieving stable and harmonious labour relations between the health authorities and unionized employees; and
>
> (b) promote the effective and efficient provision of health care to patients at the health authorities' facilities.

[483] For this reason, it submits there must impliedly be authority to order a vote funded by the government.

> **L. RE: Jurisdiction to order a Vote**
>
> The issue of the Arbitrator's jurisdiction to order a vote was raised at the hearing. NSGEU acknowledges *The Trade Union Act* and the *HAA* do not appear to contain general authority provisions as are found in some enabling statutes. It is noted, however, that the preamble of *The Trade Union Act* does declare it is an *Act* respecting the right of employees to organize and providing for mediation.... Further, although the provisions of The *Trade Union Act* concerning successor are specifically exempted from proceedings under the *HAA,* it is submitted the *HAA* provides a parallel system and the same powers should be applied to an Arbitrator acting under the *HAA.* Section 31 of *The Trade Union Act* of course specifically provides for representation votes to be taken. By analogy it is suggested the same method of determining which union should represent workers applies in the matter at hand. One notes further The *Trade Union Act* Regulations (Regulation 6) further directs that the Board has authority concerning directions, etcetera concerning votes, not only pursuant to section 31 and other enumerated sections but "for any other reason". Further, by analogy the Arbitrator under the *HAA* is clothed with authority to conduct the vote.
>
> Further, however, the NSGEU submits the general empowering section is not necessary. As set out in the NSGEU's initial written argument concerning *Charter* and other issues - 8 December 2014, section 19 of *The Interpretation Act* (which will apply to both The *Trade Union Act* and the *HAA)* provides that a public officer (which the Mediator-Arbitrator is) is given all necessary powers to do whatever is necessary to achieve the goal of the Mediator-Arbitrator's mandate (please see s. 19(b), (c) and (e)).
>
> Above and beyond powers provided by the statutes above-mentioned, it is further submitted the Arbitrator has the power to conduct a representative vote by virtue of "the doctrine of jurisdiction by necessary implication". This doctrine was reflected upon by the Supreme Court in *ATCO Gas and Pipelines Ltd. v. Alberta (Energy and Utilities Board),* 2006 SCC 4 where the Court was reflecting upon the

[237] Final Submission on Behalf of NSGEU, ¶ 33

jurisdiction of the Alberta Energy and Utilities Board. At paragraph 51 it was stated:

> The mandate of this Court is to determine and apply the intention of the legislature *(Bell ExpressVu,* at para. 62) without crossing the line between judicial interpretation and legislative drafting (see *R. v. McIntosh,* f199511 S.C.R. 686, at para. 26; *Bristol-Myers Squibb* Co., at para. 174). That being said, this rule allows for the application of the "doctrine of jurisdiction by necessary implication"; the powers conferred by an enabling statute are construed to include not only those expressly granted but also, by implication, all powers which are practically necessary for the accomplishment of the object intended to be secured by the statutory regime created by the legislature (see Brown, at p. 2-16.2; *Bell Canada,* at p. 1756). Canadian courts have in the past applied the doctrine to ensure that administrative bodies have the necessary jurisdiction to accomplish their statutory mandate:
>
> When legislation attempts to create a comprehensive regulatory framework, the tribunal must have the powers which by practical necessity and necessary implication flow from the regulatory authority explicitly conferred upon it.

Please see also *R. v. Cunningham,* 2010 SCC 10 and *Nishnawbe Aski Nation v. Eden,* 2011 ONCA 187. It should be noted in the *Nishnawbe* matter the question was whether a coroner had the implied authority to question members of the jury role to determine firstly if they were representative and secondly impartial. It was determined although there was not a specific grant of this authority it was present by necessary implication (please see paragraphs 32 and 33 re: the doctrine).

Here the NSGEU argues in fulfilling the Arbitrator's mandate pursuant to the provisions of the *HAA,* including section 90, one factor that must be considered is the wishes of the employees. Again it is submitted the way to determine employees' wishes is of course with a vote. That being so, by necessary implication the Arbitrator not only has the jurisdiction and authority to order a vote but also has the jurisdiction to see that the vote is carried out in a proper fashion. Although it appears the Arbitrator could see fit to conduct an election in any way that was proper, the most efficient manner would likely be to enlist the assistance of the Labour Board and its officers to conduct the vote in the normal fashion and report the results of same back to the Arbitrator who then could make the appropriate determinations.

Ongoing jurisdiction to direct and supervise the vote and see to the implementation of its results can be found in the above-noted legislation, the doctrine of implied jurisdiction as well as the implementation provisions of the *HAA.*

M. Funding the vote

The question of funding a representation vote was raised at the hearing. Given the structure of the *Act* it is highly unlikely there is funding built into the budget of the Arbitrator. It is submitted however that is not the question. Budgetary allocation cannot determine whether or not a government is obliged to make good a breach of democratic and *Charter* rights and whether an Arbitrator whether acting pursuant to the *Charter* or otherwise is able to fashion a remedy responsive to the breach and to ensure democratic and *Charter* rights are respected. In any event, however, it appears the government has made

> budgetary provision which would cover expenses associated with a representational vote without further budgetary adjustments.
>
> Filed with the Arbitrator is a portion of the province's 2014-2015 budget estimates. There is provision made for contract negotiations, workforce adjustment and government restructuring. The estimate 2014-2015 is $227,251,000. The cost of a representation vote would be a very small percentage of this total estimated expenditure and would cause no burden to the province.
>
> One notes also in the two previous reorganizations representative votes were funded by the province as part of the process.[238]

[484] No other union advocates representation votes. Unifor submits for the unit of employees it represents: "A "run-off vote", as proposed by NSGEU, will result in no less disruption to the lives of the employees than the Government's plan."[239]

[485] The Attorney General of Nova Scotia says the absence in the legislation of power to order a representation vote is "consistent with what the Minister of Health learned from stakeholders in his "listening and learning" tour of the province; "A strong desire to avoid run-off votes."[240]

[486] Despite the ingenuity of the NSGEU submissions, I have concluded it would be a contortionist stretch to conclude by necessary implication from the *Interpretation Act*, common law, *Canadian Charter of Rights and Freedoms* or other source that I have authority under this legislative scheme to order and supervise a representation vote or delegate supervision to another person. This was the conclusion of the Saskatchewan Court of Appeal in 1997 on review of regulations reorganizing health care in that province. That conclusion applies equally to the *Health Authorities Act*: "We are of the opinion that the Legislature, had it intended something of the sort, would have expressly provided for it and that such a requirement cannot properly be implied."[241]

[487] No one addressed the easy conceived circumstance that neither the NSNU nor NSGEU might be selected by both groups of employees so neither would achieve the double majority required to be certified for both units. What then?

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[238] Final Submission on Behalf of NSGEU, ¶ 123 - 131
[239] Submissions of Unifor Locals 4600, 4603 and 4606, ¶ 96
[240] Submissions of the Attorney General of Nova Scotia, January 5, 2015, ¶5
[241] *Saskatchewan Government Employees' Union (SGEU) v. Saskatchewan* 1997 SJ No. 277 (CA)

[488] It is not my role to comment on the legislative choice not to conduct representation votes to determine the wishes of employees. It is sufficient for me to simply state, as I have concluded, I do not have the authority in this legislative scheme to order a representation vote.

What eligible union is to be certified? (reserved for continuation)

[489] Consistent with the principles of section 53 of the *Trade Union Act* and independent employee bargaining agents free from employer interference or favour, the employers made no submissions on which union should be certified as bargaining agent for any unit and made no submissions with respect to section 90(2). However, like others, it presumed the scheme of the legislation with its combination of limitations and eligibility requirements for certification as a bargaining agent, and perhaps the NSNU's membership numbers, would direct certification of the NSNU for both Nursing units.

[490] Both the NSNU and NSGEU are eligible to be certified for the Nursing units: "to be eligible to represent a bargaining unit, a union must, immediately before the coming into force of this Section, represent the unionized employees in a bargaining unit of the same type for at least one district health authority."[242] "Type" is one of the four units.[243] It is not so narrow as to mean a unit that is composed of both Registered and Licensed Practical Nurses, which the NSGEU does not represent. Such a narrow approach has absurd results when applied to the other three units.

[491] One dilemma is that the NSGEU is eligible to represent the employees in all other units but the NSNU is not eligible to represent any unit other than the Nursing unit. This might appear to direct that the NSNU is to be certified for both Nursing units. It might be the legislators knew or assumed a union constituted exclusively for nurses would not want to represent employees in other occupations. It might be the legislators or planners assumed the NSNU represented a majority of Registered and Licensed Practical Nurses in both Nursing units and chose to include both in the same unit. If so, that was a mistaken or unverified factual assumption, perhaps driven by policy goals.

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[242] s. 89(1)(d)
[243] s. 2(1)(zj)

[492] The fundamental democratic value that no union is ever certified to be an exclusive bargaining agent for a group of employees if it cannot demonstrate majority support among the group of employees must prevail. In a democracy, legislative assemblies do not simply shuffle constituency boundaries or reallocate votes among constituencies to meet some desired goal and defeat the majoritarian principle. What cannot be done directly cannot be done indirectly by fashioning limitations and eligibility rules to dictate an outcome that supersedes the wishes of a majority of employees.

[493] There are instances when governments have acted or failed to act to disqualify a union from representing a group of employees. This happened to The Professional Institute of the Public Service of Canada, which wanted to continue to represent nurses when they became employees of the Northwest Territories government, which failed to act so it could continue to represent the nurses.[244]

[494] In the converse, unions have been certified by legislation, as is the situation for the NSGEU under the *Civil Servants Collective Bargaining Act*. These were acts to formalize relationships with a union that represented a majority of the constituent employees.

[495] There has not been legislated certification in circumstances where the union did not have majority membership or other demonstrated majoritarian support among the group it was certified to represent. It cannot be the legislative intent in this restructuring for the first time in Canadian history to impose certification of three unions as exclusive bargaining agents for bargaining units of employees without majority employee support.

[496] Simply as a practical labour relations matter, no private sector employer would ever accept having its employees represented by a union that has not demonstrated majority support among its employees. Why would a public sector employer? Why would anyone want it for the critical health care system being restructured? All employers would ask if this was done for nurses could it happen to their employees.

[497] A labour relations reality is that no private or public sector employer wants to bargain with a union or discuss grievances with a union that does not represent a

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[244] *Professional Institute of the Public Service of Canada v. Northwest Territories (Commissioner)*, [1990] 2 S.C.R. 367

majority of its employees. Employers and unions know having a relationship in which the union does not have majority employee support is not conducive to an environment in which the union can make agreements and resolve differences over the objection of individual grieving employees or groups of employees. It is not an environment conducive to productive collective bargaining. It is not an environment conducive to stable and harmonious labour relations. It is an environment conducive to ongoing disputes, grievance arbitration and failed ratification votes.

[498] This is why, in the absence of egregious employer interference, no labour relations board may certify a union knowing the union has not demonstrated majority membership or other support, often through a vote, among the group of employees.

[499] The NSNU believed it had majority support when it submitted it should be certified. And, perhaps it will after the calculations I have made are put under microscopic scrutiny and all generic positions are identified and the employees in those positions are excluded from the count.

[500] However, for now, I have concluded it cannot be implied the legislative scheme of the *Health Authorities Act* is fundamentally undemocratic and imposes on a group of employees a bargaining agent, with all its acquired rights and the loss of individual employee rights, which has not established it has majority support among the group of employees.

[501] Making a leap to imply otherwise would mean Unifor with only 9.35% of all district health authorities' acute care employees as members and a smaller percentage of Health Care unit employees could be certified to represent both the Health Care unit employees of the provincial health authority and the Health Care unit employees of IWK Health Centre where its membership is 0%. Or be certified to represent employees in the provincial health authority Support unit when it represents only 25% or so of the employees. Such an outcome would be completely contrary to the majoritarian principle underlying the basis for a union's exclusive bargaining agency on behalf of employees in their workplaces.

[502] This highlights a complicating feature of labour relations restructuring under the *Health Authorities Act*. To align the IWK Health Centre with the consolidated provincial

health authority the same union must be certified to represent the employees in the same type of unit for each employer. This does reduce the instances of collective bargaining and creates a structure that facilitates the two employers' ability through mandatory multi-employer collective bargaining to negotiate with one union common terms and conditions of employment for similar groups of employees. It facilitates but does not guarantee this outcome because the employees in the unit of one employer might not be willing by majority vote to ratify a tentative agreement that a majority of employees of the other employer will ratify.

[503] A consequence of this unique feature of the *Health Authorities Act* transitional provisions aligning the IWK Health Centre with the provincial health authority is that because they are two separate employers the union must demonstrate majority support among two groups of employees or two employers. An eligible union seeking to be certified to represent the employees of one of the four bargaining unit types must also represent the employees in the same type of unit of the other health authority employer.

[504] This limitation creates an additional hurdle eligible unions must overcome by establishing double majority support among two groups of employees of two employers in order to be certified to represent either or both groups. It serves longer term restructuring goals for acute health care in the government's plans as reported by the Department of Health and Wellness and its Transition and Design Team, but creates complications for eligible unions.

[505] The NSNU is an eligible union with demonstrated majority support among nurses in the future Nursing unit of one employer. It has not demonstrated the requisite double majority support.

[506] What are the options for a solution? Throughout this process individual parties have reconsidered and, in some cases, made significant modifications to their approach in light of more information and further reflection. The employers and unions could consent to mediated negotiations under section 92 to find a solution.

> (1) The mediator-arbitrator may conduct mediated negotiations between the district health authorities and unions in respect of the matters to be determined under Section 88 at any stage in the arbitration proceeding with the consent of the district health authorities and unions.

> (2) Where the mediated negotiations are not successful, the mediator-arbitrator retains the power to determine the matters to be determined under Section 88 by arbitration.

[507] Beyond the employers and unions, the Minister could find some way of conducting a representation vote among nurses to choose representation by the NSNU or NSGEU. I accordance with common labour relations board practice, because of their small minority percentage of membership the CUPE and Unifor local unions would not be on the ballots. With only the NSNU and NSGEU on the ballots there would be no risk of a run-off vote in each. This would be consistent with the promise of the Minister of Labour and Advanced Education that: "The government will respect the desires of the health care union members in which union they want to belong."[245] However, there is a risk one union will receive majority support among employees in the unit of one employer and the other receives majority support among employees of the other employer. This is a risk that accompanies the unique double majority limitation.

[508] Or the Minister could find some way to have all Licensed Practical Nurses of both employers vote whether they wish to be included in the Nursing or Health Care unit. If a majority votes for the Health Care unit, the NSNU will have the required double majority of Registered Nurses in the Nursing units. If the Licensed Practical Nurses vote to be included in the Nursing unit, there would have to a second vote to select a bargaining agent with the risk the outcome would differ between the two units.

[509] The House of Assembly could remove the Licensed Practical Nurses from the Nursing unit and thereby give the NSNU a double majority. Or it could combine the Nursing units for the provincial health authority and IWK Health Centre into a single or common employer unit giving the NSNU a majority (53.7%). What that might mean for the separate governing structure of the IWK Health Centre and the three other units is unclear. Perhaps there are other options.

[510] Consequently, I reserve jurisdiction on this issue to be addressed in a continuation of this arbitration.

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[245] Minister of Labour and Advanced Education, Nova Scotia House of Assembly, *Hansard Debates and Proceedings*, Assembly 62, Session 1, May 1, 2014, pp. 2639 – 2641 quoted in context above

B. Clerical Bargaining Units

[511] Currently, the nine district health authority employers and the IWK Health Centre are parties to eleven collective agreements with three unions in six agreements. CUPE Locals 2525 and 2431 negotiate together with the five district health authorities for one multi-union and multi-employer agreement. Local differences are contained in appended memorandums of agreement and letters of understanding. NSGEU, not its locals, is the party to agreements.

SSDHA	SWDHA	AVDHA	CEHHA	CHA	PCHA	GASH	CBDHA	CDHA	IWK
NSGEU (Local 89)	NSGEU (Local 90)	NSGEU (Local 91)	CUPE Local 2525				CUPE Local 2431	NSGEU (Local 246)	NSGEU (Local 23)

[512] This illustrates differences in the internal organization and structure of CUPE and NSGEU. Locals of CUPE are each trade unions certified by the Labour Board that negotiate and sign collective agreements. One aspect of the CUPE culture is that while affiliated local unions collaborate they often vigorously guard their local autonomy. Locals of the NSGEU, whose origin is with one employer, have a different legal status and role under the NSGEU constitution and affiliation under the NSGEU constitution is something entirely different than CUPE's structure.[246]

NSGEU Has Required Double Majority

[513] The NSGEU appears to have a double majority in the Clerical units. It has 100% membership in the IWK Health Centre Clerical unit.

[514] It has majority membership in the future provincial health authority Clerical unit. The CUPE local unions with members in only five of the district health authorities collectively do not have as members a majority of the employees in a consolidation of district health authority Clerical units.

[515] With the reassignment of clerical positions from Public Health and Addictions Services units to the Clerical unit and the employers' proposed reassignment of classification positions from the existing Health Care unit to the Clerical unit in the

[246] *Nova Scotia Government and General Employees Union Constitution and Bylaws*, as amended May 2013, Article 1.7 and 6

Capital District Health Authority, the NSGEU majority membership percentage will be higher in the future provincial health authority Clerical unit.

C. Health Care Bargaining Units

[516] Currently, six unions represent the employees in the ten Health Care bargaining units employed by the district health authorities and IWK Health Centre.

SSDHA	SWDHA	AVDHA	CEHHA	CHA	PCHA	GASH	CBDHA	CDHA	IWK
CUPE Local 1933	CUPE Local 835	CUPE Local 4150	CUPE Local 2525	CUPE Local 2525	CUPE Local 2525	CUPE Local 2525	Unifor Local 4600	NSGEU (Local 42)	NSGEU (Local 22)

There are four collective agreements because the four CUPE local unions collectively negotiate one multi-union and multi-employer agreement with seven district health authorities. Unifor Local 4600 negotiates one agreement with the Cape Breton District Health Authority and the NSGEU negotiates two agreements with the Capital District Health Authority and IWK Health Centre.

NSGEU Does Not Have Required Double Majority

[517] The NSGEU represents a majority of employees in the IWK Health Centre Health Care unit with its 100% membership among the employees.

[518] Subject to closer examination to verify, at November 25, 2014 the NSGEU currently represents as members a majority of employees in the nine combined district health authority current Health Care units (3,904 of 7,761 = 50.3%).

[519] However, with fewer members in the Capital District Health Authority Health Care unit after Licensed Practical Nurses are assigned to the Nursing unit and employees in other classification positions are assigned or potentially assigned to the Clerical and Support units, it loses its majority.

Amalgamated Successor Union as Bargaining Agent

[520] The unions proposed a multi-union entity as the certified bargaining agent for the Health Care units. They called it a bargaining association in August. CUPE now refers to such an entity as simply a multi-union bargaining agent. NSGEU, apprehensive such an entity will not be accepted as a bargaining agent after the rejection of the bargaining association proposal, has redirected its attention to advocating for representation votes

with enthusiastic reliance on the *Canadian Charter of Rights and Freedoms*. At the same time, it submits:

> Section 2(1)(zk)(v) defines "union" to include successors or affiliated locals of any and all of the four named unions. This definition allows the existing four unions, or any of them, to use existing or create new affiliated or successor locals, which can be considered separate "unions" as defined in the *HAA.*[247]

Employer Submissions

[521] The employers submit the *Health Authorities Act* does not permit a multi-union bargaining agent. They begin by taking no position on which union should represent each of the bargaining units,[248] but submit the *Health Authorities Act* recognizes only four unions. For this conclusion, they rely on the interpretation they attribute "union" by focusing on the word "or" in the definition of union.

> (zk) "union" means
> (i) the Canadian Union of Public Employees,
> (ii) the Nova Scotia Government Employees Union,
> (iii) the Nova Scotia Nurses' Union,
> (iv) Unifor, **or**
> (iv) a successor or affiliated local of a union referred to in subclauses (i) to (iv);[249]

[522] The employers submit there are only four eligible unions, each of which may have a successor or affiliated local but there cannot be any combination of unions. Further, the only eligible unions are those that represented a bargaining unit when the statute came into force – "to be eligible to represent a bargaining unit, a union must, immediately before the coming into force of this Section, represent the unionized employees in a bargaining unit of the same type for at least one district health authority."[250]

[523] Although the four CUPE local unions combined for one set of collective bargaining to negotiate with eight district health authorities, the employers submit there was no combination union before October 3, 2014 and a combination of unions cannot be a bargaining agent after April 1, 2015.

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[247] Final Submission on behalf of NSGEU, December 22, 2014, ¶ 93
[248] Submissions of the Employer, December 4, 2014, ¶ 130
[249] s. 2(1)(zk)
[250] s. 89(1)(d)

[524] The employers submit a "successor" must have been in existence before the *Health Authorities Act* came into force. They submit the word "successor" is included only as a drafting precaution in case one of the two provincial or two national unions had a successor unknown to the drafters of the bill. There is no current meaning or application of this term because "that ship has sailed."

[525] They further submit if "successor" includes a union that became a successor after the statute came into force, that successor would not be an eligible bargaining agent because it could not satisfy the requirement to have represented unionized employees before the statute came into force when it did not exist. They submit:

> In summary, it is likely and logical that the drafters of the legislation were covering off the possibility of changes to one of the Unions prior to the passage of the *HAA* that would create a successor. The creation of an association of unions would not create a successor. Assuming an association of unions could be a successor and therefore a "union", it would not meet the s.89(1)(d) requirements and could not be appointed as a bargaining agent. There is nothing requiring every "union" to be a bargaining agent.[251]

Despite this they submit the four listed in subclauses (i) to (iv) are the only unions and each is to become a bargaining agent for the same type of unit of employees for both employers.

[526] The employers submit there is an inherent contradiction in calling an "association" similar to the unions' August proposal a successor because all of the existing unions continued to exist. And both a union and its successor cannot exist at the same time.

> In both the *TUA* and generally, the essential nature of a succession is that an entity takes over the rights and responsibilities of an earlier entity which relinquishes them. Once the new entity succeeds it, the old entity has no further rights or responsibilities over the subject matter of the transfer of power. This is not what the Unions propose in an association of unions.[252]

[527] The employers submit no multi-union representational structure is intended.

> Ultimately, statutory interpretation is premised on determining legislative intent. The evidence shows that the parties, including representatives of government, discussed an association of unions in the summer, prior to the *HAA* being introduced. The idea was rejected, in part due to the concerns expressed by the employer representatives. Within this context it is not reasonable to suggest the

[251] Final Submissions of the Employers, ¶ 69
[252] Final Submissions of the Employers, ¶ 66

> government intended the *HAA* to provide for the outcome it had rejected unless the parties overcame those concerns during mediation. If the legislature had intended to do so, it had the means and opportunity to do so explicitly and without the need for mediation, or for that matter, arbitration. The employers ask that you apply Ockham's razor to the unions' complicated, artificial and unnecessary construction of the *HAA*.[253]

[528] Further, the employers submit if parties overcame those concerns during mediation then certain oversight and other matters would have to be addressed "perhaps requiring some form of commitment from the government to put the required statutory regime in place."[254] This is because councils of trade unions in the construction industry under the *Trade Union Act* are subject to Labour Board oversight.[255] There is no comparable oversight under the *Health Authorities Act* or in the unions' proposed bargaining association, which would have no members and cannot itself be a "trade union" under the *Trade Union Act*.

> "trade union" or "union" means any organization of employees formed for purposes that include regulating relations between employers and employees which has a constitution and rules or by-laws setting forth its objects and purposes and defining the conditions under which persons may be admitted as members thereof and continued in membership[256]

[529] The employers submit there are several practical problems with the bargaining association proposal the unions made in August in the areas of internal decision making, imposing sanctions on dissidents and ensuring coherent action and positions.

> Most importantly, the goal of provincial integration would be hampered by an association of unions approach. On paper the bargaining units would be provincial in scope and aligned with IWK. However, in practice the old boundaries would still exist. Each Union would have its "turf", and its members. Unions and individuals would still see their "turf" as a distinct entity. The provincial framework may exist, but the culture never would.[257]

[530] It is the employers' submission the *Health Authorities Act* intends to preserve some turf for each of the four unions so none will disappear as would happen if there were representation votes. It does not intend or permit new unions to be certified

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[253] Final Submissions of the Employers, ¶ 70
[254] Final Submissions of the Employers, ¶ 77
[255] *Trade Union Act*, s. 95
[256] *Trade Union Act*, s. 2(1)(w)
[257] Final Submissions of the Employers, ¶ 83

Discussion, Analysis and Decision

[531] It is implausible the drafters used the word "successor" simply to guard against the unknown possibility that provincial NSGEU or NSNU or national Unifor or CUPE had managed to disappear and have a successor sometime in 2014. This is an argument based on a desired outcome, not the plain and ordinary meaning or context of the use of the word "successor."

[532] The unions that represent unionized employees in a Health Care bargaining unit of the same type for at least one district health authority are CUPE Locals 835, 1933, 2525 and 4150, not CUPE, and Unifor Local 4600, not Unifor.

[533] Under the employers' interpretive approach, the "Canadian Union of Public Employees" and "Unifor" are defined as two of only four unions, but each would be ineligible to become a bargaining agent after April 1st because each did not represent employees in a bargaining unit before the *Health Authorities Act* came into force. This illogical result is not intended.

[534] "Successor" extends to trade union organizations that come into existence after the *Health Authorities Act* came into force. Among other things, this will ensure a successor union after April 1, 2015 will continue to hold collective bargaining rights during the indefinite time that section 32 of the *Trade Union Act* does not apply. Section 32 states:

> (1) Where a trade union claims that by reason of a merger or amalgamation or a transfer of jurisdiction it is a successor of a trade union that at the time of the merger, amalgamation or transfer of jurisdiction was the bargaining agent of a unit of employees of an employer and any question arises in respect of its rights to act as the successor, the Board, in any proceeding before it or on the application of any person or trade union affected, may by order declare that the successor has or has not, as the case may be, acquired the rights, privileges and duties under this Act of its predecessor.
>
> (2) Before issuing an order under subsection (1), the Board may make or cause to be made any examination of records or other inquiries, and may hold any hearings or representation votes that it deems necessary and prescribe the nature of evidence to be furnished to the Board.
>
> (3) Where the Board makes an affirmative declaration under subsection (1), the successor for the purposes of this Act acquires the rights, privileges and duties of its predecessor, whether under a collective agreement or otherwise.

[535] The operation and application of this section is suspended by section 83 of the *Health Authorities Act*, which states:

> (1) Sections 23 to 26, clauses 28(1)(b) to (d) and Sections 29 to 32, 40A and 40B of the Trade Union Act do not apply in respect of labour relations between a district health authority, its unionized employees and the bargaining agents for those unionized employees.
>
> (2) Sections 23 to 26, clauses 28(1)(b) to (d) and Sections 29, 31, 32, 40A and 40B of the Trade Union Act do not apply in respect of labour relations between a health authority, its unionized employees and the bargaining agents for those unionized employees.

The difference between subsection (1) and (2) is that subsection (1) applies to "district health authorities" disappearing March 31, 2015 and subsection (2) applies to "health authorities" coming into existence on April 1, 2015.

[536] Subsection (1) will operate until March 31st. How long subsection (2) will be in effect is unknown. It will be repealed when section 105 of the *Health Authorities Act* is brought into force by the Governor in Council under section 155(2) of the *Health Authorities Act* – "Sections 105 and 106 come into force on such day as the Governor in Council orders and declares by proclamation."

[537] The term "successor" in the definition of "union" provides interim continuity allowing affected unions, such as CUPE local unions, to reorganize by merger, amalgamation or transfer of jurisdiction. This is a very predictable need at or after April 1, 2015 because of district health authority consolidation and the goal of alignment with IWK Health Centre.

[538] Union reorganization will diminish local union autonomy, as did the proposed bargaining association. A limitation on autonomy is sometimes the price of adapting to new circumstances. The current district health authority employers and their governance and management after dedicated work to their mission, vision and values are paying the price of being wound up because their work, behaviour and effectiveness was not successful. With fewer transfers dollars from the federal government, fewer executive leaders in a provincial organization based in Halifax will do better in delivering acute health care services to a population requiring more acute health care.

[539] Union reorganization in some broader based form is a predictable course of events in anticipation of what will happen with the employer consolidation. It must not

be overlooked the *Health Authorities Act* is addressing an anticipated change in employers. In the normal course, as in past health care service delivery restructurings, the labour relations restructuring process happens at the Labour Board after the event when unions are responding to events that have happened. The Q.E. II restructuring was an exception.

[540] In anticipatory labour relations restructuring proceedings unions have to first hear and then accept what the employer says it will be doing is likely to happen. There has to be a high level of confidence and trust in what the employer says and, in the private sector, that market forces will not change the employer's plans. In the public sector the unknown is political forces.

[541] In 2014, the unions acted in anticipation of district health authority consolidation without knowledge of the specifics in an effort to avoid potentially acrimonious and disruptive proceedings. This was expressed in the February 14th letter from the Nova Scotia Federation of Labour to the Premier and Minister as follows:

> We are writing to propose a straight forward approach to the labour relations aspects of your plan to create a single Provincial Health Authority to replace the present District Health Authorities. This approach will permit a smooth transition to a single health authority while minimizing disruption of the employment rights of front line employees who provide acute health care services to Nova Scotians.
>
> From previous discussions with the Minister of Health and Wellness we understand that your government will bring forward legislation in the fall which would create a Provincial Health Authority. Reorganizations in public services since 1994 have all included protections for employees to preserve their employment rights as they transition to a new organization. One of the clauses which is usually included in legislation reorganizing public services is a provision that the new entity is a successor employer to the present employers under Section 31 of the Trade Union Act. We expect that any legislation creating a Provincial Health Authority will include these standard provisions.
>
> In order to avoid the disruption of employee rights in their workplaces because of creation of the Provincial Health Authority, we propose that the merger legislation also include a provision that neither the Authority nor any of the Unions representing its employees may apply to the Labour Board to modify the existing bargaining units without the consent of all parties.
>
> This approach would facilitate the reorganization of the District Health Authorities, but avoids the reorganization of bargaining units and the disruption of the collective agreement rights of the employees delivering front line services. The Unions representing bargaining units would continue to represent their members in bargaining with the Provincial Health Authority.

[542] This can be viewed as an entirely self-interested proposal by the unions. Or it can be viewed as an experienced voice by unions which have represented health care employees for decades trying to anticipate and avoid past proceedings that were disruptive and divisive. Or it can be viewed as a cautious proposal to commit to minimal change to the status quo in case the broad plan is not acted on or changed by political forces. Perhaps the Minister's tour would cause the government to modify its broad plan or take a different course, as it did in avoiding representation votes and creating a structural alignment between the consolidated provincial health authority and IWK Health Centre. At that stage, the future plan was fluid and not solidified. The Minister was listening and learning.

[543] The subsequent events up to the August rejection of the bargaining association proposal were a continuation of efforts to avoid Labour Board successorship proceedings under the *Trade Union Act* and have the least disruption to the status quo. That was not compatible enough with the government's vision.

[544] The government decided it was better to have these issues resolved as completely as possible before, rather than after, April 1, 2015. It presented legislation that intends to resolve the predictable issues in anticipation of restructuring in a dedicated expedited process giving the unions and current employers an opportunity to select the decision maker and engage in mediated negotiations.

[545] A unique feature of this process is that it is broadened beyond the consolidating employers to include IWK Health Centre, which continues as a separate employer. The IWK Health Centre would not be a party to any successorship proceeding under the *Trade Union Act*. The composition of its bargaining units would not be made to mirror unit composition at the provincial health authority or vice versa.

[546] Including IWK Health Centre; requiring bargaining units for the two employers to be harmonized; requiring common representation of the same type of bargaining unit at both the provincial health authority and IWK Health Centre; and compelling both employers in the future to engage in multi-employer collective bargaining[258] signals the government plans a broader approach to fashioning a future integrated acute care

[258] s. 26

health system than in past restructurings. Is it incidental or a deliberate by-product of this systemic thinking approach that there will be a platform after April 1, 2015 for future consolidation of the provincial health authority and IWK Health Centre that will require minor labour relations restructuring?

[547] The unions did not anticipate the breadth of this approach in their August proposal. They were unhappy their proposal had been rejected. They were working to avoid Labour Board proceedings with inherent competition and rivalry within the limitations of the *Trade Union Act*. If their proposal was accepted by government, those limitations could be addressed by legislated amendments.

[548] The government did not see how a made in British Columbia solution was adaptable to its vision and plans. It wanted made in Nova Scotia solutions for the Nova Scotia landscape. The government's rejection of the unions' bargaining association proposal agreed by the unions and discussed in the context of assumptions about the plan for the future restructuring ended a chapter. It was followed by another in which the full scope of the restructuring plan for a provincial health care system became known to everyone.

[549] The nature of the shift and the need for a change in approach after legislation was introduced is expressed from a union perspective in the following. This must be read remembering the employer representatives may have been unaware in August of the scope of the future vison directing the legislation. Perhaps the vision goes farther than shared and integrated or merged services between the two health authorities to consolidation as one health authority and one employer or extends to other health care programs, services and sectors.

> It is important to point out that from the first meeting with the Minister of Health on June 9th through meetings of the unions, discussions between Government and legal counsel for the unions, and in meetings with Mr. King and the employer representatives on August 5th, August 20th, September 4th, that at no time did any of the employer representatives raise for discussion or consultation any measures that later appeared in Bill 1; that is the meetings and discussions that took place at every level between the unions and the government and the employers could not in any way be characterized as a consultation on what later became Bill 1; in fact, those discussions and consultations were restricted to models of bargaining associations and councils, the result of which would have

> led to a labour landscape very different than the one who's potential is outlined in the legislation.[259]

[550] The day after introduction of the *Health Authorities Act*, the Minister wrote the unions: "I remain hopeful that the mediator will be successful in helping the parties to find creative solutions." This signaled there is no pre-set solution. He did not have the solution. The unions and employers would have to broaden their perspectives beyond the proposed bargaining association model, which the Department of Health and Wellness commented the day before did not "go far enough,"[260] and search for options compatible with the vision in the *Health Authorities Act*.

[551] The limitations of the *Trade Union Act* that concerned the unions do not apply. The challenge for the unions became how far could they go to find solutions that have minimal disruption to the representation status quo. There was common recognition there would be change affecting the Licensed Practical Nurses. This became a lightning rod for change resistance.

[552] Returning to successor unions, contrary to the employers' submission, in the trade union community, successor unions under collective bargaining legislation do exist at the same time as the union they succeed. This is the essence of a "transfer of jurisdiction" which does not have to be all employees or the membership of all employers the union represents.

[553] For any number of reasons, a local union representing the employees of multiple employers will transfer jurisdiction to a newly created local union that will become the bargaining agent for the employees within the transferred jurisdiction. Perhaps there is an employer whose bargaining unit employee complement has reached a size that it warrants or the employees want their own autonomous local union. In this common situation, the original local union making the transfer continues to exist and represent employees of other employers.

[554] If any of the five CUPE local unions engaged in discussion in early 2014 to create a provincial local or locals currently represent employees of an employer other

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[259] Robin MacLean Affidavit, November 28, 2014, ¶ 63
[260] *Fact Sheet Health Labour Landscape in Nova Scotia*, September 29, 2014, http://novascotia.ca/dhw/PeopleCentredHealthCare/health-authorities-act.asp

than a district health authority, that local union would have to consider whether it merged, amalgamated or transferred jurisdiction to the new local union or another local union to preserve its representation of the employees of the employer that is not a district health authority, which might be a private sector employer in another health care sector or different business.

[555] A successorship can be in the form of a merger that results in two or more unions becoming a single union with the predecessor unions being wound up when all liabilities and responsibilities have been satisfied.

[556] A successorship can also take the form of an amalgamation in which each of the former unions continues to exist, perhaps only with a change in name. There can be minor changes with the unions continuing to operate with their pre-amalgamation structures and organization essentially unchanged. There can be limited or extensive integration of administration, services, decision making and representative leadership elections. Sometimes unions incorporate the word “amalgamated” in their name, such as the Amalgamated Transit Union.

[557] Unions like Unifor and CUPE and their leadership have as extensive knowledge and experience in the nature and intricacies of union successorship as executive, financial, accounting, legal, human resource and other professionals have in corporate mergers and acquisitions. The broader the experience, the more knowledge of possible workable options and creative solutions. The question is not whether it can be done, but what is the best way to do it in the circumstances.[261]

[558] Apart from the irony of invoking Ockhram’s razor to shave away unnecessary assumptions and to advocate for simplicity in one of the more complex successorship consolidations of bargaining units, the employer’s approach shifts the burden to the unions to accept in arbitration the employers’ approach to the legislative intention and directed outcome with which they do not and cannot agree. It assumes that, through clever legerdemain using definitions, limitations and eligibility requirements the transitional provisions of the *Health Authorities Act* create less than a Hobson’s choice,

[261] CUPE has already turned its attention to some of the issues - Wayne Thomas Affidavit, December 5, 2014, Exhibit I

perhaps a Morton's fork, which preordain for arbitration bargaining agent certification and abdicates the majoritarian principle for employee constituencies in bargaining units of separate employers. Such an intention cannot be ascribed to legislators whose very role is the result of majority choice by constituency electorates.

[559] For policy and operational goals, legislators through statutes may direct appropriate bargaining units of employees, but they do not direct those employees' choice of their bargaining agent. It cannot be assumed the intention of the *Health Authorities Act* is to target and punish individual unions and their members and to favour other unions by denying large numbers of employees their freedom to participate in the choice of their bargaining agent.

[560] There are to be eight bargaining units. One of each of the four types – Nursing, Health Care, Clerical and Support – for each of the two health authorities – the unnamed provincial health authority and IWK Health Centre.

[561] Because "each union (i) may represent only one of the four bargaining units for a health authority, and (ii) must represent the same type of bargaining unit for each health authority"[262] and "to be eligible to represent a bargaining unit, a union must, immediately before the coming into force of this Section, represent the unionized employees in a bargaining unit of the same type for at least one district health authority"[263] the options appear limited.

[562] The phrase "each union" is not limited to the four named unions in the definition of "union" with intended consequence that CUPE with no members at the separate IWK Health Centre health district after consolidation of the nine district health authorities into a second health authority will be the exclusive bargaining agent for the employees in both Health Care, Clerical or Support units. Exclusivity is a consequence of majoritarian choice, not something conferred by decree.

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[262] s. 89(1)(c)
[263] s. 89(1)(d)

Table 15: All Units – Approx. Employee Numbers – November 25, 2014

Employer	SSDHA	SWNDHA	AVDHA	CEHDHA	CHA	PCHA	GASHA	CBDHA	CDHA	IWK	Total by Union	Total by Group
Nurses	297 NSNU	295 NSNU	428 NSNU	343 NSNU	299 NSNU	357 NSNU	396 NSNU	1,081 NSNU	683 NSNU 2,547 NSGEU	987 NSNU	5,166 NSNU 2,547 NSGEU	7,713
Health Care	452 CUPE	519 CUPE	593 CUPE	300 CUPE	190 CUPE	253 CUPE	292 CUPE	1,258 Unifor	3,904 NSGEU	941 NSGEU	4,845 NSGEU 2,599 CUPE 1,258 Unifor	8,702
Clerical	152 NSGEU	192 NSGEU	237 NSGEU	151 CUPE	131 CUPE	122 CUPE	149 CUPE	513 CUPE	1,449 NSGEU	576 NSGEU	2,606 NSGEU 1,066 CUPE	3,672
Service	176 CUPE	233 CUPE	206 CUPE	120 CUPE	133 CUPE	127 CUPE	210 Unifor	545 Unifor	1,216 NSGEU	331 Unifor	1,216 NSGEU 995 CUPE 1,086 Unifor	3,297
Public Health / Addiction Services	64 NSGEU 52 CUPE	93 NSGEU	102 NSGEU	93 NSGEU	78 NSGEU	83 NSGEU	153 NSGEU	255 NSGEU			921 NSGEU 52 CUPE	973
Totals	1,193	1,332	1,565	1,000	831	939	1,197	3,653	9,821	2835	24,357	
	NSGEU 12,135 49.82%			CUPE 4,712 19.35%			NSNU 5,166 21.21%			Unifor 2,344 9.62%		

[563] Because the role of government and the House of Assembly is not to choose unions for groups of employees, this eligibility criterion must be read as an effort to preserve accumulated experience and knowledge in representing a particular group of employees, not a backhanded way to disqualify and diminish one union, enhance the presence of another or deny employee choice.

[564] The legislation must not be read as intending to benefit NSNU, CUPE and Unifor and their local unions with an endowment of hundreds of new dues paying members at the cost of NSGEU with total disregard for the wishes of employees. While the government has the right to wind up district health authorities and dismiss executives and managers in restructuring, it cannot reach across the table and assign new representational rights and responsibilities for independent trade unions or tell employees who will be their bargaining agent.

[565] Regardless how complex the restructuring, this intention cannot be presumed in interpreting labour relations successorship legislation or that such action is intended simply to offset any workplace disruption that might accompany the democratic process of representation votes. Such cavalier or cynical intentions to interfere so radically in the autonomy of employees to have independent trade union bargaining agents they select or establish to represent them cannot be attributed to elected members of the House of Assembly.

Bargaining Unit	**At Least One District Health Authority**	**IWK Health Centre**
Nursing	NSNU / NSGEU	NSNU
Health Care	NSGEU / CUPE 835, 1933, 2525 & 4150 / Unifor 4600	NSGEU
Clerical	NSGEU / CUPE 2525 & 2431	NSGEU
Support	NSGEU / CUPE 835, 1933 & 4150 / Unifor 4603	Unifor 4606

[566] There are six, not four, unions representing employees in the Health Care units of district health authorities – NSGEU, four CUPE affiliated local union and one local union affiliate of Unifor – that are eligible to represent the Health Care units at both health authorities. In all there are ten unions which are current bargaining agents representing acute care employees. An affiliated local of the NSGEU could represent

the employees in the Health Care or Clerical units. The CUPE or Unifor local unions could merge, amalgamate or transfer jurisdiction to a new affiliate. This is what CUPE was exploring in early 2014 in anticipation of government plans. Because this is an anticipatory employer successorship process, there is still time for the CUPE or Unifor locals to take that action or for NSGEU to create affiliates before a union has to assume bargaining agency responsibilities. The legislation provides more options than many assume. The unions will have to go farther than they have to find creative solutions.

[567] It must be noted that "bargaining agent" is a generic term in the *Trade Union Act* that applies to a certified and recognized union, a certified council of trade unions and an accredited employers' organization. The use of "bargaining agent" is not restricted to any particular union or type of union.

[568] Clearly, before I would make an order naming a new union as bargaining agent, I would have to be satisfied it is a "union" because it becomes a certified bargaining agent with all that implies under the *Trade Union Act* – "The bargaining agent for a bargaining unit as set out in the order is deemed to be the certified bargaining agent for that bargaining unit."[264]

[569] Can a multi-union entity be established to represent employees in the Health Care bargaining units? Yes.

[570] It is trite to note the *Interpretation Act* states: "In an enactment … words in the singular include the plural, and words in the plural include the singular."[265] This means the definition of "union" in the *Health Authorities Act* is to be read as follows:

> (zk) "union" [or unions] means
> (v) the Canadian Union of Public Employees,
> (vi) the Nova Scotia Government Employees Union,
> (vii) the Nova Scotia Nurses' Union,
> (iii) Unifor, **or**
> a successor [or successors] or affiliated local [or locals] of a union referred to in subclauses (i) to (iv)

[571] Just as CUPE and its local unions could take steps to establish an amalgamated successor or affiliate to receive the locals' representational rights before the *Health*

[264] s. 94(3)
[265] *Interpretation Act*, s. 19(i)

Authorities Act came into force, those local unions, the NSGEU or a successor affiliate of the NSGEU and Unifor Local 4600 could take steps to establish a single successor union through merger, amalgamation or transfer of jurisdiction. Forming a single successor union is going farther than the unions proposed.

[572] The new union would satisfy the requirement to have represented the unionized employees in a bargaining unit of the same type for at least one district health authority because all its predecessors did. That new union could become the bargaining agent for both health authority Health Care units as of April 1, 2015.

[573] More than one union combining to create an amalgamated successor union is not embracing minority associations in collective bargaining and departing from the majoritarian principle in the *Trade Union Act* under which a council of trade union or two unions can jointly become a single certified bargaining agent.

[574] It is recognition that unions and employees have an ability to adapt their organizational structures to varying circumstances, provided there is a single bargaining agent party to a collective agreement with the rights and responsibilities of a certified bargaining agent and, under the requirements of the *Health Authorities Act*, each successor union meets the limitations and eligibility requirements of section 89(1)(c) and (d).

[575] A certified amalgamated successor union party to a single collective agreement administered consistently for a province-wide bargaining unit will fulfill the aims "to integrate care, remove barriers and coordinate programs on a provincial basis."[266]

[576] It is consistent with the anticipatory successorship nature of the *Health Authorities Act* to have the unions creatively respond to and anticipate the employer restructuring by restructuring themselves. Creating an amalgamated successor union with representation for each of the current ten Health Care bargaining units could ensure continuing channels of communication with both the employees and local management.

[266] Submissions of the Employers, December 4, 2014, ¶ 166

[577] The intention of the *Health Authorities Act* is clearly to prepare for the transition from the existing district health authority bargaining structures and collective bargaining relationships in a manner that avoids proceedings before the Labour Board after April 1, 2015 and the necessity of representation and run off votes that often accompany successorship proceedings at the Board after employer restructuring.

[578] This approach of anticipating and addressing the issues before that date is to have the new collective bargaining relationships in place at the time the new provincial health authority employer comes into existence and that new employer and IWK Health Centre must start multi-employer collective bargaining for the eight bargaining units.

[579] The House of Assembly left it to a Mediator-Arbitrator to help fashion an approach that respects the choice not to have disruptive representation and run off votes. It is absurd to presume the intention is that one or a combination of CUPE local unions with a combined minority membership or Unifor Local 4600 with its minority membership would become the exclusive bargaining agent for all the Health Care unit employees of the separate employer IWK Health Centre without having a single member among that group of employees.

[580] If that were the outcome, could there be a greater disregard for democratic values and the majoritarian principles that underlie the certification of exclusive bargaining agents under the *Trade Union Act* and all collective bargaining legislation across Canada? Could it ever be intended that a union displace an existing certified bargaining agent and be certified as the new exclusive bargaining agent for a group of employees of an employer when it has none of the employees as members? Simply asking the question shows the absurdity and demands that this outcome be avoided.

[581] From another perspective, why would it be intended that IWK Health Centre with current relationships with three unions have a relationship with a fourth union in administering a collective agreement the new union did not negotiate and without knowledge of the past or current practices of the workplace? How does that provide workplace stability and harmony and enhance efficient and effective provision of patient care at IWK Health Centre?

[582] The employers avoid confronting these questions by not proposing what union should represent what bargaining unit. But they invite these questions without offering answers and submit a successor union cannot be formed by two or more existing unions.

[583] The simple and definitive response must be that no government or legislative assembly in a democratic society would ever countenance such a drastic departure from democratic principles and values and intend such absurd results. Legislators value the principle of majoritarian decision making, which they embody and must live by daily. Such a departure from the principle in such a major and important undertaking as acute health care restructuring cannot be imputed to them.

[584] While perhaps stated more forcefully and more often than required, I have concluded the definition of "union" in the *Health Authorities Act* permits existing unions with exclusive bargaining authority to represent employees in a Health Care unit of a district health authority to combine to form a successor union to represent the employees in the Health Care units of both health authorities after April 1, 2015.

"Nova Scotia Health Care Amalgamated Union"

[585] Before issuing an order that a successor "Nova Scotia Health Care Amalgamated Union" is the bargaining agent for each of the two health authority Health Care units, I would have to be satisfied it is a trade union under the *Trade Union Act* with a constitution and by-laws or governing constitutional instruments that contain provisions for acceptance into membership all Health Care unit employees of the two health authorities – not a council of trade unions, not a bargaining association and not a joint structure of autonomous unions that might qualify as two or more unions for joint certification under section 23(6) of the *Trade Union Act*.

> Two or more trade unions claiming to have as members in good standing of the unions a majority of employees in a unit that is appropriate for collective bargaining may join in an application under this Section and the provisions of this Act relating to an application by one union and all matters or things arising therefrom, apply in respect of this joint application and the unions as if it were an application by one union.

[586] Like the NSNU and many other unions that hold certification for multiple facilities, the "Nova Scotia Health Care Amalgamated Union" could have internal locals with

membership boundaries. Perhaps the boundaries could be tied to the provincial health authority's management zones for ease of local administration, communication and relationship building. If there are locals for internal structure, participation by members and leadership elections the locals will not hold bargaining agency status.

[587] This solution is not one existing union for all Health Care unit employees or all existing unions associated to represent each unit, but one successor amalgamated union to represent all employees in each unit.

[588] Perhaps, with employee support, the successorship union could arrange the employees in the district health authority facilities and programs that will come under the eastern management zone to be represented and serviced by the same persons who will build relationships with zone management.

[589] As it has taken the Transition and Design Team time to structure and staff the management of the provincial health authority, it will take time, although not must is available, for the leadership and staff of NSGEU, CUPE and Unifor to structure, organize and staff a successor amalgamated union for the Health Care units. I do not include NSNU because, unless I am mistaken, it is unlikely the NSNU and NSGEU will overcome their rivalry and collaborate.

[590] If the unions choose this solution, the successor "Nova Scotia Health Care Amalgamated Union" will have an initial union dues structure I must review as part of this transition planning.

[591] The successor union will have to provide information to me that it has or is in the process of setting up the systems necessary to complying with federal and provincial legislation applicable to bargaining agents.

[592] After April 1st, the employees of the Health Care units can set dues in accordance with the governing instruments. Beginning April 1st, the two health authorities will remit their employees' dues to the successor amalgamated union which will have its internal process for budgeting and support of any locals. I point this out to allow time to plan for any required changes to the SAP system.

[593] If the unions currently representing employees in the Health Care units choose to pursue this avenue, the status of the successor amalgamated union will be a matter for the agenda of the continuation of this arbitration hearing. If this is not an avenue they choose to pursue, that will also be a matter for the agenda.

D. Support Bargaining Units

[594] Currently, seven unions represent employees in the Service Support bargaining units. There are four collective agreements because the four CUPE local unions collectively negotiate one multi-employer and multi-union agreement with six district health authorities. Unifor Local 4603 negotiates two agreements with the Cape Breton District Health Authority and Guysborough Antigonish Strait District Health Authority. Unifor Local 4606 negotiates one with IWK Health Centre. NSGEU negotiates separate agreements with the Capital District Health Authority and IWK Health Centre.

SSDHA	SWDHA	AVDHA	CEHHA	CHA	PCHA	GASH	CBDHA	CDHA	IWK
CUPE Local 1933	CUPE Local 835	CUPE Local 4150	CUPE Local 2525	CUPE Local 2525	CUPE Local 2525	Unifor Local 4603	Unifor Local 4603	NSGEU (Local 42)	Unifor Local 4606

[595] Seven unions are eligible to represent employees in the Support units. The composition of the provincial health authority Support unit could be the unit with the least difference from the same type of Service Support unit in the district health authorities. This depends entirely on the number of classifications and positions reassignment from the Health Care unit to the Support unit.

[596] After reassignment Unifor Local 4606 will represent almost 100% of the employees in the IWK Health Centre Support unit. If Local 4603 had majority representation in the provincial health authority Support unit, which appears unlikely, it would be an easy step for the two locals to merge and be certified for both units.

[597] A successor union that is an amalgamation of the CUPE and Unifor locals would likely have majority membership of employees in the provincial health authority Support unit and all or almost all employees in the IWK Health Centre Support unit. The local representation of the approximately 1,200 employees of the Capital District Health Authority would have to be addressed. This scenario depends on the number of

classifications and positions reassigned from the Health Care unit to the Support unit and the resulting number of employees who are members of NSGEU.

[598] Of course, there could be a “Nova Scotia Health Amalgamated Support Union” consisting of components of former CUPE, Unifor and NSGEU members, as there could be a “Nova Scotia Health Amalgamated Clerical Union” if the NSGEU decided not to assert its majority and created a successor union with the CUPE locals. There are always difficult choices to be made with restructuring changing the status quo. Because this process is in anticipation of a future successorship there is time to make choices.

[599] Regardless what choices are made, this is a matter for the agenda of the continuation of this arbitration hearing.

[600] Under the legislation, the first three months of the six months from October 3, 2014 to April 1, 2015 are allocated to the mediation-arbitration process. The Arbitrator-Mediator’s reserved jurisdiction can be used to resolve detailed or after thought issues. At first impression, this attaches urgency to have definitive outcomes at the end of the first three months to allow for planning and implementation preparation in the second three months.

[601] However, the facts shatter that impression. The employers’ SAP system has limitations they vigorously tried to overcome in identifying classifications and positions in the face of competition for resources required for management restructuring and planning since October 3rd. No one has confidence either the employers or the unions have definitively identified all classifications and positions that require examination and agreement or decisions.

[602] There was the revelation the SAP system cannot be programmed until September, at the most optimistic, to reflect labour relations restructuring. This was a cause of some consternation and questions about simple matters like the health authorities’ ability to accurately deduct and remit union dues in accordance with each employee’s union representation and report earnings and deductions by separate district health authority and provincial health authority employers to the Canada Revenue Agency and others.

[603] There were recurring statements by the employers that operational changes immediately after April 1st were unknown in terms of innovative models of care or shared services. There were postulations dramatic change is unlikely to occur for considerable time after April 1st. For most employees, especially in the Clerical and Support units, there will be limited provincial mobility. IWK Health Centre remains a separate employer.

[604] Some of the senior management who will make the clinical and business plans to translate the vision into a plan that can be implemented and who must overcome district silos to create a provincial system have not been hired. Consequently, there is no clear timeline to have in place all the necessary elements for a robust change management process in front line service delivery. The redesigned human resources model is expected to unfold over two years, but is dependent on technology to realize its potential.

[605] And as the Minister identified from the outset, change of this magnitude must be done carefully. The employers' overview is that the merger of district health authorities and streamlining labour structures are preparatory, not final, steps.

> The merger of 9 District Health Authorities into 1 Provincial Health Authority and aligning IWK with it is about improving health care services in the province as much, if not more, than anything else. Models of care and care delivery, integration of programs, removal of barriers to access, are central to what is transpiring. This will not happen overnight. But the merger of the DHAs is an important part of the foundation for this evolution. The *Health Authorities Act* also provides a mechanism for the streamlining and integration of labour structures.[267]

[606] Neither the provincial health authority's redesigned model for human resources nor the senior member of the executive team responsible to oversee its implementation are not in place. Who will negotiate or instruct and coordinate employer negotiators in collective bargaining conducted simultaneously at four tables for reconfigured bargaining units under composite transitional collective agreements after April 1st? The timeline for shared services is years not months.

[607] The consequence is there is time to make informed, reflective decisions. More matters than what was initially thought can be decided under reserved jurisdiction. This

[267] Submissions of the Employers, December 4, 2014, p. 4

mediation-arbitration process can stay calm and carry on in the face of all the uncertainty.

11. CANADIAN CHARTER OF RIGHTS AND FREEDOMS

[608] The unions made submissions based in the *Canadian Charter of Rights and Freedoms* that the employers should not be permitted to make submissions on section 90(2):

> In determining the bargaining agent that is to represent each bargaining unit, the mediator-arbitrator shall consider whether the selection of the proposed bargaining agent will
>
> (a) be conducive to achieving stable and harmonious labour relations between the health authorities and unionized employees; and
>
> (b) promote the effective and efficient provision of health care to patients at the health authorities' facilities.

The issue became moot when the employers chose not to make any submissions.

[609] Similarly, the continuation of existing collective agreements as components of transitional collective agreements together with an agreement on integrated seniority makes moot union submissions that potential revocation or modification of contractual rights was unconstitutional.

[610] The unions' submit reconfiguring bargaining unit boundaries and the classification positions included and excluded from current bargaining units infringes constitutionally protected freedom of association, particularly in the case of Licensed Practical Nurses. This submission is not made with respect to extinguishing the Public Health and Addiction Services units or reassigning classification positions inconsistently in two or more units.

[611] The substance of the focus on Licensed Practical Nurses is they have not and will not have their workplace issues addressed in a mixed nurses unit because their issues have not been properly addressed when in a mixed nursing unit. If they are forced into a unit represented solely by the NSNU it will be a "substantial interference" with the advancement of their issues. An association of bargaining agents would

guarantee protection of their interests. Needless to say the NSNU disagrees and the Licensed Practical Nurse member of the Executive Board disagrees.[268]

[612] In 2003, the Quebec government passed legislation restructuring bargaining units in the health and social services sectors. The legislation established four bargaining units per facility. Membership in each was defined by job classifications. Some unions lost all of their members. Others increased membership. Historical bargaining relationships were changed. The legislation made several other changes to the labour relations structure. In 2011, the Quebec Court of Appeal decided the government could redefine bargaining units because no particular bargaining scheme is entrenched in the *Charter*. It decided legislation that sets bargaining unit boundaries and composition, but does not compel membership in a specific trade union, is constitutional because a bargaining unit is distinct from the union that will represent the employees in the unit. The Supreme Court of Canada denied leave to appeal.[269] The ILO Committee on Freedom of Association did not conclude the legislation was not in conformity with the principles of freedom of association.[270]

[613] Which union better represents the interests of Licensed Practical Nurses and provides better opportunities for advancement of their workplace and professional issues and their individual personal fulfillment is not a subject for arbitration. Legislation directing all Licensed Practical Nurses will be included in one rather than two appropriate bargaining units is not an unconstitutional infringement of their freedom of association.

[614] If the rationalization of bargaining units for good faith reasons results in a change in bargaining agent for some Licensed Practical Nurses based on majority support for the new bargaining agent, this is not an unconstitutional violation of the numerical minority employees' freedom of association. Individual Licensed Practical Nurses are

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[268] Maria Langille Affidavit, December 1, 2014

[269] *Québec (Procureur général) c. Confédération des syndicats nationaux* (CSN), 2011 QCCA 1247 (CanLII), ¶ 93 - 94; [2011] S.C.C.A. No. 424

[270] Case Nos. 2401 – 2403; For previous discussion about international obligations see James E. Dorsey, "International Labour Conventions and the I.L.O.: Application in British Columbia" (1985), 43 the Advocate 619; *Canada Labour Relations Board: Federal Law and Practice* (1983) (Carswell Legal Publications), c. 2

free to maintain membership in a union they choose in addition to the union certified as their bargaining agent.

[615] The manner in which mediation and arbitration unfolded with the face-to-face in room arbitration hearing freely accepting and admitting proffered information and reply affidavits concluded in less time than scheduled. There were scheduled evidentiary and legal submissions for a month afterwards. This undermines the presumed factual basis for submissions that the expedited process amounted to a constitutional interference with employees' ability through their bargaining agents to meaningfully participate in a process that could have profound consequences for them.

[616] The unions' remaining submissions on the effect of the *Canadian Charter of Rights and Freedoms* on the interpretation and application of the *Health Authorities Act* mainly concern representation votes and multi-union representational structures. The submissions are advanced by the unions in an attempt to rebalance what they perceive to be legislation skewed in favour of the employers.

[617] The unions submit any scope of discretionary interpretation or decision making should be exercised to right the balance. The definition of "union" must be construed to include multi-union structures that will enable the employees to maintain "historical associational patterns" and established relationships in urban and rural communities.[271]

[618] At the heart of the unions' submissions is the proposition:

> Establishing and maintaining employee associations are at the core of protected associated activities, and these associative activities must be done according to the wishes of the employees affected, and not the employer or the government. Representation and participation in a trade union is the choice of employees, and includes choice of the structure and composition of unions. Employers have no say in employees' choice of bargaining agent; to allow same constitutes a breach of fundamental rights and freedoms as guaranteed by the *Charter.*[272]

[619] An inherent dilemma in making a *Charter* challenge to legislation based on anticipated or potential interpretation and application of the legislation is that the interpretation might not be the one found to be the intent of the legislation. Although the challengers' intention might be to bolster an interpretation advocated by the challengers,

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[271] CUPE Submission, November 24, 2014, ¶ 18
[272] NSGEU Preliminary Outline of Charter Argument, November 27, 2014, ¶ 10

as is the case with CUPE's application, the submissions still address "potential violations" of *Charter* rights.

[620] I do not think the *Health Authorities Act* as I have determined its intent and have interpreted and explained its interrelated provisions violates any freedom of association rights protected by the *Charter*.

[621] The *Health Authorities Act* does impose a freeze on collective bargaining until April 1, 2015 and suspends employees' rights to revoke or change bargaining agents during and after these successorship restructuring proceedings until the Governor in Council determines.[273] Its purpose and intention is to freeze the status quo for a limited time to prevent new unions entering the landscape with applications for certification; existing unions applying to displace current bargaining agents for existing bargaining units; unionized employees from applying for revocation of certification; and unions or employers making successorship applications to the Labour Board. There is no compliant this violates *Charter* rights.

[622] The restrictions on changing bargaining agents under the *Trade Union Act* are transitional to provide stability to create the restructured platform. When they are repealed employees in a bargaining unit will be free to choose to be represented by a different trade union under the *Trade Union Act*. The transitional restrictions do not create monopoly unions. So long as they are maintained for a transitional period and no longer, they will not interfere with the bargaining unit groups of employees in the eight units from establishing or joining another union.

[623] No collective agreement provision has been nullified or changed except for seniority provisions by agreement. No employee has lost seniority and there is provision for future seniority in each bargaining unit on an equal basis among the employees in the unit.

[624] Section 89(1)(c) is the only provision of the *Health Authorities Act* that has been interpreted and is intended to be administered in a manner submitted to be unconstitutional.

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[273] s. 155(2)

(c) each union

(i) may represent only one of the four bargaining units for a health authority, and

(ii) must represent the same type of bargaining unit for each health authority

This limitation on the representational capacity of the unions and the eligibility requirement in section 89(1)(d) does limit employee choices.

[625] This limitation does not have the "effect of making it impossible to act collectively to achieve workplace goals."[274] Nor does it prevent employees from maintaining their union membership or the formation of a union. An amalgamated successor union can be fashioned in a manner that respects employees' associational rights as advocated by the unions.

[626] This limitation does require employees to respond to the employer restructuring by forming unions that represent employees in province-wide bargaining units with one multi-employer collective agreement per unit. The government sees this as a critical element in achieving the public policy goal of having provincial program and service delivery with province-wide employee mobility. This public policy goal is advanced as a means to help maintain the sustainability of universal health care by streamlining administration and collective bargaining.

[627] What this limitation does is require the employees to go farther than the unions' proposed bargaining association and the unions to cooperate to avoid run-off votes.

[628] The *Health Authorities Act* does not deny or substantially interfere with employees' ability to associate or their access to engaging in meaningful negotiations with their employer through a collective bargaining process to attain their objectives.

[629] The *Health Authorities Act* as interpreted above is not a contravention of employees' constitutional workplace freedom of association rights. As the Minister of Labour and Advanced Education stated, it respects the majority wishes of health care unionized employees in appropriate bargaining units to form unions to which they wish to belong and represent them as their bargaining agent. The unions' *Charter* applications are dismissed.

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[274] *(Attorney General) v. Fraser*, [2011] 2 S.C.R. 3, ¶ 46

[630] Through the diligence and cooperation of the employers and unions there is a final determination on the integration of seniority of unionized employees in each bargaining unit and the collective agreements to remain in force and apply to employees in each bargaining unit. These determinations will answer most questions employees have about the personal impact of the employer restructuring and the change of employer. They will help frontline supervisors planning important aspects of the daily delivery of health care services.

[631] There is still work to do to determine the composition of each bargaining unit and the bargaining agent to represent each unit. These matters will be scheduled for the continuation of this arbitration under my retained jurisdiction. Schedule 3 is a copy of the order I make. A certified copy will be forwarded to a prothonotary of the Supreme Court of Nova Scotia in accordance with section 95(2) of the *Health Authorities Act*.

[632] I am indebted to counsel, the leadership and staff representatives of the unions and employers who worked tirelessly to meet my demands and the timelines of this process. Compiling, absorbing and presenting the immense amount of information and material that constitutes the record of proceedings and educating me on the nuances of Nova Scotia acute care labour relations was a challenging task. Any errors or oversights I have made in reporting, summarizing and addressing the issues are entirely my responsibility and will be corrected in future proceedings.

JANUARY 17, 2015, NORTH VANCOUVER, BRITISH COLUMBIA

James E. Dorsey

James E. Dorsey, Q.C
Mediator-Arbitrator

Schedule 1 – Integration of Seniority

MEMORANDUM OF AGREEMENT

Health Authorities Act

Integration of Seniority of Unionized Employees

WHEREAS the Provincial Government has decided to merge the nine District Health Authorities to create a Provincial Health Authority;

AND WHEREAS the Nova Scotia Government and General Employees Union, Nova Scotia Nurses' Union, Canadian Union of Public Employees and Unifor ("the Unions") represent the employees of the District Health Authorities;

AND WHEREAS the Provincial Government has indicated that it wishes to merge the bargaining units represented by the Unions and create provincial bargaining units;

AND WHEREAS section 86(1)(d) of the *Health Authorities Act* requires the representatives of the District Health Authorities and the Unions to, with the assistance of the mediator-arbitrator, determine the integration of seniority of unionized employees in each bargaining unit;

THEREFORE the Unions agree as follows:

1. No employee of the ten employers covered by the *Health Authorities Act* will lose seniority as a result of integration of seniority of unionized employees.
2. The employers will identify cases where a Regular (permanent) employee accrues casual seniority hours since January 1, 2008, and were not given credit for those hours when that employee became a regular (permanent) employee. For registered nurses and licensed practical nurses only, the employer will identify cases where the employee accrued casual seniority hours since February 26, 2004, and were not given credit for those hours when that employee became a regular (permanent) employee. Those accrued casual hours need to be divided by 1950, assigned a calendar value and added to the employee's March 31, 2015 regular seniority date.
3. On April 1, 2015, the provincial health authority will recognize an employee's seniority at March 31, 2015 with any of the nine district health authorities under any collective agreement in effect March 31, 2015.
4. On and after April 1, 2015:
    a) The provincial health authority will recognize continuous service with the provincial health authority as an accumulation of additional seniority as of March 31, 2015.
    b) Regardless of any contrary or conflicting provision in a collective agreement, "Regular seniority" will be defined as the "most recent date of hire into a regular position in the bargaining unit" and "Casual seniority" will be defined as the "accrual of hours paid since the most recent date of hire into a casual position in the bargaining unit".

c) Separate seniority dates and seniority lists for Regular and Casual employees will continue unless otherwise agreed between a bargaining agent and employer.

d) Seniority of full time and part-time Regular employees will be based on continuous service in the bargaining unit in which the employee is employed.

e) Seniority of Casual employees will be based on actual hours worked (to a maximum of 1950 hours in a calendar year) in the bargaining unit in which the employee is employed.

f) Regardless of any contrary or conflicting provision in a collective agreement, when an employee transfers from a casual to a regular position, the employee's Casual seniority hours will be divided by 1950 and assigned a calendar value which will determine the employee's regular seniority date, which will be prior to the date of hire into a regular position.

g) Regardless of any contrary or conflicting provision in a collective agreement, when an employee transfers from a regular position to a casual position, the employee's Regular (permanent) seniority at the date of transfer will be multiplied by 1950 to establish the employee's accrual of hours for the employee's date of hire into the casual position. For this conversion process only, Employees who worked less than fulltime hours during some or all of their time as a regular (permanent) employee will have their hours of seniority prorated accordingly.

5. In no case will any employee accrue more than 1950 hours seniority per year for the purposes of the above.

6. Seniority will be calculated in the same fashion for employees whose full time hours are 1820 or 2080 hours per year, except 1820 hours or 2080 hours will be substituted for 1950 in the calculations set out herein.

7. In the event two or more employees have the same seniority date, their placement on the seniority list will be determined by random draw.

8. In the event a casual employee's conversion to regular employment status results in the same seniority date as a regular employee, the casual employee will be placed below the regular employee on the seniority list.

9. The same calculation of seniority will apply to employees of the IWK, but their seniority lists will be separate from the Provincial Health Authority.

10. No later than February 2, 2015, each of the ten employers will provide Regular and Casual seniority lists with calculated seniority dates to be implemented April 1, 2015 to each union with which it has a collective agreement.

11. The unions will review the lists and identify any issues or concerns it has to each employer no later than March 13, 2015.

    On or before April 15, 2015, the provincial health authority and the IWK Health Centre will deliver Regular and Casual employee seniority lists for April 1, 2015 to each bargaining agent for each bargaining unit the bargaining agent

represents. Said list will include an accumulation of Casual Hours between January 1, 2015 and March 31, 2015 and/or seniority credited under #2 for each affected Employee.

12. Collective agreements will be amended to include definitions of regular and casual seniority, being:

    “Regular Seniority” shall be the seniority with which an employee was credited as an employee at April 1, 2015 plus continuous service in the bargaining unit on/and after April 1, 2015.

    “Casual Seniority” shall be the seniority with which an employee was credited as an employee as of April 1, 2015 plus hours worked on and after April 1, 2015.

13. Nothing herein precludes the parties from negotiating issues regarding seniority in collective bargaining or in an agreement prior to collective bargaining.

Schedule 2 – Interim Protocol Regarding Collective Agreements

1. Definitions for the purposes of this Protocol:
   a) "**Former Seniority Pool**" means the seniority pool established by an Original Collective Agreement.
   b) **"Former Bargaining Unit"** means a bargaining unit that existed as of March 31, 2015.
   c) "**Integrated Seniority**" means seniority under the Integration of Seniority of Unionized Employees Memorandum of Agreement [Schedule 1].
   d) "**New Bargaining Unit**" means a bargaining unit established as of April 1, 2015.
   e) "**Original Collective Agreement**" means the collective agreement that applied to an employee as of March 31, 2015.
   f) **"Seniority Provisions"** means provisions that give employees rights that depend upon their seniority including, but not limited to, provisions respecting the posting of vacancies and new positions, promotions, transfers, layoffs and recalls.
   g) "**Successor Employer**" means as of April 1, 2015 the Provincial Health Authority or IWK Health Centre as required by context.
   h) "**Transitional Collective Agreement**" means a composite collective agreement established by this protocol effective April 1, 2015.

Applicable Collective Agreement Terms and Conditions (exceptions below)

2. Subject to the provisions herein, all provisions of the Original Collective Agreement that covers an employee will continue to apply to the employee on and after April 1, 2015 regardless of the New Bargaining Unit in which the employee is placed.

3. Employees who apply for and obtain a classification position to which a different Original Collective Agreement applies will be subject to the Original Collective Agreement applicable to the employee's new classification position.

4. A newly hired employee will be covered by the Original Collective Agreement applicable to the classification position for which the employee is hired.

5. If the terms and conditions of more than one Original Collective Agreements apply to the employees in a New Bargaining Unit, all provisions of the Original Collective Agreements shall form part of a single composite Transitional Collective Agreement to which the Successor Employer and the bargaining agent for the New Bargaining Unit are the only parties.

6. A Successor Employer and the bargaining agent for a New Bargaining Unit may agree in writing to modify their Transitional Collective Agreement to apply or modify the application of all or any provision of an Original Collective Agreement in

respect of some or all employees in the New Bargaining Unit. Any such modification or amendment is subject to the bargaining agent's ratification process.

7. A Transitional Collective Agreement will continue to operate until a new replacement collective agreement is negotiated, ratified and effective between the bargaining agent for a New Bargaining Unit and a Successor Employer on or after April 1, 2015.

Seniority Provisions (exceptions below)

8. Under a Transitional Collective Agreement seniority provisions will be applied on the basis of Former Seniority Pools using seniority lists under the applicable Original Collective Agreement as modified by Integrated Seniority.

9. Until a new collective agreement replaces a Transitional Collective Agreement, employees who apply for a position to which a different Original Collective Agreement applies will not have their seniority counted for the purposes of such application. However, upon being awarded such a position, the employee's Integrated Seniority will apply and continue to accrue.

10. Notwithstanding paragraphs 8 and 9, employees in classification positions moved from a Former Bargaining Unit of one type to a New Bargaining Unit of a different type will have their seniority transferred from the Former Seniority Pool. These employees will be entitled to exercise their seniority rights in the new seniority pool. In the event these employees apply for and obtain a position in a New Bargaining Unit, they will then be subject to all terms and conditions of the Original Collective Agreement applicable to the new position.

11. Notwithstanding anything herein, employees in the Former NSGEU Public Health and Addiction Services bargaining units shall, under the applicable Transitional Collective Agreements, continue to be treated as a segregated seniority pool as they were under their former seniority pool.

12. For further clarity, except as set out in this protocol, during the term of a Transitional Collective Agreement, seniority lists shall not be used to expand or limit the rights of employees to move between Original Collective Agreements, except to the extent that those rights exist under the applicable Original Collective Agreements.

IWK Health Centre

13. Wherever it is applicable, a separate process will apply equally to "Transitional Collective Agreements" at the IWK.

Dispute Resolution

14. Any dispute between the Successor Employer and a Bargaining Agent for a New Bargaining Unit regarding the interpretation or implementation of this protocol shall be resolved by Mediator-Arbitrator James E. Dorsey, Q.C. after obtaining written

submissions from the parties unless, at his sole discretion, Mr. Dorsey wishes to hear evidence and/or oral argument, which may be done by telephone or video conference of in another form of hearing.

Schedule 3 - Order

HEALTH AUTHORITIES ACT, S.N.S. 2014, c. 32

CANADIAN UNION OF PUBLIC EMPLOYEES, Locals 835, 1933, 2431, 2525, 4150
NOVA SCOTIA GOVERNMENT AND GENERAL EMPLOYEES UNION
NOVA SCOTIA NURSES' UNION
UNIFOR, Locals 4600, 4603 and 4606

UNIONS

SOUTH SHORE DISTRICT HEALTH AUTHORITY
SOUTH WEST NOVA DISTRICT HEALTH AUTHORITY
ANNAPOLIS VALLEY DISTRICT HEALTH AUTHORITY
COLCHESTER EAST HANTS HEALTH AUTHORITY
CUMBERLAND HEALTH AUTHORITY
PICTOU COUNTY HEALTH AUTHORITY
GUYSBOROUGH ANTIGONISH STRAIT HEALTH AUTHORITY
CAPE BRETON DISTRICT HEALTH AUTHORITY
CAPITAL HEALTH AUTHORITY
IZAAK WALTON KILLAM HEALTH CENTRE

EMPLOYERS

ATTORNEY GENERAL OF NOVA SCOTIA

ATTORNEY GENERAL

WHEREAS effective April 1, 2015 the *Health Authorities Act*, S.N.S. 2014, c. 32, establishes as a body corporate a health authority for the Province (the "provincial health authority") that displaces the South Shore District Health, South West Nova District Health Authority, Annapolis Valley District Health Authority, Colchester East Hants Health Authority, Cumberland Health Authority, Pictou County Health Authority, Guysborough Antigonish Strait Health Authority, Cape Breton District Health Authority and Capital District Health Authority (collectively the "district health authorities") and designates the IWK Health Centre a second health authority;

AND WHEREAS sections 81 through 104 of the *Health Authorities Act* provide for mediated negotiations and arbitration to resolve labour relations issues related to the provincial health authority becoming a successor employer to the district health authorities until such time after April 1, 2015 in respect of each bargaining unit that a collective agreement is concluded for each bargaining unit;

AND WHEREAS the Unions and the Employers agreed to the appointment of Mr. James E. Dorsey, Q.C., as Mediator-Arbitrator;

AND WHEREAS the Minister of Health and Wellness appointed Mr. Dorsey on October 9, 2014 as Mediator-Arbitrator pursuant to the *Health Authorities Act*;

AND WHEREAS the Unions and the Employers engaged in mediated negotiations before proceeding to arbitration which finally determined some, but not all, of the interrelated issues as reported in the attached decision dated January 18, 2015;

AND WHEREAS there are further determinations to be made in respect of each bargaining unit in accordance with the Mediator-Arbitrator's retained jurisdiction;

AND WHEREAS the final job classification composition and the number of unionized employees in classification positions in each of the eight bargaining units is to be determined in accordance with the attached decision;

AND WHEREAS the majority wishes of the employees in classification positions in each bargaining unit for the bargaining agent to represent them cannot be determined until the final composition of each bargaining unit is determined;

IT IS HEREBY ORDERED IN THE INTERIM:

1. The integration of seniority of unionized employees in each bargaining unit effective April 1, 2015 and the process for determining employees' integrated seniority and resolving any disputes over employees' integrated seniority shall be in accordance with Schedule 1 in the attached decision.
2. Effective April 1, 2015 the collective agreements pertaining to employees in each bargaining unit shall be in accordance with the protocol in Schedule 2 in the attached decision.
3. Effective April 1, 2015, the appropriate bargaining units for both the provincial health authority and IWK Health Centre shall be a nursing bargaining unit, a health care bargaining unit, a clerical bargaining unit and a support bargaining unit as described in section 90(1) of the *Health Authorities Act* with a job classification composition to be finally determined

JANUARY 18, 2015, NORTH VANCOUVER, BRITISH COLUMBIA

James E. Dorsey, Q.C
Mediator-Arbitrator