Reorganization of Saskatchewan's Health Labour Relations

Health Labour Relations
Reorganization Commission

January 15, 1997

Saskatchewan

The Health Labour Relations
Reorganization Commission

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January 15, 1997

The Honourable Robert W. Mitchell
Minister of Labour
Room 355 - Legislative Building
Regina, Saskatchewan
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Dear Mr. Minister:

Enclosed are The Health Labour Relations Reorganization (Commissioner) Regulations and my accompanying report. I thank you for having entrusted this important responsibility and formidable challenge to my competence and judgement.

Your government and all its agencies provided every assistance that I requested. The affected unions participated vigorously. The Saskatchewan Federation of Labour and national bodies to which some of the unions are affiliated made every effort on behalf of their affiliates to find an acceptable outcome. The Saskatchewan Association of Health Organizations and its members provided valuable assistance and vigilant representations throughout the process. Many other organizations and individuals took time to make written and personal representations.

A small dedicated staff in your Ministry worked tirelessly to help me strive for success. Any failings in the regulated solutions not meeting the current problems or becoming unforeseen problems tomorrow are entirely mine.

The regulations substitute 45 appropriate bargaining units for the current 538. They reduce the incidence of health sector collective bargaining from 25 collective agreements to 9 or 10, depending on the outcome of a representation vote in one unit.

Individual employee seniority and accumulated service is protected as employees move into or from one bargaining unit to another.

The incidents of rivalry, jurisdictional and representational disputes among unions and employees cannot be totally eliminated. However, it will be drastically reduced from the previous experience.

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The trade union to be certified as the exclusive bargaining agent is determined for 43 of the units. The Labour Relations Board will supervise representative votes among the employees in the remaining 2 units.

The structures for orderly collective bargaining established by the regulations will enable both service delivery integration and, over time, the development of consistency in terms and conditions of employment. Because no existing collective agreement is prematurely terminated, the new structures do not impose any additional costs without agreement in collective bargaining.

There are many opinions on what bargaining unit and collective bargaining configuration best matches the seamless, single entry, fully integrated health service envisioned for Saskatchewan. The options and their consequences have presented tough issues and hard choices.

In submitting my regulations I have one deep regret. I have been unable to find a solution which maintains each trade union's current represention without unduly compromising the ability of the health delivery service to meet its full potential or without creating a collective bargaining structure that would not be orderly. There is no joy in an outcome that may exclude any trade union, which through its leaders has worked earnestly to support health service reform and the workers who deliver those services.

At the same time, the reorganization in these regulations respects my mandate and will enable the provincial health system to move forward toward its goal of healthier individuals and a healthier population in Saskatchewan.

Yours very truly,

James E. Dorsey
Commissioner

Acknowledgement

I came to Saskatchewan as a stranger to the unions and employers who invited and empowered me to make far reaching decisions affecting their existing rights and responsibilities. The help, respect and confidence that they and all others extended throughout the process reflects the best of prairie hospitality.

To the union officers and representatives and to the leadership of SAHO and the various health districts and affiliates that I met, I have sincere gratitude for their patience, participation, support and assistance.

To the responsible Ministers, I am thankful for their unswerving confidence in me and their resolve to enable me to discharge my responsibilities through periods of calm and conflict.

The daily work of the commission was done by only two people at any time.

Allan Barss did everything - no matter how complex or how trivial. He did so willingly and in good humour, quick to laugh. He remained calm and efficiently focused to the end despite the rising tension. His loyalty to the task included challenging me and offering constructive criticism. I am greatly indebted to him and his family.

Grace Marbach served as a willing, dedicated and diligent administrator under adverse personal circumstances. Her work was ably finished by Sheila Bissonnette.

Ted Boyle and Terry Stevens capably responded to all requests for help. Their help was essential to the work of the commission.

To each of them and the many others in Saskatchewan Labour who helped the commission fulfill and meet its mandate on time, thank you.

Jim Dorsey

Prologue

This publication is not designed to interpret the legislation. It is not intended to be used in court. Please use the original legislation whenever you wish to interpret or apply the law.

For the readers' information the Regulations found in Appendix N were approved by Cabinet, signed by the Lieutenant Governor-in-Council and filed with the Registrar of Regulations on January 17, 1997.

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Introduction

Public health care is the most vital of social programs in Canada. It originated in Saskatchewan and is being vigorously regenerated in Saskatchewan.

Freely selected trade union representation and free collective bargaining by independent trade unions is a democratic tenant of social justice in Saskatchewan.

These two basic elements of Saskatchewan society vie for prominence in the mandate of this commission. This report and the accompanying regulations seek an appropriate balance between the two within a purposeful reading of the commissioner's authority.

The traditional divisions of labour among health care workers and the traditional methods of service delivery are being challenged and changed.

In some parts of Canada health reform is still being planned. Health reform is a reality in Saskatchewan. Organizational and structural change since 1993 has been dramatic and widespread. Operational change is happening and will continue to happen. The traditional divisions of labour among health care workers and the traditional methods of service delivery are being challenged and changed.

The nature and extent of change differs across the province as each local health district board makes its choices about pace, priorities and direction. The changes have created friction and dislocation. Often they have had detrimental consequences for individual health care workers and their families. New organizations have been created and many others have disappeared to the consternation of some.

Change will continue to happen - maybe become more extensive. Some health care services were overdeveloped during the expansionary era of the 1950's to 1980's. Other critical areas were underdeveloped.

The current efforts are to realign the level and mix of services. At the same time, advances in knowledge and science, as well as changes in provincial demographics, will continue to drive demands for and necessitate change.

The limits on available public health care resources require that the pace of change be quick. There is urgency in completing the initial and most traumatic organizational changes that are to support the longer term goals of efficiency, local decision making and improved health outcomes for the population and individuals.

Organizational structures that deliver health care services are merely vehicles and servants of the desired goals. Yet the governance, managerial, administrative and operational structures support complex networks of personal and organizational relationships throughout the health system.

Everywhere the changes threaten the survival of existing rights for both individuals and organizations.

Drastic dislocation of past relationships is happening in Saskatchewan and across Canada in the restructuring accompanying health reform through program and organizational devolution and regionalization. Everywhere the changes threaten the survival of existing rights for both individuals and organizations.

Resistance to change is understandable when individuals and organizations can foresee and actually experience loss with change. Employer identity, trade union representational rights, employee entitlements and benefits, job identity, career hopes and the security of all of them are dependent upon survival of past relationships and organizations and the maintenance of existing networks through any change into the future.

Success in passing through restructuring to a state where the health goals can be earnestly pursued means identifying and addressing the effects of the changes on existing relationships and rights. This can be done under

existing legislation and through existing institutions and processes, like labour relations boards, which are accustomed to dealing with incremental and evolutionary change. It can be done by agreement and accommodation among the parties asserting rights. These avenues were pursued in Saskatchewan.

Or it can be done by some special process intended to be responsive to the wholesale change that is being undertaken. At the request of the trade unions representing over 96% of unionized employees in the health sector and the organization representing employers directly affected by health care restructuring, the Saskatchewan Legislature adopted a special, single purpose process to undertake a comprehensive redefinition of relationships and rights for the trade unions, the employees they represent and their employers. At their request, I was appointed commissioner.

More flexible in procedure than a quasi-judicial administrative tribunal and divorced from ballot box politics, the commissioner is mandated to make regulations.

More flexible in procedure than a quasi-judicial administrative tribunal and divorced from ballot box politics, the commissioner is mandated to make regulations. The task is to redefine rights and reshape relationships to support the health reform restructuring and its service delivery goals; to enable the development of consistency in terms and conditions of employment over time; and to promote orderly collective bargaining relationships within new structures. This is to be done in the context of change and the history of union representation.

This is an extraordinary labour relations and rights determination process for an extraordinary situation.

This is an extraordinary labour relations and rights determination process for an extraordinary situation. The decision-making is a mixture of health and collective bargaining public policy. The tension is between creating results which will best serve the future for the provincial community and preserve important, usually hard won, often cherished, existing individual and organizational rights and relationships.

The commission's process has sought to identify and understand the facts and problems, isolate imagined problems and identify solutions for those that are real. Principled criteria for assessing the merits of possible solutions have been tempered to recognize the practicalities, pragmatism and existing relationships that are necessary to sustain every day dealings.

The goal has not been to prescribe a textbook, optimum result. It has been to find a result that responds to the real problems, generates few new problems and can work because it receives broad support.

Wellness: An Integrated Vision For Health

A wellness vision of tomorrow's health system is a holistic vision of the determinants of healthy populations and healthy individuals. It is not a new vision. The reduction of morbidity and mortality by prevention and treatment was the "modern conception of health insurance" in the 1940's.[1]

Proponents of the social insurance movement advocated and achieved their goal piecemeal. All the while, there were voices calling for integration of the disparate schemes addressing the risks of sickness, old age, family needs, disability and unemployment.

> *"It is necessary to be aware of associated and comparable contingencies: to appreciate, for example, the similarities and transitions between disability and old age; or between unemployment and certain forms of sickness so far as they involve absence from work. When all this has been done, it is finally necessary to recognize the essential unities of social security - to fit together, in other words, all the branches of social insurance and social provision in such a way that they support each other, and work together as a coherent administration. ... The*

> *demand for comprehensiveness is not mere academic straining for perfection: it is one of the practical realities of economic and efficient operation."* [2]

In current times, integration is discussed in terms of a seamless continuum of services encompassing health promotion and protection and disease prevention; health maintenance and wellness; facility and community-based care; and specialized institutional care. The larger strategic direction is to shift the focus and resources from treatment and care to health promotion and overall wellness.

The Saskatchewan vision of working together toward wellness "incorporates a definition of health that includes an individual's physical, mental, social, cultural, economic and spiritual wellbeing."[3] It embraces the comprehensive World Health Organization definition:

> *"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs and, on the other hand, to change or cope with the environment."*

One of the challenges in achieving the improvement in quality of life that is to accompany a wellness focus and its goals is reformation of delivery service structures to improve co-ordination, achieve integration and meet needs where there are gaps in the system.

The wellness strategies of better use of health resources, expansion of community-based services and integration and co-ordination of the delivery of services requires change to past structures and relationships to achieve improved planning and delivery of services.

> *"When we began to plan Medicare, we pointed out that it would be in two phases. The first phase would be to remove the financial barrier between those*

giving the service and those receiving it. The second phase would be to reorganize and revamp the whole delivery system - and, of course, that's the big item. That's the thing we haven't done yet."[4]

In adopting the wellness vision and framework for a new approach in 1992, the Government of Saskatchewan said that now is the time to get on with the necessary fundamental and broad-based change.

Structural reform of the delivery system is a transitional step to reform of programs, services and delivery methods.

Structural reform of the delivery system is a transitional step to reform of programs, services and delivery methods. The health reform change process is a marathon not a sprint. The vision is a future health care system with the following characteristics:

"
- *extensively controlled by local people meeting local needs determined at the local level*
- *home and community based services will be the predominant form of service delivery*
- *in-patient hospital services will largely provide intensive care*
- *most surgery will be done as day surgery*
- *an increased array of options for supportive care will exist such as housing with varying degrees of security and helping services*
- *only a small proportion of people age 75+ will be in intensive supportive care institutions*
- *there will be very few large institutions for supportive care*
- *there will be fewer nursing home beds and people will stay in their homes with appropriate supports like personal medical alarms or reside in small special care units*
- *appropriate community care will be available 24 hours a day, 7 days a week*
- *emergency response will be widely available and very responsive*

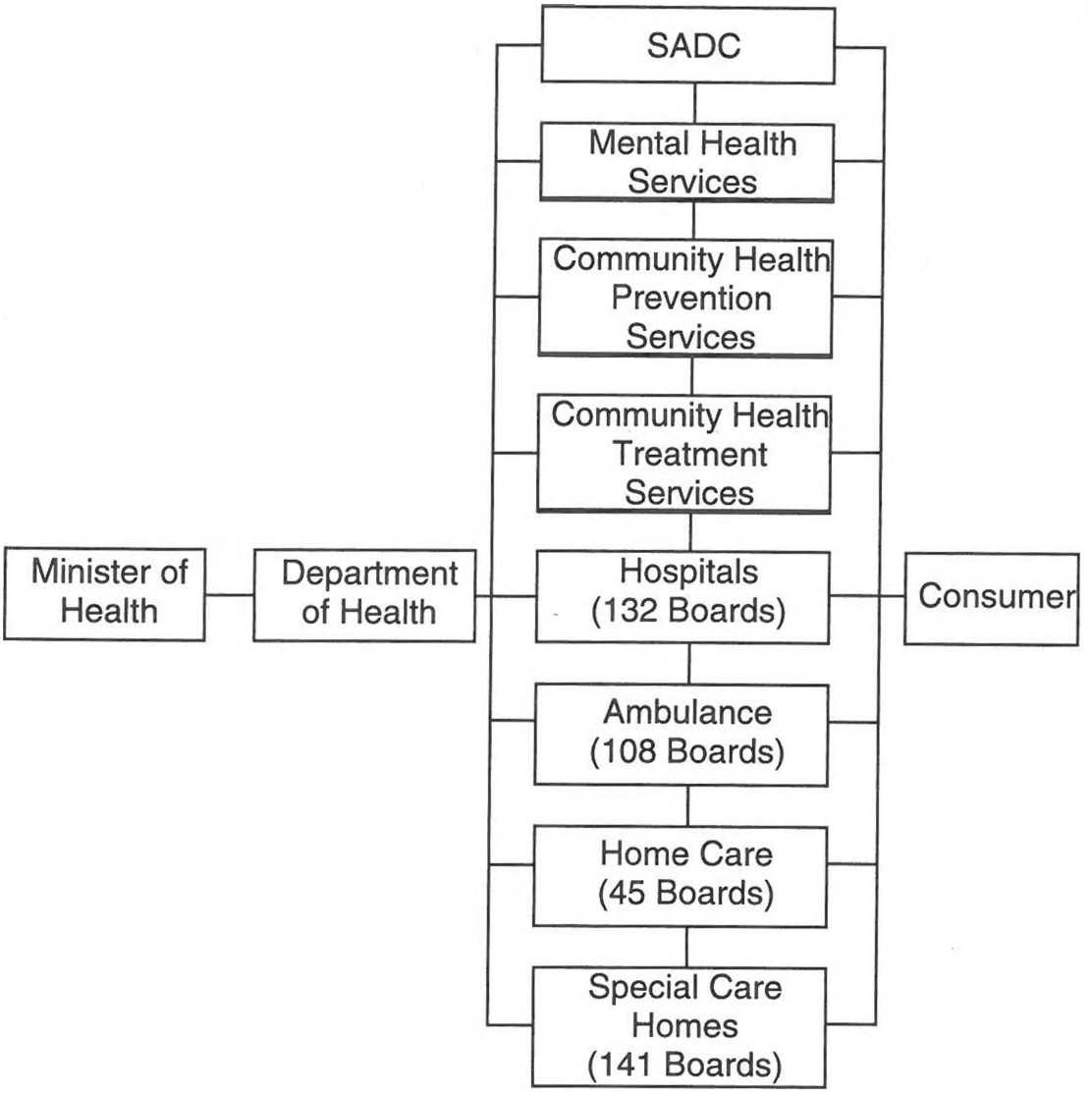
- *there will be fewer doctors and the right balance will exist between specialists and general practitioners*
- *nurses and other health professionals will have expanded roles*
- *fewer drugs will be prescribed*
- *there will be fewer environmental risks*
- *children will be better educated about high risk behaviours*
- *the public will be better educated about health, the health system and their personal responsibility."*[5]

Health care workers will deliver services and support at and beyond any site at which they may be based.

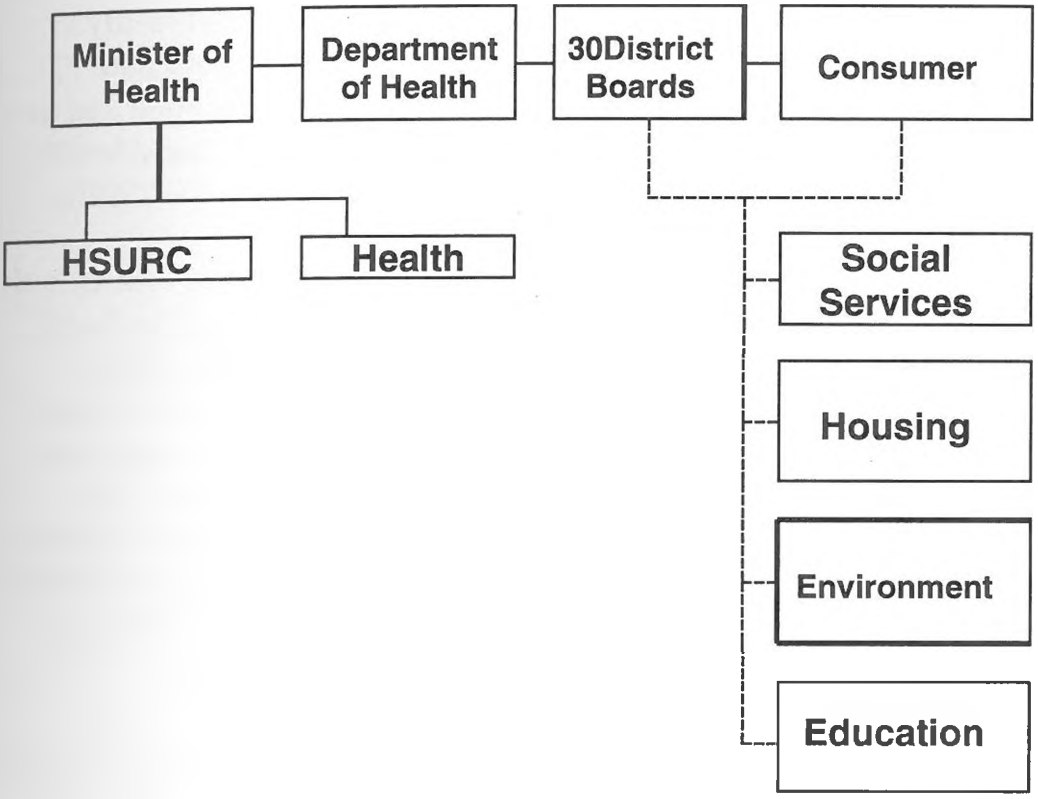
As a vehicle to realize this vision, the service delivery system is being changed from a segregated to an integrated structure. Within that structure both citizen and health care worker is to have ease of mobility throughout a wall-less service system. Health care workers will deliver services and support at and beyond any site at which they may be based.

The Saskatchewan health service system before and after reform can be depicted by the following charts.

Health Service System Prior to Reform



Health Service System After Reform



Regional Structure For Integrated Service

Like other current health reform initiatives, it is not an idea from the 1990's.

Consolidating comprehensive, health related decision-making authority on a regional or community basis has been pursued both nationally and internationally to achieve healthier outcomes for populations and individuals through better resource allocation and more effective service delivery. Like other current health reform initiatives, it is not an idea from the 1990's.

Canada's first regional health council was established as a pilot project in 1946 in Saskatchewan. The Swift Current Health Region had responsibility for the administration of hospital, medical and public health services. Governed by rural mayors, it raised local revenue and received provincial tax dollars. One assessment was that: "In terms of economic efficiency, the regional program provided comparable services at less cost than elsewhere in the province."[6] Slowly, others followed the Saskatchewan lead.

As regionalization was introduced within provinces and other countries, it became the means to a mixture of goals: "more responsive and democratic decision-making, more equitable and appropriate services, and better cost control."[7] In 1969 the Task Force on the Cost of Health Services in Canada concluded that:

> *"The concept of area-wide or regional planning for health facilities and services has been accepted as a viable, effective approach, and is required if integrated and balanced health care systems are to be achieved. The need is so evident and the economies and improvements so significant, that regional planning should proceed immediately. Its purpose is to evaluate health care needs, assess resources, define goals and objectives, establish priorities and decide*

on courses of action for co-ordinated development of health services and facility needs."[8]

Some of the benefits that were foreseen were: avoiding duplication of expensive, specialized, ineffectively utilized services; undertaking shared services and bulk buying; substituting different types or methods of care delivery; and maximizing the benefits of capital and operating budgets.[9] Four reasons were identified for the need to regionalize services - medical specialization; the reduction in distances through transportation; the increasing public character of health institutions; and regional disparities.[10] Resource and equipment allocation were generally seen as the means by which health care providers would be integrated across the entire health care system.

Regionalization may include both health and social services. It may be as expansive as planning, funding, management, service delivery and revenue generation. The current rationales include "the potential for cost containment, improved public participation, enhancements to health promotion and primary health care delivery and greater responsiveness to local needs."[11]

One logic of regional control and decision-making is that "a change in where power resides will have an impact on the accountability for and performance of the health and social services system."[12] The change in the seat of power will create new accountabilities. Local participation will result in service improvement decisions for local needs and better co-ordination and integration. A better performing system will provide better health outcomes and be more cost effective.

One current popular term for regionalization is "devolution." This term connotes decentralization of programs and services from the provincial government to regional authorities.

"Devolution" has been ongoing for several years in Saskatchewan. Individual services and facilities like the Saskatchewan Cancer Foundation and long term care homes have been peeled away from executive government and made stand alone self-governing agencies. Home care has been delivered by 45 home care district boards. Ambulance services have been overseen by 108 ambulance district boards.

But regionalization also includes the centralizing, through amalgamation of disparate organizations, of locally delivered programs and services into broader regional authorities.

Designing and implementing a regionally directed health system is exceedingly complex. There is no proven right way. No Canadian approach has received rigorous evaluation to determine if it has succeeded in some or all of its stated goals.[13]

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The 1989 *Saskatchewan Commission on Directions in Health Care* embraced the policy of regionalization as the foundation for the future health care system.

> *"The basic building block of this new system is the idea that the people it serves must have ownership and responsibility for their local health care system, must determine how it is used and managed, and establish its priorities. The Commission is recommending a system divided into health services divisions governed by powerful councils that are locally elected and funded mainly through the Department of Health. These councils will be responsible for putting together the broad-based package of health care services required in their*

area, uniting under one umbrella health protection and promotion, community-based services, institutions, ambulances and more." [14]

The Commission envisioned ten rural, two urban and three northern divisions. The urban divisions would have responsibility for selected province-wide services. The 1992 white paper, *A Saskatchewan Vision for Health,* reinforced the concept of local decision-making and control of health services.

The recommendations were enacted in 1993 through *The Health Districts Act.*[15]

"The Health Districts Act is enabling legislation. It promotes the integration of services through the creation of health districts and district health boards. Integration is encouraged through the amalgamation of existing health corporations such as union hospitals, home care boards, special care homes, and ambulance boards, with district health boards.

This integration, Mr. Speaker, will bring real benefits to the health system by moving many hundreds of fragramented, health delivery structures into 25 or so integrated, coordinated boards -- boards which have a clear mandate to effectively plan for and deliver a full range of health programs.

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Specifically, it allows for the creation of health districts and district health boards. It prescribes the make-up of district health boards, with the majority of members being elected by district residents through a ward system. It provides for the amalgamation or merger of existing health corporations with health boards to better integrate and coordinate service delivery. It prescribes the powers and duties of district health boards, which includes the ability to plan, manage, and delilver health services to district

residents. It allows municipalities to enter into voluntary funding arrangements with district health boards. And it ensures that district boards are accountable to both district residents whom the boards serve and the provincial government which provides most of their funding.

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This Act does not predetermine health district boundaries. We are asking communities to come together and to develop health districts as much as possible through consultation with their adjacent communities. It does not affect existing health-provider labour agreements, which must be honoured by district health boards; nor does it require private health corporations to amalgamate with district health boards, in recognition of the unique character and mission many of these corporations bring to our health system. Of course, we will be encouraging them to amalgamate, but it doesn't require it. And where we have encouraged this amalgamation in the province it has taken place, in some cases with very little encouragement from us.

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It is important however, Mr. Speaker, to remember that health reform is not an end in itself. Health reform is a means to achieve our goal. Our real goal is a system that is more wellness oriented. To achieve wellness, we need a health system where wellness can be nutured, indeed where it will flourish.

We need a system that is more coordinated and integrated to deal with the problems that I've indicated to you, and a system that is capable of providing a broad range of comprehensive services within a district. And we are working to set in place the structure that willl promote and sustain wellness and allow us to achieve our goal, a system based on wellness that will result in improved health for Saskatchewan people."[16]

Through local decision-making there emerged 30 health districts. The northern districts have yet to be established. The first health board elections in Canada were held in Saskatchewan in 1995.

The boundaries of the districts were established by local decision-making according to specified criteria: at least 12,000 population within a continuous land area which accounts for geographic barriers, population distribution, trading and commuting patterns, location of current facilities and population health status. Naturally, traditional community rivalries and friendships, eagerness to align with quality facilities and services with husbanded resources and perceptions about the best alliances to maintain resident local services were part of the factors in the boundary decisions. Some of the outcomes, like Rolling Hills Health District and the irregular protrusions in the boundaries of other districts, are striking.

Regardless of whether individual configurations defy explanation, the districts are the foundational organizational structure for the delivery of health services in Saskatchewan. The past program delivery divisions among acute, long term, ambulance, home care, mental health, prevention, and so on were sustained by divisions in organizational structure and specific purpose funding. These divisions have been replaced by organizational and, more and more, by operational integration of service delivery.

Three hundred and sixty-six autonomous entities were amalgamated into the thirty districts. The amalgamated entities were: 120 rural hospitals, 12 other hospitals, 108 ambulance districts, 83 special care homes and 43 home care services.

At the same time as districts were established, 52 rural hospitals and integrated facilities were closed or converted to community health centres. Sixty-three

Three hundred and sixty-six autonomous entities were amalgamated into the thirty districts. The amalgamated entities were: 120 rural hospitals, 12 other hospitals, 108 ambulance districts, 83 special care homes and 43 home care services.

organizations of a denominational, community, aboriginal or for private profit character in sixteen districts have retained their separate existence, but have had to become affiliated with districts on which they are dependant for their funding and support for their role in the community. Their role and relationships to the districts continues to evolve and be further defined.[17] In the case of St. Paul's Hospital it was represented to the commission that the relationship between the district and affiliate was so close that they could be treated as one employer for all labour relations purposes.[18] They have entered into a joint service management partnership to provide shared services and have an integrated management team.

While integration holds the promise of improved, cost-effective service delivery for the public funded health services, it means diminished autonomy for the affiliates. This commission's regulations further this loss of autonomy. As a result, the affiliates' relationship to the central health care employer agency, Saskatchewan Association of Health Organizations, will require further definition.

Organizational and service patterns are not, and will not be, contained within, nor confined to, the geographic areas of the districts. Some health districts, like the large urban ones, supply services to other districts. Some affiliates, like Extendicare (Canada) Inc., are affiliated with more than one district. Some districts are partners in shared service providers like the North Saskatchewan Laundry and Support Services Ltd. Some contract service providers contract with more than one district.

Some of the public health services formerly provided by the provincial government are delivered on a service area basis. There are ten service areas among the 30 districts. These service areas have coterminous boundaries with the districts and a contiguous landmass.

The regional structure for service delivery is intended to be flexible and adaptable to local priorities and to achieve integration in ways that have not yet been tried or even planned.

They are self sufficient in these services, reflect trading and service patterns and accommodate the minimum relocation of devolved program staff.

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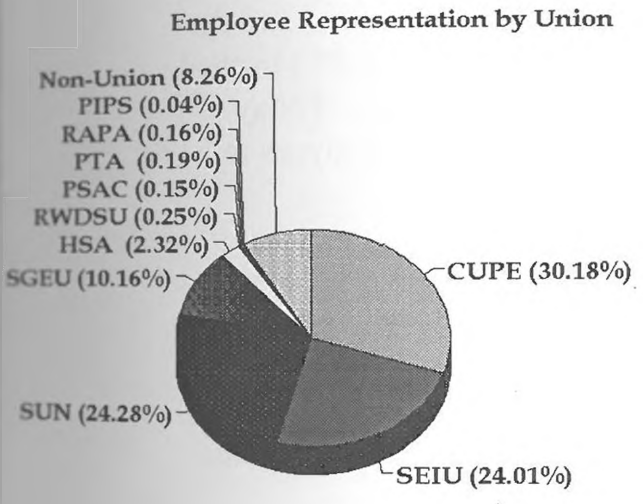
Labour Relations Organization Before Regionalization



The current organization of labour relations is an evolutionary result of competitive trade union organizing, Labour Relations Board bargaining unit policy and case by case decision-making, voluntary collective bargaining structures and government policy from time to time about entitlement to engage in collective bargaining and the organization of the delivery of health services. The current labour relations organization is hinged on the identity of the employer and the nature of the service that it delivers.

Historically, employees employed in health care chose representation by trade unions which demonstrated an interest in representing them in their place of employment. In 1934 the employees of the Regina General Hospital joined the Regina Civic Employees Association, Local 21 which was chartered by the Trades and Labour Congess of Canada.

With the enactment of collective bargaining legislation in 1944 modelled on the American Wagner Act and the Federal wartime regulations in P.C. 1003, trade unions were certified with exclusive right to represent employees in appropriate bargaining units, whose composition was determined by the Saskatchewan Labour Relations Board.

As a general policy matter, the Board determined that the preferable grouping of employees into appropriate bargaining units for collective bargaining purposes was all employees of the employer, regardless of the diversity of occupations and skills among the group.

As a general policy matter, the Board determined that the preferable grouping of employees into appropriate bargaining units for collective bargaining purposes was all employees of the employer, regardless of the diversity of occupations and skills among the group.

In 1944 the employees at the Regina General Hospital formed the Regina General Hospital Employees Association, Local 176 which was certified December 10, 1947. It became a local of CUPE in 1963 when the National Union of Public Service Employees and the National Union of Public Employees (NUPE) formed the Canadian Union of Public Employees. Today 131 locals of CUPE represent over 9,800 employees in 139 bargaining units.

The Saskatchewan Government Employees Union (SGEU) has origins as early as 1913. The provincial government employees who it represented included health workers. It was the first trade union certified under the 1944 *Trade Union Act* by the new Labour Relations Board.

As the provincial government's role in health programs expanded in post-war years, the SGEU's role and membership expanded. Major long term care facilities were opened by the provincial government: Parkland Regional Care Centre in Melfort; Palliser Regional Care Centre in Swift Current; Lakeside Nursing Home in Wolsely; and Wascana Rehabilitation Centre in Regina.

The employees, regardless of occupation, were included

in the province-wide, all employee group covered by the collective agreement between the provincial government and SGEU.

The Service Employees' International Union (SEIU) first became active in Canada in 1941 It established its first local in Saskatchewan in 1946 and received its first certification to represent health care workers at St. Paul's Hospital. Today three locals of the SEIU represent over 7,800 health sector employees in 100 bargaining units.

In the 1960's persons who previously considered collective bargaining an inappropriate method for settling their terms and conditions of employment with their employer began to demonstrate more interest and militancy in attaining collective representation. One legislative response in 1966 was to exclude some of them from the definition of "employee" so they could not engage in legislatively sanctioned collective bargaining. Trade unions had to organize around these groups and the Labour Relations Board had to exclude them from its bargaining unit determinations.[19]

When the legislation was later amended to give them the same rights as their fellow employees,[20] issues arose about whether they were to be included in the same units as other employees and did they wish to be represented by the same trade unions.

Nurses were not legislatively excluded employees. They had a history of representation at individual work sites by eight Staff Nurse Associations that had not sought trade union status or certification by the Labour Relations Board. In 1968 the Saskatchewan Registered Nurses Association (SRNA) sought to bargain a provincial agreement with The Saskatchewan Health-Care Association representing eight hospitals. Subsequently, the Staff Nurses' Associations sought and

received certification to represent bargaining units of nurses.

At the Nipawin Union Hospital the SEIU was certified for a unit that included graduate, but not registered, nurses. The Nipawin District Staff Nurses Association applied for certification for a unit including the graduate nurses. This created a representational rights dispute between the two organizations. Although the Nipawin District Staff Nurses Association abandoned its claim to represent graduate nurses, the Labour Relations Board had to inquire into several matters, including whether the Association was a *bona fide* trade union. The SEIU alleged that it was not because it was organized and influenced by the SRNA.

The Labour Relations Board found that a large proportion of SRNA's members were management persons and that it was dominated over the years by management persons. The SRNA Council was the prime mover in setting up the Staff Associations throughout the province. With "extreme regret" the Board found that the Nipawin District Staff Nurses Association was a "company dominated organization" that did not have the capacity to give authentic, independent representation.[21] While the Saskatchewan Court of Appeal quashed the Board's decision, the Court was reversed and the Board's decision was reinstated by the Supreme Court of Canada.[22]

Amalgamating laundry services was a common efficiency initiative in Canadian health care in the early 1970's

The consequence was the amalgamation of 43 Staff Nurses' Associations in 1974 to form the Saskatchewan Union of Nurses. Since then SUN has evolved into a self-described "dedicated craft union" with 240 locals representing over 7,800 nurses.

Amalgamating laundry services was a common efficiency initiative in Canadian health care in the early 1970's. In Saskatchewan the Regina General

Devolution of central government services to independent governing bodies was also a feature or health reorganization in the 1970's.

Hospital, Grey Nuns Hospital and Wascana Rehabilitation Centre formed the Hospital Laundry Services of Regina located close to the offices of the Saskatchewan Joint Board, Retail, Wholesale and Department Store Union, Local 568. The RWDSU was certified to represent a single bargaining unit of all employees of the laundry service in 1971.

Devolution of central government services to independent governing bodies was also a feature or health reorganization in the 1970's. Provincial government devolution of facilities occurred at Parkland (1977), Palliser (1977), Wascana (1979) and Lakeside (1986). In 1979 the Saskatchewan Cancer Foundation replaced the functions of the Saskatchewan Cancer Commission and Government of Saskatchewan. In each case, the SGEU retained representational rights for units of all employees with their new employer by virtue of its successor rights under *The Trade Union Act*. In the case of Palliser the SEIU displaced the SGEU in 1982 following a representational campaign and Board supervised representation vote.

Devolution of facilities from the Federal Government to autonomous bodies was accompanied by preservation of representational and collective agreement rights at the Saskatoon Veterans Home along the same bargaining unit divisions as in the federal public service. The Public Service Alliance of Canada (PSAC) represents most employees, including licensed practical nurses, and the Professional Institute of the Public Service (PIPS) represents a minority, including nurses.

Employees in institutional psychiatric care settings, including nurses, were represented by NUPE in North Battleford and Weyburn. CUPE succeeded to NUPE. When these services were decentralized into eight

components CUPE, Local 600 continued to maintain representation.

Since 1968 the Centre.[23] The voluntary recognition was extended to the Plains Health Centre and the Pasqua Hospital when they joined Wascana to form the South Saskatchewan Hospital Complex. Its members include one person providing services to residents of the Santa Maria Citizen's Home. During the commission's process PTA decided to transfer its membership to the Health Sciences Association of Saskatchewan.

In 1989 a local of the International Association of Fire Fighters called the Regina Ambulance and Paramedic Association (RAPA) was certified for a unit of all employees of the Regina Area Municipal Road Ambulance District. The group consists of emergency medical technicians, paramedics and communications officers.

For nurses the Labour Relations Board has made an exception to its policy not "... to segregate professionals and other groups of employees into separate bargaining units because a multiplicity of units does not foster industrial stability through effective collective bargaining, a basic purpose of the Trade Union Act."

For nurses the Labour Relations Board has made an exception to its policy not "... to segregate professionals and other groups of employees into separate bargaining units because a multiplicity of units does not foster industrial stability through effective collective bargaining, a basic purpose of the Trade Union Act." It concluded in 1983 in a practice confirming decision, after hearing representations from SUN, CUPE and SEIU, that:

> *"The evolution of bargaining relationships in the health care field in general leads the Board to the conclusion that Registered and Graduate Nurses and Registered Psychiatric Nurses and Graduate Psychiatric Nurses employed and functioning as such have a sufficiently strong community of interest with each other that they should as a general policy be treated as belonging to the same unit of employees for collective bargaining purposes."*[24]

At the same time, the Board declined, as a matter of general practice, to remove anyone from an existing unit with an established collective bargaining relationship or include graduate and registered nurses that are not "employed and functioning as nurses."

With the devolution of municipal and provincial government services to the districts, the district employee complement now includes public health nurses formerly employed by municipalities and the Province and represented by CUPE and SGEU. CUPE has retained representation of nurses in mental health facilities. SGEU has retained representation of nurses and all employees at Parkland, Lakeside and Wascana. In total, SGEU represents approximately 480 nurses, while CUPE represents approximately 445. The SEIU represents only 23 nurses at Palliser and PIPS represents 11 at the Saskatoon Veterans Home.

The question of whether all nurses should be in one bargaining unit has been a hotly debated issue. Employers and most unions say they should. Public health nurses, some psychiatric nurses and nurses at Wascana Rehabilitation Centre, SGEU and CUPE, Local 600 oppose such a grouping. If there are any change, they fear loss of their jobs and predict dire health consequences for the public.

Home care programs were developed in the 1980's and the SGEU was certified in 1981 for the Alliance of the Youth and Elderly in Saskatoon. In 1986, 45 home care districts were created with independent governing boards.[25] Through a concerted effort acquiesced to by other unions, the SGEU began a campaign that resulted in certification for units of employees other than nurses of 23 of the home care boards. SEIU organized one group in Melfort. Upon amalgamation with health districts these home care units were fragmented

according to the geographic boundaries of the thirty districts. The last two numbers of the Labour Relations Board file number in the following table is the year SGEU applied for certification.

LRB NO.	EMPLOYER	NEW HEALTH DISTRICT
333-81	Alliance for the Youth & Elderly Society	Saskatoon
100-85	South Country Home Care #7	South Country/South Central
061-86	Battleford & District Homecare #24	Battlefords
068-86	Thunder Creek Homecare #6	Moose Jaw/Thunder Creek
096-86	Saskatoon Homecare #45	Saskatoon
157-86	Prince Albert Pineland Homecare #28	Prince Albert
014-89	Lanigan Regional Homecare #43	Living Sky/Central Plains
206-91	Estevan Area Homecare #9	Southeast
260-91	North West Homecare #26	Northwest/North Valley/Touchwood
024-92	Melville & District Homecare #38	Qu'Appelle/East Central
078-92	Fort Pelley-Livingstone Homecare #40	Assininboine Valley
082-92	Touchwood Hills Homecare #40	Touchwood Qu'Appelle/Regina
112-92	Greenhead Homecare #23	Greenhead/Gabriel Springs/
		Prince Albert/North
128-92	Wakaw-Cudworthe Homecare #30	Central/Central Plains
219-92	Canora Homecare #35	Assiniboine Valley
088-93	Potash Country Homecare #37	North Valley/East Central
110-93	Biggar & District Homecare #22	Greenhead/Saskatoon
149-93	West Central Homecare #21	Prairie West/Greenhead
153-93	Outlook and District Homecare #17	Midwest/Prairie West
170-93	Beechy-Eston Homecare #18	Midwest/Prairie West
069-94	Yorkton and District #36	East Central
100-94	Watrous-Davidson Homecare #16	Living Sky
100-94	Yellowhead Emerald Homecare #41	Living Sky

With some small exceptions, the home care workers consist of certified home health aides, assessor/coordinators and several administrative, clerical and financial positions. The certified home care aides have worked only in private homes. By voluntary agreement the SGEU has achieved a single collective agreement for all home care workers who it represents.

SUN obtained certification for 19 units of home care nurses. The nurses represented by SUN were included under the single collective agreement covering acute care.

While the exemption of nurses from all employee units is almost complete, the conflict over exemption of other groups of employees has provided the greatest source of

representational disputes among the unions over the past twenty five years.

Just as the SRNA was the impetus for collective bargaining for nurses, on September 13, 1972 nine paramedical societies met for the purposes of establishing an organization to undertake collective bargaining. This was one month after amendments to *The Trade Union Act*[26] allowed their members to bargain collectively. They sought to follow the lead of similar movements in British Columbia and Alberta. In a hurried response to an application to the Labour Relations Board by the SEIU to include certain employees previously excluded from its unit at the Saskatoon City Hospital, the groups formed Health Sciences Association of Saskatchewan (HSAS) on November 4, 1972 to appear to oppose the SEIU application on November 7.

Applications for certification were later filed by HSAS for several units at various hospitals. The SEIU challenged the *bona fides* of HSAS as a trade union. The Labour Relations Board found that the HSAS had not been duly constituted as an organized body.[27] On April 8, 1973 HSAS reconstitued itself and new applications were filed. The first at St. Paul's Hospital was dismissed July 13, 1973.

Then on October 29, 1973 the Saskatchewan Labour Relations Board called for submissions on what type of bargaining unit is most appropriate in health care institutions. This was its first comprehensive review of the question. In the result, the Board considered that:

> *"... an appropriate unit which could be effective (while not necessarily being the unit which in its opinion would be most appropriate) could be a unit comprised of employees with university or equivalent training background, provided that the number of such employees in any given institution are sufficiently large to form a viable and distinctive group."*[28]

A certification was issued to the HSAS on December 14, 1973 for a unit of "all registered and professionally qualified employees employed and functioning as physiotherapists, pharmacists, dietitians, social workers and registered occupational therapists, employed by the University Hospital." At Saskatoon City Hospital it was physiotherapists, physical therapists and pharmacists.[29] At Swift Current, Shaunavon, Moosomin, and Eatonia Union Hospitals and Lloydminister Hospital, the Board found the unit to be too small to be appropriate.[30]

The Board expressed views about segregating employees into separate units; the overall difficulty it had with the issue; and the approach that it would take in the future.

> *"Many views have been expressed from time to time as to possible groupings of hospital employees for collective bargaining purposes. The Board is of the general view that an over-all employer unit is a desirable unit in such an institution. Having said that, however, the Board hastens to add that it is also of the opinion that it need not find such a unit to be the only appropriate unit."*[31]
>
> **********
>
> *"The Board, in this case, spent many sessions and many hours in deliberation before coming to a final decision. In many respects the decision herein was probably one of the most difficult made by the Board over a long period of time.*
>
> *During the deliberations of the Board some ten votes were taken during these in-camera sessions. On six matters, the Board was unanimous, in four matters the Board split in 4-1 decisions but the interesting fact here is that the dissent in these four matters was in each case cast by a different member of the Board (including the Chairman). The final decision is therefore, truly a consensus in every sense of the word and was concurred in by all members of the Board."*[32]

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> *"The Board is of the view that no cut-and-dried formula can or should be laid down as to appropriate units in hospitals - the determination as to an appropriate unit must be made in each application on the basis of the factual situation."*[33]

The Board maintained its approach that "... atomization or fragmentation is not appropriate for viable, meaningful or effective collective bargaining." [34] In some cases a representation vote was held and HSAS was not successful.[35]

The following year, the Board, with a dissenting opinion from two members, dismissed an application at St. Paul's Hospital by HSAS because the employer bargained with HSAS when SEIU was the certified bargaining agent for the employees.[36] This precipitated a one day strike by the paramedic employees at St. Paul's. The HSAS was certified for a unit of pharmicists and physical therapists at St. Paul's in 1986.[37] It was expanded in 1990 to include dietitians and speech language pathologists and again in 1991 to include occupational therapists.[38]

The medical laboratory technologists attracted their own test case and determination by the Borad in the 1970's. The Saskatchewan Association of Medical Laboratory Technologists unsuccessfully sought certification for a separate unit at Pasqua Hospital, Regina General Hospital and the Plains Health Centre in 1976.[39] It applied again in 1977 for units at twenty two hospitals where the employees were represented by either CUPE or SEIU. The Board treated the application at the Regina General Hospital as a test case for all the applications and took a fresh look at the question of the appropriateness of separate units for medical laboratory technologists. Again, it did not find the unit appropriate and dismissed all the applications.[40]

The Board maintained its policy of limiting the separate unit to employees with university or equivalent training background provided there was a sufficient number of them. However, there was a notable exception in 1981. Without written reasons, the Board certified HSAS for a separate unit of laboratory, radiology and nuclear medicine technologists at Royal University Hospital.[41]

Despite that decision, in the 1980's the Board generally adhered to a policy preventing bargaining unit poliferation. It denied an application by HSAS for a separate unit of pharmacists and dieticians at the Plains Health Centre.[42] The HSAS applied again for an expanded group and the Board undertook a second general health care bargaining unit review with public hearings and submissions received from many parties.

The Board decided to carve out of the all employee unit a unit of licensed professionals involved in direct patient care with legislated protection of title. It included all, not just some, of the "employees providing professional paramedical services at the hospital." It also described the group as "all of the degreed professionals engaged in direct patient care in the entire hospital." It cautioned HSAS not to see its decision as an invitation "to make further inroads into the larger bargaining unit." HSAS has consistently ignored all such cautions.

In making the decision, the Board expressly did not include "employees providing what are commonly described as qualified technical services. That group, which includes various types of technicians and technologists, is often difficult to distinguish from other groups of employees, particularly while they are engaged in in-hospital training."[43] The Board refused to extend its appropriateness finding to a community health centre.[44]

In 1991 Dean Ish of the College of Law was appointed by the Chair of the Labour Relations Board to attempt to find a consensus among the unions and employers on

rationalizing health care bargaining units. He concluded that the parties were not interested in reaching a mediated solution.

On May 25, 1993, on the eve of the creation of health districts, the HSAS achieved an enlargement of the group it carved out at the Royal University Hospital. The HSAS had made its application "emphatic that it has no further designs on the S.E.I.U.'s bargaining unit." With no contrary position from the employer, the Board assumed that the employer saw "nothing inappropriate with the application" and found that:

> *"If the Board was working from a clean slate, the employees in the ten disputed classifications and the employees in the H.S.A.'s technical unit, would almost certainly be assigned to the same unit. There is no rational line that can be drawn between the two groups of technical employees."*

The Board decided that the employees in the ten classifications could be appropriately represented in either unit by either union and directed a representation vote to determine the employees' wishes. It expressly stated that this was not a new policy direction, but the inevitable consequence of the unreasoned 1981 decision.

> *"Finally, this decision should not be construed as an endorsement of the criteria developed by the applicant for this application, if an application is subsequently brought to create technical units at hospitals where they do not already exist. The crucial decision that this technical unit was appropriate was not made today, but in 1981, when the applicant was certified. We are merely acknowledging that a technical unit of this description already exists at Royal University Hospital, and that employees, whose career interests are arguably consistent with those of the employees already in the unit should now be given an opportunity to register their preference."*[45]

Over the years no bargaining unit boundary beachhead has been left unexploited to its fullest by the HSAS and each breach has driven the Board to revisit it. In the case of employee wishes determining whether groups may boundary hop, the Board was later compelled to state:

> *"Though the Board was willing to allow the employees, on that one occasion, to state their preference as between the bargaining unit to which they might more logically belong, and that in which, for reasons of history, they were then located, this should not be seen as an invitation that groups of employees can move from one bargaining unit to another simply by signifying their support for such a move, at least in the absence of some compelling argument that the configuration of bargaining units so created would be more appropriate or more conducive to industrial stability or health labour relations."*[46]

The result of over two decades of organizing efforts, litigation, review and turmoil over appropriate bargaining unit configuration is that the HSAS represents approximately 750 employees in eight bargaining units and is party to one collective agreement.

In the 1990's the Board has been steadfast in restricting the creation of new units or the carving up of existing units. It restated that the situation at the Royal University Hospital must be viewed in the "context of a unique factual situation" and distinguished situations where the issue involved the representation of previously unrepresented employees as opposed to encroaching or poaching on existing units.[47]

Despite its efforts over the years to adhere to a consistent policy approach to bargaining unit determination, the Board acknowledged that "... there has been no more testing case than that of the health care sector. It would be a brave person who would assert that the line of cases concerning the definition of bargaining units in this context has revealed a clear set of principles, or even one

which has been applied with complete consistency." After reviewing the history, the Board concluded that:

> *"... the Board has had considerable difficulty in assessing the significance of the traditional criteria for determining the appropriateness of bargaining units in the particular context of the health care institutions, and in accommodating the evolution which is continually taking place in the administration and delivery of health services."*

While the segregation of nurses into separate units has been widely accepted and finally established, there is no corresponding recognition of the appropriateness or need for a separate technical or professional unit based upon education, skills, occupational associations and so on. Those who do advocate for, or accept such a unit, do not agree on the criteria for inclusion. If they do, they do not agree on whether many occupations do or do not meet the criteria.

While recognizing in an earlier case in 1994 that "separate paramedical professional units have been accepted as viable,"[48] the Board refused to carve a separate paramedical professional and technical unit out of the all employee unit at the Wascana Rehabilitation Centre of the Regina District Health Board.[49] At the same time, it certified the HSAS for a unit of assessor/coordinators in home care.[50]

Before this commission the HSAS has proposed ever expanding lists of occupations to include in a professional or technical unit. It has done so based on criteria that it finds elastic enough to encompass most occupations that express an interest to be included.

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This was the single most difficult issue for the commission. The problem was made more difficult by the history of relationships between HSAS and other unions and the language of distinctiveness and superiority used by

many to justify the unit, its configuration, its title and the groups to be included.

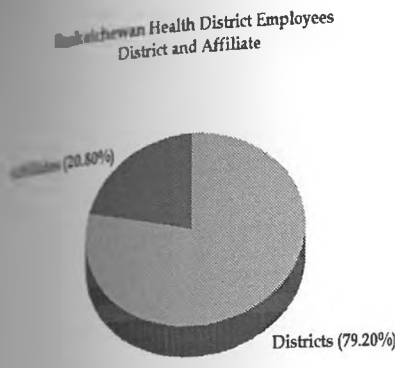
In the face of the organizational reform in health care, the Labour Relations Board did not think that "...these changes necessitate a wholesale restructuring of existing bargaining units, and the possible disruption of established relationships which this would entail." [51]

The Board declined at all times to establish standard health care bargaining units. It has maintained its preference for single employer, comprehensive bargaining units. Of course, it has not decided that any particular trade union may not represent any unit found appropriate.[52]

Exclusive bargaining rights based on certification to represent employees in a bargaining unit are the underpinnings of collective bargaining relationships. Over time employers and unions consolidate collective bargaining around common unit configurations to reduce the incidence of collective bargaining and to establish a uniformity in terms and conditions of employment, including broad based benefit plans.

Employers collaborate to coordinate collective bargaining and delegate bargaining responsibility to a common agent. In 1972 the 37 hospital boards with unionized employees authorized the Saskatchewan Health-Care Association (SHA) to bargain for them. SHA had been founded in 1918 as a non-profit organization to provide health related services. It was incorporated under a 1959 statute.[53] Consulting, employee benefit administration and employee relations were some of the services. In 1966 it appointed its first labour relations specialist. Over time SHA bargained single union, provincial collective agreements.

The Saskatchewan Association of Special Care Homes (SASCH) was founded in 1958. It bargained collective agreements for its long term care facility membership. In 1975 and 1976 it negotiated a single agreement jointly



with SEIU and CUPE. Differences between the unions led to separate tables in 1978. The first provincial agreement with SUN was negotiated in 1989.

The Saskatchewan Home Care Association (SHCA) was founded in 1981. It authorized SHA to negotiate on its behalf with SGEU and SUN.

SHA, SASCH and SHCA were funded by a combination of membership dues and provincial grants. On July 1, 1993 the three merged into one under the name The Saskatchewan Association of Health Organizations. SAHO operates as a successor under the SHA statute of incorporation. Its membership is voluntary. Affiliates may be members but are not included among those on the governing body. To date, proposed resolutions to amend SAHO's bylaws to include affiliate members on the governing body have not received the requisite approval by SAHO's membership.

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Rivalries, Jurisdictional Disputes and Restructuring

"When will it all end?" captures the refrain of those who are frustrated with the organizational rivalry and group squabbles in health care that are so keenly pursued. The rivalry seem to be endemic to a system that has evolved to a highly fragmented organization of work. They cut across unions, employers, unionized and non-unionized employers and employee groups, and a wide array of groups with varying credentials and training asserting some exclusive right to practice and monopoly on certain competencies or work.

Most see the rivalries and their accompanying competency jealousies as debilitating. Few see the self-interest they so often expresses as compatible with the enlightenment and co-operation necessary for the health system of the future. Privately and publicly this commission's process was another venue for many of these rivalries to be acted out. No one has a clear answer to "When will it all end?"

Many of these conflicts are beyond the mandate of this commission. However, they find expression in union, employer and employee positions on unit configuration and composition. Some seek to separate their group from their rivals. Others want to associate with those that they perceive will enhance their status to gain leverage toward their longer term goals. Some place freedom of employee choice above integration of service delivery or consistency in terms and conditions of employment. Others seek to prevent either further credentialization or deskilling in the system.

This review and discussion is limited to issues of central relevance to labour relations organization.

Within many industries under various organizational structures trade unions often find a rapprochement that minimizes disputes of a representational nature. This becomes necessary if there is to be order and efficiency. The natural rivalry of autonomous and competitive organizations is tempered by a sense of mutual benefit in avoiding conflict by acceptance bilaterally or through a central body, like a provincial federation of trade unions, an allocation of representational jurisdictions. The unions or central body may establish a dispute resolution mechanism that any aggrieved union may invoke and which interprets and enforces the jurisdictional assignments.

In health care the effectiveness of such a system is not wholly within the control of unions and employers. Professional associations with separate agendas and goals may question any accommodation. They can act to generate conflict that ultimately finds expression in disputes between unions and employers. As well, educational institutions can, and do, design programs and graduate new specialized or hybrid skilled workers that can become the focus of representational and jurisdictional disputes. Employer work assignment decisions which can generate jurisdictional disputes are also beyond the control of the unions.

Employees represented by the same union, different locals of one union or separate, autonomous unions may claim exclusive right to perform certain work because of their special qualifications, the past work assignment practices, the bargaining unit boundaries of exclusive representation, inter-union agreements or contractual agreements with the employer.

> *"In addition to this essential feature of work assignment jurisdictional disputes they may be motivated by apparent or hidden rivalries between unions, by the desire to expand, and so on. Then the*

exclusive right to an assignment is but an honourable guise to cover an act of gross piracy."[54]

Distinguishing whether the source of any particular dispute is union rivalry, union jurisdiction claims based on some custom, right or agreement or employer work assignment is not helpful in the work of the commission. What must be recognized and highlighted is that there is a history of vigorous rivalry among the unions representing Saskatchewan health workers. There is no existing forum for establishing and policing union representation assignments among all of the unions. And the very purpose of health reform is to change the past patterns of work assignment.

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The union rivalry has long predated the health reform initiative and the work of the commission. Its intensity at both the organizational and personal level is real. It affects behaviour. It affects each union's approach in searching for solutions that balance the competing interests and rights.

HSAS is not affiliated with the Saskatchewan Federation of Labour or any other organization that can perform a referee or policing function among its member unions. It has grown by raiding other unions, not by organizing previously unrepresented employees. The Labour Relations Board has described HSAS as "... a trade union and a rival of the SEIU's."[55] To their credit, these two unions recently overcame their long-standing rivalry to jointly enter into a Framework Agreement with Saskatoon District Health Board and St. Paul's Hospital to facilitate the consolidation of laboratory services in a manner respectful of the interest of the employer, its employees and the unions.[56] It would be naive in the extreme to say that this is an end to the "territorial struggle" between the two unions.[57]

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In a 1995 case involving HSAS, SUN and SGEU the Labour Relations Board felt compelled to observe that:

> *"We cannot but be aware of certain tensions which exist among trade unions representing employees in the health care field. Though this friction originated before the current round of health care reform, the changes which are now taking place have done nothing to ameliorate it. There were expressions at this hearing of mutual distrust and hostility which presumably were only pale reflections of their manifestations in less formal settings."*[58]

Inter-union representational disputes have been heightened by health care reform and its threat to job security because of facility closures, funding reductions, amalgamation of employers and devolution of programs and transfers of employees from the provincial and municipal governments to district employers. Either broadening or shrinking the horizons of the group of employees to which an individual relates for purposes of seniority and job security is a substantial alteration of existing rights and security for the individual. Depending on their situation, individuals and their unions face both group expansion and shrinking situations and have sought to assert and maintain their prior rights.

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Saskatchewan health reform architects foresaw the need to address the labour adjustment imperatives of restructuring. They did not include trade union representational rights as a factor in district boundary making. Nor did they slow the process of change to await the outcome of any resolution of foreseeable conflict. The approach adopted in 1992 was as follows:

> *"Jobs will likely be affected by the changes to health districts. Broad consultation and discussion are critical to determine the best approach to this human resource issue. A labour relations review committee, reporting to the Minister of Health, will be established immediately to consider and recommend*

needed strategies. This committee will consult widely with all affected parties."[59]

What the committee found is instructive in understanding the difficulties the unions and employers have had in adapting to the new order.

> *"As health services expanded under the medicare system over the past three decades so too did the number of hospitals, special care homes and community health facilities. Like medicare itself the healthcare labour relations system evolved in a pragmatic fashion. Workers chose to be represented by a variety of unions, and employers adopted different tactics when dealing with unions. For the most part unions and employers both simply followed the labour relations practices found in the commodity producing private sector. This has led to a system which is ill suited to meet the challenge of a dramatically reformed medicare system."*[60]

The committee found that the future is in power sharing, not hoarding, and that adaptations are necessary from both employers and unions to make the system perform to its full potential. It found the bargaining structure and processes to be "exceedingly complex" with their integrity threatened by "serious strains" that were being further stressed by health care reform.

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Unions viewed employers as having anachronistic attitudes and approaches. Employers found inter-union rivalry an impediment to problem solving. The committee commented that:

> *"The number of unions in itself may not be significant in developing and maintaining a well-run system if individual unions share a common philosophy, but*

> *they do not. Indeed, the two major support unions, SEIU and CUPE, refuse to sit with one another at the same bargaining table, while SUN for its part remains apart from the support unions negotiating tables. HSAS ignores them all."*[62]

The committee concluded that:

> *"There was a broad recognition that open, effective communication among all parties was badly lacking. This communications weakness held true whether it involved the Associations and Government, Associations and their members, Unions and Management or Unions and Government."*[63]

The consequence in the face of the added stress of health reform restructuring was:

> *"... universal frustration because of the absence of agreed-upon procedures to expedite the integration of services within and between facilities that had different collective agreements. Employers suggest unions ought to resolve this matter; unions were looking to government for some guidance; while the District Boards were inclined to look to the Labour Relations Board for solutions. All agreed that the problem had to be dealt with since it was confusing an already complex process."*[64]

The committee's recommendations directed greater union co-operation, more government leadership in addressing labour adjustment issues, pursuit of provincially negotiated standarized agreements for all of the sector, accreditation of a single employer voice and negotiation of a transfer and merger agreement among the parties. If such an agreement is not negotiated "in the near future the matter should be referred to a special sub-committee of the Labour Relations Board for immediate disposal."[65]

In its service agreements with the Health Districts the Government has required the districts to agree to participate in a provincial system of collective bargaining, seek to foster and maintain a positive and participatory

labour relations environment and conclude a transfer/merger agreement within the district "for the purposes of providing a co-operative and orderly framework for the movement of staff associated with the restructuring of health services."[66]

Inter and intra-union transfer and merger agreements have been negotiated, but they are not universal in their application and operation across district employers, affiliate employers and trade unions. Various agreements covering the circumstances of individual employees and broader itinerate movement agreements have been concluded. In the Saskatoon Health District, a global posting agreement applicable to most of the employers has been concluded with the major unions.

In March, 1996 the Health Providers Human Resources Committee established in early 1995 reported to the Minister of Health. It concluded that the effects of health reform have included:

> "▸ *certification orders that reflect the previous institutional structure, not the new health district structure;*
>
> ▸ *multiple collective agreements for each employer (district health board); and*
>
> ▸ *different wage and benefit rates within the same occupational group."*[67]

The committee recorded that:

> *"From the perspective of district health boards the current misalignment problems have created major impediments to:*
>
> ▸ *program planning;*
> ▸ *moving and transferring staff*

- *flexible use of health providers and development of a seamless health human resource system;*
- *ensuring that the same value is given to institutional, community and home care and this value is reflected in the remuneration of these providers;*
- *minimizing the costs of collective bargaining; and*
- *sustaining community services."*

While recognizing the need for greater co-operation the existing legal rights and obligations of the parties had to be respected. It recommended:

> *"That restructuring bargaining units to better fit employer-employee relationships is urgently required and that the provincial government assign this high priority and provide adequate resources to the Labour Relations Board to enable it to respond promptly to realignment requests."*[68]

At that time there were major applications pending before the Labour Relations Board from the unions and employer in Saskatoon. The SEIU was seeking to consolidate its bargaining rights and include some employees represented by HSAS. The HSAS was asking the Board to carve further groups out of SEIU units, replace it for the SEIU in another unit and consolidate all of its units. The Saskatoon District Health Board was asking the Board to revoke all existing rights and create three district wide units.

The Board had consistently expressed preference for private, party resolution of the changes necessary to accommodate the new structures. In September, 1994 it had stated that the answer to the rights issues arising under collective agreements and the operational problems being experienced cannot "... be satisfactorily addressed by a wholesale redefinition of bargaining units on the part of the Board."[69]

"It is true that the process of consolidation, merger or transfer of departments or services within the Health District poses a number of complicated and serious questions. Among these issues are the significance of seniority accrued in one bargaining unit when an employee or group of employees are moved to another unit, the access of employees to vacancies or promotion opportunities, bumping rights and appropriate supervisory structures. In our view, however, the key to resolving these questions lies, not in the redefinition of bargaining units - a process which could not provide comprehensive answers to these matters in any case - but in the acknowledgement of existing obligations and the application of the provisions of existing or modified collective agreements. Where individual collective agreements do not provide adequate answers, it is possible that some process of discussion may be necessary to resolve questions which cut across collective agreements or whose solution may affect more than one group of employees. In evidence before the Board, there was reference to such mechanisms as the 'transfer and merger agreements' concluded between the Regina District Health Board and a group of trade unions representing groups of employees in that district. The conclusion of such agreements is consistent, in our view, with the pragmatic approach traditionally followed by the parties to collective bargaining in the health sector, and is also consistent with the approach taken by this Board to the recognition of bargaining rights in this field.

It may prove to be the case, of course, that there are aspects of the altered labour relations environment for which it is appropriate to invoke the assistance of the Board. We are not persuaded, however, that there are grounds on which we should upset the collective bargaining rights and relationships which have grown up between trade unions and health care employers in order to pursue the goal of standardization of health care bargaining units."[70]

Later in 1994, the Board continued to favour change accommodation "within the framework of existing

relationships which were established prior to the implementation of the reforms."[71] It accepted that, ultimately, there may have to be consolidation or merger of "existing bargaining units which may produce a new configuration of bargaining units."[72] In 1995 the Board stated that:

> *"Since the vast majority of health care facilities are now amalgamated with health care districts, and the district boards have become the sole employer for most employees within those districts, the meaning of such concepts as 'all-employee units' must be reappraised in the light of the altered character of these relationships."*

Consistent with its rights adjudication role and responsibilities, the Board was steadfast in its view:

> *"Throughout the process of restructuring and redefinition which has been taking place, this Board has been at pains to state our view that our role is to consider and comment on the incremental changes as they take place, not to preside over the implementation of some entirely new configuration of bargaining."*[73]

The Board adhered to its approach of dealing with restructuring on a case by case basis "without radically altering bargaining rights" into 1996. It did so acknowledging that as a result of restructuring:

> *"... inter-union conflicts have arisen over the intermingling of employees in the reorganization of health care services within a District, the creation of new positions within the District structure, and the assignment of duties which may have to be performed outside the boundaries of the specific facilities which have in the past been the basis of union bargaining rights."*

****

> *"Perhaps this approach does not always provide simple and clear guidelines for determining all the issues that may arise when new or modified positions are created. It is the Board's hope that this decision will provide some additional guidance to the parties for their future reference."*[74]

The Board characterized its approach as "pragmatic or functional" to the "multitude of complex problems related to the structure and process of collective bargaining between the newly-structured employers and the trade unions representing employees."

As employer restructuring became more pervasive and its effects became more pronounced, the Board was signalling that the new relationships may render existing rights of limited import.

> *"In trying to determine how established bargaining relationships may require modification or redefinition to meet the new conditions, we have indicated that the old descriptions of bargaining units or the extent of bargaining rights may have limited meaning in new circumstances."*[75]

Within six weeks legislation was being introduced to establish this commission. The process of self-determination and accommodation to which the Labour Relations Board deferred and which it prompted the parties to pursue was not reaching conclusions that met the needs of the unions and employers. Some of those needs and conclusions are illustrated by the following examples.

- A CUPE local is certified for all employees at the Weyburn Special Care Home, including nurses. The district decides to operate a day wellness program for home care clients at the Home and creates a new RN and Nurses Aide position. The former is posted in SUN's jurisdiction and the latter in SGEU's. CUPE files an unfair labour practice.

- Public health nurses in Regina do not move between service within the city (provided by CUPE members formerly employed by the City) and rural service (provided by SGEU members formerly employed by the Province).

- Palliative Care Services were consolidated at a single site in Regina. An agreement could not be reached to enable a social worker affected by a change of union representation to retain her seniority.

- The inability to have employees move between facilities means that the district must hire a large pool of part time or casual employees. In one case a secretarial position servicing two Regina facilities was split into two part time positions.

- Relocating services like printing in Regina into the Wascana Rehabilitation Centre results in SGEU asserting exclusive jurisdiction and CUPE filing an unfair labour practices complaint

- Social workers in Regina do not provide district wide standby coverage because they are divided between CUPE and HSAS.

- The Heritage Manor and Kindersley Hospital dietary departments in Prairie West Health District were integrated. The SEIU dietary aide cannot cross the doorway into the CUPE hospital working area with the meal carts.

- In South Central Health District SGEU public health nurses do client assessments and SUN nurses do physical assessment and hands on care for the same client.

- In North Central Health District an SGEU public health nurse and a SUN home care nurse will each travel from Melford to St. Brieux to see a client.

- In Battlefords Health District transportation services are consolidated but the drivers' units are not. When a van is need to transfer a patient from one hospital to another one driver will take the van from the depot to the hospital. Another driver will take the van from the first hospital to the second and back while the first driver waits to return the van to the depot.

- In Parkland Health District a SUN home care nurse will visit a new mother to provide hands on care on the same day that the SGEU public health nurse visits to provide health education.

- In some districts maintenance/journeymen may work in other facilities. In others they will not be permitted.

Commission Constitution, Process and Mandate

Having pursued avenues of self-help through mutual agreement and accommodation as far as possible at the time, some unions applied to the Labour Relations Board to consolidate their existing rights and extend their scope to establish an area of exclusive jurisdiction. The HSAS and SEIU were doing it in the Saskatoon District. The SGEU and SAHO agreed to jointly apply to resolve SGEU's representational rights in relation to home care programs. The Saskatoon District applied to have the bargaining units among its employees completely reorganized.

Under the Board's auspices there developed discussion that led to a request to the government by CUPE, SGEU, SEIU and SUN, with SAHO's concurrence, for appointment of an independent commission with a broad mandate:

"1. To determine appropriate bargaining unit configuration for Health Districts in the province, taking into account the principles of the Trade Union Act;
2. Ensure to the extent possible that current representation rights enjoyed by the unions are preserved;
3. Enforce provincial bargaining arrangements between the parties."

The unions stated that the problems "...require immediate attention in order that health care delivery not be negatively impacted by a serious industrial relations breakdown."

The unions stated that the problems "...require immediate attention in order that health care delivery not be negatively impacted by a serious industrial relations breakdown." They acknowledged that the efforts to date had not been fully successful and that it was not desirable to litigate to a solution before the Labour Relations Board.

> *"Up until this point in time, it had been hoped by all parties that the problems of intermingling and unit construction resulting from the reform process, could be solved by the unions themselves, without having to use a third party. However, because of the complexity of changing bargaining unit configuration uniformly across the province, and changing the provincial bargaining framework to conform to that new reality, the unions have determined that the Saskatoon application would not provide for the ability for all affected employees and employers to have input.*
>
> *There is currently no legal authority to change the bargaining unit structure outside of applications to the Labour Relations Board on an individual employer basis by either the union or District Board, which would be an incredibly time-consuming and costly process for all concerned, considering there are thirty employers involved. In addition, the Board has no authority to order broader and more cost-effective mechanisms for bargaining multi-employer/multi-union collective agreements."*[76]

The HSAS did not sign the proposal because it did not contain a direction to the commission to consider a factor that it thought advantageous to its situation.

The Government acceded to the request and enacted *The Health Labour Relations Reorganization Act*.[77] The establishment of the commission was an initiative of the principal parties themselves, not the government. Apparently to underscore this, on the day of the introduction of the bill, June 13, 1996, the proponents of the commission individually affirmed to the Government caucus Members of the Legislative Assembly that they were asking for this commission. Each was later introduced to the Assembly as representatives of the organizations requesting the legislation.[78] The statute received third reading and was passed June 24, 1996.

On July 12 it was proclaimed. After consultation with the requesting unions and SAHO, the commissioner was appointed July 15 for a term expiring January 31, 1997.[79] The Minister directed that the regulations be submitted to him on or before January 15, 1997.[80]

The statute defines the health sector employers and employees to whom it applies and allows the commissioner to recommend that it be extended by regulation to additional prescribed health sector employers and, by implication, to their employees and the unions that represent them.[81] For purely technical reasons, one recommendation is being made with respect to La Ronge Health Centre which has not been officially approved as a hospital.

The commissioner is to "examine the organization of labour relations between health sector employers and employees"[82] and "may determine the practice and procedure to be followed in conducting the examination."[83] With a small team and resources provided by Saskatchewan Labour, an inquiry process was outlined and required data was identified.

Newsletters, included as an Appendix to this report, were issued periodically sharing information, asking questions, inviting participation and providing reports on the

activities and progress of the commission. The newsletters were broadcast by facsimile machine and anyone who requested was added to the distribution.

Submissions were invited and many were received. An inventory of all documents received by the commission was maintained and available to any person on request. Its availability was broadcast in the newsletter. A copy is included as an Appendix.

Public presentations of submissions were received in Regina and Saskatoon during the week of October 7 to 11, 1996. Most major parties chose to appear and engage in discussion about their submission with the commissioner.[84] Representations and submissions were received in writing and in meetings with the commissioner. The occurrences of meetings were reported in the newsletter.

A reorganization proposal was delivered on November 28 for extensive comment and revision.[85] Draft regulations were released on a limited circulation for technical review and comment.[86]

During the term of the commission's inquiry there has been a limitation on parties making, and the Labour Relations Board considering, applications pursuant to *The Trade Union Act* "with respect to any matter that is or may be covered by the regulations to be made by the commissioner."[87] This prohibition had several effects. It denied certain employees the opportunity to choose represention by a trade union during the term of the commission. It created a temporary respite from inter-union representational and jurisdictional disputes before the Labour Relations Board. It prevented unions and employers from seeking to gain advantage at the Labour Relations Board for strategic reasons in the commission's examination.

The significant milestones in the commission's procedure were as follows:

Dates	Event
July 12	Proclamation of statute
July 15	Appointment
July 16 - 17	1st meeting with parties
July 19	1st Information Bulletin
August 27	2nd Information Bulletin
September 3 - 6	1st round of consultations - Regina
September 10	3rd Information Bulletin
September 26 - 27	1st round of consultations - Saskatoon
October 1	4th Information Bulletin
October 1 - 4	1st round of consultations - Regina
October 7	5th Information Bulletin
October 7 - 11	Public Meetings - Regina and Saskatoon
October 15	6th Information Bulletin
October 28	7th Information Bulletin
November 4 - 8	2nd round of consultation - Regina
November 14	8th Information Bulletin
November 28	Present proposal in principle - Regina
November 29	9th Information Bulletin
December 10 - 13	3rd round of consultations - Regina
December 16	10th Information Bulletin
January 6	11th Information Bulletin
January 8	Circulate draft regulations
January 6 - 10	4th round of consultations - Regina
January 15	12th Information Bulletin
January 15	Report and regulations
January 31	Termination of appointment

The operating signposts that the commission adopted for its practice and procedures were the values and goals of openness, fairness, impartiality, independence, integrity, respectfulness, economy, efficiency, effectiveness, thoroughness, principled decision-making, pragmatism and creativity.[88]

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The parties co-operation with the commission in supplying relevant information and analysis was only limited by the ability of existing systems to generate the data in the manner desired. The amalgamation process has not yet achieved full information system integration. Extensive efforts were made by all of the unions, SAHO and the commission to verify the data gathered, determine its reliability and understand its limiting characteristics. There are some significant challenges to be met in

developing systems that can accurately report the number of employees in each occupation in each district.

As a consequence, there are disparities in definitions about who is an employee, who is whose employee, how many employees work part time in two or more bargaining units and are members of two or more trade unions, how many employees work under a collective agreement in one work situation in the district and in another situation where there is no collective agreement in the same district, in another district or with an affiliate, and so on.

As is always the case in any multi-party stakeholder process, some parties sent representatives dedicated to communication and mutual problem solving for the good of the entire group or some broader policy objective. Others sent representatives focused on strategic negotiations, who became more focused as the process unfolded. Each group contributed to the final outcomes.

The commissioner is mandated and required to "make regulations reorganizing labour relations between health sector employers and employees and resolving issues arising out of that reorganization."[89] For that purpose the commissioner may make regulations:

> *"(a) defining appropriate units for the purposes of this Act and establishing the composition of those appropriate units;*
>
> *(b) determining trade union representation of employees in any appropriate unit;*
>
> *(c) respecting the integration of employees in any appropriate unit;*
>
> *(d) respecting any matters the commissioner considers appropriate arising out of the integration of employees in any appropriate unit, including the integration of seniority of employees who were previously represented by a trade union and the recognition of service of employees who were not previously represented by a trade union;*

(e) stablishing a multi-employer bargaining structure through the designation of bargaining councils and representative employers' organizations;

(f) respecting the establishment of articles of association for bargaining councils and representative employers' organizations;

(g) if an appropriate unit established pursuant to clause (a) consists of employees who are covered by two or more collective bargaining agreements:

(i) determining which one of the collective bargaining agreements will apply to all employees in the appropriate unit; or

(ii) fixing a common expiry date for all of those collective bargaining agreements;

(h) delegating to the board any of the commissioner's responsibilities pursuant to this subsection that the commissioner considers appropriate, including the authority to determine any matter or thing that is to be determined or established by the commissioner in the regulations;

(i) respecting any other matter or thing the commissioner considers necessary to carry out the intent of this Act."[90]

In conducting the examination, the commissioner is directed to consider the following:

"(a) the new employment relationships that have been established and that will be established as a result of restructuring the delivery of health services pursuant to the enactment and application of The Health Districts Act;

(b) the need to promote the integration of the delivery of health services;

(c) the need to facilitate the development over time of consistency in terms and conditions of employment amongst health sector employers and employees;

(d) the history of trade union representation amongst employees of health sector employers and the need to promote orderly collective bargaining between health sector employers and employees;

(e) any additional matters prescribed in the regulations made by the Lieutenant Governor in Council."[91]

No additional matters were prescribed in regulations by the Lieutenant Governor in Council.

No additional matters were prescribed in regulations by the Lieutenant Governor in Council.

These factors clearly depart from general Canadian collective bargaining legislation. There is no mention of the usual appropriate bargaining unit determination factors, such as access to or viability of collective bargaining, community of interest, industrial stability, lateral mobility, administrative efficiency and convenience or the agreement of the parties. There is no mention of the factors often considered in determining community of interest among a group of employees, such as the nature of the work performed, the skills of employees, the conditions of employment, geographic circumstances, functional coherence or interdependence of the operation, conditions of employment or the wishes of the employees.

There is another equally, if not more, significant departure. Collective bargaining legislation like *The Trade Union Act* is concerned with maintaining existing trade union bargaining rights through sales, mergers and integration of employers and their components.[92] Representational rights are acquired within an organizational structure and managerial style at the time of certification or voluntary recognition. The law maintains and protects those rights through changes in ownership, organizational structure and operational integration.

Usually, it is only at the moment of employee intermingling that labour relations boards consider the transfer of rights from one trade union to another through the consolidation of the bargaining units that they represent. Even then, the presumption is that existing rights will be preserved unless they cannot be accommodated within the new structure without creating undue fragmentation or jeopardizing rational collective bargaining and industrial stability.

Although the unions' request for the commission asked that the mandate include ensuring "to the extent possible that current representation rights enjoyed by the unions be preserved," it was not included in the legislation.

Although the unions' request for the commission asked that the mandate include ensuring "to the extent possible that current representation rights enjoyed by the unions be preserved," it was not included in the legislation. The directive is to consider the history of trade union representation and the need to promote orderly collective bargaining. To varying degrees the unions assigned value to other unions' history as warranting some continuing representational rights or justifying the ending of ongoing representation. History was cited both as the basis of entitlement to maintain representation and the justification to extinguish representational rights.

While not expressly in the legislative mandate, the commissioner searched for a rational accommodation that did maintain current representational rights. Some unions and the Saskatchewan Federation of Labour worked toward this goal. The challenge was to produce constructive co-operation among unions under the threat of the loss of some or all of any one union's rights through the force of commissioner regulation. Meeting the challenge stretched the good will of many representatives. To the credit of the unions, they repeatedly closed ranks against options that maintained current representation but did not secure health reform goals.

The emphasis and primary focus of the mandate is on creating structures that respond to the need to promote integration of health services delivery and orderly collective bargaining and to facilitate the development over time of consistency in terms and conditions of employment. Maintenance of existing rights, as reflected in the history of representation, is only one, not the primary, concern in reorganizing the entire health sector bargaining units, representation rights and collective bargaining structures.

The uniqueness of the situation is further illustrated by the inclusion in the regulation making authority of "the

recognition of the service of employees who were not previously represented by a trade union" as a matter respecting the integration of employees in any appropriate unit.[93] The normal practice of the Labour Relations Board is to respect the wishes of employees when asked to add previously unrepresented employees to an existing unit. For example, the Board did not allow SGEU's application to add physiotherapists to its unit at Wascana Rehabilitation Centre without their support for the accretion.[94]

But the overall health care restructuring and integration of services and employees has presented a degree of intermingling of previously unionized and unrepresented employees that parties and the Board have concluded, as they did at the Cut Knife Health Complex, "... can no longer be sensibly divided between a unionized bargaining unit and a non-union group ... ."[95] In those cases and the ones when the intermingling is of employees represented by different unions,

> *"The riddles posed by the configuration in the new institution could be solved neither by allowing one of the trade unions which represented a unit of employees in one of the merged entities to lay claim to all of the employees on the basis of its certification order, nor by trying to maintain two separate groups of employees within the new structure."*[96]

In such cases, the Board would likely order a representation vote to determine which union is to be the exclusive bargaining agent as it did at the Wolf Willow Lodge.[97]

The commissioner is given the option of including previously unrepresented employees in a bargaining unit and according them accumulated seniority in the form of retroactive recognition of service. In this respect, the commissioner may depart from the approach of the Board under *The Trade Union Act* in dealing with the inclusion

in bargaining units of employees in health district administration offices[98] or other district positions.[99]

The commisioner may also create multi-union and multi-employer structures, determine which collective agreement will apply to a unit, alter the expiry date of a collective agreement and exercise other powers that the Board does not have.

The commisioner may also create multi-union and multi-employer structures, determine which collective agreement will apply to a unit, alter the expiry date of a collective agreement and exercise other powers that the Board does not have. These powers to establish alternate legislative codes to *The Trade Union Act* have generally been exercised in the past in Saskatchewan by the Legislative Assembly. An example is the amalgamation creating the Saskatchewan Institute of Applied Science and Applied Technology when appropriate units were legislated, existing certification orders were nullified and previously unrepresented employees were included in the newly created bargaining units.[100]

Finally, the commissioner is empowered to address consequences of reorganization - any matter arising out of the integration of employees in a new unit; establishment of articles of association of bargaining councils or representative employees' organizations; fixing common expiry dates for collective agreements or determining which collective agreement will apply to all employees in a unit; delegating responsibilities to the Labour Relation Board; and "any other matter or thing the commissioner considers necessary to carry out the intent" of the statute.[101]

Labour Relations Reorganization

Introduction

There is universal recognition that the true determinants of healthy populations and individual health are social, physical and psychological environments, wealth and socio-economic status, and, lastly, medical and other

health care services that relieve suffering, maintain and restore function and preserve life.[102]

The allopathic medical model assigns dominance and gatekeeping to physicians. It basically operates on a mechanical, repair shop model of the human body with emphasis on illness and injury. Investigation, testing and diagnosis of causes of abnormality is to lead to treatment and cure. Each of the steps are to be scientific with subcategories of expert knowledge and skills possessed by specially trained, credentialized and maybe self-regulating groups.

Our public health funds are overwhelmingly directed to the last and predominantly to allopathic medicine - penetration of the body by surgery and drugs - derisively referred to as "cuts and chemicals".[103] There are exceptions, such as chiropractic treatment and midwifery.

The allopathic medical model assigns dominance and gatekeeping to physicians. It basically operates on a mechanical, repair shop model of the human body with emphasis on illness and injury. Investigation, testing and diagnosis of causes of abnormality is to lead to treatment and cure. Each of the steps are to be scientific with subcategories of expert knowledge and skills possessed by specially trained, credentialized and maybe self-regulating groups.

Ascendance in the health care power hierarchy is achieved through established bodies of knowledge and specialties. These areas of expertise receive recognition and legitimacy through group identity as a licensed, registered, accredited or other occupation with an exclusive scope of practice or turf. Group advancement, empowerment and recognition, individual occupational fulfilment and relationships among the groups often results in clash within, and political action outside, the health care provider community to achieve recognition and exclusivity of scope of practice.

For many groups the centre of their expertise may be the prevailing treatment approaches, current public policies or advancements in technology. New discoveries, policy shifts and new diagnostic or treatment equipment can produce a new group that follows the now familiar evolutionary pattern to scientific, technical, social and political status. These groups have become most prevalent in physician support in the acute care

environment of immediate, intense diagnosis and treatment.

Some health care provider groups seek to advance group goals through professional bodies, legislative grant of scopes of practice, self-regulatory bodies or trade union representation. Some pursue most or all. Some pursue only one.

The history of trade union representation and the legacy of bargaining unit and collective bargaining configurations embodies much of this dynamic. Some groups have succeeded in finding support within industrial relations policy for expression of this health care group dynamic. Some are frustrated that they have not been differentiated into separate bargaining units or not as extensively as they would like. Some are frustrated that their group goals have had to contend with representation by multiple unions. Some are indifferent to this. Some are ambivalent about collective bargaining as an avenue to pursue their goals. Some are ambivalent or uncertain about what associations with other groups and which unions will be the most strategic choice to pursue their group goals.

Almost all are anxious or frustrated that health care reform has not necessarily been healthy for them. They face changes in their physical, social and psychological environments and job security. They face income uncertainty and concern that changes in treatment approaches will not improve cure and health outcomes.

Many have seen this commission as an opportunity to advance group interests or as a threat to their health at work. The reorganization embodied in the accompanying regulations and summarized in this report is intended to enable the employees who have dedicated their careers to the delivery of health services to adjust and benefit from the changes that are so rapidly occurring in their daily, working lives.

Appropriate Bargaining Units

The beginning of appropriate bargaining unit determination is a community of employees defined by personal and pragmatic relationships through shared work environments. This small, geographically limited group broadens as its members realize that their circumstance and interests are common with, and not disparate from, all employees of their common employer regardless of occupation or location.

The larger group's community is not founded upon personal contact, cultivated personal relations or an intimate sense of community. It is a somewhat accidental association and economic tie among fellow employees dependant upon the same decision-making management. This larger community most often finds expression through representation by industrial trade unions, rather than craft unions.

Despite its diversity, the all employee industrial style group may still be a personal community and an integral part of a larger community than a work site or employer's organization. This is easily seen in rural Saskatchewan where all employee units, including nurses and other care providers, are common and share a local community focus.

The elimination of large and small differences in circumstances and entitlements is to enable the greatest mobility and flexibility in order to achieve the most cost effective and efficient delivery of services for the benefit of the entire region and province.

Smaller groups at a single site or in a single community naturally envelope themselves in the security of their community and see it as their natural boundaries. They may deliberately choose to surround themselves with differences that serve as barriers from intrusion by others from other sites or communities and thereby enhance their security.

Integration of the delivery of health services is directed to the removal of these barriers. The elimination of large and small differences in circumstances and entitlements is

to enable the greatest mobility and flexibility in order to achieve the most cost effective and efficient delivery of services for the benefit of the entire region and province. Consistency in terms and conditions of employment, including the rules of work, is, to varying degrees, both a goal of equitable treatment for those rendering the same service paid for by the one taxpayer and a means to attain efficiency through the elimination of barriers based on small differences.

A province-wide job classification review and evaluation is being undertaken. Nothing in this commission's regulations is intended to replace any of that process. The need to continue it is self-evident.

> *"One recurring but pressing problem is the lack of standarization of wages and benefits among different collective agreements. To illustrate, we were given the example of Registered Nurses (RNs). RNs are covered by eight separate agreement, each with its pay scales. ... What may have been an undesirable situation when each sector was to some extent an entity unto itself, will become intolerable as District Boards remove service and occupational boundaries. Another problem closely related to the previous one is the lack of a province-wide classification system essential for reasons of equity as well as efficient budgetary and labour-force planning."*[104]

Nurturing healthy values and goals within the spirited adversarial system of collective bargaining, while pursuing the shared goal of renewing the health system in a period of rapid and relentless change, requires that there be a broad perspective.

A province-wide job classification review and evaluation is being undertaken. Nothing in this commission's regulations is intended to replace any of that process. The need to continue it is self-evident.

Provincial consistency in terms and conditions of employment and attaining integration are interrelated. Each is needed to achieve the other and each is part of the cost to achieve the other. Both require broad based bargaining units and collective bargaining structures. Nurturing healthy values and goals within the spirited adversarial system of collective bargaining, while pursuing the shared goal of renewing the health system in a period of rapid and relentless change, requires that there be a broad perspective. The perspective has to be beyond organizational autonomy and group differentiation.

Yesterday's local bargaining units are not the vehicle to tomorrow's health system.

As much as possible and as quickly as is manageable, the provincial perspective in resource allocation and shared decision-making through collective bargaining must be the platform for realizing the Saskatchewan vision. In the current world environment, with the unfettered globalization of capital markets, the community of interest in the labour market that should be given primacy is the provincial market to support the regional leadership and initiatives that are to be the impetus for regenerating public health care.

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.[105] 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 physicians, technical, skilled maintenance, business office clerical, guards and all other non-professional.

The optimum units that will best serve the circumstances of Saskatchewan are standard, broadly based, all employee units with limited and specific exceptions.

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.[106]

The optimum units that will best serve the circumstances of Saskatchewan are standard, broadly based, all employee units with limited and specific exceptions. The need for integration requires that they cross organizational and program distinctions, as has been done through employer amalgamation and affiliation. This can be achieved with multi-employer units, including employees of health districts and affiliates in the same unit. For historical and current reasons, there is a need for specific exceptions for special situations.

Health Services Provider - First Standard Unit

The basic unit is the health service provider unit. Its geographic scope is the health district. It is a multi-employer unit including all employees of a health district and all currently represented employees of the affiliates of the district except those employees in another unit, chiropodists, chiropractors, dentists, optometrists and physicians.

The listed excluded occupations are not included in any unit. These primary care providers are either not currently employed by a health sector employer or are excluded. Their inclusion in a bargaining unit in the future is not addressed in these regulations. Those questions, should they arise, will be addresed by the Labour Relations Board.

This unit description, like the description of other units, does not address the question of who is a management or confidential person under the reorganized district structure. That determination is the task of the Labour Relations Board. The unit does not include any persons or employees currently excluded by agreement or the Labour Relations Board, except groups of unrepresented employees. They continue to be excluded until the parties agree or the Board decides otherwise.

This unit does include all currently unrepresented groups of employees of the health district, but not the affiliates. The need to promote integration requires that the health district employees be treated consistently, with barriers distinguishing them by union representation or being unrepresented eliminated. To a very large extent, with some exceptions, the work done by currently unrepresented employees of the health districts is part-time work.[107]

Affiliates are autonomous entities and their employees are under their management. The inclusion of currently unrepresented employees of an affiliate in a unit can await their decision to be included or a review of individual situations by the Labour Relations Board on the application of some person. Their continued exclusion means that they will not have the benefit of recognition of their service as an accumulation of seniority under the regulations. Unions and employers may agree to that benefit in the future.

Two Laundry Services

The two largest health care laundry services in Saskatchewan are in dissimilar situations, although each is the product of decisions in the 1960' and 1970's to consolidate and share laundry services.

In the north, the North Sask Laundry & Support Services is a shared service independent of, but owned by ten districts and one northern hospital. The main plant is in Prince Albert and has 40 full and part time employees represented by a local of CUPE. It is operating at approximately one-third its tonnage capacity. The North Sask Laundry & Support Services is not a "health sector employer." The initial reorganization proposal by the commissioner proposed that it be included as a health sector employer and treated as an affiliate of the Prince Albert Health District.

In the south, the largest laundry was a separate entity from 1970 to 1993 when its ownership and operation were assumed by the Regina District Health Board. Its services extend to several southern health districts. It also is operating at approximately one-third capacity. Although plans for the future scope of operations and the method of service delivery of the Regina District Health Board Laundry Services Department have not been fully developed, the initial reorganization proposal included these employees, with their history of representation by RWDSU, in the Regina Health District based health services provider unit.

After careful review of both situations, it has been concluded that the need to promote the integration of the delivery of health services now and in the foreseeable future does not require change to the current bargaining unit structure of these two laundries. No recommendation will be made to include the North Sask Laundry & Support Services as a health sector employer. The

existing laundry services bargaining unit in the Regina Health District will be included in the appropriate bargaining unit reorganization. SAHO will be designated as the exclusive authority to bargain for the Regina Health District with respect to the collective agreement for this unit, which will continue to be represented by RWDSU.

Four Northern Health Services

There are four "health service employers" in northern Saskatchewan outside the current district organization. They are St. Joseph's Hospital (Ile a la Crosse), St. Martin's Union Hospital (La Loche), La Ronge Health Centre and Uranium City Municipal Hospital. The bargaining unit configuration and collective bargaining structures for employees of these employers will mirror, and be integrated with, those within the districts. This will set the platform for future transition to health district boards or any other structure developed for the northern communities.

For Private Profit Employers

There are only two health sector employers which are private for profit shareholder corporations. Both are affiliates in the districts where they operate homes. Extendicare (Canada) Inc. operates three special care homes in the Regina Health District, one in Saskatoon Health District and one in Moose Jaw/Thunder Creek Health District. It has provincial, multi-site collective agreements with SEIU and SUN. Chantelle Management operates one home in the Swift Current Health District. It has collective agreements with SEIU and SUN.

Because of their distinct minority and unique status as private for profit employers, each of these employers and their employees will be excluded from the multi-employer unit configuration which includes districts and affiliates.

Because of their distinct minority and unique status as private for profit employers, each of these employers and their employees will be excluded from the multi-employer unit configuration which includes districts and affiliates.

affiliates. There will be two bargaining units at each - a unit for nurses and one for all other employees.

The three nurse and the three all other employee units of Extendicare (Canada) Inc. in Regina will be consolidated into two units. There will be one provincial collective agreement for the resulting three nurse and three all other employee units in Regina, Saskatoon and Moose Jaw.

SAHO will not be designated as the bargaining agent for either Chantelle Management or Extendicare (Canada) Inc. They will continue to conduct their own collective bargaining.

Health Support Practitioner - Second Standard Unit

A single, province-wide, multi-employer health support practitioner unit is the second standard unit. It is an exception to the all employee health services provider units.

Some of the listed community based occupations may require further definition. In the absence of party agreements, the Labour Relations Board can give the precise definition.

This is a unit of specifically named occupations that have been accepted for exclusion from the all employee unit since the 1970's. The list includes some additional occupations that expand its reach across the spectrum of services from acute care to prevention. This gives the members of the unit and its bargaining agent an interest in, and a need to be sensitive to, the full range of health services. Some of the listed community based occupations may require further definition. In the absence of party agreements, the Labour Relations Board can give the precise definition.

The unit consists of all employees in the named occupations of the thirty districts and the four northern health sector employers, including previously

unrepresented employees of both and all currently represented employees of affiliates of the 30 districts.

Employees in the listed occupations are included in the unit if they are employed and function in one of the listed occupations. They are also included if they are employed in another position, regardless of its title, for which the employer requires, as a minimum, registration pursuant to an Act giving the exclusive right to use a title or description of a listed occupation. This will not encompass all of the listed occupations. Some of them do not have protection of title under a statute. It does not encompass any occupation that may have statutory protection of title if it is not a listed occupation.

The unit does not include interns, students and other similar status leading to full credentialization. It does not include assistants of listed occupations, regardless of how closely they may work together. These employees are in the health service provider unit. While both students and assistants work closely with the listed occupations, teamwork from the operating room to the home is a defining characteristic of health services. It is a reason to limit, not expand, this exception to all employee units.

Technologists and technicians of the many sorts in health care are not included. Currently, the majority are in all employee units. Only a distinct minority are in HSAS units. To standardize units they should all be in one or the other. The Labour Relations Board's consistent preference has been to have them in the all employee unit. That makes eminent sense in this reorganization because the majority are there now and future disputes over various new technologies should be avoided.

An exception is made for emergency medical technicians. This is because of the unique working circumstance and relationship with paramedics in their emergency response and transporting vehicles. Two units in the cab of one vehicle is to be avoided.

These pre-hospital emergency care workers are included in this unit to ensure that they have a provincial platform and one single collective agreement applicable to all of them. Geographic limits to their unit should not exist. They should have no jurisdictional borders to their mobility and deployment between health district as they respond to calls and transport patients.

Everyone from the surgeon to the specialized laundry worker dealing with contamination and biohazardous waste performs an important role in either the diagnosis or treatment of individuals in the care of their health or in promoting health and preventing illness. The role of the care aide establishing and sustaining an empathetic and friendly relationship with an individual may be as, or more important to, the person's health and well-being than the role of the person giving episodic treatment.

Many of pre-hospital emergency care workers are part time employees or volunteers and work for other employees or in a nurse or health services provider unit. Some nurses work part time in other capacities in a health services provider unit. It is the work function, not the individual, that is in the unit and individuals will be in this unit because of their employment to do this work. Volunteers are not employees in this unit.

Health care is largely a science based discipline. Many occupations involve technical proficiency or scientific knowledge. Many require a course of study at university or other post-secondary institution to acquire that knowledge or technical proficiency. Many occupations are members of a dizzying array of organizations dedicated to the advancement of their discipline that set standards of conduct, censure in some fashion and proclaim their professionalism. Many occupations with varying degrees of specialized knowledge require the exercise of varying degrees of independence of judgement and action.

Everyone from the surgeon to the specialized laundry worker dealing with contamination and biohazardous waste performs an important role in either the diagnosis or treatment of individuals in the care of their health or in promoting health and preventing illness. The role of the care aide establishing and sustaining an empathetic and friendly relationship with an individual may be as, or more important to, the person's health and well-being than the role of the person giving episodic treatment.

All of the possible indicia for bargaining unit distinction are fertile ground for ongoing debate. Job content, task performance, training requirements, prestige, socio-economic status, expertise, specialization, credentialization, commitment, ethics, standards, autonomy, organizational affiliation, importance to the public welfare, special relationship with fellow members of the occupation and the public interest and other factors simply serve to create degrees of differences. They do not meaningfully define predictable categories of occupations.

The selection of the name "health support practitioner" for this unit is deliberately vague. None of the employees in these listed occupations is truly independent. Each is an employee and works within a bureaucracy with constraints on independence. The status that it confers, if any, is recognition that historically there has been a separate unit.

Designating one group "professional" with its many meanings in our current vernacular invites debate. The modern health care system with its reliance on knowledge, science, service and technology will continue to generate many subspecializations that will view themselves as professionals and promote credentialization. In turn, there will be labour market ramifications that will appear in the workplaces. However, no useful purpose is served by this phenomenon finding expressing in perpetuating the type of bargaining unit boundary disputes that have consumed so many resources in the past thirty years.

The selection of the name "health support practitioner" for this unit is deliberately vague. None of the employees in these listed occupations is truly independent. Each is an employee and works within a bureaucracy with constraints on independence. The status that it confers, if any, is recognition that historically there has been a separate unit. The list of occupations essentially reflects the original agreed unit without its expansion to the technical and technologist occupations that slipped into the group through the unreasoned decision of 1981. The listed occupations in the areas of diagnosis and treatment have a common characteristics of being mainly involved in direct patient care in a continuing, supportive role, not episodic, interventions. The list is expanded to stretch across the spectrum of health services.

The Labour Relations Board will have to demonstrate resolve to maintain this unit's configuration or provide cogent reasons why occupations should be added to or removed from this unit. Every occupation outside will have an argument by analogy that it is comparable to another or an amalgam of characteristics of others in the unit. Acceptance that employee choice is a determinant for inclusion will encourage unit hoping and perpetuate trade union rivalry and representation disputes.

A separate unit for nurses regardless of their educational qualifications and field of nursing was accepted by the Labour Relations Board as a standard unit in health care.

Nurse - Third Standard Unit

A separate unit for nurses regardless of their educational qualifications and field of nursing was accepted by the Labour Relations Board as a standard unit in health care. That decision has helped shape the transition to a standard, multi-employer unit for all nurse employees of a district, whether currently represented or not, and all currently represented employees of all affiliates of the district employed and functioning as a Registered and Graduate nurse.

Encounters with the intensity with which some nurses distinguish themselves according to education or field of nursing is repeatedly arresting.

Encounters with the intensity with which some nurses distinguish themselves according to education or field of nursing is repeatedly arresting. Perhaps it is not so surprising when the diversity of workplaces, nursing practice and education is considered.[108] This diversity in the larger context of social change and new attitudes, beliefs, patterns of behavior and values about the role of women and "women's work" produces a clash of old and new cultures - history, common experiences and social environment - which finds expression within nursing, as it does in other occupations.

If there is one visible demarcation, it is between the majority who practice in hospital and institutional settings and the minority who practice in occupational health, school health, physician's offices, parish nursing, community health, visiting nursing and so on. In the

work of the commission, the primary area of distinction has been between public or community health nursing and institutional nursing. The two were previously provided by separate employers and the nurses are represented by different unions.

The community health nursing focus of health promotion and disease prevention generally is supported by baccalaureate nursing education with population health as the goal. It was practiced as an employee of the provincial government or a municipality. Nurses were not included in separate bargaining units. They were in all employee units represented by SGEU and CUPE. Through their representatives and activist leaders they have expressed great distress at being included with the nurses represented by SUN. Not the least of their concerns is a mass migration of laid off nurses from institutions to public health threatening their job security.

One SGEU and one CUPE represented public health nurse expressed it this way:

> *"A NURSE IS NOT A NURSE. Nurses in community health/public health require much different skills than nurses in acute/long term care settings. As it stands now the basic requirements for practice as a public health nurse is different than for practice in an acute care or long term setting. I am very much afraid that once we are made to be part of SUN this may no longer be so. We will then have nurses practicing public health nursing who have never had any theory or experience in public health, communicable disease prevention or community development. This knowledge basis is not a requirement for nurses that do not have a degree."*
>
> **********
>
> *"Grouping all nurses together, with dissimilar interests could result in internal conflicts within the unit to the disadvantage of the employees and the advantage of the employer. Nurses, under SUN,*

> *because of their training, skills and duties as they relate to direct patient care within health care institutions, do NOT share a sufficient community of interest with Public Health nurses within the community. The function of acute care or institutional nursing is distinctive from public health nursing. It is not transferable. It is our contention that there are these 'craft' distinctions, and a broad general nursing unit to encompass all nurses is inappropriate. Within public health, the general feeling is that all degree professionals belong grouped together. Therefore, the public health nurses should be grouped with the nutritionists, public health inspectors, and if there should be any speech pathologists, physiotherapists, etc."*

In contradiction to this view SAHO submits that an "... attempt to segregate and fragment professionals on the basis of the amount of time they spend in the community as opposed to institutional facilities will not work, and ignores the needs of health care restructuring."

SUN recognizes that nurses "have the broadest scope of practice of any health care professional." It points to its members' work experience and education.

> *"Working for more than one employer and/or in more than one agency is quite common among SUN's membership. Almost one-quarter (22%) also work for at least one other employer, either just one other employer (18%) or 2 or more (4%). Among these nurses working for more than one employer, about equal proportions work for either a SUN-represented employer (10%) or an employer represented by another bargaining agent or in a non-unionized workplace (12%). This data would suggest that over 800 SUN members work, in addition to their SUN job, in non-union agencies (i.e. a non-union home care) or in jobs already represented by SGEU, CUPE or SEIU. A change in representation for these nurses may then be more smoothly handled."*

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> *"Most SUN-represented nurses are diploma prepared as Registered Nurses (83%) or Registered Psychiatric Nurses (5%). Twelve percent have a Nursing or Psychiatric Nursing degree at the BScN or MScN(.4%) level. The data does not show the number of dual registrants."*

SUN's vision of nursing practice includes integration of fields of practice that are currently segregated.

> *"For example, in order to provide comprehensive service, the nurse working in a health centre in a Saskatchewan town with a population of 650 persons, needs to be able to hold blood pressure clinics, sessions on farm occupational health and safety, assess and diagnose patients, and deliver home care services. Currently, that work may occur in that one town in four different bargaining units, with two different unions."*

Nursing work is fragmented along physical and mental illness lines. While institutional based nursing work is fragmented among areas of competence along the lines of the medical model in the acute setting, the absence of accredited specialization is a reflection of an unwillingness to completely accept the medical model.

The efforts to reduce costs have fragmented nursing along task lines with some tasks assigned to assistants, orderlies, licensed practical nurses, care aides and other assisting occupations. Some nurses oppose the removal of restrictions on scope of practice as simply a way to move tasks, not care, to the lowest cost provider. Some oppose health care reform as a further fragmentation moving the caring part of curing to untrained, unpaid, unsupported, female family members.

Nursing includes the work of licensed practical nurses. But neither SUN nor the Saskatchewan Association of Licensed Practical Nurses or any of the unions representing licensed practical nurses propose the

inclusion of RNs, RPNs and LPNs in the same unit. One review of their roles has concluded that:

> *"If one reviews the educational preparation of LPNs, RNs and RPNs it is clear that the traditional gap between the groups is narrowing. The LPN course is one year and the RN and RPN programs are two years. At Wascana Institute, the first year is basically the same for LPNs, RNs, RPNs, the only difference being that the LPN takes a clinical nursing practice course while the RN and RPN take Drug Administration 11."*[109]

The conclusion was that RPNs after 1999 will have "essentially the RN diploma education."[110] Despite their similarities and their ability to become partners in projects like the National Nursing Competency Project, they are not ready for any closer association.

Within nursing, "a nurse is not a nurse" but nursing is a common field of practice.

Within nursing, "a nurse is not a nurse" but nursing is a common field of practice. The differences about priorities and the fears about job security have to be faced within nursing. One unit for all graduate and registered nurses will provide a platform for confronting and resolving the differences.

Multi-union Collective Bargaining Structures

The legislation allows for the establishment of multi-union bargaining councils for the purposes of bargaining collectively on a "multi-employer and multi-bargaining unit basis."[111] A council may include locals of trade unions. In the case of SUN, SGEU and HSAS certified bargaining rights are not held by separate chartered locals. Certification under the regulations continues in this manner where there is certification of these unions.

CUPE has 131 certified locals. As indicated throughout the process, the regulations transfer all bargaining rights

for the new established bargaining units to the Canadian Union of Public Employees and not to its separate locals. CUPE is the bargaining agent. Designating a bargaining council of CUPE locals would simply preserve what must change. Local unions must be restructured along health district bargaining unit lines, just like seniority lists will have to be developed to encompass each health service provider unit. By certifying CUPE, the internal restructuring can proceed quickly so there will be local elected voices in each unit without the need for further changes. The integration of seniority lists can be done without delay while the new locals are being structured.

There are only three locals of SEIU in Saskatchewan with distinct geographic areas of responsibility. Each is to be certified under the regulations for units that reflect its current scope of responsibility. They are to negotiate one collective agreement.

There was no enthusisam for bargaining councils of distinct unions.

There was no enthusisam for bargaining councils of distinct unions. Drawing on past experience, CUPE advocated the following:

> *"Simply put, the general rule for bargaining structures should be district-wide bargaining units, with the employees in each bargaining unit represented by a single trade union. This will result in all employees of a district within a bargaining unit being represented by a single trade union and covered by a single collective agreement. Such a structure should virtually eliminate jurisdictional fights between competing unions. This is a significant benefit of moving towards district-wide structures. With employees covered by one collective agreement, the available job opportunities will be allocated according to the provisions of that collective agreement. Such a result is obviously fairest to the workers who will be affected by the employment consequences of the decisions made by the District Health Boards.*

To continue with bargaining units that are less than district-wide is to enshrine a regime which will be plagued by an endless series of jurisdictional disputes, whenever work is transferred or new positions are created. Competing unions, seeking only to represent the best interests of their members, will be required to challenge decisions which allocate work opportunities to the jurisdiction of other unions to protect their jurisdiction and the employment opportunities of their members. The possibility of jurisdictional challenge will loom over every decision a District Health Board is required to make about the allocation of work. Furthermore, the complexity and difficulty of this situation is magnified where the competing unions have collective agreements which contain different provisions respecting the allocation of job opportunities. Seniority provisions in different collective agreements may have a variety of 'yardsticks' to determine which factors govern where there are competing applications for a vacancy. Some agreements contain sufficient ability clauses while others have relative ability or hybrid clauses. In addition, the application of seniority may be employer-wide, bargaining unit-wide or restricted to department or classification."

SAHO stated its perspective much more forcefully:

"Councils of Unions: a multi-union unit is not acceptable to the employers. Attempts to work with voluntarily organized Councils of Unions have been unsuccessful. The councils did not work. Services remained fragmented. The desire of unions to preserve its numbers compromises service delivery. For health districts this turf protection is counter productive and leads to many of the same problems as the 'Stove Pipe' situation mentioned earlier. Involved unions very often did not agree on disposition of issues. The dynamics among unions was hostile at times. The unions experienced difficulty with progressive dialogue amongst themselves. Power struggles among the unions was perceived to be a common occurrence. The process of working with a Council of Unions on day to day issues was very time consuming and non-productive. The result of

formalizing this arrangement of a Council of Unions would be chaotic indeed."

SGEU alone advocated a multi-union solution: "Our proposal is essentially a reorganization of bargaining in the province rather than a reorganization of appropriate units. ... What difference does it make to the employer as to which union receives the check off?" The proposal was single bargaining tables of multiple unions representing the same occupations among the employees of the same employers with one provincial table for wages and benefits to be phased in over several years.

There would be four bargaining councils and four province-wide agreements - nurses (institutional and community), all others (institutional and community). SGEU and CUPE would be in all four councils. SUN, HSAS and SEIU would be in two. SGEU would negotiate alone for a fifth agreement for northern community health services. Each union would be able to follow its members and their work from site to site and employer to employer.

The resulting representation would not be the exclusive representation embedded in *The Trade Union Act*, but a new approach. There would be little or no change or loss of membership for any union, except for the five smallest unions (RWDSU, RAPA, PTA, PIPS and PSAC) each with less than 90 members. The 306 employees affected would have the right to choose to be represented by CUPE, SEIU or SGEU. "Ninety-nine percent of union members would remain with their current union!"

The other unions were neither willing nor prepared to undertake such a complex and radically different approach to trade union representation and collective bargaining. Some of the recriminations during this process cemented the resolve and demonstrated that the proposal is unworkable at this time.

The history of trade union representation and the need to promote orderly collective bargaining leads to the conclusion that a structure that avoids or minimizes multi-union collective bargaining is most desirable and practical.

Multi-employer Representation and Bargaining Structures

The history and experience of multi-employer bargaining is quite different. Provincial agreements negotiated by a single employer agent have evolved as the rule in the public health sector.

The regulations will designate SAHO as the representative employers' organization with exclusive authority to bargain collectively on behalf of all health sector employers who have employees in each multi-employer and northern services unit.

The statute allows for the designation of representative employers' organizations, which are "the exclusive agent authorized to bargain collectively on behalf of all or a group of health sector employers."[112] The regulations will designate SAHO as the representative employers' organization with exclusive authority to bargain collectively on behalf of all health sector employers who have employees in each multi-employer and northern services unit. Many see the designation of SAHO as that representative employers' organization as simply formalizing what is now and has been in place for some time.

Some of the affected employers do not share this view. The Catholic Health Association of Saskatchewan and some health districts want to assure their voice, vote and participation in decision-making within SAHO.

> *"By legislating SAHO as the exclusive bargaining agent the recommendations fundamentally change the existing relationship between SAHO and its members. SAHO, as you are aware is made up of members who participate on a voluntary basis. SAHO receives its mandated responsibilities from its membership and is therefore a 'servant' of that membership. By legislating SAHO as the exclusive bargaining agent,*

SAHO will presumably receive this portion of its mandate from legislation which changes the relationship on which the association was created. Health Districts have responsibility for providing service which includes, as an integral part, managing and compensating its workforce. Health Districts, through this legislation, will have lost the ability to choose their bargaining agency and potentially the ability to negotiate the terms in which it directs and compensates its employees. Moreover, SAHO would continue to exist in this capacity whether the membership wished to continue this voluntary association or not.

We believe that Health Districts cannot retain responsibility without adequate authority. Having said this, we realize that SAHO in the past has performed the negotiation of collective agreements in the province admirably and, regardless of whether that fact becomes legislated or not, is likely to continue that role. Our problem is not with SAHO performing that function or with the concept of a single bargaining agent, our problem is with the manner in which SAHO would receive its mandate."[113]

Currently, the SAHO board of directors consists of 12 directors. Each represents a designated geographic zone. Seven are from rural health districts; two from each of the Saskatoon Health District and Regina Health District and one from Northern Health Services. The process for selection of the directors is outlined in article 22 of SAHO bylaws:

"The province is divided into 10 zones. Attached is a copy of the zone map. Within each zone the health district boards and the affiliate employers vote for a director to the SAHO board. Eligible candidates must be a member of a health district board but not an employee of a health district board or an employee of an affiliate facility. Board members of affiliate facilities who are members of a health district board are eligible to be a director of the SAHO board."

Rather than establishing articles of association or delegating that responsibility to the Labour Relations Board, it is being left largely to the employers as a matter for their domestic affairs within SAHO.

There will have to be a review of this governance structure to determine what adjustments should be made. Rather than establishing articles of association or delegating that responsibility to the Labour Relations Board, it is being left largely to the employers as a matter for their domestic affairs within SAHO. The regulations simply assure continued membership and financial support for SAHO by all those it is designated to represent. If an appropriate accommodation of the competing interests cannot be reached, the Legislative Assembly can amend the private statute under which SAHO is incorporated.

Integration of Employees

For employees covered by a collective agreement their job security at times of lay-offs and their entitlement to benefits and advancement is dependant in part on their seniority. Seniority is defined by the parties to collective agreements in various ways but does not operate beyond the scope of the collective agreement. The application of seniority is generally site, local union or bargaining unit in scope.

Integrating bargaining units and groups of employees requires that the seniority issue be addressed.

Integrating bargaining units and groups of employees requires that the seniority issue be addressed. Including previously unrepresented employees who have no seniority means their service has to be recognized as an accumulation of seniority. The commissioner is given express authority to address these questions by making regulations:

> *"(d) respecting any matters the commissioner considers appropriate arising out of the integration of employees in any appropriate unit, including the integration of seniority of employees who were previously represented by a trade union and the recognition of service of employees who were not previously represented by a trade union;"*[114]

Under the regulations made by the commissioner existing seniority is preserved and portable into the new units regardless of which union was or becomes the bargaining agent.

The inability to make merger and transfer agreements recognizing the portability of seniority has cost a small number of employees in specific circumstances the loss of their seniority since the organization of health districts. For their integration into the new units, their lost seniority is reinstated.

For previously unrepresented employees their service with the health district is to be recognized for calculating seniority. Because health districts did not exist before 1993, their service with the predecessor employer amalgamated into the health district is also to be recognized. These employees receive seniority recognition without previously contributing to the efforts of the unions. Nonetheless, the regulations will entitle them to seniority at no cost to each of them in past union dues or other payment.

Under the regulations made by the commissioner existing seniority is preserved and portable into the new units regardless of which union was or becomes the bargaining agent.

There are many ways to calculate seniority with varying rules about the effects of breaks in service and other matters. The establishment of each employee's seniority date and accumulation of seniority is to be on the same basis as other employees in the unit.

The previously unrepresented employees are treated as newly organized employees for purposes of union security and may choose to become or not become a union member, but will make payments to the union in accordance with *The Trade Union Act.*

Any disputes about the application, operation or interpretation of these entitlements for all employees integrated into new units are to be resolved by an expedited or standing dispute resolution processes, perhaps with some right of access to the process by

Many and varied local party agreements exist as adjuncts to, incorporated parts of, or separate from collective agreements. They confer benefits and entitlement on employees. The regulations will maintain the continuance of these agreements with the necessary modifications.

individuals as well as unions and employees. The regulations expressly enable the parties to establish such a dispute resolution mechanism by agreement between SAHO and one or more of the trade unions. Failing such agreement the dispute resolution process is arbitration under *The Trade Union Act.*

The integration of employees must not terminate existing benefit entitlement under collective agreements. This is especially important for employees who are away from the workplace at the time of the integration and who are dependant on continuance of these benefits for them and their families. The entitlement of employees receiving benefits under a disability or other plan will be determined in accordance with the terms of those plans.

Many and varied local party agreements exist as adjuncts to, incorporated parts of, or separate from collective agreements. They confer benefits and entitlement on employees. The regulations will maintain the continuance of these agreements with the necessary modifications. Some will become redundant because of the reorganization. Some can be easily renegotiated. Some, like at Saskatoon Veteran Home, create commitments and entitlement for many years. Any changes to these agreements can be made by the parties within the context of the reorganized rights and relationships.

Trade Union Representation

In bargaining units where there are no changes or merely consolidation the regulations maintain bargaining rights. This is the case for units of employees at northern health services, the Regina Health District laundry and for private profit employers.

SUN is to be the bargaining agent for the nurse units. It currently represents the overwhelming majority of nurses.

Some of the health services providers units are overwhelmingly represented by SEIU or CUPE and should remain that way. Examples are Regina and Saskatoon. For others, some rationalization is required. These considerations are reflected in the reorganization of representation rights affecting CUPE and SEIU.

For the other units, where no union has an overwhelming majority or a union has at least 25% of the employees as members, the representation is to be determined by employee vote. The 25% threshold is reflective of the threshold for a similar, but not identical, situation under *The Trade Union Act*.[115]

There will have to be a representative vote in the health support practitioner unit.

Agreements between unions to merge, amalgamate or transfer members during or after the commission, such as between HSAS and PTA, are to be accepted in determining evidence of the percentage.

The date as of which membership percentages are to be determined is left to the Labour Relations Board since there is no "date of application" in this situation. The purpose is to determine representation. It is a responsibility delegated to the Board. Therefore, the choice of not being represented by a union is not to be included on the ballot. The manner of the ballot, mail or ballot boxes is to be determined by the Board. The regulations provide for run-off representation votes, should it be necessary.

There will have to be a representative vote in the health support practitioner unit. As of April 1, 1997 certain employees of the provincial government at the Calder Centre and the Saskatchewan Hearing Aid Plan will be transferred to district health boards and included in this unit. If the vote is after April 1 and the devolution has proceeded as planned, they will be eligible to vote. If the vote proceeds quickly or the devolution is delayed they may not be. A regulation ensures their eligibility to vote in any event.

Collective Agreements

When a new unit consists of a grouping of employees covered by two or more collective agreements, the options include immediate bargaining for a single agreement, application of only one of the agreements to all employees, maintaining all agreements to their expiry dates or finding a common expiry date for them.

The situation will have some confusing aspects, but it is transitional, not permanent.

Most of the current collective agreements have passed their expiry date and are being negotiated. Only a few expire in 1997 or early 1998. In this situation the preferable option is to maintain all agreements and allow the parties to negotiate adjustments. The trade unions will become successor parties to other unions' agreements and will have to administer these agreements until new agreements are negotiated.

For previously unrepresented employees, each union and SAHO will have to determine which collective agreement applies to which employees and what adjustments will have to be made to include them.

The situation will have some confusing aspects, but it is transitional, not permanent.

There will have to be negotiation of the merging and melding of existing collective agreements. The creation of new units does not automatically extend existing "unit" rights to the scope of new units. Benefits do not automatically move to either the highest or lowest among the agreements. Consistency and any cost to achieve it are to be incurred over time - probably a number of years and rounds of collective bargaining.

Collective Bargaining

In future collective bargaining, SAHO will negotiate one collective agreement with each trade union for all of the

health service or nurse units that it represents. In the case of the three unions that are locals of SEIU there will be one agreement for all three. The result will be as follows:

Units	Agreements
SAHO/nurse	1
SAHO/support practitioner	1
SAHO/service provider	2 or 3
SAHO/Regina Laundry	1
Extendicare/nurse	1
Entendicare/all employees	1
Chantelle/nurse	1
Chantelle/all employees	1
Total	9 or 10

In place of a current labour relations organization with 25 collective agreements, there will be only 9 or 10 agreements, depending on the ultimate representation decisions at the Labour Relations Board. Excluding private for profit employees, there will be 5 or 6 collective agreements in place of 21.

The combination of a single representative employers' organization and one agreement per trade union or the three locals of SEIU will promote orderly collective bargaining.

The combination of a single representative employers' organization and one agreement per trade union or the three locals of SEIU will promote orderly collective bargaining.

Regulations

Every effort was made to meet the spirit of the guidelines in the provincial government Code of Regulatory Conduct in the commission's decision-making, process and communication.

Healthy public policy has been defined as "any course of action adopted and pursued (by government, business or

other organization) that can be anticipated to improve (or has improved) health and reduces inequities in health."[116]

All conceivable courses were pursued to exhaustion in fashioning the regulations. As stressful as it was and will be for many persons, the final outcome will improve health and reduce inequities.

Appendix A

1. Canada, Special House of Commons Committee on Social Security, *Health Insurance* (Ottawa: 1943), p. 3.

2. L.C. Marsh, *Report on Social Security for Canada to Special Committee on Social Security* (Ottawa: 1943), p. 17.

3. *A Saskatchewan Vision for Health* (Regina: 1992), p. 5.

4. Tommy Douglas from the 1982 film *Folks Call Me Tommy.*

5. Saskatchewan Health, *Overview of the Restructuring of the Health System in Saskatchewan*, Presentation to Commission, October 7, 1996.

6. Robin F. Badgley, "Regionalization of Health Services in Canada" (1982), 18 Israel Journal of Medical Sciences 375 at pp.379-80.

7. Sharmila L. Mhatre and Raisa B. Deber, "From Equal Access to Health Care to Equitable Access to Health: A Review of Canadian Provincial Health Commissions and Reports" (1992), 22 International Journal of Health Sciences 645 at p. 664.

8. *Task Force Report on the Cost of Health Services in Canada*, Vol.1 (Ottawa: 1969), p. 19.

9. *Task Force Report on the Cost of Health Services in Canada*, Vol.2 (Ottawa: 1969), p.7 - 9.

10. Thomas J. Boudreau, "Regionalization of Health Services", Appendix 1 in *Task Force Report on the Cost of Health Services in Canada*, Vol.2 (Ottawa: 1969), pp. 31 - 53.

11. Peg Folsom, Jodey Porter, Don Richmond, Ron Saddington and Joy Warkentin, *Devolution of Health and Social Services in Ontario: A Framework for Evaluating Devolution* (Toronto: Premier's Council on Health, Well-being and Social Justice, 1994) at p. 1.

12. Ibid, p.13.

13. Peg Folsom, Jodey Porter, Don Richmond, Ron Saddington and Joy Warkentin, *Devolution of Health and Social Services in Ontario: Refocusing the Debate* (Toronto: Premier's Council on Health, Well-being and Social Justice, 1994).

14. *Future Directions For Health Care in Saskatchewan*, (Regina; 1990), p. 4.

15. S. S. 1993, c. H-0.01 See Appendix C.

16. Minister of Health, Saskatchewan Legislative Assembly, Hansard, March 10, 1993, pp. 246-247.

17. See Walter Podiluk, *Partners in Health Care: District Board-Affiliate Agencies* Regina: 1996); *The Health District Amendments Act*, S.S. 1996, c.47.

18. Section 37.3 of *The Trade Union Act* allows separate employers to be treated as one employer in circumstances where there is common control and direction of associated or related businesses, undertakings or activities despite separate legal identities. The Saskatoon District Health Board submitted that those circumstances exist between it and St. Paul's Hospital.

19. *An Act to Amend the Trade Union Act*, S.S. 1996, c.83

20. *Trade Union Act*, S.S. 1972, c. 137 effective August 1, 1972.

21. Nipawin District Staff Nurses Association v. Nipawin Union Hospital and Service Employees' Local Union No. 333 (1973), Decisons of the Saskatchewan Labour Relations Board and Court Cases Arising Therefrom, Vol. III (1965 - 1974), p.274.

22. Service Employees' International Union Local 333 v. Nipawin District Staff Nurses Association of Nipawin et al [1975] 1 S.C.R. 382.

23. See Saskatchewan Government Employees' Union -and- Wascana Rehabilitation Centre and Physical Therapists Association, unreported File No. 236-92 (February 11, 1993).

24. Saskatchewan Union of Nurses -and- Gull Lake Union Hospital Board, unreported, Labour Relations Board File No. 257-83 (December 12, 1983). See also Regina Pioneer Village Staff Nurses Association v. Regina Pioneer Village (1973), 3 Saskatchewan Labour Relations Board 285 and The Health Sciences Association of Saskatchewan -and- The Co-operative Health Centre, unreported Labour Relations Board File No. 008-86 (February 19, 1987).

25. *The Home Care Act*, S.S. 1986, c. H-4.01

26. Supra, note 19

27. Health Sciences Association of Saskatchewan v. City Hospital, Saskatoon and Service Employees' Union, Local 333 (1973), Decisons of the Saskatchewan Labour Relations Board and Court Cases Arising Therefrom, Vol. III (1965 - 1974), p. 306.

28. Health Sciences Association of Saskatchewan v. University Hospital, Saskatoon and Service Employees International Union, Local 333 (1973) Decisions of the Saskatchewan Labour Relations Baords and Court Cases arising Therefrom, Vol III (1965 - 1974), p. 348.

29. Health Sciences Association of Saskatchewan v. Saskatoon City Hospital, Saskatoon and Service Employees' Union, Local 333 (1973), Decisons of the Saskatchewan Labour Relations Board and Court Cases Arising Therefrom, Vol. III (1965 - 1974), p. 357.

30. Health Sciences Association of Saskatchewan v. Swift Current Union Hospital and Service Employees International Union, Local 336 (1973), Decisions of the Saskatchewan Labour Relations Board and Court Cases Arising Therefrom, Vol. III (1965 - 1974), p. 359.

31. Health Sciences Association of Saskatchewan v. University Hospital, Saskatoon and Service Employees International Union, Local 333, (1973), Decisions of the Saskatchewan Labour Relations Board and Court Cases Arising Therefrom, Vol. III (1965 - 1974), p. 352.

32. Ibid, p. 355.

33. Ibid, p. 353.

34. Health Sciences Association of Saskatchewan v. Holy Family Hospital, Prince Albert and Canadian Union of Public Employees, Local 81 (1974), Decisons of the Saskatchewan Labour Relations Board and Court Cases Arising Therefrom, Vol. III (1965 - 1974), p. 418 at 419.

35. E.g., Health Sciences Association of Saskatchewan v. Victoria Union Hospital Board and Canadian Union of Public Employees, Local Union 84, unreported Labour Relations Board File No. 194-73-4 (November 15,1974).

36. Health Sciences Association of Saskatchewan v. St. Paul's Hospital, Saskatoon and Service Employees' Union, Local 333 (1974), Decisons of the Saskatchewan Labour Relations Board and Court Cases Arising Therefrom, Vol. III (1965 - 1974), p. 423.

37. Labour Relations Board File No. 079-86.

38. Service Employees International Union, Local 333 v. St. Paul's Hospital and Health Sciences Association of Saskatchewan (1993) 2nd Quarter, Saskatchewan Labour, Report 78.

39. Saskatchewan Association of Medical Laboratory Technologists v. South Saskatchewan Hospital Centre and Canadian Union of Public Employees, Local Union 1612, unreported Labour Relations Board File No. 334-75 (January 9, 1976).

40. Saskatchewan Association of Medical Laboratory Technologists v. Regina General Hospital and Regina hospital Employees' Union, Local 176 (CUPE) and Service Employees' International Union, unreported Labour Relations Board File No. 617/618-77 (May 31, 1978).

41. Saskatchewan Labour Relations Board File No. 35 - 81.

42. Health Sciences Association of Saskatchewan v. South Saskatchewan Hospital Centre and Canadian Union of Public Employees, Local 1838 unreported Labour Relations Board File No. 413/414-84 (March 1, 1985).

43. Health Sciences Association of Saskatchewan v. South Saskatchewan Hospital Centre and Canadian Union of Public Employees, Local 1838 unreported Labour Relations Board File No. 421/422-85 (February 14, 1987).

44. The Health Sciences Assocaition of Saskatchewan -and- The Co-operative Health Centre, unreported Labour Relations Board File No. 008-86 (February 19, 1987).

45. Health Sciences Association of Saskatchewan -and- Royal University Hospital, unreported Labour Relations Board File No. 210-90 (May 25, 1993).

46. Service Employees' International Union, Local 33UH -and- Royal University Hospital, unreported Labour Relations Board File No. 272-93 (September 26, 1994).

47. Health Sciences Association of Saskatchewan -and- St Paul's Hospital, unreported Labour Relations Board File No. 292-91 (March 3, 1994).

48. Service Employees' International Union -and- Saskatoon District Health Board at Parkridge Centre, unreported Labour Relations Board File No. 015-94 (September 26, 1994) where the SEIU was certifed to represent a previously unrepresented unit of social workers, speech therapists, physical therapists, occupational therapists and speech language pathologists.

49. Health Sciences Association of Saskatchewan -and- Wascana Rehabilitation Centre and Saskatchewan Government Employees' Union, unreported Labour Relations Board File No. 265-93 (October 18, 1994).

50. Health Sciences Association of Saskatchewan -and- Regina District Health Board, unreported Labour Relations Board Files No. 025/118-95 (July 18, 1995).

51. Health Sciences Assocaition of Saskatchewan -and- Saskatoon City Hospital, unreported Labour Relations Board File No. 266-93 (September 26, 1994).

52. Service Employees' International Union -and- Saskatoon District Health Board at Parkridge Centre, unreported Labour Relations Board File No. 015-94 (March 2, 1994).

53. *An Act to Incorporate Saskatchewan Hospital Association Saskatchewan Hospital Association Act*, S.S. 1959, c.117.

54. Gerard Dion, "Jurisdictional Dispute" in H. Carl Goldenberg and John H.G. Crispo, ed., *Construction Labour Relations* (Toronto: 1968), pp. 333 -375 at p. 334.

55. Health Sciences Association -and- Service Employees International Union, Local 333 and Medical Arts Laboratory (1989) Ltd., unreported File No. 134-95 (July 4, 1995).

56. Framework Agreement, May 9, 1996.

57. This is the character that the Saskatchewan Labour Relations Board assigned to the relationship in its *Annual Report 1994-95*, p. 4.

58. Health Sciences Association of Saskatchewan -and- Regina District Health Board [1995] Saskatchewan Labour Report 131 at 137.

59. *A Saskatchewan Vision for Health*, p. 17.

60. *New Directions for Healthcare Labour Relations in the 1990s: A Report to the Minister of Health of Province of Saskatchewan* (May, 1993), p. 1. This report is the report of the two members Mr. Ron Reavley, Regina Pioneer Village and Dr. Ray Sentes, University of Regina. The chair Dr. Kurt Wetzel, University of Saskatoon submitted his analysis privately to the Minister.

61. Ibid, p. 25.

62. Ibid, p. 23.

63. Ibid, p. 24.

64. Ibid, pp. 24 - 25.

65. Ibid, p. 42.

66. 1996/97 Master Service Agreement, p. 5.

67. Report of the Health Providers Human Resource Committee, *The Education, Regulation and Utilization of Saskatchewan Health providers: Adapting to Health Reform and Changes in Society* (Regina:1996), p. 23.

68. Ibid, p. 26.

69. Service Employees' International Union Local 333 -and- Saskatoon District Health Board at Parkridge Centre, unreported Labour Relations Board File No. 015-94 (September 26, 1994).

70. Health Sciences Association of Saskatchewan -and- Saskatoon City Hospital, unreported Labour Relations Board File No. 266-93 (September 24, 1994), p. 6.

71. Service Employees' International Union Local 333 -and- Southwest District Health Board, unreported Labour Relations Board File No. 158-94 (December 1, 1994), p. 5.

72. Ibid, p. 6.

73. Saskatchewan Union of Nurses -and- The Saskatoon City Hospital, unreported Labour Relations Board File No. 050-93 (May 26, 1995), p. 3.

74. Service Employees' International Union Local 333 -and- North Central District Health Board, unreported Labour Relations Board File No. 224-95 (February 21, 1996), pp. 3 - 4; 5 - 6.

75. Saskatchewan Union of Nurses -and- Prince Albert District Health Board, unreported Labour Relations Board File No. 304-95 (April 30, 1996).

76. "Proposal for the Establishment of an Independent Health Labour Relations Commissioner," March 13, 1996, Appendix B.

77. S.S. 1996, c. H-0.03.

78. *Saskatchewan Legislative Debutes, Hansard*, June 13, 1996, p. 2567.

79. s.4.

80. s.6(3).

81. ss.6(6)(b) and (7).

82. s.5(1).

83. s.5(5).

84. A tabular summary of the various positions advanced by the major presentations is included as Appendix H.

85. See Appendix I.

86. See Information/Bulletin # 11, January 7, 1997, Appendix K.

87. s.9(1)(a).

88. See Information/Bulletin # 1, July 18, 1996, p.2, Appendix K.

89. s.6(2).

90. s.6(2)(a) to (i).

91. s.5(6)(a) to (e).

92. See s. 37.

93. s. 6(2)(d).

94. Saskatchewan Government Employees' Union -and- Wascana Rehabilitation Centre, unreported Labour Relations Board File No. 236-92 (February 11, 1993).

95. Saskatchewan Union of Nurses -and- Twin Rivers District Health Board, unreported Labour Relations Board File No. 109-94 (July 7, 1994).

96. Ibid, pp. 3 - 4.

97. Saskatchewan Health- Care Association -and Service Employees' Union, Local 36, unreported Labour Relations Board File No. 091/099/152-92 (July 27, 1992).

98. E.g., Service Employees' International Union, Local 336 -and- Southwest District Health Board, unreported Labour Relations Board File No. 158-94 (December 1, 1994); Service Employees' International Union, Local 336 -and- Swift Current District Health Board, unreported Labour Relations Board File No. 011-95 (March 21, 1995).

99. E.g., Service Employees' International Union, Local 333 -and- North Central District Health Board, unreported Labour Relations Board File No. 224-95 (February 21, 1996).

100. The Institutes Act, S.S. 1986, 1987, 1988, c. I-9.1; *The Regional Colleges Act*, S.S. 1986, 1987, 1988, c. R-8.1; Strickland et al v. Saskatchewan Institute of Applied Science and Technology et al (1993), 113 Sask. R. 192 (C.A.) affirming (1990), 102 Sask. R. 98 (Q.B.)

101. S. 6(2).

102. Robert G. Ennes, Morris L. Barer and Theodore R. Marmor (eds.), "Why are Some People Healthy and Others Not? The Determinants of Health of Populations" (New York: 1994).

103. Pat Armstrong and Hugh Armstrong, *Wasting Away: The Undermining of Canadian Health Care* (Toronto: 1996).

104. *New Directions for Healthcare Labour Relations in the 1990s: A Report to the Minister of Health of Province of Saskatchewan* (May, 1993), pp. 23 - 24. This report is the report of the two members Mr. Ron Reavley, Regina Pioneer Village and Dr. Ray Sentes, University of Regina. The chair Dr. Kurt Wetzel, University of Saskatoon submitted his analysis privately to the Minister.

105. *Report of the Hospital Inquiry Commission*, (Toronto: 1974), p. 41.

106. For some of this overview in more detail see the pre and post-conference papers from Alberta Labour Relations Board, Emerging Labour Relations Issues in the New Health Care Environment (Edmonton, September 24 and 25, 1996).

107. Supra, note 103. The percentatge of part-time in 1991 for all occupations ws 42.1%. For ambulance personnell it was 71.2%.

108. See Alice J. Baumgart and Jennice Larsen, eds., *Canadian Nursing Faces the Future: Development and Change* (Toronto: 1988).

109. Gwen Curtis, "Discussion Paper on Roles of LPNs, RNs and RPNs" (unpublished, June 1996, SUN Board of Directors), p.2.

110. Ibid, p.12.

111. s. 6(1)(a).

112. s. 6(1)(b).

113. Prairie West Health District submission, December 23, 1996.

114. S.6(2)(d)

115. *Trade Union Act*. See Public Service Alliance of Canada - and - Casino Regina - Saskatchewan Gaming Corporations [1996] Sask. L.R. B.R. 454.

116. John Miller, "Public Policy, Health Policy, Healthy Public Policy: What's the Difference" in Conference Proceedings of Healthy Public Policy Development - Science, Art, or Chance? (Prairie, Region Health Promotion Research Centre, April 29-30, 1996), p. 4.

Appendix B

Request for Commission

PROPOSAL FOR THE ESTABLISHMENT OF AN INDEPENDENT HEALTH LABOUR RELATIONS COMMISSIONER

BACKGROUND

In December, 1992, the Government of Saskatchewan established a Labour Relations Review Committee to report directly to the Minister of Health respecting among other things, "... needed changes and new approaches to employee relations." Presumably, the establishment of such a Committee came about as the result of a recognition by the Government and the Department that there would be problems with regard to imposing a new delivery structure (i.e. the Wellness model), on an industrial relations structure that mirrored the old health delivery model.

This recognition is reflected in the following points contained in the Terms of Reference:

> 2. To consider the most effective and efficient collective bargaining and administrative methodology...
>
> 4. To recommend timely, effective and acceptable mechanisms to resolve union jurisdictional questions.
>
> 5. To recommend timely, effective and acceptable mechanisms that facilitate the integration of employee and union(s) from different facilities with different collective agreements to a single employer.

While the three-person Committee did not have a unanimous, single report, the two reports that were ultimately filed with the Minister both contained numerous recommendations and options which were not acted upon.

Now, some three years later, the very problems that were addressed at that time by both Unions and Employers in the Health Sector have arisen and require immediate attention in order that health care delivery not be negatively impacted by a serious industrial relations breakdown.

There are a number of factors that have brought the situation to a head. Among them are:

1. The devolution of government services to the District Health Boards, resulting in intermingling of unionized staff as District Health Boards consolidate program management and delivery. This happened as of April 1, 1995.
2. The applications by the Saskatoon and Regina District Health Boards to the Labour Relations Board to redefine the appropriate units for the purposes of collective bargaining, and other related applications.

In a document outlining problems being faced by the Saskatoon Health Board as a result of the reorganization of health delivery, they state ..."To achieve a seamless service, the system must provide ease of mobility of both the patient and the health care

provider." They further claim that they are unable to develop such a seamless system until such time as the "patchwork" of union jurisdiction involving multiple unions and bargaining units is resolved.

In response to this Application, the unions involved in the Health Sector met on January 10/11, 1996, in a pre-hearing meeting called by the Labour Relations Board to determine whether there was an ability to resolve the issues raised by the Application without a full hearing.

All parties impacted by the Application were in attendance, including representatives from the Saskatoon Health District, SAHO and the Department of Labour Conciliation Services Branch.

This meeting and others held since January, have been productive, but have led the unions to conclude that the problems raised by the employer in Saskatoon, must be resolved on a province-wide basis, as they are not peculiar to a single employer.

THE PROPOSAL

Up until this point in time, it had been hoped by all parties that the problems of intermingling and unit construction resulting from the reform process, could be solved by the unions themselves, without having to use a third party. However, because of the

complexity of changing bargaining unit configuration uniformly across the province, and changing the provincial bargaining framework to conform to that new reality, the union's have determined that the Saskatoon application would not provide for the ability for all affected employees and employers to have input.

There is currently no legal authority to change the bargaining unit structure outside of applications to the Labour Relations Board on an individual employer basis by either the union or District Board, which would be an incredibly time-consuming and costly process for all concerned, considering there are thirty employers involved. In addition, the Board has no authority to order broader and more cost-effective mechanisms for bargaining multi-employer/multi-union collective agreements.

We, the undersigned unions, are therefore requesting that the Government appoint an independent Commission to hear representations from all affected parties.

The mandate of such a Commission shall be :

1. To determine appropriate bargaining unit configuration for Health Districts in the province, taking into account the principles of the Trade Union Act;
2. Ensure to the extent possible that current representation rights enjoyed by the unions are preserved;
3. Enforce provincial bargaining arrangements between the

parties.

The Commission would be composed of a single Commissioner with sufficient staff and resources to carry out its' mandate in a timely and efficient manner.

In the interests of expediting the resolution to these problems, we are requesting that the Commission, once established, conclude it's work in six months.

_____ for CUPE

_____ for HSAS

_____ for SEIU

_____ for SGEU

_____ for SUN

March 13, 1996.

e Commissioner

its' mandate

o these problem

shed, conclude

CUPE

HSAS

SEIU

SGEU

SUN

Head Office
May 27, 1996

Mr. Brian King
Deputy Minister
Saskatchewan Labour
1870 Albert Street
Regina, Saskatchewan
S4P 2S8

Dear Mr. King:

Re: **Terms of Reference**
Commission on Health Care Union Jurisdiction

Thank you for the invitation to submit our views on the terms of reference for appointment of a Commission. We support the establishment of a Commission to enquire into and determine the restructuring of the bargaining unit configuration within the health care sector on the condition that we are able to agree to the terms of reference. With this understanding we set out our identification of the salient facts, the resulting issue, conclusions and necessary enabling legislation.

Facts:

1. Prior to 1992, the original health care sector Saskatchewan Labour Relations Board certification orders reflected that the appropriate bargaining unit was one which exclusively represented all employees of specified classifications of the employer subject to exclusions so designated in the certification order.

2. During the years 1992-94, three hundred fifty-seven (357) corporations providing health care services were amalgamated into 30 health districts.

3. The anticipated outcome from amalgamation of multiple employers within each health district was consolidation of health delivery services to delete unnecessary duplication of services and integrate community, acute and long term institutional care in a manner which provides a seamless service delivery model focused on prevention and/or absence of illness, management of acute illness and enhancement of quality of life.

4. The result of the merger was that the thirty (30) health district boards made up of multiple employer organizations inherited employees within scope of approximately 450 bargaining units. Each unit was autonomous in its governance and bound by its own certification order and collective agreement. Each bargaining unit, for the most part, represented a minority number of employees of the health district within the classifications of the original certification order.

...2

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SASKATCHEWAN
ASSOCIATION OF
HEALTH
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Saskatoon Office:
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Saskatoon, Saskatchewan S7H 5H9
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5. To integrate program services within each district requires employees to move freely within the community, acute care and long term care services of the program.

6. Currently, employees from various bargaining units (of same union affiliation and/or different unions) work together side-by-side in the same program each doing their own job without intermingling. This practice perpetuates costly, fragmented service delivery.

7. Initially, Merger/Transfer Agreements and Itinerant Movement Agreements were used to accommodate transfer and movement of employees between bargaining units. These agreements are not sufficient to effect the intermingling of workers required to integrate health service programs of the employer.

8. Rivalry and turf protection among local units working within the same program impedes the operations of the employer.

9. Attempts at intermingling employees of different bargaining units by agreement have been very difficult and to the extent any attempts have been successful, it has been accomplished only by protracted case by case negotiations. As a result service delivery often continues to be fragmented; and, a difficult work environment exists for employees.

Issue:
Is restructuring of the bargaining unit configuration within the health care sector necessary to implement health reform in Saskatchewan?

Is legislative intervention required to effect the necessary restructuring of bargaining units?

Conclusion:
Over the last three years, the parties have been unable to resolve union jurisdictional issues created by legislated health reform in Saskatchewan. The current jurisdictional boundaries are defined by facility. These boundaries presuppose work will remain within the facility walls, and that the medical institutional model of health service delivery will remain unchanged. These jurisdictional boundaries prevent efficient management of human resources, negate principles of health reform and bring disharmony to the labour relations climate.

Intermingling is a natural consequence of any merger or amalgamation of two or more businesses. Intermingling of employees is essential to the survival of the merged business. Employees performing the same job functions need to be consolidated into the same bargaining unit.

...3

With health reform the issue is much greater. The entire Saskatchewan health care industry is affected, creating a provincial issue that cannot equitably be resolved on a case by case basis. Therefore the Saskatchewan Labour Relations Board is not the appropriate forum to address this issue. The process would be protracted with fragmentation of service delivery.

As each application will be decided on its own merits, the result may be inconsistent decisions throughout the province. This would further jeopardize industrial harmony. Rivalry among unions may intensify and thereby jeopardize service delivery. A Commission with the power to resolve the health care sector labour jurisdictional issue provincially can accomplish this task in an expeditious manner.

The difficulty to intermingle staff beyond the boundaries of their designated bargaining unit has negatively impacted on the ability of most health districts to carry out the legislated mandate to provide health care service to the residents of Saskatchewan. Jurisdictional issues among the various bargaining units of the same employer affect the day to day operations of the health districts. Inappropriate bargaining units have disrupted and frustrated organizational decisions and consequential administration of the applicable collective bargaining agreement.

Recommendation:
To appoint a Commission with the following terms of reference:

- to determine the number and composition of appropriate bargaining units of employees within each health district required to promote an integrated health care delivery system which effectively and efficiently utilizes human and financial resources in a fair, equitable and harmonious manner ensuring there be as few appropriate bargaining units as possible;
- to determine which unions within the geographic boundaries of each health district shall represent health care workers; and,
- to further determine all outstanding ancillary issues including the applicable collective bargaining agreement for each unit, the process of implementation of the collective agreement and the merging of seniority of employees.

Enabling Legislation:
To effect the terms of reference, amendment to the *Health District Act* is required. Orders in Council/Regulations will not suffice.

Amendment to the *Health Districts Act* H-0.01 ss 1993, to include a section which provides:

1. (a) The Lieutenant Governor in Council may appoint a Commission to investigate and determine the appropriateness and composition of health sector bargaining units; to determine the union to represent employees in each restructured unit; to determine merging of seniority of in-scope employees; and to facilitate dispute resolution in regards to implementation of restructured units.

...4

(b) For the purposes of this section, an appropriate bargaining unit means a unit which promotes efficient, effective use of human and financial resources.

(c) The Commission shall have the powers:

(1) to restructure and consolidate the bargaining units of similar/same employee classifications of the employer into one bargaining unit.

(2) to identify the appropriate bargaining units within each district ensuring as few appropriate bargaining units as possible.

(3) to determine the trade union to represent each appropriate bargaining unit.

(4) to establish the mechanism of seniority determination of all employees within each restructured unit including employees who are brought in scope or change bargaining units, unions or collective agreements as a result of consolidation of currently existing bargaining units.

(5) to provide that the seniority credit of in-scope employees previously not included in a bargaining unit is deemed to be equal to the employee's service with the district health board and predecessor facility.

(6) to determine which collective bargaining agreement is in effect for each bargaining unit and determine the process of implementation of the collective agreement.

(7)(i) to exclude from the restructured bargaining unit those positions that were excluded from the previous bargaining units as more particularly identified in the prior certification orders of the Saskatchewan Labour Relations Board;

(ii) alteration to the exclusion of positions pursuant to S1(c)(7)(I) will be dealt with by application to the Saskatchewan Labour Relations Board.

(8) to issue interim or final orders with respect to representational rights and associated issues.

(9) to determine and adopt such rules, procedures and process as deemed appropriate.

(d) In addition to the foregoing powers, a Commission appointed pursuant to this section will exercise all power and authority of a Commission appointed under the *Public Inquiries Act*.

(e) The Saskatchewan Labour Relations Board has no jurisdiction over matters within the jurisdiction of the Commission.

(f) Orders defining the appropriate bargaining unit shall have the same force and effect as an order of the Saskatchewan Labour Relations Board.

...5

(g) Any agreement, award, decision or interim award, direction or declaration or ruling by the commissioner is final and binding and shall not be questioned, challenged or reviewed by the Labour Relations Board of Saskatchewan, or any court, and no order shall be made, or process entered into or proceedings taken in any court, whether by way of application for judicial review, or otherwise, to question, review, prohibit or restrain the Commission, or any of his/her proceedings.

Again, many thanks for the opportunity to have input into the terms of reference for the Commission. If you need further information or clarification of our position please do not hesitate to call.

Yours truly,

Brian Morgan
Vice-President, Human Resource Services

c: SAHO Board of Directors
Arliss Wright, President & CEO, SAHO
Mr. Terry Stevens, Executive Director, Labour Relations, Saskatchewan Labour
Mr. Mick Grainger, Senior Labour Relations Consultant, Saskatchewan Health

Appendix C

CHAPTER H-0.03

An Act respecting the Reorganization of Labour Relations between Health Sector Employers and Employees

Short title

1 This Act may be cited as *The Health Labour Relations Reorganization Act*.

Interpretation

2(1) In this Act:

(a) **"board"** means the Labour Relations Board continued pursuant to *The Trade Union Act*;

(b) **"board order"** means an order of the board made pursuant to *The Trade Union Act*;

(c) **"collective bargaining agreement"** means a collective bargaining agreement as defined in *The Trade Union Act*;

(d) **"commissioner"** means the commissioner appointed pursuant to section 4;

(e) **"employee"** means a person who is an employee within the meaning of *The Trade Union Act*;

(f) **"health sector employer"** means:

(i) a district health board as defined in *The Health Districts Act*;

(ii) a hospital, nursing home or other institution approved pursuant to *The Hospital Standards Act*;

(iii) a special-care home licensed pursuant to *The Housing and Special-care Homes Act*; and

(iv) any other person who is prescribed in the regulations made by the Lieutenant Governor in Council;

(g) **"minister"** means the member of the Executive Council to whom for the time being the administration of this Act is assigned.

(2) Unless a contrary intention is expressed in this Act or the regulations, the words and phrases defined in *The Trade Union Act* apply to this Act, the regulations and any order made pursuant to this Act. 1996, c.H-0.03, s.2.

Application of Act

3 This Act applies to health sector employers and employees. 1996, c.H-0.03, s.3.

Commissioner appointed

4 The minister shall appoint a commissioner to carry out the responsibilities of the commissioner assigned by this Act. 1996, c.H-0.03, s.4.

Examination

5(1) The commissioner shall examine the organization of labour relations between health sector employers and employees.

(2) Subject to subsection (3), the commissioner shall complete the examination on or before the date set by the minister.

(3) If the minister considers it appropriate or necessary, the minister may extend the time by which the commissioner shall complete the examination.

June 13, 1996 - 11:58 a.m.

(4) In conducting the examination, the commissioner has the powers of a commissioner appointed pursuant to *The Public Inquiries Act* and may receive and act on any evidence or information on oath, affidavit or otherwise that the commissioner considers proper, whether that evidence is admissible in evidence in a court of law or not.
(5) The commissioner may determine the practice and procedure to be followed in conducting the examination.

(6) In conducting the examination, the commissioner shall consider the following:
(a) the new employment relationships that have been established and that will be established as a result of restructuring the delivery of health services pursuant to the enactment and application of *The Health Districts Act*;
(b) the need to promote the integration of the delivery of health services;
(c) the need to facilitate the development over time of consistency in terms and conditions of employment amongst health sector employers and employees;
(d) the history of trade union representation amongst employees of health sector employers and the need to promote orderly collective bargaining between health sector employers and employees;
(e) any additional matters prescribed in the regulations made by the Lieutenant Governor in Council. 1996, c.H-0.03, s.5.

Regulations

6(1) In this section:
(a) **"bargaining council"** means an association of trade unions, including locals of trade unions, formed for the purpose of bargaining collectively on a multi-employer and multi-bargaining unit basis;
(b) **"representative employers' organization"** means an employers' organization that is the exclusive agent authorized to bargain collectively on behalf of all or a group of health sector employers.
(2) The commissioner shall make regulations reorganizing labour relations between health sector employers and employees and resolving issues arising out of that reorganization and, for that purpose, may make regulations:
(a) defining appropriate units for the purposes of this Act and establishing the composition of those appropriate units;
(b) determining trade union representation of employees in any appropriate unit;
(c) respecting the integration of employees in any appropriate unit;
(d) respecting any matters the commissioner considers appropriate arising out of the integration of employees in any appropriate unit, including the integration of seniority of employees who were previously represented by a trade union and the recognition of service of employees who were not previously represented by a trade union;
(e) establishing a multi-employer bargaining structure through the designation of bargaining councils and representative employers' organizations;
(f) respecting the establishment of articles of association for bargaining councils and representative employers' organizations;
(g) if an appropriate unit established pursuant to clause (a) consists of employees who are covered by two or more collective bargaining agreements:
(i) determining which one of the collective bargaining agreements will apply to all employees in the appropriate unit; or
(ii) fixing a common expiry date for all of those collective bargaining agreements;
(h) delegating to the board any of the commissioner's responsibilities pursuant to this subsection that the commissioner considers appropriate, including the authority to determine any matter or thing that is to be determined or established by the commissioner in the regulations;
(i) respecting any other matter or thing the commissioner considers necessary to carry out the intent of this Act.
(3) Subject to subsection (4), the commissioner shall submit his or her regulations to the minister on or before the date set by the minister.

(4) If the minister considers it appropriate or necessary, the minister may extend the time by June 13, 1996 - 11:58 a.m.

which the commissioner shall submit his or her regulations.

(5) The regulations made by the commissioner do not come into effect until they are:

(a) approved by the Lieutenant Governor in Council; and

(b) filed with the Registrar of Regulations in accordance with *The Regulations Act, 1989*.

(6) The Lieutenant Governor in Council may make regulations:

(a) defining, enlarging or restricting the meaning of any word or phrase used in this Act but not defined in this Act;

(b) subject to subsection (7), prescribing a person as a health sector employer;

(c) respecting additional matters the commissioner shall consider when conducting an examination;

(d) setting a date for the purposes of clause 9(2)(c);

(e) respecting any other matter or thing the Lieutenant Governor in Council considers necessary to carry out the intent of this Act.

(7) The Lieutenant Governor in Council shall make a regulation pursuant to clause (6)(b) only on the recommendation of the commissioner. 1996, c.H-0.03, s.6.

Regulations as board orders

7(1) A regulation that is made by the commissioner pursuant to this Act and that has come into effect has the same force and effect as a board order and is to be treated for all purposes as if it were a board order.

(2) Without limiting the generality of subsection (1), a regulation made by the commissioner is enforceable in the same manner as a board order.

(3) A regulation made by the commissioner pursuant to this Act may amend, vary or rescind a board order.

(4) In the case of any conflict between the regulations made by the commissioner pursuant to this Act and a board order, the regulations prevail. 1996, c.H-0.03, s.7.

Board may not amend regulations

8 Until the expiry of three years from the date that the regulations made by the commissioner are filed with the Registrar of Regulations, the board shall not make an order pursuant to clause 5(a) or (b) of *The Trade Union Act* that amends, varies or rescinds those regulations. 1996, c.H-0.03, s.8.

Limitation on applications

9(1) During the period prescribed in subsection (2):

(a) no trade union or other person shall make any application to the board pursuant to *The Trade Union Act* with respect to any matter that is or may be covered by the regulations to be made by the commissioner; and

(b) the board shall not consider any application, including any application made before this Act comes into force, with respect to the matters mentioned in clause (a).

(2) For the purposes of subsection (1), the prescribed period commences on the date this Act comes into force and ends on the earliest of:

(a) the date the regulations made by the commissioner are filed with the Registrar of Regulations;

(b) 90 days from the date the commissioner submits the regulations to the minister pursuant to subsection 6(3); and

(c) a date set by the Lieutenant Governor in Council. 1996, c.H-0.03, s.9.

Powers of board

10(1) For the purpose of carrying out the intent of this Act, in addition to the powers conferred on it by this Act and the regulations made by the commissioner, the board has all the powers conferred on it by *The Trade Union Act*.

(2) Subject to section 8, the board may make any order that it considers appropriate respecting any matter arising out of the reorganization of labour relations between health sector employers and employees that is not addressed in the regulations.

(3) An order made by the board pursuant to this Act or the regulations is enforceable in the same manner as a board order.

(4) There is no appeal from an order or decision of the board pursuant to this Act, and the proceedings, orders and decisions of the board are not reviewable by any court of law or by any *certiorari*, mandamus, prohibition, injunction or other proceeding. 1996, c.H-0.03, s.10.

Act to prevail

11 This Act, any regulation or any order by the board made pursuant to this Act or the regulations prevails in the case of any conflict between:

(a) this Act, the regulation or the order by the board made pursuant to this Act or the regulations; and

(b) *The Trade Union Act*, any other Act, any regulations made pursuant to any other Act, any board order or any collective bargaining agreement. 1996, c.H-0.03, s.11.

Coming into force

12 This Act comes into force on proclamation. 1996, c.H-0.03, s.12. **[Proclaimed in force effective July 12, 1996.]**

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Appendix D

Statutes - Health District Act
The Health Districts Act

being

Chapter H-0.01 of the *Statutes of Saskatchewan, 1993* (effective May 24, 1993) as amended by the *Statutes of Saskatchewan*, 1996, c.47.

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CHAPTER H-0.01

An Act respecting Health Districts

SHORT TITLE AND INTERPRETATION

Short title

1 This Act may be cited as *The Health Districts Act*.

Interpretation

2 In this Act:

(a) **"affiliate"** means a person prescribed as an affiliate who:

(i) operates a facility; and

(ii) receives funding to operate the facility from a district health board;

(a.1) **"ambulance board"** means a board as defined in *The Ambulance Act*;

(b) **"ambulance district"** means a district as defined in *The Ambulance Act*;

(c) **"chairperson"** means a chairperson for a district health board designated or deemed to have been designated pursuant to subsection 6(5) or elected pursuant to subsection 7(9) or 13(4);

(d) **"department"** means the department over which the minister presides;

(e) **"district health board"** means a district health board established or deemed to have been established pursuant to section 5;

(f) **"facility"** means a facility in or from which services are provided;

(g) **"fiscal year"** means the period that commences on April 1 in one year and ends on March 31 in the following year;

(h) **"health corporation"** means:

(i) a union hospital board;

(ii) an ambulance board; or

(iii) a prescribed body corporate;

but does not include a corporation that is incorporated, continued or registered pursuant to *The Business Corporations Act*;

(i) **"health district"** means a health district established or deemed to have been established pursuant to section 3;

(j) **"home care services"** means home care services as defined in *The Home Care Act*;

(k) **"hospital"** means a hospital, a nursing home or an institution that is approved pursuant to subsection 3(1) of *The Hospital Standards Act* or any former *Hospital Standards Act*;

(l) **"Indian band"** means a band as defined in the *Indian Act* (Canada);

(m) **"Indian reserve"** means a reserve as defined in the *Indian Act* (Canada);

(n) **"minister"** means the member of the Executive Council to whom for the time being the administration of this Act is assigned;

(o) **"municipality"** means:

(i) an urban municipality;

(ii) a rural municipality within the meaning of *The Rural Municipality Act, 1989*;

(ii.1) a northern municipality within the meaning of *The Northern Municipalities Act*; or

(iii) The City of Lloydminster;

(p) **"prescribed"** means prescribed in the regulations;

(q) **"services"** means health services, home care services, social services or any prescribed services;

(r) **"union hospital board"** means a board as defined in *The Union Hospital Act;*

(s) **"union hospital district"** means a hospital district as defined in *The Union Hospital Act*;

(t) **"urban municipality"** means an urban municipality as defined in *The Urban Municipality Act, 1984*;

(u) **"vice-chairperson"** means a vice-chairperson of a district health board designated pursuant to subsection 6(5) or elected pursuant to subsection 7(9) or 13(4);

(v) **"ward"** means a ward established pursuant to section 3. 1993, c.H-0.01, s.2; 1996, c.47, s.3.

ESTABLISHMENT OF HEALTH DISTRICTS AND BOARDS

Establishment of health districts and wards

3(1) In this section, **"land"** includes land that forms the bed or shore of a body of water.

(2) Subject to subsections (3) and (4), the Lieutenant Governor in Council may make an order:

(a) establishing any area within Saskatchewan as a health district; and

(b) assigning a name to the health district.

(3) Subject to subsection (4), the Lieutenant Governor in Council may make an order establishing an area within Saskatchewan as the health district of one or more of the following district health boards:

(a) the Prince Albert District Health Board mentioned in section 9;

(b) the Regina District Health Board mentioned in section 10;

(c) the Saskatoon District Health Board mentioned in section 11.

(4) Subject to subsection (5), no health district is to include:

(a) a portion of an urban municipality unless it includes all of that urban municipality; or

(b) any area that is not connected to every other area within the health district by land that is also included in the health district.

(5) Clause (4)(b) does not apply to an area that is part of an Indian reserve.

(6) Where the boundaries of an urban municipality included in a health district are altered:

(a) the health district is deemed to include the urban municipality as altered; and

(b) if the alteration of the boundaries of the urban municipality results in the inclusion of an area that was in another health district, the other health district is deemed not to include that area.

(7) The Lieutenant Governor in Council may make an order:

(a) establishing areas within a health district or groups of persons residing within a health district as wards; and

(b) subject to subsection 7(2), specifying the number of members of the district health board that are to be elected from

each ward. 1993, c.H-0.01, s.3.

Consultations

4 Before an order is made pursuant to section 3, the minister shall carry out consultations in the manner and to the extent that the minister considers appropriate:

(a) in the case of an order pursuant to subsection 3(2) or (3), within the area to be included in the proposed health district; and

(b) in the case of an order pursuant to subsection 3(7), within the health district or the proposed health district in which wards are to be established. 1993, c.H-0.01, s.4.

Establishment of district health boards

5(1) Subject to sections 9, 10 and 11, the Lieutenant Governor in Council may make an order establishing a district health board for a health district.

(2) A district health board is a corporation having the name "_____District Health Board", the blank being filled in to correspond with the name of the health district.

(3) Subject to subsection (4) and clause 13(3)(e), a district health board shall consist of not more than 12 members.

(4) The Regina District Health Board and the Saskatoon District Health Board shall consist of not more than 14 members. 1993, c.H-0.01, s.5.

Appointment of first board members

6(1) The Lieutenant Governor in Council:

(a) subject to subsection (2) and to subsections 9(3), 10(3) and 11(3), shall appoint the first members of each district health board; and

(b) may make subsequent appointments of members to a district health board until the first election of members pursuant to section 7.

(2) No person is to be appointed as a member of a district health board pursuant to subsection (1) unless the person is nominated by a person who resides in the health district.

(3) Subsection (2) does not apply to:

(a) the reappointment of a person previously appointed; or

(b) appointments made within 24 months after the coming into force of this Act to the Prince Albert District Health Board, the Regina District Health Board or the Saskatoon District Health Board.

(4) Each member appointed pursuant to this section:

(a) is appointed at pleasure; and

(b) holds office:

(i) in accordance with subsection 7(1); or

(ii) where no election has been held pursuant to section 7, for the term specified in the order and thereafter until the member is reappointed or a successor is appointed.

(5) The Lieutenant Governor in Council may designate one of the members appointed to a district health board pursuant to this section who is a resident of the health district as chairperson and another member who is a resident of the health district as vice-chairperson. 1993, c.H-0.01, s.6.

Election and appointment of board members

7(1) The members of a district health board who are appointed pursuant to section 6 hold office until the first meeting of the district health board that is held after an election pursuant to this section.

(2) Subject to any regulations made pursuant to clause 40(1)(i) or (j), the residents of a health district shall elect eight members to the district health board in elections conducted in accordance with the regulations.

(3) Subject to any regulations made pursuant to clause 40(1)(i) or (j), where an order has been made pursuant to subsection

3(7) establishing wards for a health district, the members mentioned in subsection (2) are to be elected in accordance with the order:

(a) where the wards consist of areas within the health district, by the residents of the wards; and

(b) where the wards consist of groups of persons, by the persons within those groups.

(4) A member of a district health board who is elected pursuant to this section holds office from the first meeting of the district health board following the election for that office, and continues to hold office until the next election for that office, unless the office is sooner vacated.

(5) In addition to the members mentioned in subsection (2), the minister may appoint:

(a) not more than six additional members, in the case of the Regina District Health Board and the Saskatoon District Health Board; and

(b) not more than four additional members, in the case of any other district health board.

(6) Subject to subsection (6.1), no person is to be appointed as a member of a district health board pursuant to subsection (5) unless the person is nominated
by 10 persons who reside in the health district.

(6.1) In the case of the Regina Health District and the Saskatoon Health District, two of the persons appointed as members of the district health board may be persons who are nominated by one person who resides in the health district and nine other persons who are residents of Saskatchewan.

(7) Subsection (6) does not apply to the reappointment of a person previously appointed.

(8) Each member appointed pursuant to this section:

(a) is appointed at pleasure; and

(b) holds office for a term of not more than four years and thereafter until the member is reappointed or a successor is appointed.

(9) At the first meeting of a district health board after an election pursuant to this section, and thereafter from time to time, the members shall elect a chairperson and a vice-chairperson from among the members.

(10) No proceedings, decisions or actions of a district health board are void, voidable or subject to challenge by reason only of any defect in the appointment of a member. 1993, c.H-0.01, s.7; 1996, c.47, s.4.

Board members in Northern Saskatchewan Administration District

8(1) Subsection 5(3) and sections 6 and 7 do not apply to a health district where more than 50% of the land that comprises the health district is situated within the Northern Saskatchewan Administration District.

(2) Members of a district health board for a health district described in sub-section (1) shall be elected or appointed in accordance with the regulations. 1993, c.H-0.01, s.8.

Prince Albert Health Board

9(1) The Prince Albert Health Board established pursuant to *The Crown Corporations Act* is continued as a district health board under the name Prince Albert District Health Board.

(2) The Prince Albert District Health Board is deemed to have been established pursuant to section 5.

(3) The members of the Prince Albert Health Board continue as the members of the Prince Albert District Health Board for the terms for which they were appointed to the Prince Albert Health Board, and are deemed to have been appointed pursuant to section 6.

(4) The chairman of the Prince Albert Health Board continues as the chairperson of the Prince Albert District Health Board and is deemed to have been designated pursuant to subsection 6(5). 1993, c.H-0.01, s.9.

Regina Health Board

10(1) The Regina Health Board established pursuant to *The Crown Corporations Act* is continued as a district health board under the name Regina District Health Board.

(2) The Regina District Health Board is deemed to have been established pursuant to section 5.

(3) The members of the Regina Health Board continue as the members of the Regina District Health Board for the terms for which they were appointed to the Regina Health Board, and are deemed to have been appointed pursuant to

section 6.

(4) The chairman of the Regina Health Board continues as the chairperson of the Regina District Health Board and is deemed to have been designated pursuant to subsection 6(5). 1993, c.H-0.01, s.10.

Saskatoon Health Board

11(1) The Saskatoon Health Board established pursuant to *The Crown Corporations Act* is continued as a district health board under the name Saskatoon District Health Board.

(2) The Saskatoon District Health Board is deemed to have been established pursuant to section 5.

(3) The members of the Saskatoon Health Board continue as the members of the Saskatoon District Health Board for the terms for which they were appointed to the Saskatoon Health Board, and are deemed to have been appointed pursuant to section 6.

(4) The chairman of the Saskatoon Health Board continues as the chairperson of the Saskatoon District Health Board and is deemed to have been designated pursuant to subsection 6(5). 1993, c.H-0.01, s.11.

Variations

12(1) Subject to subsection (2) and subsection 3(4), the Lieutenant Governor in Council may make an order:

(a) varying the boundaries of a health district by adding any area to, or removing any area from, the health district;

(b) varying any ward within a health district; or

(c) varying the number of members to be elected from each ward to a district health board.

(2) Before an order is made pursuant to subsection (1), the minister shall carry out consultations in the manner and to the extent that the minister considers appropriate:

(a) in the case of an order pursuant to clause (1)(a):

(i) with the district health board for the health district; and

(ii) within any area that is to be added to or removed from the health district; and

(b) in the case of an order pursuant to clause (1)(b) or (c), with the district health board for the health district. 1993, c.H-0.01, s.12.

Disqualification of elected board member

12.1(1) An elected member of a district health board is disqualified from holding office as a member of the board if:

(a) the member has ceased to reside in the health district;

(b) the member is not qualified to be nominated or elected or to hold office pursuant to this Act;

(c) the member has absented himself or herself from three or more consecutive meetings of the district health board without the authorization of the district health board;

(d) while in office, the member has been convicted of an indictable offence; or

(e) the member is required to vacate his or her office in accordance with any regulations made pursuant to clause 40(1)(t).

(2) An elected member of a district health board who becomes disqualified pursuant to subsection (1) shall vacate his or her office as a member of the board, and the remaining members shall declare that office to be vacant and shall immediately notify the minister of that fact.

(3) Notwithstanding subsection (2), the office of an elected member of a district health board is not vacated, and the member is not prevented from voting or acting as a member of the district health board until:

(a) the member resigns; or

(b) on application by a person who is qualified to vote in an election for members of the district health board, a judge of the Court of Queen's Bench determines that the member is disqualified from holding office. 1996, c.47, s.6.

Disqualification of appointed board member

12.2(1) An appointed member of a district health board is disqualified from holding office as a member of the board if:

(a) the member has absented himself or herself from three or more consecutive meetings of the district health board without the authorization of the district health board;

(b) while in office, the member has been convicted of an indictable offence; or

(c) the member is required to vacate his or her office in accordance with any regulations made pursuant to clause 40(1)(t).

(2) Where an appointed member of a district health board becomes disqualified pursuant to subsection (1), the district health board shall notify the minister and the minister shall terminate the appointment of the member.

(3) The office of an appointed member of a district health board is not vacated, and the member is not prevented from voting or acting as a member of the district health board, until the appointment of the member is terminated by the minister. 1996, c.47, s.6.

AMALGAMATIONS

Amalgamation of health districts

13(1) Subject to clause 3(4)(b), the Lieutenant Governor in Council may make an order amalgamating two or more health districts where the amalgamation is requested by the district health boards of each health district to be amalgamated.

(2) An order pursuant to subsection (1):

(a) comes into force on the later of:

(i) 30 days after the day on which it is published in *The Saskatchewan Gazette*; and

(ii) the day specified in the order; and

(b) must assign a name to the amalgamated health district.

(3) When an order pursuant to subsection (1) comes into force:

(a) the health districts mentioned in the order are amalgamated as one health district under the name assigned in the order to the amalgamated health district;

(b) the district health boards for each of the health districts mentioned in the order are amalgamated as one corporation under a name determined in accordance with section 5 by the name assigned in the order to the amalgamated health district;

(c) the assets, liabilities, rights and obligations of the amalgamating district health boards continue as the assets, liabilities, rights and obligations of the amalgamated district health board;

(d) the amalgamated district health board:

(i) is deemed to have been established pursuant to section 5; and

(ii) continues to be the district health board for the amalgamated health district;

(e) subject to subsection (5), the members of the amalgamating district health boards continue as the members of the amalgamated district health board;

(e.1) the members of the amalgamated district health board hold office until the first meeting of the district health board that is held after an election pursuant to subsection (7);

(f) any wards established within the health districts mentioned in the order are disestablished; and

(g) the amalgamated health district is deemed to have been established pursuant to section 3.

(4) At the first meeting of the amalgamated district health board after the amalgamation, and thereafter from time to time, the members shall elect a chairperson and a vice-chairperson from among the members.

(5) Where an amalgamated health board requests it, the minister may:

(a) terminate the membership of the members of the amalgamated district health board; and

(b) appoint, from among the persons who were members of the amalgamated district health board immediately before the termination mentioned in
clause (a):

(i) not more than 12 members to the district health board; or

(ii) where one of the amalgamating health boards is the Regina District Health Board or the Saskatoon District Health Board, not more than 14 members to the district health board.

(6) The members of a district health board appointed pursuant to subsection (5) are deemed to have been appointed pursuant to section 6.

(7) Subsequent members of an amalgamated district health board to which this section applies shall be elected or appointed in accordance with the regulations. 1993, c.H-0.01, s.13; 1996, c.47, s.7.

Amalgamation of health corporations and district health boards

14(1) One or more health corporations and a district health board may amalgamate and continue as one corporation in accordance with this section.

(2) Where one or more health corporations and a district health board wish to amalgamate, they shall execute a notice of amalgamation in accordance with subsection (3) and file the notice with the minister.

(3) A notice of amalgamation:

(a) is to be in the prescribed form;

(b) is to be executed by a duly authorized officer of:

(i) each health corporation pursuant to a resolution of the board of directors of the health corporation authorizing its execution; and

(ii) the district health board pursuant to a resolution of the board; and

(c) is to specify the effective date of the amalgamation.

(4) No notice of amalgamation with respect to a health corporation that is incorporated or continued pursuant to *The Non-profit Corporations Act* or *The Co-operatives Act, 1989* is valid unless the amalgamation is approved by the members of the health corporation in the prescribed manner.

(5) On receipt of a notice of amalgamation, the minister may issue an order:

(a) amalgamating the corporations in accordance with the notice; and

(b) declaring the effective date of the amalgamation to be the effective date specified in the notice.

(6) The minister shall not issue an order pursuant to subsection (5) after the effective date specified in the notice of amalgamation has passed.

(7) An order issued pursuant to subsection (5) is to be both published in *The Saskatchewan Gazette* and filed with the Director appointed pursuant to *The Business Corporations Act* not later than 30 days after the effective date specified in the order.

(8) Failure to comply with subsection (7) does not affect the validity of an order.

(9) On the day that an amalgamation takes effect:

(a) the amalgamating health corporations and the district health board are amalgamated as one corporation under the name of the district health board;

(b) the members of the district health board continue as the members of the amalgamated corporation and are deemed to have been elected or appointed as the members of the amalgamated corporation pursuant to the provisions of this Act pursuant to which they were elected or appointed to the district health board;

(c) the chairperson and vice-chairperson of the district health board continue as the chairperson and vice-chairperson of the amalgamated corporation and are deemed to have been designated or elected as the chairperson and vice-chairperson of the amalgamated corporation pursuant to the provisions of this Act pursuant to which they were designated or elected as chairperson and vice-chairperson of the district health board;

(d) the bylaws of the district health board continue as the bylaws of the amalgamated corporation;

(e) all membership interests in the amalgamating health corporations are extinguished;

(f) subject to section 19, the assets, liabilities, rights and obligations of the amalgamating health corporations and the

district health board continue as the assets, liabilities, rights and obligations of the amalgamated corporation;

(g) the amalgamated corporation:

(i) is deemed to have been established pursuant to section 5; and

(ii) continues to be the district health board for the health district bearing the corresponding name;

(h) where an amalgamating health corporation is a union hospital board, the union hospital district of the union hospital board is disestablished; and

(i) where an amalgamating health corporation is an ambulance board, the ambulance district of the ambulance board is disestablished. 1993, c.H-0.01, s.14.

Payments by amalgamated corporations to municipalities

15(1) Subject to the regulations, prior to an amalgamation pursuant to section 14, the amalgamating corporations may enter into an agreement in contemplation of the amalgamation that requires the amalgamated corporation to pay any amounts of money specified in the agreement or transfer any property specified in the agreement to a municipality or any other person.

(2) A copy of an agreement made pursuant to this section:

(a) must be filed with the minister; and

(b) where the agreement is entered into before the notice of amalgamation is filed, must be filed along with the notice of amalgamation pursuant to subsection 14(2).

(3) An agreement made pursuant to this section is binding on the amalgamated corporation and may be enforced by any person with a sufficient interest. 1993, c.H-0.01, s.15.

Automatic amalgamation of certain health corporations

16(1) Notwithstanding *The Union Hospital Act* and *The Ambulance Act*, on the one hundred and twentieth day after the day on which a health district is established:

(a) each union hospital district that is located within the health district is disestablished and the union hospital board for each of those union hospital districts is dissolved;

(b) each ambulance district that is located within the health district is disestablished and the ambulance board for each of those ambulance districts is dissolved; and

(c) subject to section 19, the assets, liabilities, rights and obligations of each union hospital board and ambulance board dissolved pursuant to this subsection are transferred to, and become the assets, liabilities, rights and obligations of, the district health board for the health district.

(2) Where an order has been made pursuant to subsection 14(5) for the purpose of amalgamating a union hospital board or an ambulance board with a district health board, subsection (1) does not apply to:

(a) the union hospital board or the union hospital district of the union hospital board; or

(b) the ambulance board or the ambulance district of the ambulance board.

(3) Where the union hospital board of a union hospital district does not operate a hospital, subsection (1) does not apply to that union hospital district or that union hospital board until all of the land included in that union hospital district is included within one or more health districts.

(4) Where the union hospital board of a union hospital district operates a hospital that is not situated within a health district, subsection (1) does not apply to that union hospital district or that union hospital board until that hospital is included within a health district.

(5) Subsection (1) does not apply to an ambulance district or the ambulance board of an ambulance district until all of the land included in the ambulance district is included within one or more health districts.

(6) Where a union hospital board or an ambulance board is dissolved pursuant to subsection (1), the minister shall issue a certificate of dissolution in the prescribed form that sets out:

(a) the name of the union hospital board or ambulance board that was dissolved;

(b) the name of the district health board to which the assets, liabilities, rights and obligations of the union hospital board or ambulance board were transferred; and

(c) the date of the dissolution.

(7) Notice of a dissolution pursuant to this section is to be published in *The Saskatchewan Gazette* not later than 30 days after the date of dissolution specified in the certificate of dissolution.

(8) Failure to comply with subsection (7) does not affect a dissolution. 1993, c.H-0.01, s.16.

When certain health districts established

17(1) For the purposes of section 16, certain health districts are deemed to have been established on the days determined in accordance with this section.

(2) Where two or more health districts amalgamate as one health district pursuant to section 13, the amalgamated health district is deemed to have been established on the latest of the days on which the amalgamating health districts were established.

(3) In the case of a union hospital district described in subsection 18(3), the health district in which that union hospital district is deemed to be located is deemed to have been established on the latest of the days on which the several health districts in which the union hospital district is situated were established.

(4) In the case of an ambulance district described in subsection 18(4), the health district in which that ambulance district is deemed to be located is deemed to have been established on the latest of the days on which the several health districts in which the ambulance district is situated were established.

1993, c.H-0.01, s.17.

Where certain union hospital and ambulance districts located

18(1) For the purposes of section 16, certain union hospital districts and ambulance districts are deemed to be located in the health districts determined in accordance with this section.

(2) Where a union hospital district is not situated entirely within one health district, and the union hospital board of that union hospital district operates a hospital that is situated within a health district, the union hospital district is deemed to be located in the health district in which the hospital is situated.

(3) Where a union hospital district is not situated entirely within one health district, but all of the land included in the union hospital district is included within one or more health districts, and the union hospital board of that union hospital district does not operate a hospital, the union hospital district is deemed to be located in the health district in which the largest area of land included in the union hospital district is situated.

(4) Where an ambulance district is not situated entirely within one health district, but all of the land included in the ambulance district is included within one or more health districts, the ambulance district is deemed to be located in the health district in which the largest area of land included in the ambulance district is situated. 1993, c.H-0.01, s.18.

Indebtedness of union hospital boards

19(1) Where a union hospital board amalgamates with a district health board pursuant to section 14 or is dissolved pursuant to section 16, the Saskatchewan Municipal Board shall make payment in satisfaction of:

(a) the outstanding debenture indebtedness of the union hospital board, in accordance with the terms of the debenture; and

(b) any loan owed by the union hospital board that is to be repaid after the end of the fiscal year in which the amalgamation or dissolution takes place, in accordance with the terms of the loan.

(2) Where the Saskatchewan Municipal Board is responsible for making payments pursuant to subsection (1), the Saskatchewan Municipal Board shall, in each year until the debenture or loan is retired:

(a) apportion among the municipalities that were wholly or partly included in the union hospital district on the day prior to the amalgamation or dissolution the amount required to meet the obligations of the Saskatchewan Municipal Board in relation to the debenture or loan for that year; and

(b) provide each municipality mentioned in clause (a) with a statement setting out the amount to be raised by the municipality for the purpose of meeting the obligations of the Saskatchewan Municipal Board in relation to the debenture or loan for that year.

(3) Within 60 days after a municipality receives a statement from the Saskatchewan Municipal Board pursuant to subsection (2) showing the amount to be raised by the municipality, the council of the municipality shall forward that amount to the Saskatchewan Municipal Board.

(3.1) Where a municipality fails to pay the amount set out in a statement issued pursuant to subsection (2) within the 60-day period mentioned in subsection (3), the municipality shall pay to the Saskatchewan Municipal Board interest on the amount set out in the statement or any portion of that amount that is outstanding, calculated in accordance with subsection (3.2).

(3.2) For the purposes of subsection (3.1):

(a) the interest rate is the prime rate of interest of the chartered bank that holds the general revenue fund; and

(b) interest is calculated on a daily basis on the amount outstanding, from the first day after the expiry of 60-day period mentioned in subsection (3).

(3.3) Where a municipality fails to pay the amount set out in a statement issued pursuant to subsection (2) within the 60-day period mentioned in subsection (3), the Saskatchewan Municipal Board may file in the office of a local registrar of the Court of Queen's Bench a certified copy of the statement and, on filing, the amount set out in the statement or any portion of that amount that is outstanding, plus interest calculated in accordance with subsection (3.2), is enforceable in the same manner as a judgment or order of the court.

(4) Any sums to be paid by a municipality pursuant to this section may be included in the general municipal levy or may be raised by a special levy. 1993, c.H-0.01, s.19; 1996, c.47, s.8.

CHANGES TO NAMES

Changes to names of district health boards and health districts

20(1) Where requested to do so by a district health board, the Lieutenant Governor in Council may make an order changing the name of the district health board.

(2) Where the name of a district health board is changed, the name of its health district is automatically changed to correspond with the new name of the district health board. 1993, c.H-0.01, s.20.

ORDERS

Orders to be published

21 No order made pursuant to section 3, 5, 12 or 20 comes into force before it is published in *The Saskatchewan Gazette*. 1993, c.H-0.01, s.21.

Record of orders

22(1) Where an order is made by the Lieutenant Governor in Council pursuant to this Act, the Clerk of the Executive Council shall certify a true copy of the order and file it with the minister.

(2) The minister shall retain in the department:

(a) every certified copy of an order filed pursuant to subsection (1);

(b) every order made by the minister pursuant to this Act;

(c) every notice of amalgamation filed pursuant to section 14; and

(d) every certificate of dissolution issued pursuant to section 16.

(3) The minister shall make the documents mentioned in subsection (2) available for public inspection during the normal office hours of the department.

(4) The minister may issue certified copies of:

(a) any certified copy of an order that is filed pursuant to subsection (1);

(b) any order made by the minister pursuant to this Act; or

(c) any certificate of dissolution issued pursuant to section 16.

(5) In addition to any other manner by which an order or certificate may be proved, a certified copy purporting to be issued pursuant to subsection (4) is, in the absence of evidence to the contrary, proof of the original order of the Lieutenant Governor in Council or the minister or the original certificate of the minister, as the case may be, and its contents without proof of the office or signature of the person purporting to have signed the certification.

(6) Without limiting the generality of subsection (5), a certified copy purporting to be issued pursuant to subsection (4) may be filed with the registrar of a land titles office and, when so filed, shall be accepted, in the absence of evidence to the contrary, as proof of the original order or certificate, and its contents without proof of the office or signature of the person purporting to have signed the certification.

1993, c.H-0.01, s.22.

ACTIVITIES AND POWERS OF BOARDS

District health board a not-for-profit corporation

23(1) A district health board is a not-for-profit corporation.

(2) The activities and affairs of each district health board shall be carried on without the purpose of gain for the members of the district health board, and any profits or other accretions to the district health board shall be used in promoting its activities and affairs.

(3) Subject to section 24, the members of each district health board shall serve without remuneration, and no member shall directly or indirectly receive any profit or personal financial benefit from the position of member. 1993, c.H-0.01, s.23.

Allowances and expenses

24 The Lieutenant Governor in Council may determine any reasonable remuneration and reimbursement for expenses that are to be payable to the members of a district health board, and the remuneration and reimbursement for expenses are to be paid from the funds of the district health board. 1993, c.H-0.01, s.24.

Quorum

25 A majority of the members of a district health board, one of whom is the chairperson or the vice-chairperson, constitutes a quorum. 1993, c.H-0.01, s.25.

Powers of district health boards

26(1) A district health board may provide services, and for that purpose may:

(a) periodically assess the health needs of the persons to whom the district health board provides services;

(b) prepare and maintain a plan for the provision of services;

(c) co-ordinate the services that it provides with the services provided by other providers of services and with other related activities;

(d) promote and encourage health and wellness;

(e) periodically evaluate the services that it provides;

(f) co-operate with the Government of Canada and its agencies, the Government of Saskatchewan and its agencies, the governments of other provinces and territories of Canada and their agencies, any other government organization, Indian bands and any other persons for the purpose of providing services;

(g) subject to this Act and the regulations, make bylaws and rules governing the activities and affairs of the district health board;

(h) subject to section 28, purchase, lease or otherwise acquire real property;

(i) subject to section 28, sell, lease or otherwise dispose of real property when that real property is no longer required or when the district health board considers it desirable to do so;

(j) subject to section 28 purchase, lease or otherwise acquire personal property;

(k) subject to section 28 sell, lease or otherwise dispose of personal property when that personal property is no longer required or when the district health board considers it desirable to do so;

(l) accept grants, donations, gifts and bequests of real or personal property;

(m) subject to subsection (2), manage, invest and expend all moneys and manage all property that belongs to the district health board;

(n) subject to section 28, construct, operate and manage facilities;

(o) provide funding:

(i) subject to section 26.1, to other persons who provide services; or

(ii) subject to the approval of the minister and to any regulations made for the purpose of this clause, to any other person;

(p) employ or engage the services of any person;

(q) provide superannuation and other benefits for its employees;

(r) enter into agreements with the Government of Canada or its agencies, the Government of Saskatchewan or its agencies, the government of any other province or territory of Canada or its agencies, any other government organization, Indian bands or any other persons;

(s) subject to the regulations, determine the charges to be made for services provided by the district health board;

(t) co-operate with persons who provide education or training to students of disciplines, occupations and professions that provide services;

(u) appoint committees to provide advice to the district health board;

(v) exercise any other rights, powers and privileges that are necessary, incidental or conducive to the exercise of the powers conferred on the board by this Act.

(2) A district health board may invest moneys only in those securities in which trustees are permitted to invest pursuant to *The Trustee Act*.

(3) In exercising the powers given to a district health board pursuant to this Act:

(a) each member of the district health board shall act in the best interests of all of the residents of the health district; and

(b) the district health board shall:

(i) comply with the provisions of this Act, the regulations and any agreement between the district health board and the minister pursuant to section 33; and

(ii) conduct its activities and affairs in a manner that is consistent with and that reflects the health policies, goals and priorities established by the minister. 1993, c.H-0.01, s.26; 1996, c.47, s.9.

Agreements with affiliates

26.1(1) After 120 days have elapsed after the day on which an affiliate is prescribed, and subject to subsections (8), (9) and (10), no district health board shall provide funding to an affiliate unless the district health board and the affiliate have entered into a written agreement for that purpose.

(2) An agreement required by subsection (1) must:

(a) provide for an audit of the accounts of the affiliate at least once in each fiscal year by an independent auditor who possesses the prescribed qualifications and is appointed for the purpose by the affiliate;

(b) set out the services to be provided for the district health board by the affiliate;

(c) set out the funding to be provided by the district health board and stipulate that the funding is to be used for no purpose other than providing services;

(d) require the affiliate to provide to the district health board in a timely manner any information requested by the district health board, in any form requested by the district health board, respecting the activities of the affiliate that the district health board requires to fulfil its responsibilities pursuant to this Act;

(e) specify the term of the agreement and provide for termination of the agreement by either party on not less than 180 days' notice to the other party;

(f) set out a process for resolving disputes under the agreement, including the provision of remedies for breaches of the agreement; and

(g) provide for any other prescribed matter.

(3) The district health board for the health district in which an affiliate provides service may request the minister to appoint a mediator to assist the parties to enter into an agreement if the district health board and the affiliate have not entered into a written agreement after 45 days have elapsed after the day on which the affiliate is prescribed.

(4) Where the minister receives a request pursuant to subsection (3), the minister may appoint a mediator if the minister considers it appropriate to do so.

(5) Where a district health board and an affiliate have not entered into an written agreement after 60 days have elapsed after the day on which the affiliate is prescribed, and the district health board has not requested the minister to appoint a mediator pursuant to subsection (3), the minister may appoint a mediator if the minister considers it appropriate to do so.

(6) The minister may determine the remuneration and reimbursement of expenses payable to a mediator, and those amounts are to be paid by the district health board and the affiliate in the proportions determined by the minister.

(7) Where the district health board and the affiliate have not entered into a written agreement within 45 days after the appointment of the mediator, the mediator shall report the matter to the minister.

(8) Where the minister receives a report pursuant to subsection (7), the minister may set the terms governing the provision of funding by the district health board to the affiliate for services provided by the affiliate and the provision of services by the affiliate to the district health board, and those terms are deemed to constitute a written agreement required by subsection (1) that is binding on the parties.

(9) Where an agreement made pursuant to this section is to expire or terminate, and the district health board and affiliate have not entered into a new agreement, the district health board may, not later than 30 days prior to the date of expiration or termination of the agreement, request that the minister:

(a) extend the term of the agreement for a period of not longer than 90 days;

(b) appoint a mediator; or

(c) both extend the term of the agreement and appoint a mediator.

(10) Where the minister exercises the powers set out in subsection (9):

(a) the agreement is extended for the period specified; and

(b) where a mediator is appointed, the provisions of subsections (6) to (8) apply. 1996, c.47, s.10.

Power to borrow

27(1) Subject to subsection (2), a district health board may borrow any sums of money that it considers necessary for its purposes and may secure those loans to the lender by mortgages, bills of exchange, promissory notes or hypothecation of its revenues or by any other instrument required by the lender.

(2) A district health board shall obtain the approval of the minister before borrowing an amount that exceeds the prescribed amount unless:

(a) the amount borrowed is required to meet the operating expenditures of the district health board in any fiscal year until the revenues for that year are available;

(b) the amount is borrowed in increments that do not exceed one-twelfth of the estimated revenues to be received by the district health board in that year;

(c) the amount borrowed is to be repaid within 12 months after the day on which it is borrowed; and

(d) the loan is to be paid out of, and is to be a first charge on, the revenues received by the district health board. 1993, c.H-0.01, s.27.

Restrictions on powers of district health boards

28 Unless it obtains the approval of the minister, a district health board shall not:

(a) purchase, lease or otherwise acquire for consideration any interest in real property where the total amount to be paid to acquire the interest exceeds a prescribed amount;

(b) sell, lease or otherwise dispose of any interest in real property where the value of the interest exceeds a prescribed amount;

(b.1) purchase, lease or otherwise acquire for consideration any interest in personal property where the total amount to be paid to acquire the interest exceeds a prescribed amount;

(b.2) sell, lease or otherwise dispose of any interest in personal property where the value of the interest exceeds a prescribed amount; or

(c) construct or renovate any facility where the cost of the construction or renovation exceeds a prescribed amount. 1993, c.H-0.01, s.28; 1996, c.47, s.11.

Public health services

29(1) The minister may enter into an agreement with any district health board to provide public health services on behalf of the minister within any area specified in the agreement.

(2) A district health board that enters into an agreement pursuant to this section:

(a) may provide public health services on behalf of the minister within the area specified in the agreement in accordance with any terms and conditions contained in the agreement;

(b) may appoint a medical health officer and public health inspectors for the purposes of *The Public Health Act* to exercise the powers of medical health officers and public health inspectors within the area specified in the agreement;

(c) subject to the agreement, possesses all of the powers in relation to the area specified in the agreement that the council of a municipality acting as a board of health possesses in relation to the municipality by virtue of *The Public Health Act*.

(3) Notwithstanding clause (2)(c), the council of a municipality that is located within the area specified in an agreement pursuant to this section continues to possess the powers of the council of a municipality acting as a board of health pursuant to *The Public Health Act*. 1993, c.H-0.01, s.29.

Voluntary funding by municipalities

30(1) Notwithstanding anything in *The Rural Municipality Act, 1989*, *The Urban Municipality Act, 1984*, *The Northern Municipalities Act*, or *The Lloydminster Municipal Amalgamation Act, 1930*, the council of a municipality may:

(a) enter into an agreement with a district health board to provide funds to the district health board; or

(b) convey any real or personal property, for any consideration that may be agreed on or by gift, to a district health board.

(2) Any sums to be paid by a municipality pursuant to an agreement with a district health board may be included in the general municipal levy or may be raised by a special levy. 1993, c.H-0.01, s.30.

MISCELLANEOUS

Annual estimates

31(1) Prior to the day fixed by the minister, a district health board shall, for each fiscal year, prepare and deliver to the minister a statement setting out:

(a) the detailed estimated expenditures of the district health board;

(b) the sources of any revenues and the estimated revenue from each source; and

(c) the details of any proposed services or activities and their estimated costs.

(2) No statement prepared pursuant to this section is to project an operating deficit unless the district health board obtains the approval of the minister to do so. 1993, c.H-0.01, s.31; 1996, c.47, s.15.

Grants

32 The minister may make grants to district health boards for the purposes of this Act.

1993, c.H-0.01, s.32.

Agreements

33 The minister may enter into agreements with district health boards respecting:

(a) grants that are made pursuant to this Act; or

(b) any other matter related to the activities or affairs of a district health board. 1993, c.H-0.01, s.33.

Use of revenues

34 Subject to any agreement entered into pursuant to section 33, all revenues received by a district health board are available for any of the purposes of the district health board. 1993, c.H-0.01, s.34.

Reports

35(1) A district health board shall submit to the minister, in a form specified by the minister, any reports that the minister may request from time to time.

(2) Without restricting the generality of subsection (1), a district health board shall, within three months after the end of each fiscal year or at any other time approved by the minister, submit to the minister, with respect to that fiscal year:

(a) a report of the district health board's services and activities and their costs;

(b) a detailed audited set of financial statements;

(c) a detailed audited schedule of investments; and

(d) a report on the health status of the residents of the health district and the effectiveness of the district health board's programs. 1993, c.H-0.01, s.35.

Audit

36 The accounts of a district health board shall be audited at least once in each fiscal year by an independent auditor who possesses the prescribed qualifications and is appointed for the purpose by the district health board. 1993, c.H-0.01, s.36.

Public meetings

37(1) At least twice in each fiscal year, a district health board shall conduct a meeting of the district health board to which the general public is permitted access.

(2) At one of the meetings mentioned in subsection (1), the district health board shall present:

(a) an operation and expenditure plan for the next fiscal year; and

(b) a report on the health status of the residents of the health district and the effectiveness of the district health board's programs. 1993, c.H-0.01, s.37.

Public access to bylaws

38 A district health board shall retain in one of its offices a copy of every bylaw that it enacts and make those copies available for public inspection during the normal office hours of the district health board.

1993, c.H-0.01, s.38.

PUBLIC ADMINISTRATOR

Public administrator

39(1) The Lieutenant Governor in Council may at any time appoint a public administrator to manage the affairs of a district health board where:

(a) the district health board requests that a public administrator be appointed; or

(b) the minister is of the opinion that:

(i) the district health board has contravened an agreement with the minister pursuant to section 33 and is not prepared to provide services in the manner required by the agreement;

(ii) the district health board has ceased to function or is otherwise not capable of carrying out its responsibilities; or

(iii) for any other reason, it is in the public interest that a public administrator be appointed.

(2) Subject to subsection (3), a public administrator has:

(a) the exclusive right to exercise all of the powers of the district health board; and

(b) the exclusive control of the assets of the board, including the right to dispose of them.

(3) The Lieutenant Governor in Council may prescribe terms and conditions governing the powers and duties of a public administrator.

(4) On the appointment of a public administrator pursuant to this section, the members of the district health board cease to hold office.

(5) At any time after the appointment of a public administrator, the Lieutenant Governor in Council may terminate the appointment and:

(a) appoint another public administrator; or

(b) appoint new members for the district health board in accordance with section 6.

(6) The members of a district health board appointed pursuant to clause (5)(b) are deemed to have been appointed pursuant to section 6.

(7) The Lieutenant Governor in Council may determine any reasonable remuneration and reimbursement for expenses that are to be payable to a public administrator, and the remuneration and reimbursement for expenses are to be paid from the funds of the district health board. 1993, c.H-0.01, s.39.

Public administrator

39.1(1) The Lieutenant Governor in Council may at any time appoint a person as a public administrator to manage the affairs of an affiliate if the minister is of the opinion that:

(a) the safety of persons cared for by the affiliate is, for any reason, being jeopardized;

(b) the members of the board of the affiliate have resigned and are not being immediately replaced;

(c) the affiliate is not otherwise carrying out its responsibilities under an agreement pursuant to section 26.1; or

(d) for any other reason, it is in the public interest that a public administrator be appointed.

(2) Subject to subsection (3), a public administrator appointed pursuant to subsection (1):

(a) has the right to exercise all of the powers of the affiliate that relate to the operation of the facility or program that the affiliate operates; and

(b) has control of all assets of the affiliate that relate to the facility or program that the affiliate operates, including the power to dispose of those assets in the everyday operations of the affiliate.

(3) The Lieutenant Governor in Council may set the terms and conditions governing the powers and duties of a public administrator.

(4) On the appointment of a public administrator, the directors and any other members of the board of the affiliate cease to have any powers relating to the assets or the operation of the facility or program for which the public administrator was appointed.

(5) The Lieutenant Governor in Council may at any time terminate the appointment of a public administrator and return control of the assets and the operation of the facility or program to the board of the affiliate.

(6) The Lieutenant Governor in Council may determine the remuneration and reimbursement of expenses payable to a public administrator, and those amounts are to be paid from the funds of the affiliate.

1996, c.47, s.17.

REGULATIONS

Regulations

40(1) For the purpose of carrying out this Act according to its intent, the Lieutenant Governor in Council may make regulations:

(a) defining, enlarging or restricting the meaning of any word or expression used in this Act but not defined in this Act;

(b) generally governing the activities and affairs of district health boards;

(b.1) prescribing persons as affiliates for the purposes of operating facilities and receiving funding for the operation of facilities from district health boards;

(c) establishing standards to be met by district health boards and affiliates in providing services and operating facilities;

(c.1) respecting:

(i) the monitoring and enforcement of standards established pursuant to clause (c);

(ii) the appointment of bodies, including bodies outside the department, to monitor and enforce standards established pursuant to clause (c);

(d) respecting charges for services provided by district health boards and affiliates;

(e) establishing eligibility requirements for persons to receive services;

(f) prescribing bodies corporate as health corporations for the purposes of clause 2(h);

(g) prescribing services for the purposes of clause 2(q);

(h) governing the election of members of district health boards and any matters that relate to or arise from those elections, including, without limiting the generality of the foregoing, regulations:

(i) respecting the frequency of elections;

(ii) respecting the qualifications of electors and candidates;

(iii) respecting electoral officials and prescribing and governing their qualifications and responsibilities;

(iv) governing advertising by or on behalf of candidates, including regulations prohibiting advertising or any class of advertising in prescribed circumstances;

(v) respecting election procedures, including nomination of candidates, places and times of voting, voting and enumeration of electors;

(vi) prescribing any forms required for the conduct of elections;

(vii) respecting the counting and recounting of votes;

(viii) respecting controverted elections;

(ix) respecting the calling of the first meeting of members after an election;

(x) respecting the vacating of a position by an elected member;

(x.1) providing that contraventions of specified provisions of the regulations constitute offences and prescribing the penalties to be imposed on summary conviction for those offences;

(i) respecting the election or appointment of members to a district health board in circumstances where an election is held and there is a failure to elect the required number of members;

(j) respecting the filling of vacant positions on a district health board by appointment, by-election or otherwise and including the conduct of by-elections;

(k) governing the composition of district health boards to which sub-section 8(2) applies, the manner in which persons become members of those district health boards and the holding of office by those members;

(l) respecting payments and transfers to be made pursuant to section 15;

(m) for the purposes of clause 26(1)(o), respecting the provision of funding to persons other than persons who provide services;

(m.1) for the purposes of subsection 26.1(2), prescribing additional matters to be contained in agreements between district health boards and affiliates;

(n) for the purposes of subsection 27(2), prescribing the amount that may be borrowed by a district health board without obtaining the approval of the minister;

(o) for the purposes of clause 28(a), prescribing the maximum amount that may be paid by a district health board to acquire an interest in real property without the approval of the minister;

(p) for the purposes of clause 28(b), prescribing the maximum value of an interest in real property that may be sold, leased or otherwise disposed of by a district health board without the approval of the minister;

(p.1) for the purposes of clause 28(b.1), prescribing the maximum amount that may be paid by a district health board to acquire an interest in personal property without the approval of the minister;

(p.2) for the purposes of clause 28(b.2), prescribing the maximum value of an interest in personal property that may be sold, leased or otherwise disposed of by a district health board without the approval of the minister;

(q) for the purposes of clause 28(c), prescribing the maximum amount of costs of construction or renovation that may be incurred by a district health board without the approval of the minister;

(r) **Repealed.** 1996, c.47, s.18.

(s) for the purposes of section 36 and clause 26.1(2)(a), prescribing the qualifications of auditors;

(t) with respect to conflicts of interest for members of district health boards:

(i) prescribing those things that constitute a conflict of interest;

(ii) requiring district health boards to make bylaws respecting conflicts of interest and respecting the contents of those bylaws; and

(iii) otherwise governing conflicts of interest;

(u) prescribing any forms that are required for the purposes of this Act;

(v) prescribing any other matter or thing required or authorized by this Act to be prescribed in the regulations;

(w) respecting any other matter or thing that the Lieutenant Governor in Council considers necessary to carry out the intent of this Act.

(2) The power to make regulations pursuant to subsection (1) in relation to any person, matter or thing includes the power to create categories of those persons, matters or things and to make different regulations for each of those categories. 1993, c.H-0.01, s.40; 1996, c.47, s.18.

CONSEQUENTIAL AMENDMENTS

S.S. 1979, c.C-19.1 repealed

41(1) *The Community Health Unit Act* is repealed.

(2) The Saskatoon Community Health Unit is disestablished and the board of the Saskatoon Community Health Unit is dissolved.

(3) The assets, liabilities, rights and obligations of the board of the Saskatoon Community Health Unit immediately prior to the coming into force of this section are transferred to, and become the assets, liabilities, rights and obligations of, the Saskatoon District Health Board. 1993, c.H-0.01, s.41

R.S.S. 1978, c.S-55 repealed

42(1) *The South Saskatchewan Hospital Centre Act* is repealed.

(2) The Board of Governors of the South Saskatchewan Hospital Centre is dissolved.

(3) The assets, liabilities, rights and obligations of The Board of Governors of the South Saskatchewan Hospital Centre immediately prior to the coming into force of this section are transferred to, and become the assets, liabilities, rights and obligations of, the Regina District Health Board. 1993, c.H-0.01, s.42.

R.S.S. 1978, c.U-4 repealed

43(1) *The University Hospital Act* is repealed.

(2) The University Hospital Board is dissolved.

(3) The assets, liabilities, rights and obligations of The University Hospital Board immediately prior to the coming into force of this section are transferred to, and become the assets, liabilities, rights and obligations of, the Saskatoon District Health Board. 1993, c.H-0.01, s.43.

S.S. 1986, c.W-4.001 repealed

44(1) The *Wascana Rehabilitation Centre Act* is repealed.

(2) The Board of Governors, Wascana Rehabilitation Centre is dissolved.

(3) The assets, liabilities, rights and obligations of the Board of Governors, Wascana Rehabilitation Centre immediately prior to the coming into force of this section are transferred to, and become the assets, liabilities, rights and obligations of, the Regina District Health Board. 1993, c.H-0.01, s.44.

Appendix E

LIST OF ALL TRADE UNIONS AND LOCALS

Canadian Union of Public Employees (C.U.P.E.) Local Unions

District/Facility or Program:	Local#
Assiniboine Valley Health District	
Eaglestone Lodge/ Kamsack & District Nursing Home	1161
Gateway Lodge (Canora, Norquay, Invermay)	1830
Canora Union Hospital	89
Preeceville Hospital	1903
Kamsack Union Hospital	2048
Invermay Health Centre	2374
Norquay Health Centre	2383
Battlefords Health District	
Battleford Union Hospital	83
Saskatchewan Hospital/Battlefords Mental Health Centre	600-5
Regional Care Centre	600-6
Lady Minto Health Centre	1809
River Hights Lodge	1827
Central Plains Health District	
Wadena Union Hospital	1304
Lakeview Lodge (Cudworth)	1852
Pleasant View Care Home (Wadena)	2240
East Central Health District	
Yorkton Union Hospital	519
Anderson Lodge	519-1
Yorkton Mental Health Centre	600-4
Foam Lake Union Hospital	1304-5
Jubilee Nursing Home	1304-9
Langenburg Health Centre	1861
Theodore Health Centre	1958
Gabriel Springs Health District	
Wakaw Union Hospital	885
Rosthern Union Hospital	1631

Greenhead Healht District

Wilkie Union Uospital	1516
Wilkie and District Nursing Home	2826
Unimac Pioneer Lodge (Unity)	1772
Unity Union Hospital	1917

Living Sky Health District

Last Mountain Pioneer Home (Strasbourg)	1304-8
Wynyard Union Hospital	2237
Wynyard and District Housing Corporation (Golden Acres Nursing Home)	2239
Manitou Lodge (Watrous)	1950
Watrous Union Hospital	2238

Lloydminster Health District

Lloydminster Hospital	766
Lloydminster and District Senior Citizens' Lodge	3587

Midwest Health District

Davidson Union Hospital	1304-6
Dinsmore Health Care Centre	1745
Rosetown Union Hospital	2234
Wheatbelt Centennial Lodge Inc. (Rosetown)	2263

Moose Jaw/Thunder Creek Health District

Moose Mountain Health District

North Central Health District

North East Health District

North Valley Health District

Centennial Special Care Home (Esterhazy)	1738
Ituna and District Pioneer Lodge	1918
Ituna Health Care Centre	2402

Northwest Health District

Meadow Lake Union Hospital	1549
L. Gervais Memorial Health Centre	1913
Loon Lake Union Hospital and Special Care Home	1942
Northland Pioneer Lodge (Meadow Lake)	2236

Parkland Health District

Hafford Hospital/Hafford and District Nursing Home	1828
Spiritwood Union Hospital	1981
Idylwild Seniors Lodge (Spiritwood)	3567
Big River Union Hospital	1984
Lakewood Lodge (Big River)	3385
Rabbit Lake Integrated Facility	2475
Evergreen Health Centre (Leoville)	3444

Pasquia Health District

Tisdale Union Hospital	828
Porcupine Plains Union Hospital	828-1
Red Deer Nursing Home Inc. (Porcupine Plains)	828-2
Hudson Bay Union Hospital	828-3
Hudson Bay Pioneer Lodge	3118
Rose Valley Integrated Care Facility	1304-2
Kelvington Union Hospital	1304-3
Kelvindell Lodge (Kelvington)	2943

Pipestone Health District

Grenfell Health Centre	1829
Grenfell and District Pioneer Home	3486
Wolseley Memorial Union Hospital	1864

Prairie West Health District

Kindersely Union Hospital	3857-06
Kerrobert Union Hospital/Dodsland Health Centre	3857-05
Eatonia District Health Care Centre Inc.	3857-02
Jubilee Lodge Inc. (Eston)	3857-04
Eston Union Hospital	3857-03

Prince Albert Health District

Victoria Union Hospital	84
Psychiatric Centre	600-7
Northern Housing Devolpment (1973) Inc. (P.A.)	3186
Birch Hills Memorial Health Centre	885-1
Kinistino Union Hospital	885-2
Kinistino & District Housing Corporation	2120
North Sask Laundry and Support Services	3736

Regina Health District

Long Lake Valley Integrated Care Centre	1787
Regina General Hospital	176
Pasqua Hospital	1612
City of Regina (Health Workers)	7

Community Health Services	1831
Plains Health Centre	1838
Cupar and District Nursing Home Inc.	3065
Cupar Health Centre	2401

Rolling Hills Healht District

Herbert Union Hospital	2528

Saskatoon District Health Board

Community Health Unit	59
Saskatoon Community Clinic & Westside Clinic	974
University Hospital	600-9

South Central Health District

Weyburn General Hospital	482
Souris Valley Regional Care Centre	600-1
Weyburn Mental Health Centre	600-2
Weyburn and District Special Care Home	1844
Pangman Health Centre	3710

South Country Health District

Kincaid Wellness Centre	2708

Southeast Health District

Estevan Regional Nursing Home	1836
South East Saskatchewan Road Ambulance Assoc.	3445
Gainsborough and Area Health Centre	1848
Galloway Health Centre (Oxbow)	1885
Lampman Community Health Centre	2495
Municipal Road Ambulance (Oxbow)	3727

Southwest Health District

Maple Creek Union Hospital	86
Eastend Wolf Wilow Health Centre	2297

Swift Current Health District

Touchwood Qu'Appelle Health District

St. Joseph's Union Hospital (Lestock)	1304-11
Parkland Lodge (Balcarres)	2400
Fort Qu'Appelle Indian Hospital	3404
Balcarres Union Hospital	2460

Twin Rivers Health District

Turtleford Union Hospital	1549-1

St. Walburg Union Hospital	1549-3
Lakeland Lodge (St. Walburg)	2995
Paradise Hill Union Hospital	1549-4
Maidstone Union Hospital	1893
Manitou Health Centre (Neilburg)	1998
Cutknife Health Complex	2032

St. Joseph's Hospital (Estevan)	80
Holy Family Hospital (Prince Albert)	3833
Mont. St. Joseph's Home Inc. (P.A.)	1518
St. Elizabeth Hospital (Humboldt)	88
St. Michael's Hospital (Cudworth)	885-3
Regina Pioneer Village Ltd.	1138
Santa Maria Senior Citizens' Home (Regina)	2569
Regina Lutheran Home	3330
St. Peter's Hospital (Melville)	1143
St. Anthony's Hospital (Esterhazey)	1610
St. Joseph's Hospital (Gravelbourg)	1481
Foyer D'Youville Home (Gravelbourg)	1481
Societe Joseph Breton Inc. (Village Pascal, North Battleford)	2586
St. Joseph's Hospital (Ile a la Crosse)	1561-1
St. Martin's Union Hospital (La Loche)	2726
La Ronge Health Centre	1786
Uranium City Municipal Hospital	1561
Lakeview Pioneer Lodge Inc. (Wakaw)	1852-1
Buena Vista Lodge Inc. (Kerrobert)	3857-01
Pioneer Haven Co. Inc. (Kerrobert)	3857-02

Radville Marian Health Centre	1940
St. Joseph's Health Centre (Macklin)	1957
St. Paul Lutheran Home (Melville)	2399
Pine Island Lodge Ltd. (Maidstone)	3292
Gull Lake and District Special Care Home Inc.	3340
Humboldt and District Housing Corporation (St. Mary's Villa)	2513
TOTAL NUMBER OF CUPE LOCAL UNIONS:	139

Health Sciences Association of Saskatchewan (HSAS)

Physical Therapists Association (PTA)

Professional Institute of Public Servants (PIPS)

Public Service Alliance of Canada (PSAC), Saskatoon Vetrans Home Union

Regina Ambulance and Paramedics Association (RAPA), IAFF Local #3268

Retail, Wholesale and Department Store Union, Saskatchewan Joint Board, Local #568

Service Employees International Union (S.E.I.U.) Local #299

Service Employees International Union (S.E.I.U.) Local #333

Service Employees International Union (S.E.I.U.) Local #336

Saskatchewan Government Employees Union (S.G.E.U.)

Saskatchewan Union of Nurses (S.U.N.) Local Unions:

District/Facility or Program:	Local#
Assiniboine Valley Health District	
Gateway Lodge	97
Fort Pelly Livingston District #34	210
Assiniboine Valley District Home Care	214
Canora Union Hospital	45
Preeceville Hospital	3
Preeceville Lions Housing Corporation Ltd.	177
Kamsack Union Hospital	78
Kamsack District Nursing Home	147
Invermay Health Centre	236
Norquay Health Centre	238
Battlefords Health District	
Battleford Union Hospital	33
Battlefords District Home Care	220
Lady Minto Health Centre (Edam)	91
River Heights Lodge	117
Central Plains Health District	
Wadena Union Hospital	72
Watson Health Centre	38
Quill Plains Centennial Lodge	183
Spalding Health Centre	41
Lakeview Lodge (Cudworth)	227
Pleasant View Care Home (Wadena)	250
East Central Health District	
Yorkton Union Hospital	43
Anderson Lodge	244
East Central Health District Home Care	207
Foam Lake Union Hospital	40
Jubilee Nursing Home (Foam Lake)	165
Langenburg Health Centre	4
Theodore Health Centre	138
Gabriel Springs Health District	
Wakaw Union Hospital	13
Rosthern Union Hospital	2

Greenhead Healht District

Wilkie Union Uospital 108
Wilkie and District Nursing Home 197
Biggar Union Hospital 53
District Home Care #20 200
Diamond Lodge (Biggar) 137
Unimac Pioneer Lodge (Unity) 222
Unity Union Hospital 6

Living Sky Health District

Last Mountain Pioneer Lodge (Strasbourg) 241
Wynyard Union Hospital 15
Golden Acres Nursing Home (Wynyard) 119
Lanigan Hospital 82
Central Parkland Lodge (Lanigan) 150
Nokomis Health Centre 25
Watrous Union Hospital 51

Lloydminster Health District

Lloydminster Hospital 71
Lloydminster and District Senior Citizens' Lodge 221

Midwest Health District

Beechy Community Health Centre 130
Davidson Union Hospital 1
Arm River Housing Corporation (Davidson Prairie View) 216
Dinsmore Health Care Centre 32
Kyle Health Centre 17
Beechy-Eston Home Care #1 201
Lucky Lake Health Centre 95
Milden Union Hospital 145
Outlook Union Hospital 179
Outlook District Nursing Home 155
Elrose Health Centre/Golden Years Lodge 153
Rosetown Union Hospital 8

Moose Jaw/Thunder Creek Health District

Moose Jaw Union Hospital 68
Central Butte Union Hospital 129
Regency Manor (Central Butte) 148
Craik Health Centre 96

Moose Mountain Health District

Brock Health Centre (Arcola) 10
Moose Mountain Lodge (Carlyle) 223
Redvers Health Centre 55
Centennial Haven (Redvers) 225
Kipling Memorial Health Centre 65
Moose Mountain Health District Home Care 245
Wawota District Special Care Home Inc. 208
Wawota Memorial Health Centre 52

North Central Health District

Nirvanna Pioneer Villa (Melfort) 170
Melfort Union Hospital 44

North East Health District

Nipawin Union Hospital 5
Nipawin District Nursing Home 181
Carrot River Union Hospital 23
Pasquia Special Care Home (Carrot River) 226
Smeaton District Health Centre 42
Zenon Park Community Health Centre 230
Arborfield Special Care Lodge 228
Arborfield Health Centre 114

North Valley Health District

Centennial Special Care Home (Esterhazy) 161
Ituna and District Pioneer Lodge 247
Ituna Health Care Centre 83

Northwest Health District

Meadow Lake Union Hospital 30
L. Gervais Memorial Health Centre (Goodsoil) 125
Loon Lake Union Hospital and Special Care Home 76

Parkland Health District

Hafford Hospital and Special Care Home 47
Spiritwood Union Hospital 92
Idylwild Seniors Lodge (Spiritwood) 218
Parkland Home Care (Spiritwood) 256
Shellbrook District Hospital 89

Shellbrook Parkland Terrace 254
Big River Union Hospital 93
Lakewood Lodge (Big River) 217
Wheatland Lodge Inc. (Leask) 253
Rabbit Lake Integrated Facility 215
Evergreen Health Centre (Leoville) 175

Pasquia Health District

Tisdale Union Hospital 14
Pasquia District Home Care (Tisdale) 240
Sasko Park Lodge (Tisdale) 132
New Market Manor (Tisdale) 234
Porcupine Plains Union Hospital 16
Red Deer Nursing Home (Porcupine Plains) 172
Hudson Bay Union Hospital 94
Hudson Bay Pioneer Lodge 154
Rose Valley Integrated Care Facility 20
Kelvington Union Hospital 19
Kelvindell Lodge (Kelvington) 188

Pipestone Health District

Grenfell Health Centre 26
Grenfell Pioneer Home 202
Montmarte Integrated Health Care Centre 50
Indian Head Union Hospital 29
Golden Prairie Home (Indian Head) 144
Moosomin Union Hospital 35
Eastern Saskatchewan Pioneer Lodge (Moosomin) 118
Broadview Union Hospital 67
Broadview District Centennial Lodge 191
Whitewood Health Centre 84
Whitewood District Nursing Home 152
Wolseley Union Hospital 21

Prairie West Health District

Kindersely Union Hospital 11
Heritage Manor (Kindersely) 157
Wild Goose Home Care (Kindersley) 219
Eatonia Health Care Centre 206
Dodsland Health Centre 195
Prairie West Health District #16 (Luseland) 212

Jubilee Lodge Inc. (Eston) 199
Eston Health Centre 194
Kerrobert Union Hospital 56

Prince Albert Health District

Victoria Union Hospital 62
Northern Housing Devolpment (1973) Inc. (P.A.) 135
Birch Hills Memorial Health Centre 27
Kinistino Union Hospital 58
Kinistino District Nursing Home 176

Regina Health District

Long Lake Valley Integrated Care Centre 59
Wascana Home Care #15 224
Regina General Hospital 106
Pasqua Hospital 105
Plains Health Centre 74
Cupar Health Centre 156

Rolling Hills Healht District

Herbert Union Hospital 189
Gull Lake Union Hospital 131
Mankota Health Centre 143
Ponteix Health Centre 186
Prairie Health Centre (Cabri) 61
Vanguard Health Centre 204

Saskatoon District Health Board

Borden Community Health Centre 182
Deslile Community Health Centre 248
Home Care Board #45 141
Parkridge Centre 151
City Hospital 107
Royal University Hospital 75

South Central Health District

Weyburn General Hospital 63
Home Care District #8 192
Bengough Health Centre 203
Centennial Home Inc. (Bengough) 166
Coronach District Health Centre 113
Pangman Union Hospital 54

South Country Health District

Kincaid Health Centre 88
Grasslands Health Centre (Rockglen) 37
Lafleche Health Centre 139
South Country Home Care 146
Assiniboia Pioneer Lodge/Ross Payant 163
Assiniboia Union Hospital 31

Southeast Health District

Estevan Regional Nursing Home 48
Southeast Health District Community Care 184
Gainsborough and Area Health Centre 28
Galloway Health Centre (Oxbow) 36
Fillmore Health Centre 49
Lampman Community Health Centre 60
Mainprize Manor (Midale) 123

Southwest Health District

Maple Creek Union Hospital 103
Cypress Lodge (Maple Creek) 110
Leader Union Hospital 80
Western Senior Citizens' Home Inc. (Leader) 252
Shaunavon Union Hospital 87
Shaunavon Special Care Home 251
Border Health Centre (Climax) 205
Eastend Wolf Wilow Health Centre 112

Swift Current Health District

Pioneers Lodge (Swift Current) 171
Swift Current Regional Hospital 69

Touchwood Qu'Appelle Health District

St. Joseph's Union Hospital (Lestock) 85
Silver Heghts Special Care Home (Raymore) 213
Touchwood-Qu'Appelle Home Care (Fort Qu'Appelle) 246
Parkland Lodge (Balcarres) 174
Balcarres Union Hospital 9

Twin Rivers Health District

Turtleford Union Hospital 90

Turtle River Nursing Home (Turtleford)	243
St. Walburg Union Hospital	81
Lakeland Lodge (St. Walburg)	196
Maidstone Union Hospital	12
Twin Rivers Home Care (Maidstone)	242
Manitou Health Centre (Neilburg)	24
Cutknife Health Complex	86

St. Joseph's Hospital (Estevan)	104
Holy Family Hospital (Prince Albert)	70
Mont. St. Joseph's Home Inc. (Prince Albert)	193
Duck Lake & District Nursing Home Inc.	167
Bethany Pioneer Village Inc. (Middle Lake)	168
Providence Place (Moose Jaw)	124
Extendicare Ltd. 1151 (Moose Jaw)	99
Chantelle Management Ltd. (Swift Current Care)	159
St. Elizabeth Hospital (Humboldt)	34
St. Michael's Hospital (Cudworth)	57
The Border-ling Housing Company (Carnduff)	134
Regina Pioneer Village Ltd.	255
Extendicare Elmview/Sunset (Regina)	66
Santa Maria Senior Citizens' Home (Regina)	158
Extendicare Parkside (Regina)	100
Regina Lutheran Home	164
Cupar and District Nursing Home Inc.	169
St. Peter's Hospital (Melville)	102
St. Anthony's Hospital (Esterhazey)	115
St. Joseph's Hospital (Gravelbourg)	64

Foyer D'Youville Home (Gravelbourg)	
Societe Joseph Breton Inc. (Village Pascal, North Battleford)	127
St. Joseph's Hospital (Ile a la Crosse)	73
St. Martin's Union Hospital (La Loche)	120
La Ronge Health Centre	109
Uranium City Municipal Hospital	116
Lakeview Pioneer Lodge Inc. (Wakaw)	178
Buena Vista Lodge Inc. (Kerrobert)	162
Kindersely Senior Care Inc. (Heritage Manor)	157
Pioneer Haven Co. Inc. (Kerrobert)	211
Radville Marian Health Centre	79
St. Joseph's Health Centre (Macklin)	128
Golden Twilight Lodge Inc. (Macklin)	229
St. Paul Lutheran Home (Melville)	7
Pine Island Lodge Ltd. (Maidstone)	209
Gull Lake and District Special Care Home Inc.	160
Sherbrook Community Centre (Saskatoon)	22
St. Paul's Hospital (Saskatoon)	101
Extendicare (Saskatoon)	111
Saskatoon Convalescent Home	121
Jubilee Residence Porteous	126
Jubilee Residence Stensrud	233
St. Ann's Senior Citizens' Village Corporation	136
Oliver Lodge (Saskatoon)	142
Sunset Lutheran Home	149
Newhope Pioneer Lodge Inc. (Stoughton)	231

Humboldt and District Housing Corporation
(St. Mary's Villa) 122

TOTAL NUMBER OF SUN LOCAL UNIONS: **240**

Appendix F

MINISTER'S ORDER

TO APPOINT A COMMISSIONER PURSUANT TO

THE HEALTH LABOUR RELATIONS REORGANIZATION ACT

I, Eric Cline, Minister of Labour, pursuant to section 4 of *The Health Labour Relations Reorganization Act*, do hereby appoint James E. Dorsey as a commissioner to carry out the responsibilities of the commissioner assigned by that Act.

The commissioner's appointment shall expire on January 31, 1997.

Pursuant to subsection 6(3) of *The Health Labour Relations Reorganization Act*, the commissioner shall submit his regulations to the Minister on or before January 15, 1997.

The commissioner shall be paid an honoraria of $185 per hour.

The commissioner shall be paid reasonable expenses for travel and sustenance incurred in the performance of his duties, such expenses to be calculated as and from the date of the appointing order.

Dated at Regina, Saskatchewan, this 15th day of July, 1996

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Minister of Labour

Appendix G

Saskatchewan Collective Bargaining Agreements

SASKATCHEWAN COLLECTIVE BARGAINING AGREEMENTS

PARTIES	EXPIRE DATE
CUPE - SAHO Provincial	12/31/97
CUPE 600 - Public Service Commission	09/30/96
CUPE 600-1 - Souris Valley Regional Care Centre	09/30/94
CUPE 600-6 - Battlefords Regional Care Centre	09/30/94
CUPE 600-9 - Psychiatric Rehabilitation Services, Saskatoon	09/30/94
CUPE 59 - Saskatoon Community Health (Tentative Agreement)	12/31/97
CUPE 1831 - Community Health Services (Regina)	12/31/94
CUPE 3445 - South Eastern Saskatchewan Road Ambulance	03/31/94
CUPE 3736 - North Sask Laundry	12/31/94
SEIU - SAHO Provincial	12/31/94
SEIU 299 and 333 - Extendicare	12/31/94
SEIU 299 - Moose Jaw and Central Butte Ambulance	12/31/94
SEIU 336 - Chantelle Management	12/31/94
SEIU 299 - Moose Jaw Alcohol and Drug (Angus Campbell Centre	03/31/95
SEIU 333 - St. Louis Rehab	03/31/95
SEIU 299 - Red Cross Regina	12/31/94
SEIU 333 - Red Cross Saskatoon	12/31/94
SUN - SAHO Acute Care/Home Care	03/31/96
SUN - SAHO Long Term Care	03/31/96
SUN - Extendicare	03/31/96
SUN - Chantelle Management	03/31/96
SUN - Red Cross	03/31/96
SGEU - Public Service Commission	09/30/97
SGEU - SAHO Home Care	03/31/98
SGEU - SAHO (Wascanna Rehab, Lakeside, Parkland)	12/31/97
SGEU - Cancer Foundation	09/30/94
PIPS - Treasury Board (Term Extended by Legislation)	09/30/97
PSAC - Treasury Board	04/04/91
RAPA - Regina District Health Board	12/31/97
PTA - Regina District Health Board	12/31/94
RWDSU - Regina District Health Board (Laundry Services)	12/31/94
HSAS - SAHO Provincial	12/31/94

Appendix H

Summary - Current Bargaining Proposals

CURRENT BARGAINING UNIT PROPOSALS

SUMMARY OF POSITION: Appropriate Bargaining Units	**CUPE**	**SEIU**	**SUN**	**SGEU**	**HSA**	**RWDSU**	**SAHO**	**SDHB**	**RDHB**	**EXTENDI CARE**
Status Quo - site or program based - retain all existing bargaining unit structures.				✓						
Status Quo - site or program based - change bargaining units only where there is significant intermingling. Limit geographic extent of any new units.		✓								
Status Quo - site specific- no representations with respect to the health sector generally.						✓				✓
New Units - description - district wide - one unit of all RNs & RPNs and one residual unit of all other employees. Two bargaining units/district.			✓							
New Units - description - district wide - one unit of all RNs & RPNs, one unit of all other professionals, and one residual unit of all other employees. Three bargaining units/district.					✓			✓	✓	
New Units - description - as above - no more than three bargaining units in Regina and Saskatoon and two units in all other districts.	✓						✓			
Affiliates - Status Quo		✓		✓						
Affiliates - new units - merge with health district units - multi employer certification.	✓		✓							
Affiliates - new units - separate units for each employer - two units/employer - one unit of all RNs and RPNs and one residual unit of all other employees.							✓	✓	✓	

SUMMARY OF POSITION: **Collective Bargaining Structures**	**CUPE**	**SEIU**	**SUN**	**SGEU**	**HSA**	**SAHO**	**SDHB**	**RDHB**
Representative Employers' Organization - voluntary participation.						✓		
Representative Employers' Organization - mandatory participation.	✓		✓				✓	
Provincial Collective Agreements - one agreement per union - council of locals to bargain at provincial table.	✓	✓	✓					✓
Provincial Collective Agreements - one agreement for each of four health sectors. Where more than one union represents workers in the sector then the unions form a bargaining council to negotiate all non-wage provisions. All wage provisions would be bargained at a single table for all employees in the province by a bargaining council of all unions.				✓				
Local Agreements - retain	✓	✓						✓
Local Agreements - abolish			✓				✓	

SUMMARY OF POSITION: **Trade Union Representation**	**CUPE**	**SEIU**	**SUN**	**SGEU**	**HSA**	**SAHO**	**SDHB**	**RDHB**
Status Quo - All members remain in their union. If there is significant intermingling of employees that use LRB rules to govern a representation vote (ie demonstrate 25% support).		✓						
Council of Unions - all union members remain in their unions. All unions having members in a bargaining unit form a bargaining council.				✓				
Exclusive Representation - one union representing all workers in a unit. Commissioner designates the union where a clear majority exists, otherwise LRB conducts a representation vote.	✓	✓	✓			✓	✓	✓
Exclusive Representation - one union representing all workers in a unit. LRB conducts a vote in all cases.					✓			
Exclusive Representation - multiple units in a district - one union represents all workers in similar units in the district.						✓	✓	✓
Non-unionized employees of a health district - provide a process that would allow them to stay out of the bargaining unit.					✓	✓	✓	✓
Non-unionized employees of a health district - include them in a bargaining unit.	✓							
Non-unionized affiliate employers - status quo.		✓				✓		
Non-unionized affiliate employers - include employees in a bargaining unit if a district-wide multi-employer bargaining unit is created.								

SUMMARY OF POSITION: Implementation Issues	**CUPE**	**SEIU**	**SUN**	**SGEU**	**HSA**	**SAHO**	**SDHB**	**RDHB**
Seniority/service - Leave up to unions to negotiate.					✓			
Seniority/service - merge and recognize all seniority of employees represented by another union or service of employees not previously represented.	✓	✓				✓	✓	✓
Collective Agreements - leave all in place and establish a common expiry date.						✓	✓	✓
Collective Agreements - designate one collective agreement to apply to all employees in the unit.		✓	✓					
Dispute Resolution - managerial exclusions - delegate all matters to the Labour Relations Board.			✓				✓	✓
Dispute Resolution - seniority - parties refer all implementation issues to grievance/arbitration, or some other dispute resolution mechanism.						✓	✓	✓
Dispute Resolution - other implementation issues - regulate an mandatory process involving mediation.							✓	

Appendix I

Interim Reorganization Proposal

REORGANIZATION

PROPOSAL

The Health Labour Relations

Reorganization Commission

November 28, 1996

1. CONTEXT

- HEALTH CARE REFORM
- LABOUR RELATIONS INITIATIVES
- LABOUR RELATIONS BOARD
- UNION-EMPLOYER AGREEMENTS
- UNION REQUEST FOR COMMISSION

2. COMMISSION

- SCOPE OF INQUIRIES
- MANDATE
- CONSIDERATIONS
- REGULATION MAKING RESPONSIBILITY
- RECOMMENDATION RESPONSIBILITY

3. REGULATIONS

- EFFECT
- S.L.R.B. AUTHORITY

4. OPTION EVALUATION GUIDELINES

5. CURRENT LABOUR RELATIONS ORGANIZATION

6. REORGANIZATION PROPOSAL

- BARGAINING UNITS
- COLLECTIVE BARGAINING
- DETERMINING REPRESENTATION
- EXISTING AGREEMENTS
- SENIORITY AND SERVICE
- CHANGED CIRCUMSTANCES

HEALTH CARE REFORM CONTEXT

SASKATCHEWAN'S HEALTH CARE TRADITION IN A NEW SYSTEM FOR A NEW SOCIETY

Future Directions for Health Care In Saskatchewan
(Murray Commission - 1989)

- Local health care councils

  responsible for putting together the "broadbased package of health care services required for their area, uniting under one umbrella health protection and promotion, community-based services, institutions, ambulances and more."

- New employee representation structures and provincial collective bargaining

A FRAMEWORK FOR CHANGE

A Saskatchewan Vision for Health (Hon. Louise Simard - 1992)

- Service delivery integration, co-ordination and consolidation is critical to affordability, effectiveness and accessibility.

- Integration is required to ensure the flexibility to plan and manage locally

- Locally formed health districts of at least 12,000 people who must live within a continuous land area (except for aboriginal reserves) which account for "population distribution, geographic barriers, trading and commuting patterns, location of current health facilities and population health status."

- A labour relations review committee

STRUCTURAL REFORM TO SUPPORT SERVICE DELIVERY REFORM

The Health Districts Act (1993 and 1996) and **Regulations** (1995)

- Enabling integration of health services and increased community involvement through health districts and their governing boards.
- Continuation of the Regina, Saskatoon and Prince Albert Health Boards.
- Urban, but not rural, municipalities must be entirely within one district.
- Ward system elections of 8 of the 12 or 14 (Regina and Saskatoon) board members.
- Existing Midwest Board to follow statutory process to be established.
- Districts may amalgamate and boundaries may be changed to better reflect local needs by agreement and consultation.
- Existing health corporations and districts must or may amalgamate.
- Employee trade union representation not a factor or criteria.

CLOSURES, AMALGAMATIONS, BUDGET CUTS AND AFFILIATIONS

- 52 rural hospitals and integrated facilities converted to Community Health Centres or closed.

- 3% reduction in district budgets.

- 30 health districts amalgamated with:

120	Union Hospitals
12	Other Hospitals
108	Ambulance Districts
83	Special Care Homes
43	Home Care Services

- 63 affiliates in 16 districts of which 48 employ 5,987 employees represented by a trade union

Type	No.	Employees
• Denominational, Community and Aboriginal	42	5,217
• Private for profit	6	770
• Total	48	5,987

PLANNING COMPLETED FOR INTEGRATION

- Strategic planning
  - an integrated and co-ordinated continuum of health services.
- Core services transferred (1993)
- Saskatchewan Health and municipal services transferred (1995)
  - intermingling of unionized employees and consolidation of program management and service delivery.
- Program planning
  - mission, goals, objectives, workplans, evaluation.
  - options for integrated care service.
- Facilities planning
  - providing space to meet current and future needs.
  - capital funding and management.
- Needs-based allocation of resources
- Accountability framework
- First health board elections in Canada (1995)

LABOUR RELATIONS INITIATIVES

Minister of Health

Labour Relations Review Committee **(1992)**

- Part of "A Saskatchewan Vision for Health: A Framework for Change".

- To recommend needed strategies on human resource issue of jobs affected by the change to health districts.

- Terms of reference include:

    - To consider the most effective and efficient collective bargaining and administrative methodology... .

    - To recommend timely, effective and acceptable mechanisms to resolve union jurisdictional questions.

    - To recommend timely, effective and acceptable mechanisms to facilitate the integration of employee and union(s) from different facilities with different collective agreements to a single employer.

- Two reports, not a single unanimous report - chair dissented.

- Options and recommendations on provincial bargaining and labour adjustment acted upon.

Health Reform Transition Co-ordinating Committee Labour Adjustment Strategies (1993)

Transfer/Merger Agreement

- among signatory unions and districts establish organized and orderly procedures to protect the rights and benefits of employees, the recognition of union jurisdictions and provide means for employers to effectively manage human resources within the district.
- achieve a degree of uniformity and prevent the repetitive succession of local bargaining sessions on substantially the same subject matter.
- maximize employment opportunities for employees currently working in the health care system.
- accommodate the inclusion under the agreement of other bargaining units as district boards assume responsibility for them.

Career Adjustment Assistance for laid off employees ($3.4 million)

- career counselling/job placement.
- tuition reimbursement.
- relocation assistance.
- alternate employment assistance.
- severance payment.

Provincial posting of vacancies obligation

District Joint/Management Adjustment Committees

Health Providers Human Resource Committee (1996)

- Examine issues "related to preparing, regulating and utilizing providers effectively in the reformed health system."

- Recognized the trend of "increased integration and coordination of services and providers to provide continuity, efficiency and effectiveness."

- Findings include:

  - a need to rationalize programs to reduce unnecessary duplication and "turf protection" among educational programs.

  - a need to remove barriers resulting from multiplicity of collective bargaining agreements and adversarial approaches.

- Recommendations include:

  "That restructuring bargaining units to better fit employer-employee relationships is urgently required and that the provincial government assign this high priority and provide adequate resources to the Labour Relations Board to respond promptly to realignment requests."

LABOUR RELATIONS BOARD

- Bargaining unit restructuring that builds upon local site and service boundaries.

- Case by case adjudication supporting employee free choice and encouraging party resolution of problems.

- Refusal to recognize standard bargaining units at acute care hospitals.

UNION - EMPLOYER AGREEMENTS

Intra-Union Transfer and Merger Agreements

- allow district-wide seniority across bargaining units for posting and recall.
- address issues arising from transfer of services within a district allowing an employee to move "whole".

Agreements Affecting Individuals

- accommodate the transfer of individuals and their rights across bargaining units within a district.

Devolution Agreement

- address issues arising from transfer from Executive Government to districts.

Inter-Union Transfer and Merger and Itinerate Movement

- address issues that arise from consolidation of two or more units covered by one or more collective agreements.
- uneven acceptance across the districts and affiliates.
- do not include all the unions or employers in every district.
- has not been negotiated in each district.

Global Posting

- allows vacancies within a union's jurisdiction to be open to competition for a time to all employees within that union's jurisdiction in the district.

Laboratory Framework

- negotiated in Saskatoon District to facilitate restructuring and consolidation of Laboratory Services by providing for merged seniority lists and a placement process involving both SEIU and HSAS.

UNION REQUEST FOR COMMISSION

- Saskatoon District Health applies to Labour Relations Board to redefine appropriate bargaining units of its employees. (December, 1995)

- Unions conclude issues are province-wide and require province-wide resolution.

- Four unions request government to establish Commission with mandate:

    1. To determine appropriates bargaining unit configuration for Health Districts in the province, taking into account the principles of *The Trade Union Act*;

    2. Ensure to the extent possible that current representation rights enjoyed by the unions are preserved;

    3. Enforce provincial bargaining arrangements between the parties.

COMMISSION SCOPE OF INQUIRIES

The organization of labour relations between health sector employers and employees

COMMISSION MANDATE

To make regulations reorganizing labour relations between health sector employers and employees and resolving issues arising out of that reorganization on or before January 15, 1997.

CONSIDERATIONS COMMISSION MUST ADDRESS

- The new employment relationships that have been established and that will be established as a result of restructuring the delivery of health services pursuant to The Health Districts Act.

- The need to promote the integration of the delivery of health services.

- The need to facilitate the development over time of consistency in terms and conditions of employment amongst health sector employers and employees.

- The history of trade union representation amongst employees of health sector employers and the need to promote orderly collective bargaining between health sector employers and employees.

REGULATION MAKING RESPONSIBILITY

Commission may make any or all of the following:

- Define appropriate bargaining units and establishing the composition of those units.

- Determine trade union representation in any of those units.

- Integrate employees in any appropriate unit and address any matter arising out of the integration, including the integration of seniority of employees who were previously represented by a trade union and the recognition of service of employees who were not previously represented by a trade union.

- When a unit consists of employees covered by two or more collective agreements, determine which agreement will apply to all of the employees in the unit or fix a common expiry date for all of the agreements.

- Establish a multi-employer bargaining structure through the designation of bargaining councils and representative employers' organizations.

- Establish the articles of association for bargaining councils and representative employers' organizations.

- Address any other matter or thing necessary to carry out the intent of the statute.

- Amend, vary or rescind a Labour Relations Board order.

- Delegate to the Labour Relations Board any responsibility considered appropriate, including determining or establishing any matter or thing.

RECOMMENDATION RESPONSIBILITY

That the Lieutenant Governor in Council prescribe a person a health sector employer when it is not:

- a district health board under *The Health Districts Act*;
- a hospital, nursing home or other institution approved pursuant to *The Hospital Standards Act*; or
- a special-care home licensed pursuant to *The Housing and Special-care Homes Act*.

EFFECT OF REGULATIONS

- Effective when approved by the Lieutenant Governor in Council and filed with the provincial Registrar of Regulations.

- Same force and effect as a Labour Relations Board order.

- Labour Relations Board may not amend vary or rescind until three years after effective.

LABOUR RELATIONS BOARD AUTHORITY

- For the period of time from the statute coming into force to filing regulations with the Registrar of Regulations, the Board may not consider any application with respect to a matter or thing that is or may be covered by the regulations to be made by the commissioner.

- For three years the Board may not make an order that amends, varies or rescinds the regulations.

- The Board may make any order it considers appropriate respecting any matter arising out of the reorganization of labour relations between health sector employers and employees that is not addressed in the regulations.

GUIDELINES
TO EVALUATE OPTIONS AND PROPOSALS

1. In the public interest, reorganization is to further health reform goals.

2. Facility, program or service stream or sector defined units do not a adequately advance the need to promote integration of the delivery of health services.

3. Define standard bargaining units with clear, easily interpreted and easily administered boundaries.

4. Reduce the number of bargaining units and the incidence of collective bargaining by expanding the scope of units to create a platform for the development through collective bargaining of consistency in terms and conditions of employment.

5. Prefer larger, multi-disciplinary, multi-skilled, industrial style units with limited, clearly defined exceptions.

6. Individuals' seniority and recognition of service should be protected through the reorganization.

7. Whenever possible, favour union transfer and merger agreements and employee choice as the preferred methods of selecting representation ahead of regulated decision making about existing union rights.

8. Seek to maintain current representation without compromising reorganization to meet the need to promote integration of service delivery.

9. Recognize and respect existing district structure as the organizational foundation for health care reform and the primary source of future employment relationships.

10. Use multi-employer unit structures whenever reasonable to broaden the scope of units and facilitate integration of service delivery.

11. Anchor recommendations to include other persons as health sector employers in the districts' scope of responsibilities.

12. Extend bargaining units to currently unrepresented employees of districts, but not to currently unrepresented employees of affiliates.

13. Anticipate there will be future amalgamations and the creation of new health districts in the north of the province.

14. As much as possible, adhere to labour relations statutory and Board policy and existing commitments arising from health reform.

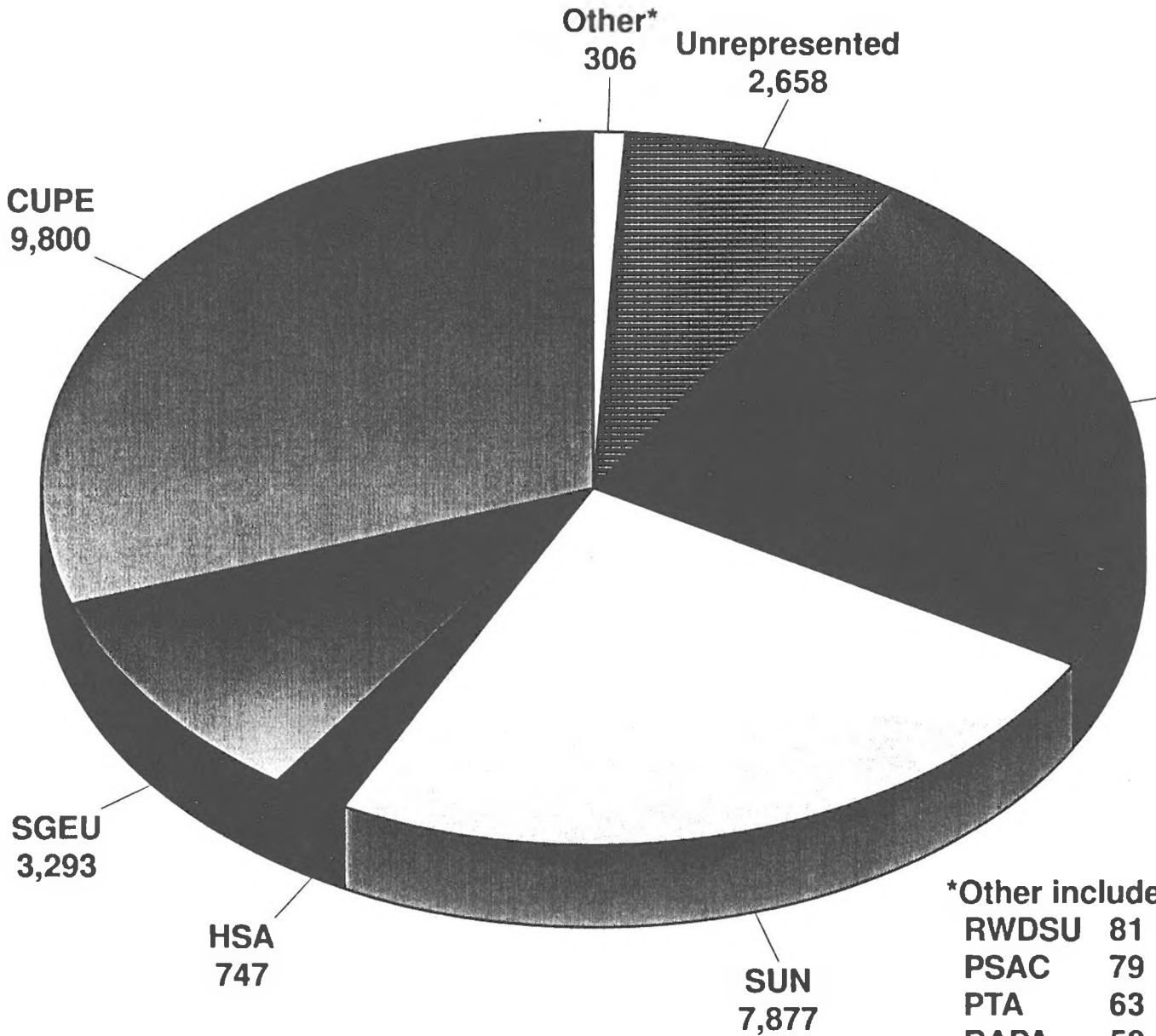
15. Anticipate the adverse impact of reorganization on morale and service delivery by minimizing points of future conflict and dispute resolution and respecting the duration of existing collective agreements.

16. Formalize existing structures for multi-employer and multi-bargaining unit collective bargaining.

CURRENT SITUATION

District Employers	30
District Unionized Employees	23,811
District Non-union Employees	2,441
Unionized Affiliate Employers	48
Unionized Affiliate Employees	5,987
Employers' Agent	1
Bargaining Units	541
Trade Union Locals	394
Collective Agreements	32

Employee Representation by Union

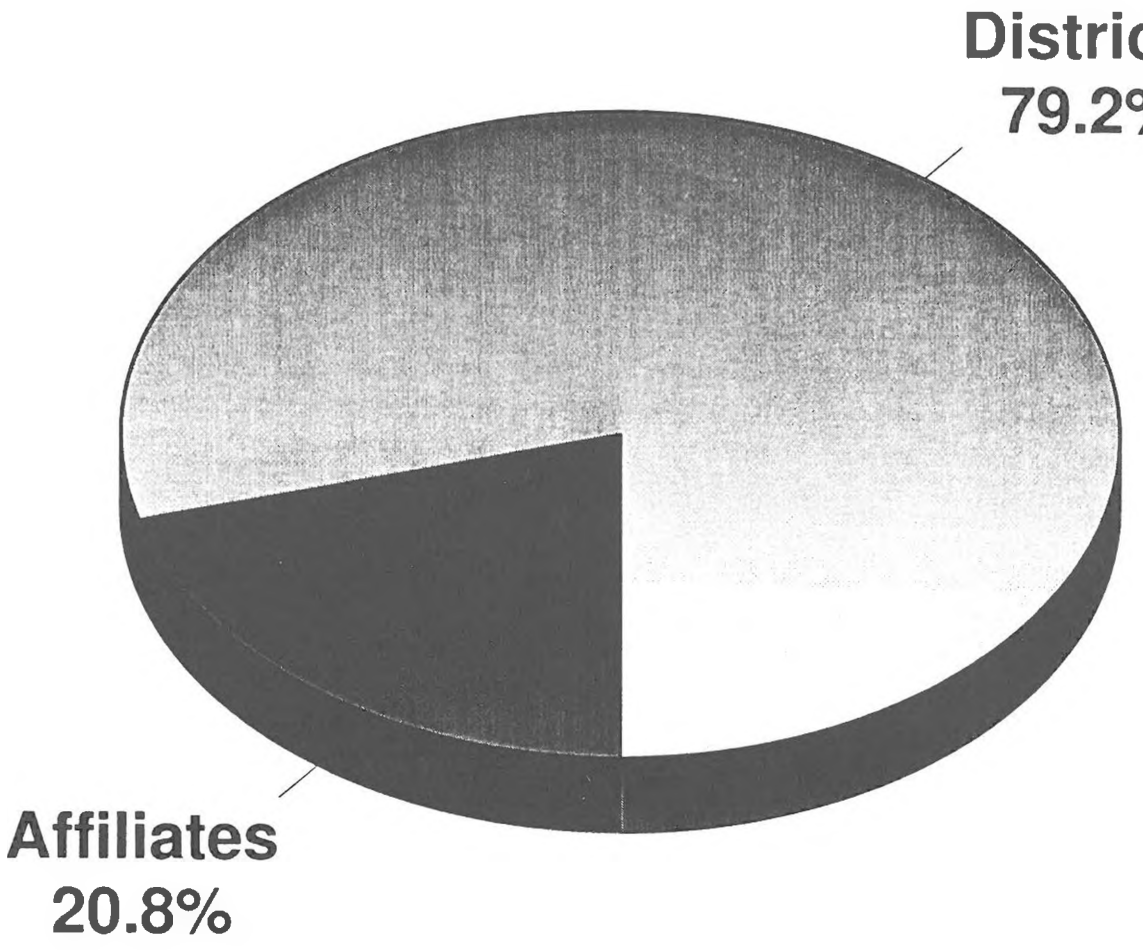


*Other includes

RWDSU	81
PSAC	79
PTA	63
RAPA	52
PIPS	31

Source: Saskatchewan Health Labour Relations Reorganization Commission

Saskatchewan Health District Employees, District and Affilliates



Source: Saskatchewan Health Labour Relations Reorganization Commission

PROPOSED STANDARD UNIT STRUCTURE

All employee, multi-employer, district broad bargaining units with 3 exceptions:

1. multi-district and multi-employer units for specific occupations.

2. for private profit employers.

3. northern health services.

ULTIMATE UNIT CONFIGURATIONS

Three Standard Units

Health Service Provider	all employees of a district and all currently represented employees of its affiliates, except physicians and employees included in the licensed provider and nurse units.
Licensed Provider	all employees of all districts and all currently represented employees of their affiliates employed and functioning in an occupation which requires that they hold a license under a current provincial statute confering exclusive rights to practice specific health care services or in an occupation which requires registration under a current provincial statute confering exclusive use of occupational title, except Licensed Practical Nurses, Registered Nurses and Registered Psychiatric Nurses.
Nurse	all employees of all districts and all currently represented employees of their affiliates employed and functioning as Registered Nurse, Registered Psychiatric Nurse and Graduate Nurse.

Eight Northern Services Units

St. Joseph's Hospital: CUPE certified (Ile a la Crosse)	1 unit of health service providers - 1 unit of nurses - SUN certified
St. Martin's Hospital: CUPE certified (La Loche)	1 unit of health service providers - 1 unit of nurses - SUN certified
La Ronge Health Centre: CUPE certified	1 unit of health service providers - 1 unit of nurses - SUN certified
Uranium City Hospital: CUPE certified	1 unit of health service providers - 1 unit of nurses - SUN certified

Twelve For Private Profit Units

Extendicare (Canada)Inc: SEIU certified	5 units of health service providers - 5 units of nurses - SUN certified
Swift Current Care Centre: (Chantelle Management)	1 unit of health service providers - SEIU certified 1 unit of nurses - SUN certified

LICENSED PROVIDER UNIT

Includes the following licensed or registered providers:

Chiropodist
Chiropractor
Dentist
Dental Therapist
Dental Technician
Denturist
Dietician and Nutritionist
Medical Laboratory Technologist
Medical Radiation Technologist
Occupational Therapist
Optometrist
Ophthalmic Dispenser
Pharmacist
Physical Therapist
Psychologist
Social Worker
Speech Language Pathologist and Audiologist

Does not include the following providers who are in another or no unit and currently have some form of registration, competency or credentialization established by existing legislation:

Health Care Provider Unit

All trades persons
Dental Assistant
Dental Hygienist
Licensed Practical Nurse

Nurse Unit

Registered Nurse
Registered Psychiatric Nurse

No Unit

Physician

HEALTH PROVIDERS REGULATED IN SASKATCHEWAN BY LEGISLATION

PROVIDER	Registration	Competency Exams	Degree	Annual Licence or Registration Certificate	Protection of Title	Exclusive Right to Practice
Chiropodists	✓	✓	✓	✓	✓	✓
Chiropractors	✓	✓	✓	✓	✓	✓
Dental Technicians	✓	✓		✓	✓	✓
Dental Therapists	✓			✓	✓	✓
Dentists	✓		✓	✓	✓	✓
- Dental Assistants	✓			✓		
- Dental Hygienists	✓			✓		
Denturists	✓	✓		✓	✓	✓
Dieticians and Nutritionists	✓	✓	✓	✓	✓	
Licensed Practical Nurses	✓	✓		✓	✓	
Medical Laboratory Technologists	✓			✓	✓	
Medical Radiation Technologists	✓	✓		✓	✓	
Occupational Therapists	✓	✓	✓	✓	✓	
Ophthalmic Dispensers	✓	✓		✓	✓	✓
Optometrists	✓	✓	✓	✓	✓	✓
Pharmacists	✓	✓	✓	✓	✓	✓
Psychologists	✓	✓	✓	✓	✓	
Physical Therapists	✓	✓	✓	✓	✓	✓
Physicians	✓	✓	✓	✓	✓	✓
Registered Psych Nurses	✓	✓		✓	✓	
Registered Nurses	✓	✓		✓	✓	✓
Speech-language Pathologists and Audiologists	✓	✓	✓	✓	✓	
Social Workers	✓		✓	✓	✓	

Main criteria for regulation - The service provided poses a risk of harm to the public.

COLLECTIVE BARGAINING STRUCTURE

Employer Representation

Saskatchewan Association of Health Organizations is to be designated as exclusive bargaining agent for collective bargaining purposes for all Health District Boards, all unionized affiliates except for private profit affiliates and certain northern health services.

It is recommended that the SAHO membership review its bylaws and its enabling statute to ensure that the Health District Boards and unionized affiliates have an appropriate and meaningful voice and role in the collective bargaining process.

Health Service Provider Units

One collective agreement between SAHO and each trade union which is certified to represent a multi-employer, district based unit or a unit at a northern health service. It will apply to all employees in all health service provider units in the province for which the union is certified.

Licensed Provider Unit

One collective agreement between SAHO and the trade union certified to represent the single multi-district, multi-affiliate and northern health services unit.

Nurse Unit

One collective agreement between SAHO and the trade union certified to represent the single multi-district, multi-affiliate and northern health services unit.

PRIVATE FOR PROFIT COLLECTIVE BARGAINING

Extendicare (Canada) Inc.

- One collective agreement covering the employees in the five units represented by SEIU
- One collective agreement covering the employees in the five units represented by SUN.

Chantelle Management

- One collective agreement covering the employees in the unit represented by SEIU
- One collective agreement covering the employees in the unit represented by SUN.

RECOMMENDED INCLUSION IN HEALTH SECTOR REORGANIZATION

North Sask. Laundry & Support Services Ltd. be included and treated as an affiliate of the Prince Albert District for purposes of bargaining unit configuration and collective bargaining structures.

NURSE UNITS

1. All registered nurses, registered psychiatric nurses and graduate nurses employed by each District Health Board and functioning as such, whether currently represented by a union or not, and all employed by an affiliate of the district and represented by a union are to be transferred into a single, multi-employer bargaining unit.

2. S.U.N. is to be certified as exclusive bargaining agent for each of these 30 units.

3. S.U.N. is to be certified under the Regulations as exclusive bargaining agent for each of the four units that it represents at St. Joseph's Hospital (Ile a la Crosse), St. Martin's Union Hospital (La Loche), La Ronge Health Centre and Uranium City Municipal Hospital.

4. Effective one year after the coming into effect of the Regulations, these 34 units are to be consolidated into a single unit and S.U.N. is to be certified as exclusive bargaining agent for this unit.

5. By majority choice Registered Nurses, Registered Psychiatric Nurses and Graduate Nurses, employed by an affiliate of a district and currently not represented by a union, may choose at any time to be included in the district based or consolidated nurse unit.

Implications

Consolidated unit replaces 240 existing bargaining units and will consist of registered and graduate nurses currently represented as follows:

SUN	7,877
SGEU	480
CUPE	379
SEIU	23
PIPS	30
Non-Union	379
Total	**9,168**

LICENSED PROVIDER UNIT

1. All licensed providers employed by a District Health Board, whether currently represented by a union or not, and all those employed by an affiliate of a district and represented by a union or by St. Joseph's Hospital (Ile a la Crosse), St. Martin's Union Hospital (La Loche), La Ronge Health Centre and Uranium City Municipal Hospital and represented by a union are to be transferred into a single, multi-employer bargaining unit.

2. By majority choice licensed providers, employed by either an affiliate of a district and currently not represented by a union, or employed by any one of St. Joseph's Hospital (Ile a la Crosse), St. Martin's Union Hospital (La Loche), La Ronge Health Centre and Uranium City Municipal Hospital and not currently represented by a union may choose at any time to be included in the single bargaining unit.

Implications

Unit replaces 9 existing bargaining units and will consist of licensed providers currently represented as follows:

HSAS	626
CUPE	619
SGEU	244
SEIU	222
PTA	66
PSAC	3
PIPS	1
Non-union	165
Total	**1,946**

HEALTH SERVICE PROVIDER UNITS

1. All health service providers other than those in a nurse or licensed provider unit, employed by a District Health Board, whether currently represented by a union or not, and all those employed by an affiliate of the district and represented by a union are to be transferred into a single multi-employer unit.

2. C.U.P.E. is to be certified under the Regulations as exclusive bargaining agent for each of the four units that it represents at St. Joseph's Hospital (Ile a la Crosse), St. Martin's Union Hospital (La Loche), La Ronge Health Centre and Uranium City Municipal Hospital.

3. By majority choice health service providers employed by an affiliate of a district and currently not represented by a union, may choose at any time to be included in the district based bargaining unit.

Implications

The 30 district based units will replace 296 existing bargaining units and encompass employees currently represented as follows:

CUPE	8,802
SEIU	6,980
SGEU	2,569
HSAS	121
RWDSU	81
PSAC	76
RAPA	52
Non-Union	2114
Total	**20,795**

DETERMINING REPRESENTATION

Certification by Regulation

The Regulations will certify a trade union for a unit, based on the representation information gathered by the Commission in the following circumstance:

More than 50% membership and no other union with 25%

In any unit where a trade union has as members more than 50% of the employees, including previously unrepresented employees, and no other union has as members 25% or more of the employees, the trade union with more than 50% of the employees as members will be certified as the exclusive bargaining agent for the unit and the existing certification orders affecting the employees in the unit will be rescinded.

Certification by Labour Relations Board

The Labour Relations Board will be delegated the responsibility to determine representation in all other circumstances in accordance with the following:

1. Agreements between unions

Agreements between unions to merge or amalgamate or to transfer or assign jurisdiction in accordance with *The Trade Union Act* filed with the Labour Relations Board within 30 days of the Regulations coming into effect will be conclusive of representation rights for the purposes of determining the extent of a union's representation in a bargaining unit.

2. Automatic certification

In any unit where by reason or agreement between unions a trade union is entitled to certification under the rule for certification by Regulation, the trade union will be certified by the Labour Relations Board as the exclusive bargaining agent for the unit and the existing certification orders affecting the employees in the unit will be rescinded.

3. Representation votes

In any unit where no trade union is entitled to automatic certification, the Labour Relations Board will conduct a representation vote to determine which trade union will be certified as the exclusive bargaining agent for the unit.

The Board will decide any issue related to the eligibility of any person to vote.

Any trade union which has as members 25% or more of the employees, including previously unrepresented employees, may request to be included on the ballot as a choice for exclusive bargaining agent for the unit.

If there are more than two unions on the ballot and no union receives a majority of the ballots cast, the Board will conduct a run-off vote with the employees having a choice between the two unions receiving the highest number of ballots.

All votes are to be conducted by the Board as soon as possible after the effective date of the Regulations.

On the basis of the choice of a majority of employees casting ballots in a representation vote a trade union will be certified by the Board as the exclusive bargaining agent for the unit and the existing certification orders affecting the employees in the unit will be rescinded.

EXISTING COLLECTIVE AND OTHER AGREEMENTS

- Unless otherwise agreed between SAHO and a bargaining agent and other non-union or non-employer party, all collective agreements and all their terms and conditions of employment and all other local, transfer and merger, devolution, itinerate movement, laboratory framework, global posting, Saskatoon Veterans Home and similar agreements continue to apply until their expiration to employees transferred between existing and new bargaining units and their employers.

- Newly certified trade unions will become successors to the existing collective agreements and any other agreements applicable to employees in the unit for which it is certified and continue as a party to any collective agreement to which it was a party until the expiration of each agreement.

- Newly represented district employees will be covered by the collective agreement currently in force that covers employees in a similar classification when a trade union is automatically certified for the unit.

- When there are two or more collective agreements and a representation vote is necessary to determine the bargaining agent, each new represented district employee will be covered by the collective agreement which he or she individually chooses regardless of which trade union is certified as bargaining agent.

SENIORITY AND SERVICE

- Seniority and service recognition will be portable for any employee who changes bargaining unit, bargaining agent or collective agreement as result of any aspect of this reorganization.

- Any employee who lost seniority recognition since the enactment of *The Health Districts Act* as a result of transferring between bargaining units or bargaining agents will have the seniority reinstated on the basis of the collective agreement covering the bargaining unit in which they were included prior to this reorganization.

- Each employee previously unrepresented by a trade union who is included in a bargaining unit by this reorganization will receive recognition of service as an accumulation of seniority calculated in accordance with the collective agreement that covers the employee and any subsequent rules or process adopted by the bargaining agent and SAHO for determining the single seniority accumulation of each employee in the unit.

- All disputes about the interpretation, application and operation of the portability of seniority and recognition of service and any consequence whatsoever are arbitrable and to be finally resolved by arbitration in accordance with *The Trade Union Act*.

FUTURE AMALGAMATIONS, REORGANIZATION AND CHANGED CIRCUMSTANCES

- All unrepresented employees who choose trade union representation in the future will be included in one of the three standard, multi-employer bargaining units represented by the applicant trade union.

- The appropriate bargaining unit for employed physicians, residents and interns employed by Health District Boards or their affiliates is a single, separate, multi-employer, provincial unit.

- In all circumstances of new amalgamations or transfer of services to existing Health District Boards, the creation of new districts, or the amalgamation or reconfiguration of existing or new districts, the standard bargaining units will be appropriate and the necessary amendments and variances will be made.

- In all circumstances of new amalgamations or transfer of services to existing districts, the creation of new districts, or the amalgamation or reconfiguration of existing or new districts, the rules with respect to seniority and service under the Regulations will apply.

- All unanticipated circumstances are to be resolved by the Labour Relations Board in accordance with the principles of the Regulations and their intent as expressed in the Report accompanying the Regulations.

- All outstanding applications before the Labour Relations Board are to be decided in accordance with the Regulations.

- All questions of who is an "employee" included in a bargaining unit under the Regulations which are not resolved by the employer and certified trade union will be decided by the Labour Relations Board.

Appendix J

Information Inventory

The Health Labour Relations
Reorganization Commission

3rd Floor, 1870 Albert St.
Regina, Saskatchewan
S4P 3V7
phone: **787-1038/1039** fax: **787-1040**
e-mail: **jim.dorsey.lab@govmail.gov.sk.ca**

Information Inventory

A. HEALTH LABOUR RELATIONS REORGANIZATION COMMISSION

1. Administration

1.1 Administration coding for Commission
1.2 Copy of the letter and contract from Saskatchewan Hotel re Meeting room for Nov. 28/96 (also in the budget file)

2. Appointment

2.1 Letter of Appointment dated July 15, 1996, signed by Eric Cline, Minister of Labour ;
2.2 Minister's Order ;
2.3 Agency Data Update ;
2.4 Health Labour Relations Reorganization Commissioner Briefing Note ;
2.5 Press Release ;
2.6 Copy of Agreement between Her Majesty The Queen and James E. Dorsey (Contract)

3. Bill 120

3.1 Bill 120

4. Held

5. Bill 120 Proclamation

5.1 Bill 120 Proclamation
5.2 Memo dated June 25, 1996, from Allan Barss to Madeleine Robertson, Crown Solicitor, requesting preparation of the Order in Council.
5.3 Memo dated June 27, 1996, from Legislative Services to Allan Barss, enclosing approved Order in Council.
5.4 Memo dated June 25, 1996, from Brian King to Doug Anguish re signing of Order in Council -- NOT SENT

6. Held

7. Held

8. Miscellaneous Commission Correspondence

8.1 Letter dated July 16, 1996, from Gwen Gray to Allan Barss, enclosing a sample form letter to be sent out to parties who have filed applications under *The Trade Union Act*

8.2 Fax to Bonnie Reid of SAHO dated July 25, 1996 enclosing a draft of health sector employer "Profile" and requesting comments

9. Held

10. Health District List; Union List; Speed Dial List

10.1 Saskatchewan Health Districts
10.2 Stakeholders Directory
10.3 Dial Directory Report as of July 19, 1996
10.4 Dial Directory Report as of December 12, 1996

11. Information Bulletins

11.3 Bulletin #1 July 19, 1996
11.4 Fax Cover Sheets and Confirmations re Bulletin #1
11.5 Bulletin #2 August 27, 1996
11.6 Fax Confirmations re Bulletin #2
11.7 Bulletin #3, September 10, 1996
11.8 Fax Confirmation sheet re Bulletin #3
11.9 Bulletin #4, Oct. 1, 1996
11.10 Fax Confirmations re Bulletin #4
11.11 Bulletin #5, Oct. 7, 1996
11.12 Fax Confirmations re Bulletin #5
11.13 Bulletin #6, Oct. 15, 1996
11.14 Fax Confirmations re Bulletin #6
11.15 Bulletin #7, Oct. 28, 1996
11.16 Fax Confirmations re Bulletin #7
11.17 Bulletin #8, Nov. 14, 1996
11.18 Fax Confirmations re Bulletin #8
11.19 Bulletin #9, Nov. 29, 1996
11.20 Fax Confirmations re Bulletin #9
11.21 Bulletin #10, Dec. 16, 1996
11.22 Fax Confirmations re Bulletin #10
11.23 Fax to Jim Dorsey to Allan Barss, draft of Bulletin #11
11.24 Bulletin #11, Jan. 6, 1997
11.25 Fax Confirmations re Bulletin #11

12. James E. Dorsey - C.V.

12.2 Copy of Profile and C.V.

13. Meeting Notes

13.1 Copy of the Agenda for first meeting on July 16, 1996 at Hotel Saskatchewan
13.2 Schedule for Saskatoon meetings of September 26 & 27, 1996
13.3 Schedule for meetings in Regina week of October 1-3, 1996
13.4 Schedule for Regina Public Hearings, Oct. 7, 8 & 9, 1996
13.5 Schedule for Saskatoon Public Hearings, Oct. 10 & 11, 1996
13.6 Schedule for Regina and Saskatchewan meetings, Nov. 4-8/96
13.7 Schedule for Regina meetings, Dec. 10th to 13th, 1996

14. Held

15. News Articles

15.3 Article in the Leader Post - June 6, 1996 based on a leaked copy of the first draft of proposed legislation "Unions could be reshaped"
15.4 Article in the Leader Post - June 7, 1996 "Union says seniority issue won't change"
15.5 News Release by Gov't of Saskatchewan announcing appointment of James E. Dorsey as Health Labour Relations commissioner
15.6 Article in the Saskatoon Star Phoenix dated July 18, 1996 "Nurses say too many hospitals understaffed"
15.7 Article in the Prince Albert Daily Herald dated July 24, 1996 "CUPE ratifies SAHO contract"
15.8 Article in the Saskatoon Star Phoenix dated August 2, 1996 "Medical lab system far from perfect"
15.9 Article in the Saskatoon Star Phoenix dated August 2, 1996 "Wellness model bitter pill for medical lab workers"
15.10 Article in the Prince Albert Daily Herald dated July 26, 1996 "Aides raised under CUPE-SAHO contract"
15.11 Briarpatch for September 1996
15.12 Article in the Toronto Globe & Mail dated August 28, 1996 "The right to the right to strike"
15.13 Article in the Weyburn Review dated August 28, 1996 "Negotiations put on temporary hold"
15.14 Article in the Leader Post dated September 7, 1996 "Aldridge says workers muzzled by health board"
15.15 Article in the Leader Post dated September 7, 1996 "Nurses' group says more staff needed"
15.16 Article in the Star Phoenix dated September 23/96 "Health battle heads to courtroom"
15.17 Article in the Star Phoenix dated September 23/96 "Cut in Dodsland health care fatal"
15.18 Article in The Leader-Post dated October 8/96 "Changes ease McKay's worry"
15.19 Article in The Leader-Post dated Friday, October 18/96 "Nurses circulating health pamphlets"
15.20 Article in The Leader-Post dated October 8/96 "Health sector unions face sorting out"
15.21 Article in The Leader-Post dated October 28/96 "Future of health care discussed at forum.
15.22 Article in The Leader-Post dated October 3/96 "Nurses told contract talks difficult"
15.23 Article in The Leader-Post dated November 25/96 "Melenchuk vows to defeat NDP"
15.24 Article in The Leader-Post dated November 25/96 "Melenchuk eyes health `sham'"
15.25 Article in The Leader-Post dated November 23/96 "Strike vote for health union"
15.26 Article in The Leader-Post dated November 29/96 "SGEU seen as loser in shuffle"
15.27 Article in Prince Albert Daily Herald dated November 30/96 "SGEU fuming over proposal"
15.28 Article in The Leader-Post dated December 14/96 "Home care growing"
15.29 Article in The Leader-Post dated December 14/96 "SGEU angry about health plans"
15.30 Article in The Leader-Post dated December 19/96 "SGEU hasn't done too well"
15.31 Article in The World-Spectator, Moosomin dated Dec. 10/96 "Health Union changes welcomed".
15.32 Article in The Leader-Post dated December 28, 1996 "An Open Letter to the Saskatchewan Governemnt".

16. Held

17. Held

18. Held

19. Employers - Regulations

20. Summary of Submissions to the Public Hearings

21. Research

21.1 Quickcite - case name : Jowsey v. Saskatchewan Government Employees Association
21.2 Written report of CCH DRS 1980 P48-796,S.(1980) 3 W.W.R. 597 Saskatchewan (C.A.) Jowsey and Wilkes v. Saskatchewan Government Employees Association and Brown
21.3 The Labour Relations Board - Binder entitled " Saskatoon District Health Board Applications 270-94; 323-95;324-95; 325-95; 326-95; 327-95; 328-95; 329 & 330"
21.4 The Labour Relations Board - Binder entitled "Saskatoon Health Cases"
21.5 Copy of (1996) S.L.R.B.D. No. 17 - LTB File No. 278-95 between Professional Association of Internes and Residents of Saskatchewan and the University of Saskatchewan - Reasons for Decision.
21.6 Copy of 135 Saskatchewan Reports 77 (1995 Q.B. No. 1923) indexed as: Saskatchewan Medical Postgraduate Committee v. Professional Association of Interns and Residents
21.7 Facts about the American Society of Clinical Pathologists received from Suzanne M. Stock
21.8 Summary of *The Institutes Act* and subsequent court cases
21.9 Copy of LRB File No. 338-84 - Reasons for Decision ; In the matter of an application for an order amending an order of the LRB between G. Wayne Hanna, Agrologist as applicant and Government of Saskatchewan, as respondent and SGEU as respondent union
21.10 Copy of the Decision of the Board - Case No. 22758 and 30717 [1996] B.C.L.R.B.D. No. 292 ; between Pacific Press and Communications, Energy and Paperworkers Union, Graphic Communications International Union, International Association of Machinists and Aerospace Workers
21.11 A guide - State Licensure and Certification of Medical Technologists and Other Laboratory Personnel
21.12 Printouts of affiliate corporate names from The Corporations Branch
21.13 Copy of Reasons for Decision LRB File No. 012-86 between Heather Johnson and the Saskatchewan's Teachers' Federation and Leader School Division #24.
21.14 Copy of LRB File No. 334-75 ; The Saskatchewan Association of Medical Laboratory Technologists and The Board of Governors of the South Saskatchewan Hospital Centre operating as Pasqua Hospital and CUPE Local 1612, Reasons for Decision
21.15 Copy of page 2567 of the Saskatchewan Hansard of June 13, 1996
21.16 Facts about the number of Medical Laboratory Technologists working in Health District facilities/affiliate facilities.

22. Held

23. Final Report

23.1 Reoganization Proposal - November 28, 1996 (Preliminary Report)

24. Report Appendices

24.1 Non-union Employees by Health District and Sector

25. Petitions Submitted to the Dorsey Commission

Held

B. UNION MEMBERSHIP AND FTE INFORMATION

1. Public Service Alliance of Canada (PSAC)

1.1 Union Profile faxed August 1, 1996 from the Commission to the Union
1.2 Fax dated August 26, 1996 advising of expiry dates for its collective agreements
1.3 Union Profile at Saskatoon District Health Board (Saskatoon Vertran's Home) and Fort Qu'Appelle Indian Hospital Ltd.

2. Regina Ambulance and Paramedic Association (RAPA)

2.1 Union Profile faxed August 1, 1996 from the Commission to the Union
2.2 Completed Union Profile
2.3 Completed Union Profile #2
2.4 Union Profile at Regina Health District

3. Health Sciences Association of Saskatchewan (HSA)

3.1 Union Profile faxed August 1, 1996 from the Commission to the Union
3.2 Completed Union Profile
3.3 HSA membership and current certification orders
3.4 Union Profile at Prince Albert Health District (Victoria Union Hospital), Regina Health District (Wascana Home Care #15; Regina General Hospital; Pasqua Hospital; Plains Health Centre)

4. Saskatchewan Government Employees Union (SGEU)

4.1 Union Profile faxed August 1, 1996 from the Commission to the Union
4.2 Fax dated August 29, 1996 advising on membership numbers
4.3 Union Profile for Home Care and Community Health in the Various Health Districts

5. Canadian Union of Public Employees (CUPE)

5.1 Union Profile faxed August 1, 1996 from the Commission to the Union
5.2 Completed Union Profile
5.3 Amalamation of Local 176, Local 3833 and Local 3857
5.4 Union Profile at Hospitals, Home Care etc. in the various Health Districts

6. Saskatchewan Union of Nurses (SUN)

6.1 Union Profile faxed August 1, 1996 from the Commission to the Union
6.2 Completed Union Profile

6.3 Union Profile at Hospitals, Home Care, Care Centre's, etc. in the various Health Districts

7. Service Employees International Union (SEIU)

7.1 Union Profile faxed August 1, 1996 from the Commission to the Union
7.2 Union employee categories and numbers
7.3 SEIU Employee Categories & Numbers by District/Facility
7.4 Union Profile at Hospitals, Home Care, Care Centres, etc. in the various Health Districts

8. Professional Institute of Public Service (PIPS)

8.1 Union Profile faxed August 1, 1996 from the Commission to the Union
8.2 Completed Union Profile
8.3 Union Profile at Saskatoon District Health Board (Saskatoon Vetrans' Home)

9. Physical Therapists Association (PTA)

9.1 Union Profile faxed August 1, 1996 from the Commission to the Union
9.2 Completed Union Profile
9.3 Union Profile at Regina Health District (Wascana Rehabilitation Centre, Plains Health Centre, Pasqua Hospital and Santa Maria Nursing Home)

10. Retail Wholesale and Department Store Union (RWDSU)

10.1 Union Profile faxed August 1, 1996 from the Commission to the Union
10.2 Completed Union Profile
10.3 Union Profile at Regina Health District (Hospital Laundry)

11. Employee Representation by Health District and Union

11.1 Tables of employee representation by Health District and by Union

12. Unrepresented Employees

12.1 Memo and notes on Swift Current Union Hospital

13. Registered Psychiatric Nurses Association (RPN)

C. UNION AND EMPLOYEE SUBMISSIONS

1. Saskatchewan Government Employees Union (SGEU)

1.1 Letter from SGEU, signed by Patricia Gallagher, dated July 22, 1996 (Fax and hard copy) advising the bargaining units represented by SGEU.
1.2 Written submission of the presentation given at the Public Hearings of Oct. 9/96
1.3 Written brief submission dated November 6, 1996 being an SGEU presentation of their meeting with the Commision on November 6, 1996
1.4 Written brief dated November 6, 1996 being a submission of SGEU Community Therapists

1.5 Written brief dated November 6, 1996 being a submission of SGEU Phychiatric Nurses
1.6 Written brief dated November 6, 1996 being a submission of SGEU Public Health Nurses.
1.7 SGEU Actuarial Report prepared by Watson Wyatt on the SGEU LTD Plan as of December 31, 1995
1.8 SGEU LTD plan financial statements as of December 31, 1995
1.9 SGEU Plan Text for the LTD Plan
1.10 Written briefs from 4 Psychiatric Nurses presented to the Commission through SGEU at their meeting with the Commissioner of November 6, 1996
1.11 Copy of an SGEU Memo dated November 4, 1996 from Earlia Folbar to Kathy Dally re SGEU Long Term Disability Plan.
1.12 Copy of SGEU Response to the Commission's Proposal of November 28, 1996.

2. **Registered Psychiatric Nurses Association of Saskatchewan (RPN)**

2.1 Fax memo from Linda Jessett of RPN, dated July 25, 1996, advising Executive Director on holidays until August 7, 1996.
2.2 Letter (their brief) dated September 27, 1996 from Roger Bitschy, President, outlining the union's concerns.

3. **Saskatchewan Union of Nurses (SUN)**

3.1 Letter from Beverly A. Crossman of SUN, dated July 23, 1996, enclosing copies of union Newsletter and Contact (filed under G1.1 and G1.2) and advising of bargaining dates for the month of September 1996.
3.2 SUN Policies
3.3 SUN Bylaws
3.4 SUN Constitution
3.5 Binder encompassing the presentation given at the Public Hearings of Oct. 9/96
3.6 Qualification specifications for three positions in nursing

4. Canadian Union of Public Employees (CUPE)

4.1 Fax from Andrew Huculak to Allan Barss dated July 26, 1996 re classification and wage rates effective October 1, 1993
4.2 Written submission of the presentation given at the Public Hearings on Oct. 8, 1996 together with Appendix I and Appendix II under separate cover
4.3 Copy of a letter to Andrew Huculak of CUPE from Kelly Kummerfield dated November 2, 1996 together with a copy of a draft Service Area Discussion Paper.
4.4 Letter from Andrew Huculak and John Welden of CUPE to the Commission dated December 9, 1996 with a request for further information and clarification of November 28th proposal.
4.5 Fax from CUPE Solicitor, John Elder to Allan Barss dated December 17, 1996 enclosing copy of SLRB decision in Casino Regina.
4.6 Letter from CUPE Local 600 to Jim Dorsey dated December 20, 1996 re Third Unit.

5. Health Sciences Association of Saskatchewan (HSA)

5.1 LRB File No. 210-90 between HSA, Royal University Hospital and SEIU, Reasons for Decision.
5.2 Written submission of the presentation given at the Public Hearings on Oct. 10, 1996
5.3 Fax submission from Alice Robert dated Nov. 8/96 re positions

5.4 Supplementary submission on specific occupations and classifications for inclusion in appropriate all-inclusive professional units
5.5 Letter from Alice Robert to Allan Barss dated December 19, 1996 advising of degree/equivalent professional classifications which should be added to list of occupations and classifications.
5.6 Faxed message from Alice Robert dated December 20, 1996 re further inclusions into "Third Unit"

6. Physical Therapy Association (PTA)

6.1 Written submission dated October 2, 1996 and received October 10, 1996.
6.2 Submission by way of letter from Gail Beggs-Lariviere to the Commissioner dated December 3, 1996 expressing concern of not determining their own union.

7. Professional Institute of the Public Service of Canada (PIPS)

7.1 Written submission dated October 23, 1996 and received October 29, 1996.

8. Retail Wholesale Department Store Union (RWDSU)

8.1 Written submission dated October 25, 1996 and received October 30, 1996

9. Public Service Alliance of Canada (PSAC)

10. Regina Ambulance & Paramedic Association (RAPA)
10.1 Wage comparison chart

11. Service Employees International Union (SEIU)

11.1 Written submission of the presentation given at the Public Hearings on October 10, 1996
11.2 Outline of effects for all Health Districts and Boards
11.3 Supplementary Submission to the Commission dated December 11, 1996.

12. Professional Staff at Pineland Home Care

12.1 Faxed letter signed by the professional staff at Pineland Home Care advising of their wish for new union representation

13. Occupational Therapists (OT's) at Wascana Rehab Centre

1. Written submission for OT's at Wascana Rehabilitation Centre requesting OT's be represented by a different union

14. Saskatchewan Association of Licensed Practical Nurses (SALPN)

14.1 Copy of letter to James Dorsey from Ede Leeson dated October 3, 1996 enclosing copies of 1984/85 Briefs to Government; 1994 Statistics on Membership; Information on trend for

RN's to register as LPN's; and a SALPN "Employers' Kit". (also filed under F.23)

14.2 Faxed copies of letters to SALPN from CUPE dated November 20, 1996 and reply from SALPN to CUPE dated November 26, 1996, submitted to the Commission to represent a reflection of union representation.

14.3 Letter to James Dorsey from SALPN members dated December 12, 1996 urging the Commissioner to place LPN's in the Licensed Provider Unit.

15. Saskatchewan Health Record Association

15.1 Written submission to the Commission dated October 17, 1996

16. Public Health Services (Part of CUPE 59)

16.1 Written submission to the Commission dated November 7, 1996

17. Professional Disciplines at Wascana Rehabilitation Centre
(Social Work; Speech and language Pathology; Psychology; Therapeutic Dietitians)

17.1 Written submission of the professional disciplines at Wascana Rehabilitation Centre to the Commission dated November 8, 1996.

17.2 Letter from Tom Robinson, Psychology Dept., Wascana Rehab Centre to the Commission dated December 10, 1996 advising of his opinions on the set up of the Licensed Providers Unit.

18. Fort Qu'Appelle Indian Hospital

18.1 Fax from SAHO to the Commission dated November 28, 1996 enclosing copy of the Canada Labour Relations Board decision re PSAC, PIPSC and Fort Qu'Appelle Indian Hospital.

18.2 Letter from PIPSC to the Commission dated December 5, 1996 enclosing copy of the Certification Order of the CLRB and the Reason for Decision with respect to the Fort Qu'Appelle Indian Hospital.

19. Canadian Prosthetists and Orthotists

19.1 Written submission of the Canadian Prosthetists and Orthotist to the Commission dated December 10, 1996 and received December 11, 1996

20. Canadian Association for Music Therapy

20.1 Written submission of the Canadian Association of Music Therapy to the Commission dated December 12, 1996 and received December 11, 1996.

20.2 Copy of the Bylaws of the Canadian Association for Music Therapy.

21. Canadian Therapeutic Recreation Association

21.1 Written submission of Lorie Herchuk Norris, Provincial Representative of the Canadian Therapeutic Recreation Association dated December 11, 1996 in support of their desire to

be placed in the Licensed Provider Unit.

22. Saskatchewan Recreation Society

22.1 Written submission of the Saskatchewan Recreation Society to the Commission dated December 12, 1996 indicating desire to be placed in Licensed Provider Unit.

23. Saskatchewan Recreation Society

23.1 Written submission of the Saskatchewan Recreation Society to the Commission dated December 12, 1996 indicating desire to be placed in Licensed Provider Unit.

D. EMPLOYER SUBMISSIONS

1. SAHO

1.1 Bylaws governing the Association
1.2 Written submission of the presentation given at the Public Hearings on October 9, 1996 encompassing Volume I and II
1.3 Copy of a memo from Brian Morgan of SAHO to several Health Districts with copy to Allan Barss requesting further employee information for the Commission.
1.4 Further written submission relating to Volume II of submission given at the Public Hearings.
1.5 Summary of Health Care Professionals by Health District
1.6 Letter from Brian Morgan to Jim Dorsey dated November 19, 1996 as a further submission following meeting of Nov. 6/96.
1.7 Letter from Bonnie Reid to Allan Barss dated November 20, 1996 enclosing information on RN's requested by the Commission
1.8 Letter from Brian Morgan to Jim Dorsey dated December 19, 1996, providing a formal response to the November 28th proposal.
1.9 Letter from Brian Morgan of SAHO to Jim Dorsey dated December 19, 1996 re further submission re November 28th proposal
1.10 Letter from Brian Morgan of SAHO to Jim Dorsey dated December 23, 1996 re presentation to Commission on October 9, 1996 on non-unionized, non-management positions.
1.11 Fax sent to Brian Morgan of SAHO from Allan Barss dated December 23, 1996 in reply to the above letter.
1.12 Transmission Report for the above noted fax - transmission successful.

2. SASKATCHEWAN CANCER FOUNDATION

2.1 BILL 84 of 1979, An Act to establish the Saskatchewan Cancer Foundation
2.2 Saskatchewan Cancer Foundation Annual Report 1994-95
2.3 Written submission subsequent to October 1, 1996 meeting with Mr. Dorsey.

3. REGINA HEALTH DISTRICT

3.1 Written submission of the presentation given at the Public Hearings on October 9, 1996

4. SASKATOON DISTRICT HEALTH

4.1 Written submission of the presentation given at the Public Hearings on October 10, 1996

5. EXTENDICARE

5.1 Written submission to the Commission under letter dated October 11, 1996
5.2 Copies of Certification Orders

6. CIRCLE DRIVE SPECIAL CARE HOME INC.

6.1 Written submission to the Commission under letter dated October 7, 1996

7. ST. ELIZABETH'S HOSPITAL (HUMBOLDT)

7.1 Affiliation Agreement between St.Elizabeth's Hospital and Central Plains District Health Board
7.2 Copy of the Resolutions Pertaining to the Association's Bylaws (affiliates)

8. CATHOLIC HEALTH ASSOCIATION (CHA)

8.1 Copy of the set up for the association
8.2 Copy of a blank Draft Memorandum of Understanding
8.3 Written submission dated November 19, 1996 from Michel G. Thibault further to meeting of October 11, 1996
8.4 Letter from Michel G. Thibault to Jim Dorsey dated November 19, 1996 with comments further to meeting of October 11, 1996.

9. SPRUCE MANOR SPECIAL CARE HOME

9.1 Written submission dated October 25, 1996

10. SUNNYSIDE NURSING HOME

10.1 Written submission of the Sunnyside Nursing Home dated October 7, 1996
10.2 Written submission of The Manitoba-Saskatchewan Conference of The Seventy-Day Adventist Church dated November 7, 1996 re Sunnyside Nursing Home
10.3 Written submission of Sunnyside Nursing Home and Manitoba-Saskatchewan Conference of The Seventh-Day Adventist Church dated November 7, 1996
10.4 Further written submission dated November 14, 1996 to clarify points of discussion during the October 28th meeting.

11. CENTRAL HAVEN SPECIAL CARE HOME INC.

11.1 Written submission dated November 1, 1996 and including a Mission Statement

12. BATTLEFORDS HEALTH DISTRICT

12.1 Written submission dated Nov. 14/96 to clarify information already received.

13. LLOYDMINSTER HEALTH DISTRICT

13.1 Letter from Greg Derkach to the Commission dated December 5, 1996 regarding a statistical error in the employee count reflecting the Lloydminster Health District.
13.2 Fax sent to Greg Derkach from Allan Barss, chart showing the Employee Representation by Health District and Union.
13.3 Fax sent to Allan Barss from Greg Derkach noting revisions to the above noted chart.

E. MEMORANDA AND LETTERS OF INDENT

1. Merger and Transfer Agreement (Labour Adjustment Strategies) between SAHO and CUPE, SGEU, SUN and SEIU
2. Framework Agreement respecting SDH Laboratory Services ; between Saskatoon District Health Board and St.Paul's Hospital as Employers and Health Sciences Association of Saskatchewan - Service Employees International Union Local 333 as Unions - Term of Agreement 1 April 1996 to 31 March 1999

F. CORRESPONDENCE

Held

G. NEWSLETTERS

1. SUN

1.1 Contact and Newsletter received under cover of letter dated July 23, 1996 (letter filed under C3.1)
1.2 Newsletter "In Crisis" received September 16, 1996
1.3 SUN Spots for August 1996

2. RWDSU

2.1 The Defender - RWDSU Newsletter for August 1996

3. C.U.P.E.

3.1 Newsletter received August 20, 1996

4. SAHO

4.1 SAHO NEWS received September 16, 1996
4.2 SAHO NEWS received December 9, 1996

5. SEIU

5.1 Legal Brief dated September 23, 1996, Volume 1, Issue 2

6. SGEU

6.1 Health Sector Newsletter for March 1996
6.2 Health Sector Newsletter for May 1995
6.3 For The Sake of Our Health newsletter
6.4 SGEU Article on DEVOLUTION
6.5 SGEU Communication Update to members regarding the November 28th report of the Dorsey Commission.

7. HSA

7.1 Dispatches newsletter for June 1996
7.2 Dispatches newsletter for July 1996
7.3 Dispatches newsletter for October 1996.
7.4 Dispatches newsletter for December 1996.

H. SASKATCHEWAN HEALTH INFORMATION

1. Map of Health Board Districts
2. List of Cities/Towns/Villages in each Health District
3. Definition of a "Special-car Home"
4. List of Licensed Special-Care Homes.
5. List of Saskatchewan Acute Care Hospitals by District - dated June 1, 1996
6. List of Affiliated Agencies by Health District.
7. Report of the Health Providers Human Resource Committee March 1996 - The Education, Regulation and Utilization of Saskatchewan Health Providers - Adapting to Health Reform and Changes in Society
8. An Executive Summary - The Education, Regulation and Utilization of Saskatchewan Health Providers - Adapting to Health Reform and Changes in Society
9. Health Reform and Health Care Union Jurisdiction (by SAHO) booklet received from Mick Grainger
10. Briefing Note received from Mick Grainger dated September 5, 1996 on the comparison of nursing FTE's since the restructuring of the health system
11. 1995 Saskatchewan Health Employer Survey Summary Report
12. Prairie Region Health Promotion Research Centre, University of Saskatchewan April 29/30, 1996 Conference Proceedings -" Healthy Public Policy Development - Science, Art

or Chance?"

13. Provincial map of the old Saskatchewan Community Health Regions
14. Provincial map of the new Saskatchewan Health Service Areas
15. District Health Board Amalgamations and Affiliations
16. 1996/97 Service Agreement (Master Agreement) between The Saskatchewan Minister of Health and the District Health Boards
17. Northern Health Sector Employees union designation and employee numbers
18. Saskatchewan Health : Direct Service Delivery Personnel
19. Employee Representation by Health District and Union
20. Written submission of the presentation given at the Public Hearings on October 7, 1996
21. Framework Agreement between the Government of Saskatchewan and the Saskatchewan Medical Association and the Saskatchewan Health-Care Association known as the Saskatchewan Association of Health Organizations
22. Copy of Service Area Discussion Paper entitled Population Needs-Based Funding.
23. Copy of Memo from Eric cline, Minister of Health to all District Health Boards enclosing a copy of Walter Podiluk's paper "Partners in Health Care, District Boards - Affiliate Agencies"
24. Copy of Saskatchewan Home Care Program District Boundary Map 1991
25. Collective Bargaining and Unionization - Ambulance Districts
26. Employee numbers and job titles at Calder and SHAP
27. Transfer of community based programs - transitional issue identification and discussion; final draft dated February 21, 1995 with Appendix and Appendix Chart
28. List of health professions regulated by legislation
29. Fax sent to Allan Barss from Len Marinos of a table on the numbers employed by selected sectors for those occupations requested.

I. LEGISLATION

1. Miscellaneous Legislation

1.1 Chapter H-0.01 - An Act respecting Health Districts
1.1a 1996 Chapter 47 - An Act to amend The Health Districts Act, to repeal The Union Hospital Act and The Lloydminster Hospital Act, 1948 and to make consequential amendments to other Acts.
1.2 The Trade Union Act
1.3 The Construction Labour Relations Act, 1992
1.4 Copy of 1959 Act to incorporate Saskatchewan Hospital Association
1.5 Copy of Chapter H-4.01 An Act respecting the Provision of Home Care Services

2. B.C. Health Sector Labour Relations Regulations

2.1 Province of British columbia - Notice of Appointment of a Health Sector Labour Relations Commissioner
2.2 Health Sector Labour Relations Regulation (B.C.)

3. B.C. Bill 48 Amendment to Health Authorities Act

3.1 Bill 48-1994 - Miscellaneous Statutes Amendment Act (No. 2), 1994 (B.C.)

4. Manitoba Regional Health Authorities Legislation

4.1 Manitoba News Release with respect to Regional Health Authorities Legislation Proposed
4.2 Table of Contents of Bill 49 and the sections of Bill 49 dealing with labour relations
4.3 Copy of Bill 49 in its entirety

5. Quebec Sectoral Bargaining Collective Agreement Decrees

5.1 Sectoral Bargaining in Quebec - A Study Of The Act Respecting Collective Agreement Decrees.

J. COLLECTIVE AGREEMENTS

1. PIPSC

1.1 Master Agreement between The Treasury Board and The Professional Institute of the Public Service of Canada (PIPSC) governing the Saskatoon Veterans Home and expires September 30, 1993.
1.2 Rates of Pay schedule dated April 1996, for the above Master Agreement.

2. SUN

2.1 SUN and Saskatchewan Association of Health Organizations (Long Term Care) for the period April 1, 1993 to March 31, 1996
2.2 SUN and Saskatchewan Association of Health Organizations (Acute) for the period April 1, 1993 to March 31, 1996
2.3 SUN and The Canadian Red Cross Society for the period April 1, 1993 to March 31, 1996
2.4 Alphabetical list of union locals.
2.5 Certification Orders
2.6 Applications to Amend Certification Orders

3. P.T. Association

3.1 Physical Therapists and Regina Health Board representing Wascana Rehabilitation Centre, Plains Health Centre and Pasqua Hospital for the period January 1, 1992 to December 31, 1994

4. C.U.P.E.

4.1 C.U.P.E. and Saskatoon District Health Board (Royal University Hospital) for the period October 1, 1991 to September 30, 1994

4.2 C.U.P.E. (Local #600-01) and Souris Valley Regional Care Centre for the period October 1, 1991 to September 30, 1994

4.3 C.U.P.E. (Saskatoon Civic Employee's Union Local No. 59) and the City of Saskatoon for the period January 1, 1993 to March 31, 1995

4.4 C.U.P.E. and Saskatchewan Association of Health Organizations January 1, 1995 to December 31, 1997

4.5 C.U.P.E. Local 3445 and South Eastern Saskatchewan Road Ambulance Association for the period April 1, 1992 to March 31, 1994

4.6 C.U.P.E. Local #974 and The Community Health Services (Saskatoon) Association Limited for the period January 1, 1992 to December 31, 1994

4.7 C.U.P.E. Local 1831 and Community Health Services Association (Regina) Ltd. For the period January 1, 1992 to December 31, 1994

4.8 C.U.P.E. Local 3736 and North Sask. Laundry and Support Services Ltd. Prince Albert, Saskatchewan for the period January 1, 1992 to December 31, 1994

4.9 C.U.P.E. Local 600-6 and The Battlefords Regional Care Centre for the period October 1, 1991 to September 30, 1994

4.10 C.U.P.E. (Local 600-2 Mental Health Centre, Weyburn; Local 600-3 Valley view Centre, Moose Jaw - including Community Living Division; Local 600-4 Mental Health Centre, Yorkton; Local 600-5 Saskatchewan Hospital, North Battleford and Battlefords Mental Health Centre; Local 600-7 Mental Health Centre, Prince Albert) for the period October 1, 1994 to September 30, 1997

4.11 Copy of letter dated August 16, 1996 from Andrew Huculak advising that Local 3727 has not yet achieved a first collective agreement

4.12 Letter of Agreement between Regina Health District and CUPE (Locals 7, 176, 1612, 1838) dated 1993 governing vacancies arising when eligible employees elect not to transfer with their service

4.13 Letter of Understanding between Regina Health Board and CUPE (Locals 176 RGH,1612 PH, 1838 PHC); SGEU (WRC); SUN (Locals 105 PH, 74 PHC, 106 RGH); HSA (PH, PHC, RGH); and Physiotherapists SSHC (WRC) dated November 25, 1996 governing movement of employees between the named bargaining units

4.14 Letter of Understanding between The Prince Albert Health Board, Holy Family Hospital, Victoria Union Hospital, Mont St.Joseph Nursing Home and CUPE Locals 81, 84 and 1518

5. **SGEU**

5.1 SGEU Certification Orders

5.2 SGEU and The Government of Saskatchewan for the period October 1, 1994 to September 30, 1997

5.3 SGEU and Saskatchewan Association of Health Organizations - Home Care Unionized Health Districts for the period April 1, 1995 to March 31, 1998

5.4 SGEU and The Saskatchewan Cancer Foundation for the period October 1, 1991 to September 30, 1994

5.5 SGEU and Regina Health District Board, Pipestone Health District Board and North Central Health District Board for the period January 1,1995 to December 31, 1997

5.6 SGEU compilation of RN's and ex.R.N.'s in non-acute care facilities

6. PUBLIC SERVICE ALLIANCE OF CANADA (PSAC)

6.1 PSAC and Treasury Board re: General Services (supervisory and non-supervisory) expires August 4, 1991

6.2 PSAC and Treasury Board re: Clerical and Regulatory (all employees) expires June 11, 1991

6.3 PSAC and Treasury Board re: Hospital Services (supervisory and non-supervisory) expires June 21, 1991

6.4 PSAC and Treasury Board re: Master Agreement - agreement between the Treasury Bd and PSAC - expires according to Article M-43 in the Agreement and is group specific

6.5 PSAC and Treasury Board re: General Labour and Trades (supervisory and non-supervisory) expires May 4, 1991

6.6 Agreement between The Government of Canada, The Government of the Province of Saskatchewan and Saskatoon District Health Board dated 18 April, 1995 with respect to the Saskatoon Veterans Home

7. SERVICE EMPLOYEES INTERNATIONAL UNION (SEIU)

7.1 SEIU Certification Orders

7.2 Balance of SEIU Certification Orders

7.3 Collective Agreement between Extendicare Health Services Inc. and SEIU Local 299 and 333, A.F.L. - C.I.O. - C.L.C. for the period January 1, 1992 to December 31, 1994

7.4 Memorandum of Agreement between Saskatchewan Association of Health Organizations and SEIU for the period January 1, 1992 to December 31, 1994

7.5 Collective Agreement between Saskatchewan Association of Special Care Homes and SEIU for the period 1 January 1992 to 31 December 1994

7.6 Collective Agreement between Saskatchewan Health-Care Association (Special Care Homes) and SEIU for the period January 1, 1992 to December 31, 1994

7.7 Collective Agreement 1992 - 1994 between The Canadian Red Cross Society Blood Transfusion Service, Regina, Saskatchewan and SEIU Local 299, Chartered by Service Employees International Union A.F.L. - C.I.O. - C.L.C.

7.8 Memorandum of Agreement between The Moose Jaw Alcohol & Drug Abuse Society Inc. (Angus Campbell Centre) and SEIU Local 299 for the period April 1, 1992 to March 31, 1995

7.9 Memorandum of Agreement between Moose Jaw - Thunder Creek Health District (Central Butte Ambulance Service) and SEIU Local 299 affiliated with Service Employees International Union A.F.L. - C.I.O. - C.L.C. for the period June 7, 1993 to December 31, 1994

7.10 Memorandum of Agreement between Lifeline Ambulance Service Ltd. and SEIU Local 299 for the period February 1994 to December 31, 1996

7.11 Letter of Understanding (regarding implementation of the SEIU - SAHO Acute Care Collective Agreement at Palliser Regional Care Centre and certain local conditions applicable thereto) between SEIU Local 336 and Palliser Regional Care Centre, operated by the Swift Current District Health Board (January 1, 1992 to December 31, 1994)

7.12 Collective Agreement between Chantelle Management Ltd. at Swift Current Care Centre and SEIU Local 336 for the period January 1, 1993 to December 31, 1994

7.13 Collective Agreement between The Board of Governors of the St.Louis Alcoholism Rehabilitation Centre and SEIU Local 333 for the period April 1, 1992 to March 31, 1995

7.14 Collective Agreement between The Canadian Red Cross Society Blood Transfusion Service, Saskatoon, Saskatchewan and SEIU Local 333 for the period January 1, 1992 to December 31, 1994

7.15 Memorandum of Agreement between Cheshire Homes of Saskatoon and SEIU Local 333 for the period April 1, 1993 to March 31, 1996

7.16 Memorandum of Agreement between SEIU Local 333 and Meadow Lake Management Limited for the period May 1, 1995 to April 30, 1998

7.17 Memorandum of Agreement between Elmwood Group Homes of Elmwood Residence Limited and SEIU Local 333 for the period January 1, 1992 to December 31, 1995

7.18 Memorandum of Agreement between Elmwood Residences Limited and SEIU Local 333 for the period January 1, 1993 to December 31, 1995

7.19 Memorandum of Agreement between The Young Women's Christian Association of Saskatchewan and SEIU Local 333 for the period January 1, 1993 to December 31, 1994

7.20 Memorandum of Agreement between Prince Albert Group Homes Society Inc. and SEIU Local 333 for the period of April 1, 1993 to March 31, 1996

7.21 Memorandum of Agreement between SEIU Local 333 and Battlefords' Ambulance Care Ltd. for the period July 1, 1993 to June 30, 1996

7.22 Binded copies of Certifications with all the District Health Boards

8. HEALTH SCIENCES ASSOCIATION OF SASKATCHEWAN (HSA)

8.1 SAHO representing Regina District Health Board, Saskatoon District Health Board and Prince Albert District Health Board and Health Sciences Association of Saskatchewan for the period January 1, 1992 to December 31, 1994

9. RETAIL, WHOLESALE AND DEPARTMENT STORE UNION (RWDSU)

9.1 RWDSU Certification Orders

9.2 RWDSU and The Regina District Health Board Laundry Services Department and expires December 31, 1994

9.3 RWDSU Certification Order

10. EXTENDICARE HEALTH SERVICES INC.

10.1 Collective Agreement between Extendicare Health Services Inc. and SUN for the period April 1, 1993 to March 31, 1996.

11. REGINA AMBULANCE AND PARAMEDIC ASSOCIATION (RAPA)

11.1 Copy of Certification Order

11.2 Collective Agreement between Regina Area Municipal Road Ambulance District and Regina Ambulance Paramedics Association (Local 3268) of the International Association of Fire Fighters, for the period May 25, 1993 to December 31, 1994

11.3 Memorandum Agreement between Regina District Health Board and Regina Ambulance Paramedics Association Local 3268 of the International Association of Fire Fighters for the period January 1, 1995 to December 31, 1997.

12. SUMMARY OF COLLECTIVE BARGAINING AGREEMENTS

K. OTHER JURISDICTIONS

L. HEALTH BOARDS

Assiniboine Valley District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Battlefords District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board
2. Copy of letter from George Gillies, President of Battlefords Health District to Honourable Robert Mitchell, Minister of Labour dated August 21, 1996, wherein Gillies provides Mitchell with written notice under Section 44.1(1) and (2) of The Labour Standards Act, that the Health District will be terminating 30 employees as of October 25, 1996.

Central Plains District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

East Central District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Gabriel Springs District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Greenhead District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Living Sky District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Lloydminster District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Midwest District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Moose Jaw - Thunder Creek District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Moose Mountain District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

North Central District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

North Valley District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

North-East District Health Board

1. Cc: of letter from Sandra Morgan, Deputy Minister of Labour to Mr. Tim Hobbins, Human Resources Coordinator of North-East District Health Bd., dated July 25, 1996.
2. Amalgamations of Health Corporations to make up the District Health Board

Northwest District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Parkland District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Pasqua District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Pipestone District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Prairie West District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board
2. Cc (to Allan Barss) of letter dated August 9, 1996 from Gwen Gray Vice-Chairperson of Saskatchewan Labour Relations Board addressed to Melanie Medlicott of C.U.P.E., regarding LRB File #051-96 Application to Amend - Jubilee Lodge, Local 3427, together with a copy of enclosures mentioned therein

Prince Albert District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Regina District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Rolling Hills District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Saskatoon District Health Board

1. List of Unions and locals in District
2. Letter from Evert Van Olst dated July 23, 1996, requesting he be added to mailing list and advising of PIPS as a Union stakeholder
3. Amalgamations of Health Corporations to make up the District Health Board

South Central District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

South Country District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Southeast District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Southwest District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Swift Current District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Touchwood Qu'Appelle District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Twin Rivers District Health Board

1. Amalgamations of Health Corporations to make up the District Health Board

Northern Health Services Branch

1. Union membership and FTE's for the four northern institutions

M. DEPARTMENT OF LABOUR INFORMATION

1. Union Membership Survey, Jan. 1995 re SGEU Regina
2. 1996 Saskatchewan Union Membership Survey re Health Sciences Assoc. Saskatoon
3. 1996 Saskatchewan Union Membership Survey re SEIU Local 299 Moose Jaw
4. 1996 Saskatchewan Union Membership Survey re SEIU Local 336 Swift Current
5. 1996 Saskatchewan Union Membership Survey re SEIU Saskatoon
6. 1996 Saskatchewan Union Membership Survey re SUN Regina
7. Union Membership Survey, Jan 1995 re CUPE Regina
8. 1996 Saskatchewan Union Membership Survey re Retail, Wholesale and Department Store Union (RWDSU) Regina
9. 1996 Saskatchewan Union Membership Survey re Physical Therapists Association (PTA) Regina
10. Directory of Labour Organizations in Saskatchewan - 1992
11. 1996 Saskatchewan Union Membership Survey (CUPE)
12. Saskatchewan Labour Relations Board Annual Report 1993-94
13. Saskatchewan Labour Relations Board Annual Report 1994-95
14. Saskatchewan Labour Annual Report 1994-95
15. B.C.'s Health Sector Collective Bargaining Restructuring: An Unfolding Story - A paper by James Dorsey presented to the Alberta Health Care Conference in Edmonton, September 24, 1996.
16. Pre-Conference Papers entitled " Emerging Labour Relations Issues in the New Health Care Environment" - Alberta Labour Relations Board conference of Sept. 24 & 25, 1996, in Edmonton
17. Evolution of Trade Union Act
18. Restructuring the Saskatchewan Health Care Industrial Relations System
19. The Labour Relations of Health Restructuring: Saskatchewan and Alberta ; Kurt Wetzel and Larry Haiven, University of Saskatchewan, 1996 CIRA Conference
20. Copy of "A Review of Health Care Labour Relations in British Columbia: The New Order" by Colin Taylor, Q.C. at the Canadian Institute Conference "Labour Management Symposium - Breakthrough Strategies for Today & Tomorrow" held in Vancouver, B.C. on October 10 & 11, 1996
21. Memo from Gwen Gray to Allan Barss dated October 29, 1996 re outstanding LRB files and attaching a list of said outstanding files for the health care sector.

22. Memo from Steven B. at Minister's Office re article in Dec, 10/96 issue in the World-Spectator (Moosomin newspaper)

N. Held

O. Held

P. **E-MAIL MESSAGES**

1. August 1/96 E-mail from Theodore (Ted) Koskie re Sec. 9 of the Health Labour Relations Reorganization Act
2. September 11, 1996 E-mail from Robert Hurlburt requesting that he be added to our mailing list for Information Bulletins, etc.
3. December 10, 1996 E-mail from Phyllis of the Premier's office re question regarding who requested reorganization commission. She would like a brief history on commission & players. Jim requested that Allan prepare a response.

Q. **OTHER EMPLOYERS NOT YET DESIGNATED**

1. **Saskatchewan Cancer Foundation**

1.1 Copy of LRB Order on an Amendment Application between Saskatchewan Cancer Foundation and SGEU dated December 9, 1991

2. **Athabasca Health Authority Inc.**

2.1 Memo from N. Duane Adams, D.M. of Health dated August 26, 1996 enclosing a copy of the Agreement and Record of Understandings regarding the establishment of Athabasca Health authority Inc. And the construction thereof.

3. SGEU and HOME CARE UNITS (Northern)

3.1 LRB Order between SGEU and GREEN LAKE HOME CARE SERVICES dated May 16, 1995
3.2 LRB Order between SGEU and TURNOR LAKE HOME CARE ASSOCIATION INC. Dated April 24, 1995
3.3 LRB Order between SGEU and BUFFALO NARROWS HOME CARE INC. Dated April 24, 1995
3.4 LRB Order between SGEU and MICHEL VILLAGE & ST. GEORGE'S HILL HOME CARE INC. Dated April 24, 1995
3.5 LRB Order between SGEU and ILE A LA CROSSE HOME CARE INC. dated April 24, 1995
3.6 LRB Order between SGEU and BEAUVAL HOME CARE SERVICES INC. dated April 24, 1995

4. NORTH SASK. LAUNDRY & SUPPORT SERVICES LTD.

4.1 Corporation's branch printout

R. THE SASKATCHEWAN LABOUR RELATIONS BOARD 1986 REVIEW

1. Appropriate Bargaining Units in the Health Care Industry - A Brief submitted to The Saskatchewan Labour Relations Board by The Health Sciences Association of Saskatchewan ; September 29, 1986

2. Saskatchewan Health Care Appropriate Bargaining Units - submitted to The Saskatchewan Labour Relations Board by the Saskatchewan Government Employees' Union ; September 1986

3. Copy of a memo from Public Service Commission Employee Relations Division to Saskatchewan Labour Relations Board dated September11, 1986 re: Request for Submissions Respecting Appropriate Units for Collective Batgaining Purposes and signed by John McPhail, Assistant Chairman

4. Submission of Canadian Union of Public Employees to the Saskatchewan Labour Relations Board - Respecting Appropriate Units for Collective Bargaining Purposes in Hospitals, Nursing Homes and other Health-Care Institutions.

5. Submission regarding request for submissions respecting appropriate units for collective bargaining purposes in hospitals, nursing homes and other health-care institutions from Physical Therapists employed at Pasqua Hospital, Plains Health Centre and Wascana Rehabilitation Centre to Saskatchewan Labour Relations Board

6. Submission of the Saskatchewan Federation of Labour to The Labour Relations Board - Regarding Appropriate Units for Collective Bargaining Purposes; September 1986

7. Brief for the Saskatchewan Labour Relations Board regarding Policies Determining Appropriate Units for Bargaining Purposes in Special Care Homes - Saskatchewan Association of Special Care Homes ; October 1986

8. A Brief prepared by the Unity Union Hospital for submission to The Saskatchewan Labour Relations Board September 18, 1986 - Appropriate Units for Collective Bargaining Purposes

9. Written Submission to The Labour Relations Board on behalf of: Service Employees International Union ; Mitchell Taylor Romanow Ching law firm

10. Saskatchewan Union of Nurses' Submission to The Saskatchewan Labour Relations Board on Health-Care Bargaining Units; September 22, 1986

11. Submission of The Saskatchewan Health-Care Association to The Saskatchewan Labour Relations Board on the question of Appropriate Bargaining Units in Health Care Institutions in Saskatchewan

12. Copies of The Saskatchewan Labour Relations Board newspaper article requesting

submission on Appropriate Bargaining Units for Health Care Institutions; article informing of the dates and times of public hearings on the matter and a copy of the hearings agenda.

13. Applications by Health Sciences Association of Saskatchewan (HSA) to Labour Relations Board, Saskatchewan to Amend and Consolidate - as follows:
1. **LRB File #5-1** - HSA as Applicant and Saskatoon District Health Board, Royal University Hospital and Saskatoon City Hospital as Respondent
2. **LRB File #5-2** - HSA as Applicant and Saskatoon District Health Board, Royal University Hospital and Service Employees International Union, Local 333 as Respondent
3. **LRB File #5-3** - HSA as Applicant and Saskatoon District Health Board, Saskatoon City Hospital and Service Employees International Union, Local 333 as Respondent
4. **LRB File #5-4** - HSA as Applicant and Saskatoon District Health Board, Parkridge Centre and Service Employees International Union, Local 333 as Respondent
5. **LRB File #5-5** - HSA as Applicant and St. Paul's Hospital and Service Employees International Union, Local 333 as Respondent
6. **LRB File # 5-6** - REPLY with Service Employees International Union, Locals 333 and 333UH as Applicant and Saskatoon District Health Board and Health Sciences Association of Saskatchewan as Respondent

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Appendix K

Information Bulletins

The Health Labour Relations
Reorganization Commission

3rd Floor, 1870 Albert St.
Regina, Saskatchewan
S4P 3V7
phone: **787-1039** fax: **787-1040**
e-mail:

Information Bulletin #1 July 18, 1996

COMMISSION BEGINNINGS

Statute Proclaimed
The Health Labour Relations Reorganization Act was proclaimed into force as of July 12, 1996.

Commissioner Appointed
Labour Minister Eric Cline announced the appointment of Jim Dorsey as Commissioner effective July 15, 1996.

"Reorganizing the health delivery system has created new employment relationships across the province," Cline said. "As a result, both the Saskatchewan Association of Health Organizations and the major health care unions came to us and requested that government appoint a commissioner to help develop a new framework for labour relations in Saskatchewan's health sector."

"I am confident that Mr. Dorsey can develop this new framework that will stand to benefit the employees as well as facilitate the integration of health services for a more efficient and effective health delivery system," he said.

"Mr. Dorsey brings a wealth of experience to this task and is eminently qualified to carry it out."

Commissioner Jim Dorsey
Jim Dorsey has served as a vice-chair of the Canada Labour Relations Board and, in 1995, worked as British Columbia's Health Sector Labour Relations Commissioner, recommending new bargaining unit structures covering 97,000 employees and 416 employers.

He has also written books and articles on employment law.

Mr. Dorsey grew up in Prince Edward Island and received his B.A. from St. Dunstan's University in Charlottetown, and his L.L.B. from Dalhousie in 1973. He and his wife Oriette have one daughter, and live in Lion's Bay, B.C.

Commission Staff
Allan Barss is the legal analyst and will be coordinating most of the research. He can be reached at 787-9737, or e-mail at: allan.barss.lab@govmail.gov.sk.ca

Grace Marbach is the administrative assistant and will co-ordinate the meetings, hearings and other activities of the Commissioner. She can be reached at 787-1038 or 787-2389.

Ted Boyle will provide communications support and can be reached at 797-4156.

Terry Stevens, the Executive Director of Labour Relations, Mediation and Conciliation Services in Saskatchewan Labour, will also provide support to the Commissioner. He can be reached at 787-5050 or on his cell at 536-1921.

How to Reach the Commission

The Commissioner's office is located in the south-east corner of the 3rd floor, 1870 Albert Street, Regina. You can phone any one of the staff above, or fax at 787-1040. An internet e-mail address will be available soon.

First Meeting

The Commissioner met with representatives of five health care unions and a representative of many of the employers on the morning of July 16.

Those in attendance and the organizations they represent were as follows:

Bev Crossman - SUN
Pat Gallagher - SGEU
Andrew Hucylak - CUPE
John Weldon - CUPE
Doug Lavallee - CUPE
George Wall - SEIU
Ted Koskie - SEIU counsel
Alice Roberts - HSA
Tim Slatery - HSA
Brian Morgan - SAHO
Bonnie Reid - SAHO counsel
Jim Ferguson
- Saskatoon District Health Board
Norma Reynolds - Regina Health District

The Process

The process will be a mixture of private meetings with the parties to hear and understand their points of view, Commission research and public presentations. Neither the available time nor the resources allow the Commission to undertake original research or extensive directed research. The Commission will rely on the interested parties to provide relevant data and information.

All materials presented or acquired by the Commission will be available to all. A system is being implemented to provide updated lists of these materials to all.

Operating Signposts

The following values and goals will serve as Commission signposts in the performance of its mandate: openness, fairness, impartiality, independence, integrity, respectfulness, economy, efficiency, effectiveness, thoroughness, principled decision making, pragmatism and creativity.

PARTIES POTENTIALLY AFFECTED

"Health Sector Employers"
The district health boards are easily identified. The Commission is compiling a list of the hospitals and other institutions approved pursuant to *The Hospital Standards Act* and the special care homes licensed pursuant to *The Housing and Special-care Homes Act.*

Are there any other persons whom the Commissioner should recommend be included as a health sector employer by Cabinet regulation under clause 6(6)(b)? Are there non-governmental organizations, social service organizations, province-wide service organizations, aboriginal operated services or any other that should be considered for inclusion as a health sector employer?

Trade Unions and Employee Associations
The following trade unions have been identified as parties likely to be affected by the work of the Commission:

- Canadian Union of Public Employees (CUPE) (locals have yet to be identified)
- Service Employees International Union (SEIU)
- Saskatchewan Union of Nurses (SUN)
- Saskatchewan Government Employees Union (SGEU)
- Health Sciences Association of Saskatchewan (HSA)
- Public Service Alliance of Canada (PSAC)
- Retail, Wholesale and Department Store Union, Saskatchewan Joint Board (RWDSU)
- Physical Therapists Association (PTA)
- Regina Ambulance and Paramedic Association (RAPA)

Are there any other voluntarily recognised or certified trade unions? Are there any uncertified employee associations or trade unions?

"Employees"
Employees are persons who are employees within the meaning of *The Trade Union Act.* They may include employees who are not presently represented by a trade union.

Who might these employees be? Who are their employers? What patient care or other health care role do they have?

GATHERING FOUNDATIONAL DATA

The Commission will establish a data base that will enable it to generate outcomes based on various options or scenarios in establishing appropriate bargaining units and collective bargaining structures.

The initial intention is to use data as of **August 1, 1996** or as close to that date as is convenient for parties to use for purposes of their individual records.

The data is to identify the number of persons - employers, employees and trade unions. While many sources of data will use FTEs, the goal is to identify counts of persons.

Individual names will not be sought, unless they are persons who are not presently represented by a trade union.

It is accepted that in this approach persons who are employed part-time by more than one employer may be counted more than once. As a result, there may be a discrepancy between the number of employees and the number of trade union members.

Profiles to be Created

1. **Present number of unionized employees** by trade union representation, employer, health service sector (e.g. mental health) and occupation (e.g. nurse or support worker)

The proposed list of health service sectors is as follows:

- acute care
- long-term care
- home care
- mental health
- public health
- ambulance
- community services

The proposed list of occupations is as follows:

- ambulance worker
- nurse
- pharmacist
- support worker
- technician
- therapist

Are these lists complete, appropriate, too detailed or not detailed enough?

2. **Present profile of employers** (the legal name), their status (e.g. district health board), the employer organization representing them, trade union representation, number of employees and bargaining units represented by each trade union and collective agreement expiry dates.

The proposed employer status designations are district health board, affiliated, denominational, profit. Are these appropriate? What others should there be?

PUBLIC PRESENTATIONS

The Commission is intending to set a time at which affected parties may make a written and public presentation to the Commission.

The time that is being considered is the week of October 7-11, 1996. Does this conflict with any other event in your calendars? Should the presentations be made in Regina, Saskatoon, or both?

LABOUR RELATIONS BOARD PROCEEDINGS

During the term of the commission's work certain proceedings may not commence or continue before the Labour Relations Board. Section 9 of the Act reads as follows:

9(1) During the period prescribed in subsection (2):

(a) no trade union or other person shall make any application to the board pursuant to *The Trade Union Act* with respect to any matter that is or may be covered by the regulations to be made by the commissioner; and

(b) the board shall not consider any application, including any application made before this Act comes into force, with respect to the matters mentioned in clause (a).

(2) For the purposes of subsection (1), the prescribed period commences on the date this Act comes into force and ends on the earliest of:

(a) the date the regulations made by the commissioner are filed with the Registrar of Regulations;

(b) 90 days from the date the commissioner submits the regulations to the minister pursuant to subsection 6(3); and

(c) a date set by the Lieutenant Governor in Council.

The Board has informed the Commission that these applications would include:

- certifications [5(a), (b) and (c)]
- amendments or recisions [5(j),(k) and (m)]
- managerial exclusions [5(j), (k) and (m)]

It advises that if a party disagrees with the Board's decision to defer, then a hearing will be convened by the Board to determine the issue.

In future bulletins the Commission will identify those applications the Board has determined are affected by s. 9(1)(b). In this respect the Commission has already received a letter from the North-East Health District regarding a community health nurse in the Village of Zenon Park and surrounding area. The nurse's position is in-scope, but there is a dispute between SUN and SGEU as to which union should be the representative. This matter would normally be decided by the Board, but instead the employer has brought it to the attention of the Commission.

COMMISSION ENDING

The Minister has determined that January 15, 1997 is the date by which the Commission will submit regulations to the Minister. The Commissioner intends to prepare a workplan that will enable him to submit the regulations on or before this date.

ONGOING COMMUNICATIONS

In order to facilitate communication and keep everyone informed about the activities of the Commission we are planning to issue periodic bulletins like this one. As long as it is useful we will continue. We welcome all suggestions of this vehicle for communication.

We invite you to share these bulletins with any party that you feel may be affected by the work of the commission. If you did not receive this bulletin directly and would like to receive regular mailings, please provide us with your name and a fax number where we can send it.

We also invite communication from you. If your organization publishes a newsletter we would like to be placed on your mailing list.

The Health Labour Relations
Reorganization Commission

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Information Bulletin #2 Aug. 27, 1996

HEALTH BARGAINING UNITS IN OTHER JURISDICTIONS

United States

In 1987 the American National Labour Relations Board undertook an extensive review of its approach to determining appropriate bargaining units in various types of health care facilities. Hearings were held in Washington, Chicago and San Francisco. The hearings were intended to provide:

"...actual, empirical, practical evidence offered by industry and union representatives who have themselves participated in or observed bargaining in the health care industry in various configurations. The Board also desires evidence from witnesses with direct knowledge about any recent changes in the delivery of health care, such as cost containment, allegedly greater integration of function between categories of health care employees, and changes in function of specific classifications of health care employees, including greater or lesser degrees of specialization, that may have an impact on the question of appropriate units."

The NLRB acted under its "rulemaking" authority, and in 1989 found that two broad units - all professionals and all non-professionals - would unduly hamper organization and effective bargaining. It decided on eight units for acute care hospitals:

- all registered nurses
- all physicians
- all professionals except registered nurses and physicians
- all technical employees
- all skilled maintenance employees
- all business office clerical employees
- all guards
- all nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees and guards.

In other health care facilities the Board declared that it would decide appropriate bargaining units on a case by case basis as it received certification applications.

The Saskatchewan LRB has no comparable statutory authority to issue general guidelines; however, the Board does issue practice notes from time to time which provide general guidance concerning the policy of the Board on particular issues.

Alberta

The Alberta *Regional Health Authorities Act* created 17 regional health authorities to deliver health care under a new system of governance. Several provincial hospitals moved from the public sector collective bargaining to the general collective bargaining regime and legislation. The legislation preserved certifications and collective agreements at those facilities.

As a practice, the Alberta Labour Relations Board has recognized five standard units in the hospital sector:

- direct nursing care
- auxiliary nursing care
- paramedical professional
- paramedical technical
- general support services

It has also recognized three standard units in the community health sector:

- nursing care
- professionals
- general support services

The ALRB announced in June, 1994 that it would continue to recognize its eight standard units. Where regions integrate hospital services and community health, the Board announced that it will use the five standard hospital units.

British Columbia

In July of 1993 the *Health Authorities Act* was enacted to create the first stage in the establishment of regional health boards and community health councils across British Columbia. This legislation followed a 1992 Royal Commission Report on Health Care and Costs entitled *Closer to Home* and a 1993 government policy entitled *New Directions For A Healthy British Columbia.*

In 1995 the Health Sector Labour Relations Commission was appointed to make recommendations regarding the composition of the appropriate bargaining units in health care in B.C. In June of 1995 the Commission recommended new bargaining unit structures covering 97,000 employees and 416 employers. At the core of the report was a recommendation to establish 10 multi-employer bargaining units based on five appropriate unit descriptions:

- residents
- nurses
- paramedical professionals
- health service and support - facilities
- health service and support - community

The recommendations of the Commission were implemented by the *Health Sector Labour Relations Regulations.*

Prince Edward Island

On September 30, 1993 the province proclaimed its *Health and Community Services Act*, implementing recommendations from the Transition Team report entitled *Partnership for Better Health.* It enabled a Health and Community Services Agency, a Council on Health and Community Services and Regional Health Authorities. Health care management responsibilities were to be transferred from the responsible provincial ministry, hospitals and other organizations to these new bodies.

Vince Ready and Colin Taylor were appointed to inquire into and report on an appropriate system of collective bargaining and a system for determining appropriate bargaining units and representational and boundary dispute resolution. They also had the power to issue orders and deal with any related issue in a rights or interest arbitration capacity. Four units were ordered:

- nurses
- administrative and social services, including dieticians, social workers, nursing attendants, nurse 3 and nurse supervisors
- acute care technical, including many clerical
- support and maintenance

One union was named to represent each of the bargaining units, as Messrs. Ready and Taylor were satisfied that each union enjoyed a clear majority of support in their respective appropriate units. This avoided the potential for divisiveness and conflict that can arise as a result of a representational vote.

One group of 300 licensed nursing assistants were evenly represented by two unions and a representational vote was held to decide that specific issue. In the end, over 750 or 23% of the employees changed bargaining agents. Several union activists and executive members were among those who changed bargaining agents. The changes in representation were as follows:

Union	Before	After	Difference
UPSE	1690	1366	-324
IUOE	440	535	+ 95
CUPE	563	660	+ 97
PEINU	560	692	+132

UPCOMING CONFERENCE

The Alberta Labour Relations Board is sponsoring a conference entitled "Emerging Labour Relations Issues in the New Health Care Environment". This one and one-half day event will explore labour relations issues that are continuing to emerge in the health care environment. Dates are September 24 and 25 in Edmonton, Alberta. For more information contact Nancy McDermid at (403) 297-2338.

FOUNDATIONAL DATA

As mentioned in the first Information Bulletin, the Commission is establishing a data base that will enable it to generate outcomes based on various options or scenarios in establishing appropriate bargaining units and collective bargaining structures.

The Commission has received data from some sources and is expecting the rest shortly. It will be shared back through future Information Bulletins as the information is collated.

PUBLIC PRESENTATIONS and OTHER MEETINGS

Public presentations are being considered for the week of October 7-11, 1996, in Regina. Arrangements must be made soon for an appropriate hearing room so if that time causes major problems for you or your organization please contact the Commission as soon as possible.

Jim Dorsey will also be in Regina during the week of September 3-6. He will be in Saskatoon September 26 and 27. During these times he will be meeting with various parties. If you would like to meet with Jim or have him attend a function please contact Grace at 787-1038.

THE "Ps" AND "Rs"

Public Institute of Professional Service (PIPS)
PIPS represents nurses and dieticians at the Saskatoon Veterans Home, a special care home that has recently merged with Sherbrooke Community Centre. They are currently covered by the larger federal collective agreement which expires in March of 1997.

Public Service Alliance of Canada (PSAC)
PSAC also has a unit at the Saskatoon Veterans Home as well as a unit at the Fort Qu'Appelle Indian Hospital. They represent maintenance staff, clerical, food preparation and laundry, and licensed practical nurses. The collective agreements expire in May, June and August of 1997.

Physical Therapists Association (PTA)
The PTA is a voluntarily recognized employee association which represents physical therapists at the Wascanna Rehabilitation Centre, the Plains Health Centre, the Pasqua Hospital and the Santa Maria Nursing Home in Regina. The collective agreement expired in 1994.

Regina Ambulance and Paramedic Association (RAPA)
RAPA is certified to represent Emergency Medical Technicians (EMTs), Paramedics and communications officers working for the Regina Health Board. The collective agreement expired on December 31, 1994.

Retail Wholesale and Department Store Union (RWDSU)
RWDSU, which is the largest private sector union in the province, has represented laundry workers at the Hospital Laundry in Regina for the past 20 years. The collective agreement is expired and it is currently in negotiations with the Regina District Health Board.

ADMINISTRATIVE MATTERS

The Commission is currently compiling documents and other information which will be listed and available for scrutiny. We are also trying to identify all of the interested parties and their contacts. If you know of some person or organization that should be included please let us know. We especially need to identify any employers who should be included within the scope of the commission's inquiry.

For example, some ambulance workers are employed by a district health board and some are employed by private contractors. The employees of the private contractors would not be involved in the inquiry unless their employers were designated as "health sector employers" by regulation. If there are employers you think should be designated the Commission should be advised as soon as possible.

The Health Labour Relations
Reorganization Commission

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Information Bulletin #3 Sept. 10, 1996

MORE THRESHOLD QUESTIONS

Who are the "*Health Sector Employers*"?

The Health Labour Relations Reorganization Act says that this group includes district health boards, hospitals, nursing homes, licensed special-care homes and other approved institutions under three statutes: *The Health Districts Act, The Hospital Standards Act* and *The Housing and Special-care Homes Act.* The Commissioner is attempting to identify each of these through Saskatchewan Health records and hopes to have a list for your review in the near future.

A "*health sector employer*" may also be "*any other person who is prescribed in the regulations made by the Lieutenant Governor in Council*". [2(f)(iv)] However, the Cabinet is given the authority to make these regulations only on the recommendation of the Commissioner. [6(7)]

The Commissioner wishes to identify who the persons are, if any, that should be considered for, and asked for their views on, such a recommendation.

Do you know of anyone who should be considered? What about laboratory and ambulance employers, the Saskatchewan Cancer Foundation, northern autonomous health care providers, or aboriginal health care services?

Undefined Words and Phrases

Other than "*health sector employer*", a defined term with a special process to have its scope enlarged, the Cabinet may make regulations "*defining, enlarging or restricting the meaning of any word or phrase used in this Act but not defined in this Act*". [6(6)(a)]

Are there any words or phrases that are likely to require defining, enlarging or restricting to enable or assist the Commission in fulfilling its mandate? Could they include phrases in the mandatory factors that the Commissioner must consider, such as "*the new employment relationships that have been established*", "*integration of the delivery of health services*", "*development over time of consistency in terms and conditions of employment*" or "*orderly collective bargaining*"? [5(6)]

Given subsection 2(2), can a word or phrase that is defined in *The Trade Union Act* be defined with a different meaning in this Act?

> **2(2)** *Unless a contrary intention is expressed in this Act or the regulations, the words and phrases defined in The Trade Union Act apply to this Act, the regulations and any order made pursuant to this Act.*

Scope of "*Organization of Labour Relations*"

The Commissioner is responsible to "*examine the organization of labour relations between health sector employers and employees.*" [5(1)]

What are all the aspects to be examined?

"New Employment Relationships"

The Commissioner must consider:

> **5(6)(a)** *the new employment relationships that have been established and that will be established as a result of restructuring the delivery of health services pursuant to the enactment and application of The Health Districts Act*;

What person or persons are the most authoritative source of information about the new employment relationships that "*will be established*"?

"Orderly Collective Bargaining"

The Commissioner must consider:

> **5(6)(e)** *the history of trade union representation amongst employees of health sector employers and the need to promote orderly collective bargaining between health sector employers and employees.*

What is the need that is being referred to and what is envisioned as orderly collective bargaining?

"Additional Matters"

The Commissioner must consider "*any additional matters prescribed in the regulations made by the Lieutenant Governor in Council*". [5(6)(e)] The Cabinet is expressly authorized to make these regulations in clause 6(6)(c). No regulations have been made.

Is there a time in the Commission's process at which any regulations must or should be made? Should the regulations made by the Cabinet require the Commissioner to consider such additional matters as provincial general revenue funding constraints or expenditure priority decisions, public sector collective bargaining policies, respect of employee wishes, inter-union or intra-union merger or amalgamation agreements?

Regulation Format

The Commissioner is to make regulations that are to be filed with the Registrar of Regulations in accordance with *The Regulations Act, 1989.* The Commissioner will determine the limitations and requirements with respect to format and language that is preferred or required.

Within the permissable options, do you have a preference about language (which will be gender neutral) or format that will make the regulations most easily accessible to you and your members or those you represent?

Amending, Varying or Rescinding LRB Orders

Regulations made by the Commissioner may amend, vary or rescind an order of the Labour Relations Board. [7(3)]

Have you identified any LRB orders that you will be asking the Commissioner to amend, vary or rescind?

Stay of Proceedings before the LRB

Since July 12, the date the Act came into force:

> **9(1)(a)** *no trade union or other person shall make any application to the board pursuant to The Trade Union Act with respect to any matter that is or may be covered by the regulations to be made by the commissioner; and*
> **(b)** *the board shall not consider any application, including any application made before this Act comes into force, with respect to the matters mentioned in clause (a).*

The period ends the earliest of:

> **9(2)(a)** *the date the regulations made by the commissioner are filed with the Registrar of Regulations;*
> **(b)** *90 days from the date the commissioner submits the regulations to the minister pursuant to subsection 6(3); and*
> **(c)** *a date set by the Lieutenant Governor in Council.*

The Cabinet has the express authority to make a regulation setting a date for the purposes of clause 9(2)(c) in clause 6(6)(d).

Do you have an application that is being delayed or prevented from being considered because of this provision? Is anyone subject to ongoing harm or loss? What are the circumstances that might require the setting of an earlier date by regulation?

Other Matters or Things

The Cabinet has the express authority to make regulations "*respecting any other matter or thing the Lieutenant Governor in Council considers necessary to carry out the intent of this Act.*" [6(6)(e)]

Have you identified what another matter or thing may be?

HEALTH REFORM READINGS

Much has been written about health reform. Some of the material that the Commission has read include:

Armstrong, Pat and Hugh Armstrong. *Wasting Away: The Undermining of Canadian Health Care*. Don Mills: Oxford University Press, 1996

Dector, Michael B. *Healing Medicare: Managing Health System Change the Canadian Way*. Toronto: McGilligan Books, 1994

Evans, Robert B., Morris L. Barer and Theodore R. Marmor, ed., *Why are Some People Healthy and Others Not? The Determinants of Health of Populations.*
Aldine de Gruyter series, 1994

Fulton, Jane. *Canada's Health System: Bordering on the Possible*. Faulkner & Grey, 1993

Haivan, Larry. "Industrial Relations in Health Care: Regulation, Conflict and Transition to the Wellness Model" in Swimmer and Thompson, ed., *Public Sector Collective Bargaining in Canada: Beginning of the End or End of the Beginning?* Queen's University: IRC Press, 1995

NUPGE, *Restructuring Health Care: Update* (April, 1994)

Rachlis, Michael and Carol Kushner. *Second Opinion: What's Wrong with Canada's Health Care System.* Scarborough: HarperCollins Publishers, 1989

Rachlis, Michael and Carol Kushner. *Strong Medicine: How to Save Canada's Health Care System.* Scarborough: HarperCollins Publishers, 1993

Sutherland, Ralph, and Jane Fulton. *Spending Smarter and Spending Less: Policies and Partnerships for Health Care Reform in Canada.* The Health Group, 1994

Can you suggest an other material that would help inform the Commission?

PUBLIC MEETINGS

Public meetings will be held October 7-9 in Regina at the Department of Labour Training Room on the 2nd floor, 1870 Albert Street, and October 10 in Saskatoon at the LRB hearing room on the 2nd floor, Sturdy Stone Building. Please contact Grace at 787-1038 to book a time for your presentation.

The process will be informal to enable an exchange between the presenter and the Commissioner. If you are planning to bring documents, please bring two copies for the Commissioner and his staff, as well as enough copies to distribute to other interested parties who may be in attendance.

All parties will be welcome to any and all sessions. As well, the meetings will be open to the public and the media should they choose to attend; however, no steps are being taken to advertise or invite representation beyond trade union bargaining agents and employers potentially affected by the Commission's inquiry.

ADMINISTRATIVE MATTERS

The Commission is compiling documents and other information. This information is listed on an Inventory of Documents. If you would like a copy of the Commission's Inventory of Documents, please contact Grace. All documents are available for scrutiny at the offices of the Commission.

If a document is in the Commission's Inventory, it is not necessary to reproduce it for your brief or any other submissions to the Commission unless you want to refer to parts of it during the discussion.

COMMISSION MILESTONES

July 15	Appointment
July 16-17	1st meeting with Minister and parties
July 19	1st Information Bulletin
August 26	2nd Information Bulletin
Sept. 3-6, 26,27, October 1-4	1st round of consultations
Sept. 10	3rd Information Bulletin

ONGOING INQUIRY

The Commissioner was in Regina the week of September 3-6 and met with CUPE, SGEU, and SAHO. He also met with the new Minister of Labour, Bob Mitchell, as well as officials from the Department of Health and board members of the Saskatchewan Registered Psychiatric Nurses Association.

On September 26 and 27 the Commissioner has meetings set up with SEIU, HSA and SUN.

The Commissioner will also be in Regina the week of October 1-4 to meet with interested parties. If you would like to meet with Jim during that time please contact Grace.

The Health Labour Relations
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Information Bulletin #4 Oct. 1, 1996

PUBLIC MEETING SCHEDULE

(as of Sept. 30,1996)

Regina Meetings October 7 - 9

October 7th
1:00 - 3:00 Saskatchewan Health
3:00 - 5:00 available to be booked

October 8th
9:00 - 12:00 available to be booked
1:00 - 3:00 CUPE
3:00 - 5:00 available

October 9th
9:00 - 11:00 SGEU
11:00 - 12:30 SUN
1:00 - 3:00 Regina District Health Board
3:00 - 5:00 SAHO

Saskatoon Meetings

October 10th
9:00 - 11:00 HSAS
11:00 - 12:00 available to be booked
1:00 - 3:00 Saskatoon District Health Board
3:00 - 5:00 SEIU

Please call to book an available time

PRELIMINARY FOUNDATIONAL DATA

Attached is a table containing a summary of the data that we have received. We have not received any data from SAHO as yet. The Commission would like to know if the information is inaccurate or incomplete.

We would also like your views on the formatting and presentation of the data.

PARTIES

"Health Sector Employers"
The 30 district health boards have been identified. The Commission has a list of the 435 agencies that have been amalgamated to form the District Health Boards. The Commission also has a list of the 76 hospitals and other institutions approved pursuant to *The Hospital Standards Act* and the 167 special care homes licensed pursuant to *The Housing and Special-care Homes Act.*

Is there any other persons whom the Commissioner could recommend be included as a health sector employer by Cabinet regulation under clause 6(6)(b). Suggestions to date include:

- MDS Labs (private, for-profit)
- Ambulance contractors (eg. MD Ambulance)
- Saskatchewan Cancer Foundation
- Canadian Red Cross
- Metis Addictions Society
- St. Louis Rehabilitation Centre
- Angus Campbell Rehabilitation Centre
- Transition House Society
- Tri-Hospital Courier Corporation
- Transplant Program
- Tuberculosis Clinic
- Saskatchewan Air Ambulance
- 15 Northern Sask Home Care Boards
- Athabasca Health Authority

If you have an opinion on these or any other

employers, you should tell the Commissioner why they should or should not be included. What are the sound operational or policy reasons that they should be included.

Trade Unions and Employee Associations

The following # certified or voluntarily recognized trade unions are parties affected by the work of the Commission:

- Canadian Union of Public Employees (CUPE) 139 Locals
- Service Employees International Union (SEIU) 3 Locals
- Saskatchewan Union of Nurses (SUN)
- Saskatchewan Government Employees Union (SGEU)
- Health Sciences Association of Saskatchewan (HSAS)
- Public Service Alliance of Canada (PSAC) 2 Locals
- Professional Institute of the Public Service of Canada (PIPS)
- Retail, Wholesale and Department Store Union, Saskatchewan Joint Board(RWDSU)
- Physical Therapists Association (PTA)
- Regina Ambulance and Paramedic Association (RAPA)

"Employees"

Employees are persons who are employees within the meaning of *The Trade Union Act.* They include employees who are not presently represented by a trade union. It appears that there are unrepresented employees working in administrative roles in district health board offices, in home care and in some institutions. More information is needed to clearly identify who these employees may be. The Commission also needs to identify how these employees may be heard in the process.

THE "C", "H" AND "S" UNIONS

Canadian Union of Public Employees

CUPE represents about 9,810 health care workers in 139 locals. Its members include support workers in acute and long term care facilities in Regina, Prince Albert, and smaller communities. Included in the total is CUPE 600, which represents over 1000 psychiatric nurses and support workers who provide mental health services. CUPE's structure is highly decentralized. Each local is an autonomous unit holding its own certification.

Service Employees International Union

SEIU represents about 8,647 health care workers in 3 locals covering 100 locations. Its members are mostly support workers concentrated in acute and long term care facilities in Saskatoon, Moose Jaw, and Swift Current. SEIU also represents some support workers in Regina and smaller communities.

Saskatchewan Government Employees Union

SGEU represents approximately 3,654 health care workers. Its members are nearly evenly divided between long term care facilities, home care, and community services in Regina, Saskatoon, and smaller communities. Many of SGEU's members worked for the Department of Health prior to health reform, and moved to employment with the Districts when community health services such as Public Health and Mental Health were devolved to the Districts.

Saskatchewan Union of Nurses

SUN represents 7,884 nurses in 238 local units. All certifications are held by SUN of Saskatchewan. Its members work primarily in acute care facilities throughout the province with a smaller number in long term care facilities and home care.

Health Sciences Association of Saskatchewan

HSAS represents 747 health care workers (full time equivalents) in 8 local units. All certifications are held by HSAS. Its members are paramedical workers concentrated in Saskatoon with smaller numbers in Regina and Prince Albert.

CENTRAL ORGANIZATIONS

The Saskatchewan Association of Health Organizations

SAHO was formed through the amalgamation of three provincial health care employer associations: the Saskatchewan Health-Care Association with members from acute care facilities; the Saskatchewan Association of Special Care Homes; and the Saskatchewan Home Care Association. The employer associations came together in response to restructuring of the health care system.

The Provincial Council of Health Care Unions

Unions which represent large numbers of health care workers have formed the Provincial Council of Health Care Unions. Representatives of CUPE, SUN, SEIU, and SGEU are meeting regularly to discuss issues of mutual concern.

FOR THE RECORD

From time to time individuals and organizations will comment publicly on the work of the Commission.

Excerpts from "The Defender"

One recent critical comment appeared in the August edition of "The Defender", a newsletter published by the RWDSU. The entire article is not reproduced here, but the following excerpts give an idea of R.W.D.S.U.'s concern:

"The cornerstone of the Saskatchewan Trade Union [Act] for more than 50 years has been the right of workers to join and participate in Unions of their own choosing. However, this right no longer exists for thousands of health workers as a result of the adoption by the N.D.P. of the Health Labour Relations Reorganization Act at the last session.

Under the new law a Commissioner... will attempt to persuade Unions in the health care sector to reduce the number of bargaining units. A simple example would be an agreement to have all nurses belong to the Saskatchewan Union of Nurses. If the unions currently representing nurses cannot agree, the all powerful Commissioner could order that it be done regardless of the wishes of the employees or unions involved..."

"Although R.W. is not a major player in health care we have represented employees of the Regina Hospital Laundry for over twenty years. However, two other large health care unions represent workers in two other similar laundries and we fear that we will be lost in the shuffle when it comes time to decide which union will be assigned the jurisdiction."

"All in all [this] is a very frightening law. Those unions who have supported it in the hope they may gain new members without spending the time and effort to organize them, may regret their decision before long."

Excerpts from "Dispatches"

The following is from the Health Sciences Associations of Saskatchewan (HSAS) June 1996 newsletter:

"In the near future either the Labour Relations Board or an independent Commissioner will ultimately determine whether there is a future for a professional health care union in Saskatchewan."

From the HSAS July 1996 newsletter:

"It was precisely to prevent the Labour Relations Board from dealing with inter-union jurisdictional issues that the large health care unions, SEIU, SGEU, SUN and CUPE, with the subsequent concurrence of SAHO, petitioned the provincial government to establish this commission.

. . .

The concern of our union, at the end of the day, is that groups of health care professional paramedicals may be forced into unions not of their own choosing."

COMMISSION MILESTONES

July 12	Proclamation
July 15	Appointment
July 16-17	1st meeting with Minister and parties
July 18	1st Information Bulletin
August 27	2nd Information Bulletin
Sept. 3-6	1st round of consultations - Regina
Sept. 10	3rd Information Bulletin
Sept. 26,27	1st round of consultations - Saskatoon
October 1-4	1st round of consultations - Regina
October 1	4th Information Bulletin
October 7-11	Public meetings - Regina & Saskatoon
November 4-8	2nd round of consultations - Regina

ADMINISTRATIVE MATTERS

The Commission's compilation of documents is listed on an Inventory of Documents. If you would like a copy of the Inventory please contact Grace. All documents are available for scrutiny at the offices of the Commission.

If a document is in the Commission's Inventory, it is not necessary to reproduce it for your brief or any other submissions to the Commission unless you want to refer to parts of it during the discussion.

ONGOING INQUIRY

The Commissioner was in Saskatoon on September 26 and 27 and met with representatives of SEIU, HSAS, SUN, the Veterans Affairs Employees Union (PSAC), Saskatoon District Health Board and Elizabethan Health Services (Humboldt).

The Commissioner is in Regina October 1-3 to meet with interested parties. There are still some times available. If you would like to meet with Jim during this time please contact Grace.

B.C. EXPERIENCE

Jim delivered a paper on the B.C. experience of health care bargaining unit reorganization at the recent conference in Edmonton sponsored by the Alberta Labour Relations Board. The conference explored many topics related to labour relations issues in the new health care environment. Copies of Jim's paper, entitled "B.C.'s Health Sector Collective Bargaining Restructuring: An Unfolding Story", will be available at the Commission's office in Regina. Pre-conference discussion papers on bargaining units, geographic boundaries and standard bargaining units are also available. We don't expect the proceedings of the conference to be available until later this fall.

CODE OF REGULATORY CONDUCT

The province has a Code of Regulatory Conduct to guide those preparing regulations for consideration by the Executive Government of Saskatchewan.
The intent is to guide policy makers so that regulations are only proposed when they are absolutely necessary.

The originator of regulations is responsible to "examine non-regulatory alternatives" and to "identify the potential costs and benefits to business and individuals resulting from the proposed regulations".

The regulatory proposal should contain "clearly articulated policy objectives and criteria on which decisions will be made and implemented". Requirements are to be "communicated in an understandable manner".

The regulatory process is to be characterized by:

- advance notice and information on proposed regulatory initiatives to the sectors most affected by them;
- opportunity for affected sectors to provide input;
- regular review to ensure continued relevancy; and
- efforts to minimize regulatory conflicts.

MANITOBA ADOPTS COMMISSION APPROACH

The Manitoba government has introduced Bill 49, *The Regional Health Authorities and Consequential Amendments Act.* Part 6 contains transitional provisions respecting labour relations and employees.

The Minister of Health may appoint a commissioner who "shall make recommendations for each regional health authority." There are provisions respecting which existing collective agreements are interim collective agreements in a region. Within six months after employment of the first employee or other effective dates the regional health authority or bargaining agent may serve notice

to bargain.

SASKATOON VETERANS HOME

The Saskatoon Veterans Home, built in the mid 60's as a 70 bed facility, was operated by the Federal Government Department of Veteran Affairs exclusively for veterans. Effective March 1, 1996 it was one of the last veterans facilities to be transferred by the Government of Canada to a provincial authority. This transfer came together with a commitment for contribution ($6 million, indexed) to the capital cost of building a 40 bed unit to which veterans will have priority access.

The Saskatoon Veterans Home building and land were leased to the Saskatoon District Health Board (SDHB) for three years for $10 per year. The lease may be extended. The SDHB could also purchase all the furnishing, equipment, etc. for $10 on the transfer date.

The veterans' access to the new veterans unit to be built will not be exclusive; rather, it will be priority access to the first bed available for the level of care required.

For 10 years the Federal Government will pay the cost of veterans' health services. After that the amount reduces each year to zero in the 14th year.

Under the agreement between the SDHB, the province and the Government of Canada, the SDHB may delegate its responsibilities. Currently responsibility for the operation of the facility is with the Sherbrooke Community Centre.

An annexed staff employment agreement provides that each employee shall be offered employment consistent with "the qualifications, functions and level of responsibility of the substantive position" held at Veteran Affairs Canada. The terms and conditions of employment with the SDHB to be covered in the letter of offer are to be as follows:

(a) An employee will be paid at the local pay rate, except that where the local pay rate is less than the regular pay rate in effect for the employee on the day immediately prior to the transfer date, the employee will be paid the regular pay rate until the local pay rate equals or exceeds the regular pay rate and, from and after that time, the employee will be paid the local pay rate;

(b) The regular pay rate shall include any retroactive increase in the regular rate agreed to or authorized by Canada after the transfer date but applicable in respect of any period prior to the transfer date;

(c) On employment by the Board pursuant to subclause 3(c), on a date subsequent to the transfer date, an employee shall be paid at the local pay rate then in effect. In relation to this employee, the regular pay rate in effect at the transfer date shall apply until the local pay rate equals or exceeds the regular rate pay rate and, from and after that time, the employee will be paid the local pay rate;

(d) The Board shall give recognition to an employee's length of service for the purposes of determining staff seniority; vacation leave schedules; lay off; and leave and benefit entitlements.

(e) An employee on probationary status with the Department at the transfer date shall on commencing employment with the Board, remain on probationary status for the stipulated period, or such lesser period imposed by the Board. In either case, the employee's probationary period commences from the date of appointment with the Department.

(f) The Board shall determine the increment date for an employee based on their last date of appointment with the Public Service of Canada;

(g) (i) The Board shall credit an employee with sick leave earned with the Public Service of Canada but not utilized by the employee prior to the transfer date;

(ii) From the transfer date, an employee will be eligible for sick leave benefits in accordance with the existing collective agreements or personnel policies of the Board;

(iii) The Board shall grant an employee sick leave, first, against credits earned with the Public Service of Canada but not utilized by the employee prior to the transfer date; and, second, in accordance with leave benefits to which the employee is entitled with the Board

after the transfer date; and

(iv) The Board shall not be required to pay, and an employee shall not be entitled to payment, for those sick leave credits earned but not utilized by the employee while with the Public Service of Canada, which have not been utilized by the employee at the date of termination or retirement of the employee from the Board.

"Length of service" is the period of continuous service in the Public Service of Canada as defined in the *Public Service Staff Relations Act*. "Continuous service" is defined in the Treasury Board Pay Manual, ch. 3, sec. 3, sec. 3.1 - revised September 1, 1992.

"Regular pay rate" is the annual basic rate of pay received by the employee, and includes supervisory differential, bilingual bonus and educational, speciality and responsibility allowances. "Local pay rate" has a similar meaning.

Union representation is addressed as follows:

Canada and the Board acknowledge that the employees of SVH are currently represented by the Public Service Alliance of Canada or the Professional Institute of the Public Service of Canada and acknowledge that this jurisdiction will be transferred to the appropriate union or unions holding jurisdiction within the Board at the transfer date.

AFFILIATES

Affiliates health care providers are separate health care providers who contract with District Health Boards to provide health care services. They are "health sector employers" if they are licensed under *The Hospital Standards Act* or *The Housing and Special Care Homes Act.*

There are 74 affiliates of the 30 District Health Boards. They were expressly recognized in 1996 amendments to *The Health Districts Act.* This Act has yet to be proclaimed into force but it is expected to be in the near future. Regulations will follow that designate each affected facility as an "affiliate".

Affiliates may be private for private profit enterprizes like Extendicare Ltd. or Chantelle Management. They may be denominational societies seeking to make profits for charitable intent like Elizabethan Health Services. They may be private for profit enterprizes not licensed under either statute like MDS Laboratories Inc. or ambulance services.

Some may have facilities in more than one district and affiliation agreements with more than one district. Some, like the Shellbrook Community Society may operate other facilities like the Saskatoon Veterans Home under operating contract with the district. Some like Elizabethan Health Services may provide services from one district into another district. Perhaps these employees will physically go to the other district to perform some services.

Are there other employers who are likely to become affiliates? Are there any other types of relationships or arrangements among existing affiliates that have not been identified?

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Information Bulletin #5 Oct. 7, 1996

FOUR UNIONS PROPOSED COMMISSION

On March 13, 1996 CUPE, SEIU, SUN and SGEU jointly proposed in writing, that the government create an independent Commission. Meetings following the SLRB pre-hearing meeting arising out of Saskatoon District applications, led them to conclude that "the problem raised by the employer in Saskatoon, must be resolved on a province-wide basis, as they are not peculiar to a single employer."

The proposal reads, in part, as follows :

" *Up until this point in time, it had been hoped by all parties that the problems of intermingling and unit construction resulting from the reform process, could be solved by the unions themselves, without having to use a third party. However, because of the complexity of changing bargaining unit configuration uniformly across the province, and changing the provincial bargaining framework to conform to that new reality, the union's have determined that the Saskatoon application would not provide for the ability for all affected employees and employers to have input.*

There is currently no legal authority to change the bargaining unit structure outside of applications to the Labour Relations Board on an individual employer basis by either the union or District Board, which would be an incredibly time-consuming and costly process for all concerned, considering there are thirty employers involved. In addition, the Board has no authority to order broader and more cost-effective mechanisms for bargaining multi-employer / multi-union collective agreements.

We, the undersigned unions, are therefore requesting that the Government appoint an independent Commission to hear representations from all affected parties.

The Mandate of such a Commission shall be :

1. *To determine appropriate bargaining unit configuration for Health Districts in the province, taking into account the principles of The Trade Union Act ;*
2. *Ensure to the extent possible that current representation rights enjoyed by the unions are preserved ;*
3. *Enforce provincial bargaining arrangements between the parties.*

The Commission would be composed of a single Commissioner with sufficient staff and resources to carry out its' mandate in a timely and efficient manner.

In the interests of expediting the resolution to these problems, we are requesting that the Commission, once established, conclude it's work in six months."

HSAS was unwilling to become a signatory to the proposal but committed to co-operate fully if a Commissioner were appointed.

"We couldn't sign the joint request if the terms of reference did not include the right of employees to choose their own union."

SAHO joined the unions in making the joint proposal to the government.

SASKATOON HEALTH DISTRICT: LRB APPLICATIONS FOCUS DISCUSSIONS

In late 1995 the SLRB received multiple, competing applications as a result of restructuring in the Saskatoon Health District.

The Saskatoon District Health Board applied to the SLRB to :

- recognize it as the successor employer to several employers and parts of business

- create three bargaining units - all registered graduate and psychiatric nurses employed and functioning as such; certain professional employees; and all other employees.

SEIU Locals 333 and 333UH applied to consolidate its existing units into a district-wide unit and expand its bargaining rights at Royal University and Saskatoon City Hospitals. At Border Union Hospital it relied upon an assignment of bargaining rights to SEIU, Local 333 by CUPE, Local 2065.

HSAS applied to consolidate and expand its units at Royal University and Saskatoon City Hospitals; be certified for a unit of 14 physical therapists, occupational therapists, social workers and speech language pathologists represented by SEIU, Local 333 at Parkridge Centre; and expand its unit at St. Paul's Hospital to include technologists (laboratory, radiology, ECG and orthopaedic) and respiratory therapists. The HSAS made similar applications to consolidate its four units in the Regina Hospital and for successorship with the Prince Albert District at Victoria Hospital.

The Board's pre-hearing on the applications was held January 10, 1996. As a result of the subsequent mediation and discussions among these and other parties that lead to the establishment of the Commission, the applications have not been heard by the Board.

LRB SPOTLIGHTS HEALTH CARE DISPUTES

In its 1993-94 and 1994-95 Annual Reports, the SLRB included comments on health industry proceedings in its summary of significant activities during the year.

" In St.Paul's Hospital, LRB File No. 292-91, the board refused an invitation by the Health Sciences Association to recognize standard bargaining units at acute care hospitals. The Board also refused to remove technical employees from the general service unit and create a separate unit for them " (1993-94, pg.6)

" In Saskatoon City Hospital, LRB File No. 266-93, the board again refused an invitation to recognize standard bargaining units at acute care hospitals. Generally, in the health care sector, the restructuring of health care has continued to generate a number of applications as unions and employers struggle to adjust to the changes. The territorial struggle between the Health Sciences Association and the Service Employees Union continued (see Parkridge Centre, LRB File No. 015-94; Royal University Hospital, LRB File No. 272-93; Saskatoon City Hospital, LRB File No. 266-93; Wascana Rehabilitation Centre, LRB File No. 265-93) " (1994-95, pg.4)

PREVIOUSLY "DEVOLVED" HEALTH SECTOR EMPLOYERS

In the 1970's the provincial government set up the Parkland Regional Care Centre, Lakeside Nursing Home at Wolseley, Wascana Rehabilitation Centre, and Palliser Regional Care Centre as self governing autonomous employers.

The SGEU was the successor trade union representing bargaining units of all employees at each facility.

In 1982 the SEIU, Local 336 applied for certification at the Palliser Regional Care Centre in Swift Current. SUN intervened. The LRB deemed an all employee unit, including nurses, to be appropriate and ordered a representation vote.

There were 201 eligible votes and 176 cast ballots. 75 voted for SGEU and 101 for SEIU, Local 336. The LRB certified SEIU, Local 336 in early 1983.

Today SGEU has a single collective agreement covering Parkland, Lakeside and Wascana Rehabilitation Centre.

NURSE NUMBERS

SUN reports its membership at 7,884. The SRNA has 9500 active members. The SRPNA has 1200 active members. Some nurses may be registered with both SRNA and SRPNA.

SAHO tentatively reports that its members employ 8,812 nurses. Some may be employed with more than on employer.

Information from Saskatchewan Health's annual health employer survey shows a reduction of 220 or 3.8% since 1991 and a shift in registered nursing positions among sectors.

Nursing FTE Positions in Selected Sectors 1991 - 1995

Sector	1991	1992	1993	1994	1995
Acute Care	4041	3931	3676	3662	3288
Special Care	886	1055	983	914	994
Community Services	227	283	309	288	357
Home Care	242	240	335	396	387
Health Centres	99	121	140	195	228
Sask. Health	33	44	45	40	41
Mental Health	245	197	247	275	309
TOTAL	5822	5868	5735	5770	5602

PRESCRIBED AFFILIATES AND AGREEMENTS WITH DISTRICT BOARDS

Amendments this year to *The Health Districts Act* require that there be a written agreement between a district health board and affiliate before any funding is provided by the board to the affiliate, more than 120 days after it is prescribed.

The agreement must :

" *(a) provide for an audit of the accounts of the affiliate at least once in each fiscal year by an independent auditor who possesses the prescribed qualifications and is appointed for the purpose by the affiliate;*

(b) set out the services to be provided for the district health board by the affiliate;

(c) set out the funding to be provided by the district health board and stipulate that the funding is to be used for no purpose other than providing services;

(d) require the affiliate to provide to the district health board in a timely manner any information requested by the district health board, in any form requested by the district health board, respecting the activities of the affiliate that the district health board requires to fulfil its responsibilities pursuant to this Act;

(e) specify the term of the agreement and provide for termination of the agreement by either party on not less than 180 days' notice to the other party;

(f) set out a process for resolving disputes under the agreement, including the provision of remedies for breaches of the agreement; and

(g) provide for any other prescribed matter. "

If a board and affiliate are unable to agree and mediation by a Ministerial appointee is not successful, the Minister may:

"*set the terms governing the provision of funding by the district health board to the affiliate for services provided by the affiliate and the provision of services by the affiliate to the district health board, and those terms are deemed to constitute a written agreement required by subsection (1) that is binding on the parties.* "

The Cabinet may appoint a public administrator to manage the affairs of an affiliate if the Minister is of the opinion that:

"*(a) the safety of persons cared for by the affiliate is, for any reason, being jeopardized;*

(b) the members of the board of the affiliate have

resigned and are not being immediately replaced;

(c) the affiliate is not otherwise carrying out its responsibilities under an agreement pursuant to section 26.1; or

(d) for any other reason, it is in the public interest that a public administrator be appointed."

An "affiliate" is a person who operates a facility in or from which services are provided, receives funding from a district health board to operate the facility and is prescribed by regulation as an affiliate.

The Cabinet makes the regulations prescribing affiliates.

To date these amendments have not been proclaimed into force, although proclamation is expected shortly. As far as we know, regulations will not be developed until the amendments to the Act are proclaimed.

RECENT READINGS

Some of the Commission's recent readings are:

- Collen Slater-Smith - *You Can't Eat Dedication: A History of the Saskatchewan Union of Nurses* (SUN: Regina, 1987)

- Health and Welfare Canada - *Achieving Health for All: A Framework For Health Promotion* (Canada:Ottawa, 1987; and Supplement to CMAS March 1, 1987 issue)

- Saskatchewan Commission on Directions in Health Care - *Future Directions For Health Care in Saskatchewan* (Government of Saskatchewan: Regina, 1990)

SASKATCHEWAN CANCER FOUNDATION

Cancer affects 1 in 3 people of whom 50% will die from the disease. In 1991 in Saskatchewan 6,300 people were diagnosed with cancer. It is expected to be 7,500 in the year 2000, including those with non-melanoma skin cancer.

There are 26,800 people dealing with cancer in Saskatchewan: 5,300 are being followed by Cancer Centres and 21,500 are on active follow-up by community physicians. 27,000 people in Saskatchewan are considered cured.

The Saskatchewan Cancer Foundation was established in 1979 by *The Cancer Foundation Act*. Its governing body must include three individuals agreed to by the Minister and each of The College of Physicians and Surgeons, the Dean of the College of Medicine and the Saskatchewan Division of the Canadian Cancer Society. The current board includes a member from the Saskatoon and Regina Health Districts. It is one of seven similar provincial foundations in Canada. The Foundation's purpose is to conduct a program for the diagnosis, prevention and treatment of cancer, which includes all forms and types of malignant and premalignant conditions. The mandatory aspects of the program are listed in the statute.

Prior to the Foundation, this mandate was the responsibility of the Government of Saskatchewan and the Saskatchewan Cancer Commission operating under *The Cancer Control Act.*

REGINA DISTRICT HEALTH BOARD LAUNDRY SERVICES

In 1971 the Hospital Laundry Services of Regina was incorporated as a regional shared-services laundry corporation with its own board of directors, it charged hospitals and others for its services. Several hospitals and other laundry departments were closed and the employees were hired by the corporation.

The R.W.D.S.U., Local 568 was certified December 15, 1971 to represent the employees.

A new laundry at 1001 Montreal Street in

Regina was built in 1985. Major upgrades in equipment occurred 5 years ago.

The corporation was amalgamated with the Regina District Health Board at the time that board came into existence. The term of the first collective agreement between R.W. and "the Regina District Health Board Laundry Services Department" expired December 31, 1994, and has yet to be renewed.

There are now 78 employees in the bargaining unit. The laundry works one shift, Monday to Friday. A local city driver is part of the bargaining unit. Other transportation is done by private courier services.

How may other "laundry workers" are there in the Regina District?

There are other laundry services set up in the province to do laundry from multiple sites. Most of these are in existing facilities and the employees are employed by a district health board. How may laundry workers are there in the province?

Some districts have joined together to utilize a central facility for to their laundry. One example is the laundry in Prince Albert. A separate non-profit corporation called North Sask. Laundry & Support Services Ltd. was established in 1967 to operate the facility. Today the Board includes members from the Battleford, Central Plains, Gabriel Springs, North Central, North West, Twin Rivers, Parkland, Pasquia, Prince Albert and North East health districts. The La Ronge Health Centre also has a seat on the Board. Since the employees of this laundry are employed by the corporation, not by the health districts, it will not be included in the regulations of the Commissioner unless the corporation is prescribed as a "health sector employer" by a Cabinet regulation. Should it be included? Are there any other laundries or other corporations providing services dedicated to health districts?

LICENSED PRACTICAL NURSES

In 1994 there were 2262 LPN's registered with the Saskatchewan Association of Licensed Practical Nurses. They were employed in the following sectors:

Acute/general hospital	1077
Nursing home	306
Rural Hospital	268
Rehabilitation	112
Doctor's offices	68
Extended care hospital	61
Home Care	60
Community Health	20
Public Health	11
Psychiatric Hospital	10
Other/unknown	269
	2262

FORT QU'APPELLE INDIAN HOSPITAL INC.

The hospital operates as an affiliate of the Touchwood Qu'Appelle Health District, although an affiliation agreement has not been concluded and signed. The hospital was run by the Government of Canada until last year, when the Touchwood File Hills Qu'Appelle Tribal Council assumed operation by agreement with the federal government. Members of the Board of Directors are appointed by the Tribal Council.

The hospital is funded partially by the Health District and partly by the Tribal Council. It is on land presently under treaty land claims by several Bands.

Prior to the transfer, employees at the hospital were represented by P.S.A.C. and P.I.P.S. Mariott Corporation also had a contract at the hospital, and C.U.P.E. represented those workers.

In March, 1996, P.S.A.C. applied to the SLRB for certification on the basis of successor rights. The employer took no position. The SLRB asked for submissions on its constitutional jurisdiction. At that point, P.S.A.C. withdrew its application and applied to the Canada Labour Relations Board. P.I.P.S. also applied to the

CLRB.

C.U.P.E. has intervened at the CLRB and takes the position that the jurisdiction is provincial.

The total unionized employees in the Health District, including the hospital, is 271. There are 46 employees at the hospital.

ERRATA

Bulletin #4 contained two errors. On Page 2 it states that the Health Sciences Association represents 747 health care workers. This is the actual number of employee, not full-time equivalents as stated in the parenthesis. Page 6 refers to the Shellbrook Community Centre. This should read Sherbrooke Community Centre.

PRELIMINARY "HEALTH SECTOR" NUMBERS

Employers	104
Employees	29,758
Trade Unions	151
Bargaining Units	542
Collective Agreements	163

ONGOING INQUIRY

The Commissioner was in Regina October 1 - 3 and met with representatives of the Saskatchewan Cancer Foundation, SGEU, College of Physicians and Surgeons, Saskatchewan Association of Licensed Practical Nurses, RAPA, RWDSU, Touchwood File Hills Qu'Appelle Tribal Council and Helmsing Funeral Chapels & Crematorium Services.

COMMISSION MILESTONES

July 12	Proclamation
July 15	Appointment
July 16-17	1st meeting with Minister and parties
July 18	1st Information Bulletin
August 27	2nd Information Bulletin
Sept. 3-6	1st round of consultations - Regina
Sept. 10	3rd Information Bulletin
Sept. 26,27	1st round of consultations - Saskatoon
October 1-4	1st round of consultations - Regina
October 1	4th Information Bulletin
October 7	5th Information Bulletin
October 7-9	Public meetings - Regina 1870 Albert Street, 2nd Floor
October 10-11	Public meetings - Saskatoon LRB Hearing Room, Sturdy Stone
November 4-8	2nd round of consultations - Regina

PUBLIC MEETING SCHEDULE UPDATE

REGINA - OCT. 7, 8 & 9

Oct. 7 - 1:00 - 3:00 PM - Regina Health Board
Oct. 8 - 1:00 - 3:00 PM - CUPE
Oct. 9 - 9:00 - 11:00 AM - SGEU
11:00 - 12:00 AM- SUN
1:00 - 3:00 PM - Regina Health District
3:00 - 5:00 PM - SAHO

SASKATOON - OCT. 10

Oct. 10 - 9:00 - 11:00 AM - HSA
1:00 - 3:00 PM - Saskatoon District Health Board
3:00 - 5:00 PM - SEIU

The Health Labour Relations
Reorganization Commission

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Information Bulletin #6 Oct. 15, 1996

PROPOSED REGULATIONS AND RECOMMENDATIONS

On the afternoon of Thursday, November 28 in Regina, Jim Dorsey will present his proposed regulations and recommendations in principle to invited, interested parties. The location will be communicated to those invited to attend when arrangements have been made.

PUBLIC MEETINGS

The Commission thanks each organization and those who represented, attended, participated or contributed to the presentations in Regina and Saskatoon. Briefs were received from Saskatchewan Health, CUPE, SGEU, SUN, Regina Health District, SAHO, HSA, Saskatoon District Health and SEIU.

TWO SLRB HEALTH CARE BARGAINING UNIT REVIEWS

First Review - 1973

On October 29, 1973, following a call for briefs in January 1973, the Nova Scotia Labour Relations Board issued " *guidelines in the determination of appropriate units for applications for certification in hospitals*". There were four units - nurses, health care employees (including technicians), office employees and residual (kitchen, housekeeping, etc.).

In New Brunswick, units were determined by schedules to *The Public Service Labour Relations Act*, RSNB 1973, c. P-25. There were eight units: technical/paramedical, scientific and professional, three groups of administrative, administrative support, patient services and institutional services.

There were no legislated or standard units or guidelines in Ontario and Manitoba.

In B.C. technical and professional employees were in the same unit while in Alberta they were in separate units.

On August 1, 1972 the existing *Trade Union Act* in Saskatchewan was replaced with a new Act designed to provide additional protection of the freedom of employees to organize in labour unions and to promote effective labour-management relations.

In particular, it extended the right of collective bargaining to individuals who were not previously covered by the statute, by removing the clauses in the previous legislation which permitted the members of professional associations to opt out of a labour union on the strength of their professional association membership.

This prompted active union organizing in 1972 and 1973 which was accompanied by inter-group and union rivalry in the health care sector.

Since 1945 the SLRB had avoided firm rule-making in bargaining unit determination.

"The Act, however, lays down no rules as to when a unit smaller than an employee unit should be determined as appropriate and whenever cases of this kind have arisen, the Board has attempted to make its decision in the manner which seems to accord best with the circumstances of the individual case." (*United Civil Servants of*

Canada, Local No. 1 v. His Majesty in right of Saskatchewan (Department of Municipal Affairs) et al (1945), Vol 1 Decisions of Saskatchewan Labour Relations Board 24 at 26. See also *United Retail, Wholesale and Department Store Employees' Union, Local 455 C.C.L. v. J.M. Sinclair Limited* (1947), Vol 1 Decisions of Saskatchewan Labour Relations Board 281.

On October 15, 1973 the SLRB issued a memorandum to all interested parties. In part, it read:

"In an effort to examine the problem of what type of unit is most appropriate for collective bargaining purposes in hospitals, nursing homes and health-care institutions in Saskatchewan, the Saskatchewan Labour Relations Board would like to receive briefs from all parties who may have an interest in the problem.

The Labour Relations Board accordingly invites written expressions of opinion on this matter, either by formal brief, memorandum or letter, such written expressions of opinion to be forwarded to reach the Board not later than November 20, 1973.

The problem with which the board is concerned arises under Section 5(a) of The Trade Union Act under which the Board has a duty to consider and make orders:

"The board may make orders:

(a) determining whether the appropriate unit of employees for the purpose of bargaining collectively shall be an employer unit, craft unit, plant unit, or a subdivision thereof or some other unit, but no unit shall be found not to be an appropriate unit by reason only that the employer or employees in the unit claims that his complement of employees in the unit is at less then full strength;"

While a decision made by the Board must in each case be based on the factual situation, nevertheless the Board feels that it should develop certain guide-lines.

A problem which has come to the Board in several instances is the potential fragmentation of bargaining units in hospitals, nursing homes and health-care institutions, and the effect of such possible fragmentation not only with respect to the employees concerned (possible weakening of bargaining power) but also with respect to hospitals, nursing homes and health-care institutions (the necessity to bargain with a large number of groups).

The Board desires to have the assistance of all parties involved (employee and employer), union, hospital, nursing home and health-care institutions. The Board would like assistance in determining whether it should consider the feasibility of establishing certain basic types of bargaining units -- as to whether an over-all unit would in some cases be feasible or desirable. The Board is of the present opinion that an inflexible unit description is probably not desirable, each factual situation must guide -- but does feel that certain over-all guide-lines could be beneficial.

The following are types of bargaining units which might be considered:

(a) general units designed to take in all employees not otherwise organized.

(b) nursing units. Are such units desirable, and if so, should they include both registered nurses and graduate nurses? What about psychiatric nurses?

(c) para-medical or similar units. Are such units desirable? Who should be included in such units? Should such units be limited to persons with university or equivalent training -- if not, should they include all persons with some specialized training, and, if so, to what extent? Should nurses be included in this type of unit?

(d) The over-all unit. This type of unit is becoming much more favoured in decisions of the National Labour Relations Board (U.S.). Our Act (and that of most Canadian provinces) is based on the original concept developed by the Wagner Act in the United States. The basis of such an over-all unit is the community of work and interest as health-care personnel.

(e) Other Units? Are there any other types of units which are desirable?

(f) Should there be a differentiation in type of unit appropriate as between large institutions and smaller institutions?

It is the desire of the Board that submissions should not be limited in scope. Innovations in proposals are welcomed."

Submissions were also invited through newspaper notices. An informal hearing was held in Regina on December 3 and 4, 1973.

One lawyer respondent questioned if the Board had the power to hold these hearings and set policy with respect to an appropriate unit. He submitted that to do so may prejudice employee rights under an Act where the convenience of the Board and employers are not to be a consideration.

HSAS proposed three units: nurses, paramedical employees and all others. SGEU and CUPE proposed the overall unit. The Saskatchewan Nursing Assistants' Association also favoured three with nursing assistants in the nursing unit. The immediate past president of SNAA strongly objected to the brief because it "*does not truly represent the beliefs of the majority of nursing assistants in Saskatchewan.*"

SEIU submitted that "*freedom of choice is a basic of democracy, but should not over-ride that which would be of benefit for the entire group.*" It proposed single, all employee units, including nursing and other paramedical employees. At the same time, it submitted that choosing to predetermine standards for appropriateness could be a "*dangerous path*", a "*dogmatic way*" and an "*abstract problem*".

SRNA and other nursing organizations or groups proposed nurses units. A submission from 41 staff nurse associations and nurse groups expressed it as follows:

"*The idea behind the principle of community of interest is that the rights of employees will be ensured and that collective bargaining will be most effective if classifications of employees with similar training, skills and duties are grouped together in a bargaining unit. Each group should have the same concerns with respect to salaries and working conditions and should work collectively to improve their lot. Grouping employees with dissimilar interests could result in internal conflicts within the unit to the disadvantage of the employees and the advantage of the employer. Nurses, because of their education, skills and duties as they relate to direct patient care, do not share a sufficient community of interest with any other group of employees within health-care institutions. The function of nursing is distinctive. It is not transferable to any other classification of employee. It is our contention that because of this "craft" distinctiveness, a nursing unit constitutes an appropriate unit for collective bargaining purposes.*"

The Saskatchewan Hospital Association said that : "*the most simplistic position would be to have one "bargaining agent" representing "all employees". It is recognized, however, that in reality there is no longer justification for taking this stance.*"

It proposed two units - auxiliary and service; and professional and technical. The latter could rationally be divided into three - nurses, paramedical and physicians.

Following the review the Board did not issue any policy statement. In a decision on December 14, 1973 it stated:

"*Many views have been expressed from time to time as to possible groupings of hospital employees for collective bargaining purposes. The Board is of the general view that an over-all employer unit is a desirable unit in such an institution. Having said that, however, the Board hastens to add that it is also of the opinion that it need not find such a unit to be the only appropriate unit. The Board, in the view which it takes of the matter, does not believe that it is called upon to determine the most appropriate unit -- the duty of the Board is to determine a unit which can be appropriate for collective bargaining purposes.*

The Board is of the view that no cut-and-dried formula can or should be laid down as to appropriate units in hospitals - the determination as to an appropriate unit must be made in each application on the basis of the factual situation in each case." (*Health Sciences Association of Saskatchewan v. University Hospital, Saskatoon and Service Employees' International Union, Loc. 333* (1973) Vol. 3 Decisions of the Saskatchewan Labour Relations Board 348 at 352-353.)

In that decision the Board, for the first time, found a para-medical professional unit to be appropriate. In doing so it said the following:

"On the evidence, the Board finds that a majority of the employees in the appropriate unit support the applicant and directs that a certification Order issue accordingly.

The Board, in this case, spent many sessions and many hours in deliberation before coming to a final decision. In many respects the decision herein was probably one of the most difficult made by the Board over a long period.

During the deliberations of the Board some ten votes were taken during these in-camera sessions. On six matters, the Board was unanimous, in four matters the Board split in 4-1 decisions but the interesting fact here is that the dissent in these four matters was in each case cast by a different member of the Board (including the Chairman). The final decision is therefore, truly a consensus in every sense of the word and was concurred in by all members of the Board.

It is recognized, of course, that the matter with respect to which the onus of responsibility was thrown upon the Board is not a matter of black and white -- it is largely a matter of opinion and the Members of the Board in coming to the decision which they did adopted the path which it was felt would be the correct decision in establishing an appropriate unit of employees for purposes of collective bargaining and which would be to the benefit of all parties concerned and conducive to the attainment of industrial peace in hospital institutions." (*ibid* at 355)

Second review - 1986

In August, 1986 the SLRB undertook a review of its policies on appropriate units in "hospitals, nursing homes and health-care institutions." The Board invited the following from interest parties:

"Although your submissions should not be limited in scope, the Board invites you to comment on the following:

(a) Units comprising "all registered and graduate nurses, registered psychiatric and graduate psychiatric nurses employed and functioning as such" are now accepted as appropriate in hospitals. Should those units be considered equally appropriate in all other health-care institutions, including nursing homes, without regard to the number of nurses who might fall within them or the fact that collective bargaining may not take place on a province wide basis?

(b) Technical and professional employees (i.e. pharmacists, dieticians, occupational therapists, social workers, physical therapists, etc.) are included in their own bargaining unit in some hospitals but not in others. Where they are included in larger bargaining units, should they be given the right to be placed in a separate bargaining unit and to choose their own bargaining agent? If so, would industrial instability result due to fragmentation of the larger bargaining unit? Should professional and / or technical employees be permitted to move in and out of the larger unit?

(c) Should the Board's policy with respect to professional and technical employees, nurses, and other groups of employees be the same for nursing homes, medical clinics and other health-care institutions as it is for hospitals, or should there be different policies for determining appropriate bargaining units depending up the nature of the institution? What should those policies be?"

Public submissions were invited through newspaper advertisements. Public hearings were held in Saskatoon and Regina October 28 and 30, 1986.

Broadly speaking, the Saskatchewan Health-Care Association proposed three standard units: registered and graduate nurses; degreed health care professionals; and service and support workers in hospitals and special care homes. In the absence of provincial bargaining in extended care, rehabilitation, special treatment facilities and home care, it favoured all employee units. It did not support inclusion of technical employees in the degreed professional unit.

The Saskatchewan Federation of Labour preferred all employee units subject to a flexible approach to smaller units in appropriate cases.

The Saskatchewan Association of Special Care

Homes proposed nursing units "*without regard to the number of nurses who might fall within*" the unit; and professional units represented by unions which specialize "*in representing the interest of that group of professional employees.*"

SUN proposed nursing units that encompassed nurses in roles beyond direct bedside patient care, such as infection control, education and specialty functions.

CUPE advised the Board to "*resist the temptation to establish standardized bargaining units in the health care sector*" and that "*it would be unwise to rely on the existence or creation of province-wide bargaining in determining whether particular bargaining units are appropriate.*" It favoured the Board's past "*flexible and ad hoc*" approach.

The physical therapists at Pasqua Hospital, Plains Health Centre and Wascana Rehabilitation Centre had been voluntarily recognized since 1968. They wished to retain that arrangement.

The Public Service Commission opposed fragmentation of existing units into occupational bargaining units.

SEIU stated that "*the organization of bargaining units in hospitals must promote the major objective of each hospital, which is to provide the best possible patient care.*" Further fragmentation of existing units should not be permitted, but the Board should not establish standard bargaining units.

SGEU endorsed the Board's past case by case determination approach.

HSAS proposed that technical and professional employees be permitted to choose to be in a separate bargaining unit.

Following the review the Board carved out and certified a 16 employee para-medical degreed professional unit out of an existing unit of 580 employees. In doing so it recounted that:

"*The Board previously rejected an attempt by HSAS to carve out 7 staff pharmacists and 3 dietitians employed at the Plains Health Centre from the CUPE Local 1838 bargaining unit. The most obvious difference between this application and the previous one is that this time the proposed bargaining unit includes all, rather than only some, of the employees providing professional para-medical services at the hospital. The evidence indicates that many of them (especially the pharmacists) have felt alienated from employees in the larger CUPE bargaining unit since 1981, and they are firmly of the opinion that their particular interests and concerns would best be represented by HSAS (In its Reasons for Decision dated March 1, 1985, , the Board expressed the view that the lack of communication between CUPE Local 1838 and the professionals in the proposed unit was the fault of both sides. It heard nothing on this application to alter its view in that regard).*" (The Plains Health Centre, LRB File Nos. 413-84 and 414-84, Reasons dated March 1, 1985)

Referring to the review process it said :

"*The parties will no doubt recognize that the unusual delay between the filing of this application and the issuing of this decision arose because of the Board's desire to receive input on an informal basis from other interested participants in the health care field. The Board issued invitations to deal with the larger issue of appropriate bargaining units in all health care institutions, and received many informative, well-reasoned and helpful briefs. It intends to respond to them in a separate statement and will not attempt to use this decision as its vehicle for doing so. It would, however, make two comments at this time.*

The first is that the Board intends to continue to deal with the question of appropriate bargaining units in hospitals and other health care institutions on a case-by-case basis. It does not intend to develop rigid, standardized bargaining units. It will continue to adhere to the long established principle that it is not required to determine the only or the most appropriate unit, but only an appropriate unit, and any determination, whenever made, of an appropriate unit will not preclude a subsequent determination that another unit, whether larger or smaller, is appropriate.

The second is that the Board will be most reluctant to permit any special group of employees forming an appropriate bargaining unit to move in and out

of a larger bargaining unit or attempt to enlarge itself at the expense of another unit. either attempt could lead to the very type of industrial instability the Board is committed to avoiding."

No separate statement was subsequently issued.

As recent as last year, the SLRB has "*refused to recognize standard bargaining units at acute care hospitals.*" (Annual Report, 1994-95, p. 4)

EMPLOYER BOARDS BEFORE AND AFTER RESTRUCTURING

Board	1991	1996
Union Hospital	120	0
Other Hospital	12	10
Ambulance Districts	108	0
Special Care Homes	141	58
Home Care	45	2
District	0	30
Total	426	100

MINISTER-DISTRICT SERVICE AGREEMENT

The Health Districts Act enables the Minister to enter into agreements with district health boards.

The 1996/97 Master Service Agreement is intended to clarify each of their responsibilities and the obligations they have to one another. Some of that Boards' responsibilities and obligations are to:

- *conclude (if it has not already done so) a Transfer/Merger Agreement with the applicable labour unions to cover all employees within the health district who are subject to a collective bargaining agreement, for the purposes of providing a co-operative and orderly framework for the movement of staff associated with the restructuring of health services;*
- *make its best possible efforts to foster and maintain a positive and participatory labour relations environment; and*
- *participate in a provincial system of collective bargaining.*" (p.5)

ONGOING INQUIRY

In addition to chairing the public meetings last week, the Commissioner met with representatives of the Health Services Utilization and Research Commission and the Catholic Health Association.

The Commission is scheduling meetings with Jim in Regina during the week of November 4 to 8.

The Health Labour Relations
Reorganization Commission

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Information Bulletin #7 Oct. 28, 1996

FOUNDATIONAL DATA

Thanks to data provided by SAHO, the Commission's foundational data is starting to look more complete. Work is ongoing to clarify any inconsistencies that remain.

Current figures indicate that 25,163 employees work for health districts and 6,837 employees work for affiliates, for a total of 32,243 employees working in the health sector. Of these, 2,421 (7.5%) are currently not represented by a trade union.

Attached is a summary sheet for the province. Specific information is available for each district which shows existing union representation on a site or program basis. Contact or visit the office of the Commission if you would like to review this information.

PROPOSED REGULATIONS AND RECOMMENDATIONS

On the afternoon of Thursday, November 28 in Regina, Jim Dorsey will present his recommendations in principle to invited, interested parties.

We are planning on meeting with the unions at 2:00 p.m. and the employers at 4:00 p.m.

The location will be communicated to those invited to attend when arrangements have been made.

FEDERAL FUNDING DIRECTS SERVICE

Latest figures from Health Canada indicate that total annual Canadian health care expenditures are about $72.5 billion, of which $52.1 billion is publicly funded through tax revenue; health insurance premiums in B.C., Yukon and Alberta; and a payroll tax in Ontario, Quebec and Manitoba. The remaining $20.4 billion comes from private insurers, workers' compensation assessments on payroll and payments on dental, drug, eyewear and other uninsured products and services.

One aspect of the history of Canadian Medicare is financial enticement and retrenchment by the Federal government. In recent years, as the cost goes up the Federal government reduces its funding. The following is a sketch of the funding history:

1947 -- Saskatchewan adopts public insurance for hospitals

1948 -- Federal government adopts National Health Grants Program providing grants to provinces for several uses, but most was used to build hospitals. The number of hospital beds increases.

1955 -- By now Newfoundland, Alberta, Ontario, B.C. and Saskatchewan have hospital insurance plans which become expensive to fund solely with provincial revenue.

1957 -- Federal government responds with *Hospital Insurance and Diagnostic Services Act.* Ottawa pays one-half of any provincial plan if it is comprehensive, accessible, universal, publicly administered and provides portable benefits.

The institutional health sector grows rapidly.

1962 -- Saskatchewan implements *Medical Care Insurance Act* after a four week strike by 90% of the doctors in the province following introduction of the legislation in 1961.

1964 -- Justice Emmett Hall's Royal Commission Report on Health Care makes many recommendations, including educating more doctors. This projected need is based on an assumption that the birth rate would continue as it had just after the war. Existing enrolment expanded and new schools were built. The prediction was 30 million people by 1986. The actual population in 1986 according to Statistics Canada was 25,309,331. The 1996 national population has grown to 29,963,631 but the result of the over-estimation of population growth has been an over supply of physicians.

1968 -- Federal government enacts *National Medical Care Insurance Act.* Federal government would pay one-half of provincial insurance plans for doctors services, if those plans strengthened standards on the five principles.

1971 -- All provinces are fully participating in Medicare.

1977 -- Federal government enacts the *Established Programs Financing Act* (EPF) and replaces fifty-fifty funding with per capita block grants. Funding is supposed to grow at the same rate as the GNP. Existing federal grants to provinces are consolidated for health and post-secondary education. The grants include both a tax portion and cash transfer. The cash transfer is to decrease as tax generated revenue increases through inflation and economic growth in a province. Some of the cash transfers are targeted to fund long term care, which expands across the country to take advantage of available funds.

1983 -- Federal government applies anti-inflation guidelines to the post-secondary education portion of the total EPF funding and the base for the future is reduced.

1984 -- Federal government adopts *Canada Health Act* that provides penalties to provinces that allow hospital user fees and physician extra billing.

1986 -- Federal government changes the formula for increases to EPF funding. Growth is to be 2% less than GNP.

1990 -- Federal government freezes EPF for three years and then after that it is to grow at GNP less 3%. A 5% growth limit is imposed on federal cost shared programs, including social assistance, for the three wealthier provinces - B.C., Alberta and Ontario.

1991 -- Federal government freezes EPF for a further two years before it can grow at 3% less than GNP. All funding may be withheld from a province in breach of the *Canada Health Act.*

1992 -- Federal government plans to introduce national day care are abandoned.

1993 -- Eligibility for unemployment insurance is reduced and benefit periods are shortened. Increased pressure on social assistance and other programs.

1995 -- Federal government replaces EPF and Canada Assistance Plan (CAP) with Canada Health and Social Transfer (CST). The new block funding will begin in 1996-97 and be $2.5 billion less than would have been transferred to the provinces under EPF and CAP. In 1997-98 there will be $4.5 billion less transferred to the provinces than under CAP and EPF. The Federal government intends to continue to enforce the *Canada Health Act* and under CAP to continue to require provision of social assistance without residency requirements. For Saskatchewan, it is estimated that the province will receive $113.5 million less in the current fiscal year, and a further $50 - 100 million less in the 1997-98 fiscal year. The Federal government said on February 27, 1995 that this "*... continues the evolution away from cost-sharing*

in areas of provincial responsibility, which has been a source of entanglement and irritation in federal-provincial relations."

With decreased federal funding, provinces are acting to shoulder the greater cost and maintain a system which meets public expectations that coverage and service will not be eroded. Reduced federal funding may mean less federal clout to enforce standards around the five principles.

SAHO

The Saskatchewan Association of Health Organizations (SAHO) is a corporation created under the authority of a private statute called *An Act to incorporate Saskatchewan Health-Care Association*, S.S. 1959, c. 117.
It is an amalgamation of three pre-existing associations: the Saskatchewan Health-Care Association (SHA), the Saskatchewan Association of Special-care Homes (SASCH) and the Saskatchewan Home Care Association (SHCA).

Membership in SAHO is currently voluntary. According to its bylaws, there are five classes of membership: Governing, Affiliate, Allied, Associate and Auxiliary. Governing members are the District Health Boards.

In addition to its responsibility for managing and operating all health care employee benefit programs, coordinating and consulting services in materials management, communications, education, payroll & systems and member advocacy, SAHO provides collective bargaining and contract administration services for its members. Currently all health sector employers, with the exception of Extendicare and Chantelle Management, assign their rights to SAHO for the purposes of bargaining provincial agreements. Members retain the right to ratify the agreements, but with the exception of some instances where ratification has been delayed, Saskatchewan has not experienced a situation where members have refused to ratify and have left the provincial table to negotiate their own deal.

PRIVATE FOR-PROFIT EMPLOYERS

There are currently two for-profit corporations which operate special care homes in the province: Extendicare (Canada) Inc. and Chantelle Management. Extendicare operates three facilities in the Regina Health District, one facility in the Moose Jaw/Thunder Creek Health District and one facility in the Saskatoon Health District. Their employees are represented by SEIU and SUN. Extendicare bargains their own contracts outside of the provincial bargaining scheme.

Chantelle Management, a corporation based in B.C., operates one facility in the Swift Current Health District. Its employees are also represented by SEIU and SUN. The Commission understands that the Health Board will cease funding that facility as a special care home in February of 1997.

CATHOLIC HEALTH ASSOCIATION OF SASK.

The Catholic Health Association is a Christian organization promoting health care in the tradition of the Catholic Church. The five primary areas addressed by the association are:

- education
- mission
- ethics
- pastoral care
- social justice

As the health care delivery system continues to evolve, the Association has expressed concerns about Catholic facilities maintaining their ownership and governance within a district health board structure, as well as their religious character, mission and values.

The Catholic Health Council is an ownership group. On behalf of the Catholic community of Saskatchewan it maintains and fosters Catholic mission, values and ethics in health care by providing responsible stewardship through the empowerment of local boards in their facilities. The Council was formed in 1977 in order to

ensure a continued Catholic presence in health care in the province.

PROFESSIONAL ASSOCIATION OF INTERNS AND RESIDENTS OF SASKATCHEWAN (PAIRS)

Unlike other provinces, interns and residents are not employed by district health boards or other health sector employers. Rather, they are employed by the University of Saskatchewan. As such, they have not been included in the work of the Commission to date.

A March 19, 1996 decision of the SLRB found that medical residents could be considered employees despite their status as students, that the actual employer was the University of Saskatchewan, and that the applicant organization (PAIRS) was a trade union and thus eligible to apply for certification under *The Trade Union Act*. A Certification Order was issued accordingly. (*Re University of Saskatchewan* [1996] S.L.R.B.D. No. 17 LRB File No. 278-95.)

INDUSTRIAL RELATIONS OBSERVER ANTICIPATES CHANGE

The review and analysis of provincial health care delivery systems and the reform underway in so many provinces has attracted attention from industrial relations observers. One observer has recently described the general lay of the land as follows:

> *"Like much of the Canadian public sector, but more dramatically, the health care system is in the process of structural change. Amid a fiscal crisis and a radical requestioning of health care policy, we are moving to what has been called a `wellness model', a model that will have tremendous implications for society as a whole and health care employees in particular. Yet even before these, the health care sector presented an especially complex and conflictual terrain.*
>
> . . . .
>
> *The internal labour force in the health sector is intricate and multifaceted. Employees range from highly skilled to unskilled. There is also a large array of specialist professions, semiprofessions and occupations, e.g. doctors, nurses, technologists, and therapists of all descriptions, with their own associations, vying for power, influence, and remuneration in the medical division of labour. Many of these groups are represented not only by professional associations but by trade unions as well. Separate `community of interest' provide for a proliferation of bargaining units into which these groups can be organized.*
>
> *The structure of collective bargaining can be very complex. Management is an uneasy amalgam of government and individual health care institutions, with the latter often represented by a multiemployer association subject to political (large P and small p) pressures. As for labour, the health care sector contains not only a proliferation of bargaining units but a multiplicity of unions, often at loggerheads with one another, representing those units. Bargaining centralization is a fact of life, but just how much centralization is appropriate is a conundrum that still bedevils the parties."* (Larry Haiven "Industrial Relations in Health Care: Regulations, Conflict and Transition to the `Wellness Model'" in Swimmer and Thompson, ed., *Public Sector Collective Bargaining in Canada: Beginning of the End or End of the Beginning?* IRC Press, Queen's University, 1995 at pp.236 and 237)

TECHNOLOGY AND THE CONTEST FOR RESOURCES

The balancing act for the foreseeable future in health care is said to be "quality, cost, technology and turf". One recent study on the effects of technology on health care human resources concluded that:

> *"Technology was generally seen as increasing - rather than decreasing - the need for staff. In discussing technological change, the delphi panellists identified a number of issues affecting human resources which were consistent with the literature and secondary data: i) there are decreasing numbers of acute care beds; ii) the patients in those beds tend to be `sicker'; iii) increasing numbers of acutely ill patients are being discharged to long term care facilities and rehabilitation centres; iv) new technologies are `saving' many individuals who previously would not have survived - adding to the increasing*

... aging of the population is also contributing to theses numbers; vi) government policy continues to favour the funding of treatment over promotion of health and prevention of disease; vii) technology tends to increase rather than decrease the need for staff; and viii) the educational needs of health care providers are changing rapidly." (Canadian Hospital Association, *The Impact of Technological Change on Human Resources in Health Care* (1990), p.4)

ONGOING INQUIRY

The Commission has scheduled meetings with Jim in Regina November 4th to 6th. He will be in Saskatoon on November 7th, then back in Regina November 8th. During this time he also hopes to visit delegates at the annual SFL convention in Regina. If you would like to meet with Jim while he is here, please call Grace to arrange an appointment.

The Health Labour Relations
Reorganization Commission

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Information Bulletin #8 Nov. 14, 1996

PROVINCE WIDE BARGAINING PRECEDENTS

The Construction Industry Labour Relations Act of 1979 replaced in 1992, implements collective bargaining "*by trade on a province-wide basis between an employers' organization and a trade union in respect of a trade division*" (s.4). Trade divisions and representative employers' organizations are determined and designated by the Minister. Union representation may be determined by SLRB supervised vote among employees. Locals of the same unions representing employees in the same trade division must form a council of locals for the purpose of bargaining collectively. In some situations the SLRB may prescribe the constitution of the council. The right to settle grievances remains with the individual employer and local trade union.

In public school education provincial teacher collective bargaining is established by 1979 legislation, *The Education Act*. The subjects for provincial and local bargaining are delineated and the union and employer bargaining committees are designated.

In 1986 the SLRB said that "*...The Education Act and the Teachers' Federation Act taken together establish a collective bargaining relationship with the Saskatchewan Teachers' Federation as bargaining agent without reference to the wishes of the teachers affected.*" They constitute a "*complete legislative code over teacher collective bargaining.*" (*Heather Johnson v The Saskatchewan Teachers' Federation and Leader School Division #24* (1986), Sept. 1986 Sask. Labour Report 66 (SLRB))

EXTENDICARE (CANADA) INC.

Extendicare (Canada) Inc. is a wholly owned subsidiary of Extendicare Inc., which also owns Extendicare (UK) Ltd. and United Health Inc. in the U.S.

Founded in 1968, it is the largest provider of long term health services in Canada. It owns and operates more than 600 long term care facilities serving over 8,000 residents in six provinces. Para-Med Health Services is a wholly owned subsidiary providing in-home care services from 50 offices in four provinces.

In Saskatchewan it owns and operates five affiliate special care homes:

Moose Jaw127 beds
Preston/Saskatoon
82 beds
Parkside/Regina
228 beds
Elmview/Regina
65 beds
Sunset/Regina
152 beds

654 beds

Six of the beds in Elmview are operated as a Quick Response Unit for the Regina Health District.

Its LTC Group Purchasing is Canada's largest provider of food, supplies and equipment to long term care serving 31 health care centres with 1,810 beds in Saskatchewan.

Extendicare does its own collective bargaining and agreement administration.

Of approximately 800 employees in Saskatchewan, 134 are represented by S.U.N. and 633 are represented by S.E.I.U. Neither Extendicare nor S.E.I.U. propose any change to the existing bargaining unit and collective bargaining structure. As well, SAHO, Regina and Saskatoon District Health Boards have not proposed any changes.

To date SUN is the only organization that is advocating a change. They favour multi-employer certifications that include all of the affiliates in a district, including Extendicare. Their rationale is that the homes either already provide or could provide district-wide services such as the Quick Response Unit in Regina. As well, employees would be better off being a part of a larger group, both from a professional development and a job security perspective.

CHANTELLE MANAGEMENT

Chantelle Management is a closely-held for private profit corporation with headquarters in B.C. It operates 7 long-term care facilities with more than 550 beds in B.C., Alberta and Saskatchewan.

Its only facility in Saskatchewan is in Swift Current. It was purchased from the Seventh Day Adventist church about 6 years ago, just after the facility was organized by the S.E.I.U.

As of the printing of this Bulletin its funding from the Swift Current Health District will end on March 31, 1997. Negotiations are ongoing to keep the facility operational.

PERSONAL CARE HOMES ACT

Personal care homes are, for the most part, small privately owned operations. They receive no provincial funding.

The Personal Care Homes Act and regulations govern all aspects of operation and licensing. Homes licensed under this Act are not "health sector employers" for the purposes of the Commission.

MORE ABOUT HEALTH SECTOR AFFILIATES

There are 14 health districts in which there are

no resident health sector affiliates. The total number of health sector affiliates in the remaining 16 health districts is 63.

The character of the affiliates is as follows:

Denominational:

Catholic	United Church
Lutheran	Salvation Army
Mennonite	Alliance
Anglican	Seventh Day Adventist

Non-denominational:

Community	Aboriginal

For private profit:

Extendicare	Chantelle Management

There are 48 affiliates whose employees are represented by a union. The employee compliment in all 63 is as follows:

Unrepresented	
846	
SUN	
	1390
SEIU	
	2677
CUPE	
	1780
HAS	
	29
PTA	
	1
PSAC	
	79
PIPS	
	31
TOTAL	
	6833

In 8 districts the employee compliment in affiliates is greater than 25% of the total of district and affiliate employees. In 3 districts, Central Plains, Gabriel Springs and North Valley, affiliate employees exceed 50%.

Prior to the recent amendments to *The Health Districts Act* the relationship of affiliates to health districts was examined by Walter Podiluk. (*Partners in Health Care: District Board-Affiliate Agencies*: February, 1996)

He concluded there are two basis elements to effective partnerships between affiliates and district health boards: (1) the affiliate has "*an opportunity to maintain its unique identity*"; and (2) "*a sharing of functions which could contribute to more effective use of human and financial resources within the agency and the districts.*" He identified the need and possibility of essential agreements (affiliation and operating); consolidation of services; sharing facilities; transfer of responsibilities; and enhancement of professional services. He also identified two additional issues, concerns and expectations:

"*One of the issues identified was the membership of affiliates on the Saskatchewan Association of Health Organizations provincial board. It was suggested that an opportunity to be part of that group would contribute to the enhancement of the partnerships between district boards and their affiliated agencies. The possibility and advisability of some arrangements which would promote communication and accountability should be pursued by officials of the Saskatchewan Association of Health Organizations and representatives of the affiliates.*

Another issue that was raised was the `sense of ownership' for some of the faith-sponsored institutions which extends beyond existing district boundaries. In every case, this applies to special care homes which were originally founded on the basis of religious, language, cultural and ethnic bonds. It is recognized that the faith-sponsored affiliates with this kind of orientation have a responsibility to provide services for those residing in the districts. At the same time, it was proposed that there must be a sensitivity to the preferences and expectations of those who would feel most comfortable in `their' nursing home regardless of its location. It is expected that admission policies would provide for the establishment of a preference list taking these factors into consideration to the utmost degree possible."

The distinct identity of affiliates is being recognized in affiliation agreements, such as those between districts and Catholic hospitals or

special care homes. Part of a common agreement reads as follows:

"A. The District Health Board and the affiliated agency share a common goal of improving the health of Saskatchewan people.

B. The District Health Board and the affiliated agency wish to work in a cooperative and effective manner to achieve that goal.

C. It is recognized that the provincial government has the authority and responsibility to:
1) establish goals and objectives for the Saskatchewan health system;
2) enact statutes and establish standards governing the organization and provision of health services; and
3) establish funding, monitoring and evaluation mechanisms for publicly funded or regulated health services.

D. It is recognized that the District Health Board has the authority and responsibility to:
1) assess health needs and establish health service priorities within the district and to ensure access to services for district residents;
2) establish operating and capital plans for health services within the district;
3) directly provide or fund the provision of health services within the district which comply with all applicable federal and provincial legislation and associated regulations;
4) coordinate and integrate district health services so they are provided in an effective and efficient manner; and
5) negotiate with, and fund the affiliated agency according to the annual operating agreements negotiated with the affiliated agency.

E. It is recognized that the affiliated agency, a Christian institution in the Catholic tradition:
1) is an integral part of the health system and has an evolving role to play in the health reform initiatives in the district and Saskatchewan.
2) shall remain a privately owned corporation governed by its own board of directors or in some publicly recognized manner;
3) has a stewardship role in maintaining its Catholic mission, values, ethics;
4) shall carry out its mission, programs and services according to the Principles and Guidelines of the Health Care Ethics Guide as approved from time to time by Canadian Conference of Catholic Bishops; and,
5) will ensure that the programs and services it delivers are provided in a manner consistent with the terms of the Operating Agreement with the District Health Board and in a manner consistent with all applicable federal and provincial legislation and associated regulations;

THEREFORE, the parties agree to the following understandings:

1. It is recognized that the District Health Board and the affiliated agency will each continue to have all the rights and powers of a corporation and will respect each other as independent autonomous agencies. The District Health Board and the affiliated agency will jointly establish consultation and communication mechanisms through which they can coordinate, review and plan issues of joint concern in a timely manner. The board of the District Health Board and the affiliated agency will review the adequacy of these mechanisms on an annual basis. "

Within SAHO, affiliates are not included as members on the governing board. Proposed resolutions to amend SAHO's bylaws to include affiliate members on the governing body have not received the requisite approval by SAHO's membership.

Some affiliates in districts which are not party to Transfer and Merger Agreements with bargaining agents have not become parties to these agreements. Often they were not included in the original negotiation of these agreements.

RECENT READINGS

Some of the Commission's recent readings are:

Marc Lalonde, *A New Perspective on Health for Canadians* (Ottawa: Minister of Supply and Services, 1974)

Kurt Wetzel and Larry Haiven, *The Labour Relations of Health Restructuring: Saskatchewan and Alberta* (1996 CIRA Conference)

Walter Podiluk, *Partners in Health Care: District Boards - Affiliate Agencies* (Saskatchewan Health: February, 1996)

Colin Taylor, Q.C., *A Review of Health Care Labour Relations in British Columbia: The New Order* (Vancouver: Canadian Institute Conference, "Labour Management Symposium - Breakthrough Strategies for Today and Tomorrow", October 10 & 11, 1996).

Dr. L. C. Marsh, *Report on Social Security for Canada* (Ottawa: 1943)

Advisory Committee on Health Insurance, *Health Insurance* (Ottawa: 1943)

Emmanuel Perszd, Shahe S. Kazzhian and Llewellyn W. Joseph (ed.) *The Mental Hospital in the 21st Century* (Toronto: 1992, Wall & Emerson Inc.)

Report of Hospital Inquiry Commission (Toronto: 1974, Queen's Printer)

Robert G. Evans, Morris L. Bauer, Greg L. Stoddard and Vandna Bhatia, *Who Are The Zombie Masters and What Do They Want?* (The Premier's Council on Health, Well-being and Social Justice, Toronto: 1994)

Framework for Evaluating Devolution (The Premier's Council on Health, Well-being and Social Justice, Toronto: 1994)

Devolution of Health and Social Services in Ontario: Refocusing the Debate (The Premier's Council on Health, Well-being and Social Justice, Toronto: 1994)

Sharmila L. Mhatre and Raisu B. Deber, *From Equal Access to Health Care To Equitable Access to Health: A Review of Canadian Provincial Health Commissions and Reports* (1992), 22 International Journal of Health Services 645-668

Robin F. Badgley, *Regionalization of Health Services in Canada* (1982), 18 Israel Journal of Medical Sciences 375-383

Focus on Health: Public Health in Health Services Restructuring (1996) 18 Canadian Journal of Public Health I-1-26

Roger Gosselin, *Decentralization / Regionalization in Health Care: the Quebec Experience* Health Care Management Review / Winter 1984, pp.9-23

REVISED "HEALTH SECTOR" NUMBERS

Employees	33,085
Employers	97
Trade Union Locals	394
Bargaining Units	523
Collective Agreements	32

DISTRICT OFFICE POSITIONS

SAHO has identified 231 positions in the District Board offices as being non-management, non-union (out-of-scope).

COLLECTIVE AGREEMENTS

The expiration date of the current and recently expired collective agreements in the health sector are as follows:

PARTIES	EXPIRE DATE
CUPE - SAHO Provincial	12/31/96
CUPE 600 - PSC	09/30/96
CUPE 600-1 - Souris Valley Regional Care Centre	09/30/94
CUPE 600-6 - Battlefords Regional Care Centre	09/30/94
CUPE 600-9 - Psychiatric Rehab Services, Saskatoon	09/30/94
CUPE 59 - Saskatoon Community Health	03/31/95
CUPE 1831 - Community Health Services (Regina)	12/31/94
CUPE 974 - Community Health Services (Saskatoon)	12/31/94
CUPE 3445 - South Eastern Saskatchewan Road Ambulance	03/31/94
CUPE 3736 - North Sask Laundry	12/31/94
SEIU - SAHO Provincial	12/31/94
SEIU 299 and 333 - Extendicare	12/31/94
SEIU 299 - Moose Jaw and Central Butte Ambulance	12/31/94
SEIU 336 - Chantelle Management	

12/31/94	
SEIU 299 - Moose Jaw Alcohol & Drug (Angus Campbell Centre	03/31/95
SEIU 333 - St. Louis Rehab	03/31/95
SEIU 299 - Red Cross Regina	12/31/94
SEIU 333 - Red Cross Saskatoon	12/31/94
SUN - SAHO Acute/Home Care	03/31/96
SUN - SAHO Long Term Care	03/31/96
SUN - Red Cross	03/31/96
SGEU - Public Service Commission	09/30/97
SGEU - SAHO Home Care	03/31/98
SGEU - SAHO (Wascanna Rehab, Lakeside, Parkland)	12/31/97
SGEU - Cancer Foundation	09/30/94
PIPS - Treasury Board	09/30/93
PSAC - Treasury Board	04/04/91
RAPA - Regina District Health Board	12/31/97
PTA - Regina District Health Board	12/31/94
RWDSU - Regina District Health Board (Laundry Services)	12/31/94
HSAS - SAHO Provincial	12/31/94

CURRENT BARGAINING UNIT PROPOSALS

A generalized summary of the current proposals by employers and trade unions is attached. This document is not intended to show every idea or position, or every nuance or exception to the general propositions. Rather, it attempts to paint a picture of the general landscape.

EMERGENCY MEDICAL SERVICES

Acute pre-hospital emergency services in Saskatchewan are provided by 74 employers employing 1375 employees. Fifty of the employers are for private profit operators and 24 are public services. Of the 24 public services some are district health board operations and some are service clubs or other community organizations that contract with the district health boards.

The for profit employers employ 621 of the 1375 employees.

The employees of six employers (totalling 156 employees) are represented by a union:

Wald Ambulance (Ponteix)	SEIU	3
Life Line Ambulance (Moose Jaw)	SEIU	22
Prairie West District Health Board (Eston Ambulance)	CUPE	15
Southeast District Health Board	CUPE	16
MD Ambulance (Saskatoon)	IAFF	48
Regina District Health Board	IAFF	52
Total employees		156

SERVICE AREAS

For administration and service delivery purposes Saskatchewan Health has clustered the thirty health districts into 10 service areas.

A service area is a "partnership among districts to meet certain of the health needs of the population currently served through department delivered services". The 10 areas are:

- Lloydminster, Northwest, Battlefords, Twin Rivers
- Prince Albert, Parkland
- North-east, North Central, Pasquia
- Greenhead, Prairie West, Midwest
- Gabriel Springs, Saskatoon, Central Plains, Living Sky
- Assinaboine Valley, East Central, North Valley
- Southwest, Swift Current, Rolling Hills
- Moose Jaw/Thunder Creek, South Country
- Touchwood Qu'Appelle, Regina, Pipestone
- Moose Mountain, South Central, South East

Service areas are to be :

- self sufficient
- have coterminous boundaries
- be a geographically contiguous landmass
- have a minimum relocation of staff headquarters
- reflect trading and service patterns.

Some of the inter-district service area program coverage include public health services and mental health services.

AMALGAMATED SERVICES AND

LEGISLATED BARGAINING UNITS

The Institutes Act and *The Regional Colleges Act* amalgamated ten existing entities into the Saskatchewan Institute of Applied Science and Technology (SIAST). The approximately 1600 employees were transferred to the new employer.

Existing certification orders were nullified and two new bargain units were created: academic staff (approximately 1200 employees) and all other employees (approximately 400).

Previously unrepresented employees were included in the legislated bargaining units.

Two unions applied for certification for the academic staff unit.

"*The two Applications for certification therefore arise out of a unique situation. Although similar, the situation is somewhat different from one in which a raiding union attempts to displace a certified union as bargaining representative, because in this case there has been a statutory decertification, alteration of the bargaining unit, and creation of an entirely new employer. It is also unlike one in which two competing trade unions attempt to represent a group of previously unrepresented employees, because in this case the SGEU's certification order and collective bargaining agreement applied to the employees until December 31, 1987.*

There are nevertheless certain similarities between the situation presently before the Board and one in which a raiding union is attempting to displace an existing certified union, and the Board notes that Section 6(2) of The Trade Union Act requires that a vote be held if a raiding union shows that 25 percent or more of the employees in an appropriate unit support it as their bargaining representative unless the Board `is satisfied that another trade union represents a clear majority of employees in the appropriate unit'. The association filed evidence of support from over 25 percent of academic staff members. The SGEU filed evidence of employee support from over 50 percent of the same employees. However, quite apart from the fact that over 100 employees appear to have signed support cards for both organizations, the evidence of employee support may not be completely reliable.

The Board has held that where a union is already certified for a portion of the unit applied for and is entitled to rely on the union security provisions of the Act, the Board cannot automatically assume that an application for membership in the union means voluntary support for an application for certification in a new and expanded unit (see The 77 Rogers Group Limited, Sask. Labour Rep., Vol. 30, No. 2, p. 35)

In this case, it is apparent from some of the support cards and from the whole of the other evidence that the parties were well aware of the intention to create a new employer named Saskatchewan Institute of Applied Science and Technology. Indeed, that is why the organizing campaigns took place. Although a small portion of the evidence filed by the SGEU indicated that employees supported it as their representative to bargain collectively with SIAST, most of the evidence was incomplete with respect to the name of the employer. That might not have been important in an ordinary application for certification, but its absence in the unusual circumstances of this case leaves it unclear whether the support cards were elicited by the SGEU pursuant to the union security provisions of the collective bargaining agreement in force when they were signed, or whether they were obtained with respect to the future, statutorily created employer."
(*Saskatchewan Government Employees Union and The Saskatchewan Institute of Applied Science and Technology Faculty Association and The Saskatchewan Institute of Applied Science and Technology* (1988), May 1988 Sask. Labour Report 42 (SLRB))

Certain engineers unsuccessfully challenged the right to include them in the unit against their wishes:

"*The legislature chose to designate two bargaining units for the purpose of collective bargaining of SIAST employees. Designation of bargaining units does not entail the creation of any group or association. There is only one body of employees divided statutorily into two groups for a specific purpose. The fact that employees are members of the union or not does not affect the determination of these artificial units. Some may be; some not. Employees do not associate one with the other to become part of one bargaining unit or the other.*

Section 14 does not interfere with the selection of bargaining agents for the units or their certification. The Labour Relations Board continues to perform those tasks. It cannot be said therefore that the plaintiffs' right of association has been violated."

. . .

"The pronouncements of the Supreme Court of Canada have consistently referred to the unique character of industrial relations. There are many references to the introduction of specialized tribunals to deal with industrial disputes and of the objectives of labour legislation across Canada, legislation intended to promote industrial peace, to equalize the bargaining positions of employers and employees by having the latter represented by unions or worker associations and so forth. Courts are ill-equipped to understand and apply the many complex economic, sociological, political and legal considerations that have gone into the evolution of labour relations in this country. Considerations which legislatures and specialized administrative bodies are far better equipped to assess and apply. In all of these cases there is a clear recognition that the field of industrial relations is unlike others and the courts have, in my respectful view, rightly paid considerable deference to the development of industrial labour relations law pursuant to statute and viewed it as an area that should, as much as possible, fall outside judicial scrutiny. I appreciate that many challenges have been made to the actions of labour relations boards and arbitrators and others in this area but for all that judicial deference is still evident."

. . .

"In the final analysis the provisions of The Institute Act and The Trade Union Act impugned here reflect a decision on the part of the legislature of this Province that certain essential safeguards should be in place to protect workers' rights. Many may argue philosophically and practically with those objectives but the plain fact is that the persons elected by the people of this Province have made that determination. It is worth noting that the section of The Trade Union Act impugned has continued in the statute book with minor modifications and through many successive governments, governments which entertained quite different political philosophies."
(*Strickland et al. v.Saskatchewan Institute of Applied Science and Technology et al.*(1990), 102 Sask.R. 98 (Q.B.))

The reasoning of Wright, J. above was affirmed and the appeal was dismissed. (*Strickland et al. v.Saskatchewan Institute of Applied Science and Technology et al.*(1993), 113 Sask.R. 192 (C.A.))

SASKATCHEWAN MEDICAL ASSOCIATION

April 26, 1995 the government of Saskatchewan, SAHO and the Saskatchewan Medical Association entered into a Framework Agreement. The agreed principles are as follows:

"Within the overall spirit of The Canada Health Act, the parties agree to the following principles:

- *The Government of Saskatchewan is responsible for the funding, planning and organization of a publicly financed health system.*
- *Saskatchewan residents should have reasonable access to insured medical services in an integrated, sustainable, publicly financed health system.*
- *District Health Boards have the responsibility to assess health requirements and deliver integrated and coordinated health services. District Health Boards will develop operating policies within the framework, standards, and financial allocation established by Government.*
- *Physicians are an integral part of the health system and as such must be included in its planning and have a defined linkage with the District Health Board management structure.*
- *The parties agree that the professional independence and integrity of physicians in the context of a direct physician/patient relationship will be respected. Physicians have the right to exercise their professional judgment in accordance with their professional Code of Ethics.*
- *Physicians have a right to collective representation respecting terms and conditions of work and reasonable compensation for their services.*
- *A broad range of payment and funding systems should be available for physician services."*

COMMUNITY AND DISTRICT UNITS PROPOSED BY SEIU

For employees who are not graduate or registered RNs/RPNs, SEIU has restated its proposal into 129 "all employee" units by

community in a district as follows:

District	SEIU	CUPE	SGEU	OTHER
Assinaboine		5		
Battlefords		3		
Central Plain	2	3		
East Central	1	3		
Gabriel Spgs	1	2		
Greenhead	2	2		
Living Sky	2	3		
Lloydminster		1		
Midwest	6	2		
Moose Jaw	3**			
Moose Mntn	5			
North Cent			1*	
North East	3			
North Valley		3		
Northwest		3		
Parkland	1	5		
Pasquia	1	4		
Pipestone	1	5	1	
Prairie West	1	3		
Prince Albert	1	2		
Regina	1**	4	1	1RWDSU
Rolling Hills	4	2		
Saskatoon	2**			
South Cent	2	3		
South Count	4	1		
District	SEIU	CUPE	SGEU	OTHER
South East	2	5		
Southwest	3	2		
Swift Curr	2			
Touchwood	1	1	1PSAC	
Twin Riv	1	5	—	—
TOTAL	52	72	3	2

* Presumes the outcome of a vote.
** Does not include Extendicare units, which would remain separate.

LABOUR RELATIONS APPLICATIONS

There has been some confusion over the provisions in *The Health Labour Relations Reorganization Act* that restrict the applications that can be made to the Labour Relations Board during this period of reorganization. Section 8 of the Act restricts the Board for a period of three years from the date of filing the Commissioner's Regulations from amending, varying or rescinding a regulation that grants a trade union bargaining rights for a specific bargaining unit (i.e. Section 5(a) and (b) orders). This provision is intended to provide some stability to the bargaining structure set by the Commissioner.

During the period between the coming into force of the act and the date the Regulations are filed, 90 days after the regulations have been forwarded to the Minister or a date set by Cabinet, whichever is earliest, the Board is prohibited from hearing any application that is or may be covered by the regulations to be made by the Commissioner (s.9). Parties are also prohibited by s.9(1) from filing such applications with the Board. This provision applies to applications made but not determined before the Act was proclaimed.

The Board is granted jurisdiction under s.10 to deal with matters relating to health care reorganization that are not addressed in the Commissioner's regulations.

The Commissioner is also entitled to delegate to the Board in his Regulations any responsibility that has been assigned to him under s.6(2) of the Act.

When applications are filed with the Board that appear to be covered by the terms and *The Health Labour Relations Reorganization Act*, the Board sends the parties a letter indicating that the application has been adjourned and will be referred to the Commissioner. The parties are given a period of time in which to advise the Board that they disagree with its ruling and to present arguments why the matter should proceed before the Board.

The Board to date has deferred applications for certification and applications to amend certification orders (name of employer, scope, exclusions, raids). It was recently brought to the Board's attention that *The Personal Care Homes Act* is not subject to the Commission review and

the Board will proceed to hear applications involving employers in that sector.

For further information, you can contact the Labour Relations Board at 787-2406.

UNIVERSITY OF SASKATCHEWAN

Employees of the University of Saskatchewan in the Department of Medicine and others work in hospitals and other health care facilities. They support the teaching and research work of the University, which includes clinical programs. In some cases they work with and do identical work to that of employees of the Health District or affiliates. In some cases, wages and benefits of employees of the Health District supporting the programs are funded by payments from the University to the Health District.

UNREPRESENTED EMPLOYEES

Health Sector employees currently unrepresented by a trade union may be employees of a District or an affiliate. They may be employed in any occupation. They may be full or part-time. They may also be employed in a bargaining unit of the same or another employer on a full or part-time basis. They may be on the fringe of a longstanding unit or one of a group of formerly unorganized employees of an amalgamated employer. They may have been recently hired into a newly created district office and administration. Some of them may not be "employees" because of their managerial or confidential responsibilities as defined in *The Trade Union Act*.

In the health sector, SAHO reports unrepresented employees as follows:

Health Districts:	Employees	FTEs
district offices	231	201.18
ambulance	654	?
home care	852	334.00
other	569	403.00
subtotal	2251	
Affiliates:	806	426.16
TOTAL	3,057	

The 231 in district offices are employed by all 30 health districts. Among the 569 "other" are the following:

Chateau Providence Inc.	46
Wheatland Lodge Inc.	59
Regina General Hospital	30
Pasqua Hospital	66
Wascana Rehab Centre	40
Plains Health Centre	16
Swift Current Hospital	33
Echo Lodge	83
Paradise Hill Hospital	19
	392

MORE BRIEFS

Since the briefs presented at the public meetings, the Commission has received written submissions from the following persons:

- SGEU - 4 briefs including submissions from community therapists, psychiatric nurses and public health nurses.
- PIPS - written submission
- RWDSU - written submission
- SEIU - proposed bargaining units based on their public presentation.
- Occupational Therapists at Wascanna Rehab
- Sask Health Records Association
- CUPE 59 - public health
- Spruce Manor Special Care Home
- Sunnyside Nursing Home and the Seventh-Day Adventist Church
- Central Haven Special Care Home

SLRB BARGAINING UNIT POLICY

The SLRB has steadfastly favoured larger and fewer bargaining units over smaller and more units in general and particularly in public sector employment.

Some of the flavour of this approach is expressed in the following excerpt from a 1985 decision:

"The Board's long standing policy of favouring larger bargaining units over smaller ones is designed to promote industrial stability through effective collective bargaining. Although that policy is certainly not confined to the public sector, fragmentation of one large bargaining unit into many smaller ones would be especially likely to destroy the possibility of effective bargaining in the public service with its very large number of employees.

The Board has frequently held that fragmentation of the all employee public sector bargaining unit into various small occupational or craft groups would not be beneficial to either the employees or the employer and that if the legislature had intended certain occupations or professional groups per se to be treated differently or excluded from the benefits of The Trade Union Act altogether, it would no doubt have said so.

Nevertheless, if an occupational or professional groups has a distinct community of interest with respect to its terms and conditions of employment, it may be excluded from a bargaining unit. See, for example, Regina Pioneer Village Staff Nurses Association v. Regina Pioneer Village Ltd. and Canadian Union of Public Employees, Local 1138, (1973) 3 SLRB Rep 285 and Saskatchewan Union of Nurses v. Gull Lake Union Hospital (LRB File No. 257-83, Reasons for Decision dated December 12, 1983) in which the Board accepted the proposition that the special community of interest shared by nurses is sufficiently strong to permit them to form an occupational or craft group in what might be viewed as an industrial setting; Service Employees International Union Local 333 and Crescent Leaseholds Ltd. (LRB File No. 453-81, Reasons for Decision dated January 5, 1982) in which the Board indicated its willingness to entertain an application for exclusion of security personnel from an all employee unit if it could be demonstrated that actual conflict existed between membership in the union and duties to the employer; and Laws & Pelkey v. Saskatchewan Civil Service Association (Sask. LRB Decision and Court Cases Arising Therefrom, Volume II, p,20) in which the Board excluded professional engineers because on the particular facts of the case it considered them to have a special community of interest.

In determining whether it would be appropriate to carve out a sub-group of employees from a larger bargaining unit on the basis that it has a special community of interest, the Board need not be confined to reviewing the nature of the sub-group's work, or the amount and method of payment, but may consider all matters that are said to give the sub-group a special commonality for industrial relations purposes. It follows that a distinct group of employees may be removed from a larger bargaining unit if for any reason it will enhance the future prospect of viable and harmonious bargaining between the certified union and the employer. However, excluding a minority group from a bargaining unit simply because it is vocal and aggressive in its dissent from the majority will not necessarily lead to increased harmony in industrial relations or decrease the likelihood of a disruptive strike. By working within the unit a minority is in a position to affect the course of a dispute, as it did during a 1979 strike of SGEU members (see Jowsey et al v. The Saskatchewan Government Employees Association et al (80 CLLC 14,007 and 80 CLLC 14,030)"
(*G. Wayne Hanna and the Government of Saskatchewan and the Saskatchewan Government Employees Union* (1985) August 1985 Sask. Labour Report 31 (SLRB))

SGEU LONG TERM DISABILITY

Since 1983 SGEU has had an LTD plan for its members administered through the SGEU.

At December 31, 1995 one of the economic assumptions for its actuarial valuation was changed from 13,500 to 15,300 members declining by 1% per annum.

Based on this and other assumptions its actuarially estimated value of present claims in force and reserves for as yet unrepresented claims was $17.4 million with assets actuarially valued at $10.9 million. The unfunded liability of $6.5 million was down from $8 million in 1994.

The SGEU and its members consider the plan to be superior in benefits, definitions, administration and other respects than the LTD plan provided through SAHO.

Continued membership in the plan and eligibility to receive benefits is dependent upon membership in SGEU and, with limited exception, employment in a unit represented by SGEU.

SGEU has provided the Commission with a legal opinion that any change in union representation as a result of the Commission's regulations could result in discontinuance of benefits (or eligibility for benefits) where union association is involuntarily severed. The opinion is that "*Under this scenario, benefits would continue for 60 days after SGEU gives these claimants `notice of cessation of benefits' (Art.6.2).*"

Noting that the plan currently has 17,000 members and without considering any additions or replacements to the membership, the opinion is that under the deficit recovery provisions of the plan, departing members would have to pay a deficit recovery surcharge to enable certain beneficiaries to stay on the plan. "*In my view, a forced severance of SGEU membership will create untold hardship and chaos for the employees directly affected along with those who have responsibility over the administration of this LTD plan*" concludes the opinion.

What regulations if any, can or should the Commission make "*respecting any other matter or thing the Commissioner considers necessary to carry out the extent of the Act.*" (s.6(2)(i)) to minimize or eliminate this "*hardship and chaos*"?

FREQUENTLY SUBCONTRACTED SERVICES

In the U.S. contracts to manage hospital departments are on the rise. The most commonly contracted services are food, emergency, housekeeping and laundry. Others are pharmacy, plant, psychiatric, financial, maintenance of clinical/diagnostic equipment, and rehabilitation/physical therapy. (Source: C.U.P.E. *The Facts on Health Care*, October, 1995)

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Sept. 10	3rd Information Bulletin
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Nov. 14	8th Information Bulletin
Nov. 28	Presentation to parties of proposals in principle
Dec. 10-13	3rd round of consultations - Regina and Saskatoon

ONGOING INQUIRY

Last week Jim was in Regina and Saskatoon. He met with representatives of the Ministry of Justice and Labour; the Public Service Commission; CUPE; SEIU; RAPA; Pipestone, Twin Rivers, Saskatoon and Regina Health Districts; SAHO; SGEU; Saskatchewan Medical Association; HSA; PTA; SUN; University of Saskatchewan; 7th Day Adventist Church; Saskatoon District Health Affiliates; Dean Dan Ish; and dietiticains, social workers, speech pathologists, music therapists, occupational therapists and exercise therapists. He toured the Wascana Rehabilitation Centre.

ADMINISTRATIVE MATTERS

The Commissions's inventory of documents continues to grow. If you would like a copy of the inventory, please contact Grace.

ERRATA

Information Bulletin #5 contained an error. The Registered Psychiatric Nurses Association of Saskatchewan was referred to as SRPNA. It should be RPNAS.

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Information Bulletin #9 Nov. 29, 1996

COMMISSION RELEASES REORGANIZATION PROPOSAL

The Commission has proposed three standard, multi-employer, functional bargaining units with different geographic scope and a provincial collective bargaining structure. The two for private profit employers and their employees are excepted. One employer, North Sask. Laundry & Support Services Ltd., is recommended to be added as a health sector employer.

The result is 36 public sector bargaining units for 32,523 employees and 83 employers in a provincial bargaining structure covered by a maximum of 5 collective agreements. SAHO is to be designated as the exclusive employer bargaining agent.

A copy of the proposal is available from the Commission. This Information Bulletin summarizes the proposal.

STANDARD UNIT STRUCTURE

The proposed three standard bargaining units for health sector employees in the province of Saskatchewan are:

- Health Service Providers
- Licensed Providers
- Nurses

Since the health district structure is the organizational foundation for health reform and the primary source of future employment relationships, the primary bargaining unit of **health service providers** will be a multi-employer unit that is district-based. With limited exceptions, it will include all employees of the district health board, plus all of the unionized employees of the other health sector employers affiliated with the district.

Exceptions from this primary unit include physicians employed by the District Health Board, employees included in another bargaining unit, and employees of an affiliate who are not unionized.

Two province-wide, multi-employer standard bargaining units for specific occupations will be the only exceptions to the 30 primary all-employee units.

The first is a unit for **licensed providers**. It includes employees of all District Health Boards, plus all of the unionized licensed providers of the other health sector employers that are currently unionized who are employed and functioning in an occupation which requires that they hold a license under a current provincial statute which confers exclusive rights to practice specific health care services or requires registration under a current provincial statute which confers exclusive use of occupational title. A table summarizing legislation regulating certain providers is attached.

The second is a unit for **nurses**. It includes employees of all District Health Boards plus all of the unionized nurses of the other health sector employers that are currently unionized who are employed and functioning as Registered Nurses, Registered Psychiatric Nurses and Graduate Nurses.

For historical reasons as well as "community of interest", Licensed Practical Nurses will not be included in either the licensed providers unit or the nurses unit, but will remain in the primary health service provider unit.

NORTHERN HOSPITALS

The four northern hospitals will be certified in the standard bargaining unit structure, one health service providers unit for each hospital represented by CUPE, with nurses and licensed providers included in the province-wide units. When new health districts are formed in the North, the only change will be a new health service providers unit for each new district.

PRIVATE PROFIT UNITS

The bargaining units at Extendicare (Canada) Inc. may be consolidated into one unit of health service providers represented by SEIU and one unit of nurses represented by SUN.

The bargaining units at the Swift Current Care Centre (Chantelle Management) will be certified with one unit of health service providers represented by SEIU and one unit of nurses represented by SUN.

OTHER HEALTH SECTOR EMPLOYERS

It is intended to recommend that North Sask. Laundry & Support Services Ltd. be included as a health sector employer and treated as an affiliate of the Prince Albert District Health Board.

FOUNDATIONAL DATA

From time to time the Commission has published foundational data and has invited comment on the numbers. The last summary sheet was sent with Information Bulletin #7, dated October 28, 1996.

Attached is the latest summary sheet for the province. Specific information is also available for each district which shows existing union representation on a site or program basis.

In some cases, the numbers represented are lower that the numbers reported by SAHO. That is because the Commission has primarily used the membership numbers reported by the Unions. The SAHO numbers tend to overstate the actual number of people working. They don't take into account the fact that the same person may be working part-time in several different facilities or programs.

Contact or visit the office of the Commission if you would like to review this information.

DETERMINING UNION REPRESENTATION

AUTOMATIC CERTIFICATION

In any unit where a trade union has, according to the Commission's numbers, more than 50% of the employees (including previously unrepresented employees) and no other union has as members 25% or more of the employees, then the trade union with more than 50% of the employees as members will be certified by Regulation as the exclusive bargaining agent for the unit.

REPRESENTATION VOTES

In any unit where no trade union is entitled to automatic certification, the Labour Relations Board will conduct a representation vote to determine which trade union will be certified as the exclusive bargaining agent for the unit.

Any trade union which has as members, according to the Commission's numbers, 25% or more of the employees (including previously unrepresented employees) may request and will be entitled to be included on the ballot as a choice for exclusive bargaining agent for the unit.

Agreements between unions to merge or amalgamate or to transfer or assign jurisdiction filed with the Labour Relations Board prior to it conducting a representation vote will be conclusive of representation rights for the purpose of determining the extent of a union's representation in a bargaining unit. There will be a deadline for the filing of any such agreements.

SOME PREDICTED OUTCOMES

HEALTH SERVICE PROVIDER

It is estimated that there would be a total of 20,675 employees in 30 district-wide Health Service Provider Units. This includes 2,114 currently unrepresented employees of the Districts. Automatic certification would occur in 22 districts as follows:

CUPE would be certified in 15 districts: Assiniboine Valley, Battlefords, Central Plains, East Central, Gabriel Springs, Lloydminster, North Valley, Northwest, Parkland, Pasquia, Prince Albert, Regina, South Central, Southeast and Twin Rivers.

SEIU would be certified in 7 districts: Moose Jaw/Thunder Creek, Moose Mountain, North-East, Pipestone, Saskatoon, Southwest and Swift Current.

Absent agreements, representation votes would be held in the remaining 8 districts: Greenhead, Living Sky, Midwest, North Central, Prairie West, Rolling Hills, South Country and Touchwood Qu'Appelle.

NURSE

It is estimated that the Nurse Unit will be comprised of 9,168 employees. SUN currently represents 7,877 employees, or 86% of the total unit. SGEU represents 480 nurses; CUPE 379; PIPS 30; and SEIU 23. There are 379 nurses currently unrepresented who will be included in the unit.

SUN would be certified as the exclusive bargaining agent.

LICENSED PROVIDER

It is estimated that the Licensed Provider Unit will be comprised of 1,946 employees. No union currently represents a majority. Only two unions represent more than 25% of the total: HSA with 626 and CUPE with 619. SGEU has 244; SEIU 222; PTA 66; PSAC 3; PIPS 1. There are 165 who are currently unrepresented who will be included.

Absent any future agreements to amalgamate or assign membership, a representation vote would be held with HSA and CUPE on the ballot.

Attached are tables which summarize the

potential outcomes for the three new bargaining units.

COLLECTIVE AGREEMENTS

All collective agreements, including all other local, transfer and merger, itinerate movement, devolution, laboratory framework, global posting, Saskatoon Veterans Home and similar agreements, will continue to apply until their expiration to employees transferred between existing and new bargaining units and their employers, unless some other agreement to the contrary is made.

All newly certified trade unions will become successors to the existing agreements applicable to employees in the unit until the expiration of each agreement.

Newly represented District Health Board employees will be covered by the collective agreement currently in force that covers employees in a similar classification when a trade union is automatically certified for the unit. When there are two or more collective agreements and a representation vote is necessary to determine the bargaining agent, each currently unrepresented employee will be covered by the one which he or she chooses regardless of which trade union is certified as bargaining agent.

SENIORITY AND SERVICE

Seniority and service recognition will be portable for any employee who changes bargaining unit, bargaining agent or collective agreement as a result of any aspect of this reorganization.

Employees who lost seniority recognition since the enactment of *The Health Districts Act* as a result of transferring between bargaining units or bargaining agents will have the seniority reinstated on the basis of the collective agreement covering the bargaining unit in which they were included prior to this reorganization.

Each previously unrepresented employee who is included in a bargaining unit by this reorganization will receive recognition of service

as an accumulation of seniority calculated in accordance with the collective agreement that covers the employee.

All disputes about portability of seniority and recognition of service will be deemed to be arbitrable and thus referred to the grievance/arbitration procedures in the party's collective agreements for final resolution.

FUTURE AMALGAMATIONS, REORGANIZATION AND CHANGED CIRCUMSTANCES

The only new bargaining unit that would be appropriate would be a single province-wide, multi-employer unit of all physicians, residents and interns employed by District Health Boards and their affiliates.

All other unrepresented employees who choose trade union representation in the future will be included in one of the three standard, multi-employer units created by this reorganization.

In all circumstances of new amalgamations or transfer of services to existing District Health Boards, the creation of new District Health Boards, or the amalgamation or reconfiguration of District Health Boards, the standard bargaining units will be appropriate and the necessary amendments and variances will made by the Labour Relations Board.

All issues related to managerial exclusions to the standard bargaining units and eligibility to vote which cannot be settled by the parties will be resolved by the Labour Relations Board.

All unanticipated circumstances are to be resolved by the Labour Relations Board in accordance with the principles of the Regulations and their intent as expressed in the Report accompanying the Regulations.

ONGOING INQUIRY

This reorganization proposal requires close scrutiny by all affected persons. Employers and unions are requested to distribute this information widely to their employees and members.

This proposal is subject to amendment and modification. Please inform the Commission of any questions or issues that have not been addressed and any concerns or objections that you may have with any aspect of the proposal.

The Commission is scheduling meetings with Jim in Regina the week of December 10-13. If you would like to meet with Jim while he is here, please call Grace to arrange an appointment.

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FINAL REPORT

The Commission must make preparations for the publication of the Final Report. To help plan for the number of copies necessary for distribution, please call, fax or e-mail as soon as possible with an estimate of the numbers that you will require.

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Information Bulletin #10 Dec. 16, 1996

SEASONS GREETINGS

As we prepare to celebrate the birth of Christ, the Commissioner and staff extend to everyone our wishes for the peace and goodwill of the Christmas Season.

DRAFT REGULATIONS

Draft Regulations will be distributed for technical review and comment by the unions and employers. The target date for distribution is January 6, 1997.

The draft Regulations will reflect the changes to the proposal presented November 28.

COURIER AND SECURITY SERVICES

Saskatoon District Health has informed the Commission that "*... courier and security services have historically been sub-contracted to non-health sector employers by Saskatoon District Health with the exception of security services at Royal University Hospital where such personnel are part of the SEIU bargaining unit. For example, at St. Paul's Hospital and Saskatoon City Hospital, long standing contractual arrangements exist with security companies whose employees at least at St. Paul's Hospital, are represented by another union.*"

FORT QU'APPELLE INDIAN HOSPITAL INC.

Effective December 1, 1995 the Minister of National Health and Welfare Canada transferred to the Touchwood File Hills Qu'Appelle Tribal Council the control, management and operation of the Fort Qu'Appelle Indian Hospital.

Funding for the delivery of health services to the members of the Tribal Council is to be provided by the Federal Government. The Tribal Council also has an agreement with the Government of Saskatchewan.

On November 14, 1996 the Canada Labour Relations Board found that: "*the normal activities of the employee and of its employers are primarily the deliver of health services to the First Nations which are members of the Touchwood File Hills Qu'Appelle Tribal Council and that the labour relations of the Fort Qu'Appelle Indian Hospital Inc. form an integral part of a primary federal jurisdiction over Indians and lands reserved for Indians. In the instant case, this is true even though the Hospital also provides health services to the general population of municipalities in the Touchwood Qu'Appelle Health District.*

The CLRB certified PIPS for a unit of registered nurses and PSAC for a unit of all employees excluding registered nurses and employees in laundry, housekeeping and dietary services."

CUPE was recognized by the employer as the bargaining agent for these employees, who were formerly employed by Marriott Management Services which provided the services under contract and had a collective agreement with CUPE.

The Commission will exclude this employer and its employees as outside the provincial health sector which it is responsible to reorganize. The Fort Qu'Appelle Indian Hospital Inc. employee representation is PSAC 30; PIPS 16; and CUPE 16. The revised employee representation in the Touchwood Qu'Appelle Health District is as follows:

CUPE	95
SEIU	42
SUN	54

SGEU
34
Non-union
90

315

STRIKE NOTICE

The RWDSU has served strike notice on the Regina Health District.

MORE DEVOLUTION

Saskatchewan Health has targeted April 1, 1997 to transfer two programs to health districts. The unionized employees in these programs are currently represented by SGEU.

Calder is an addiction counselling centre, employing the following unionized occupations:

Clerk Typist	5
Administrative Officer	1
Teacher Therapist	2
Psychologist	1
Alcoholism Rehabilitation Counsellor	42
Therapist	5
	57

Calder is to be transferred to the Saskatoon Health District.

SHAP is the Saskatchewan Hearing Aid Program, employing the following unionized occupations to be transferred to the Regina and Saskatoon Districts:

	Regina	Saskatoon
Clerk Typist	3	3
Stock Clerk	1	1
Accounting Clerk	1	
Administrative officer	1	
Audiometric Technician	3	2
Audiometric Electronics Technician	1	1
Audiologist	4	4
	13	12

LICENSED PRACTICAL NURSES

The members of the Executive Board of the Saskatchewan Association of Licensed Practical Nurses have made the following representation to the Commission: "*As individual Licensed Practical Nurses who met with you on December 11, 1996 we wish to express appreciation for the time you took to meet with us.*

As individual members of the various unions we hope we clearly expressed our concern over the lack of attention we have received in the collective bargaining process in our province.

After reviewing you initial proposal and discussing it further with you we want to clearly indicate our unanimous desire to be place in the "Licensed Providers Unit" as outlined in your document.

We acknowledge your comments respecting the history consideration when determining an appropriate place for Licensed Practical Nurses. However, we feel that history is what we learn from, what we build on, when planning for the future.

We believe that we have not been appropriately represented as a group of licensed providers of health care services. We have been split between three unions and have no united collective bargaining representation. We have had our education, regulatory requirements and annual licensing requirements ignored by unions, employers and now, (we believe) by your proposal.

We urge you to be innovative in your proposal and to take this opportunity to correct a collective bargaining problem for a large number of health care providers. Accept the challenge and place us in the Licensed Providers Unit for the three year period. If, after this period of time, our members, unions and / or employers find difficulty with this scenario we can look at other options."

REGISTERED PSYCHIATRIC NURSES

The RPNAS has written to the Commission as follows: "*The Registered Psychiatric Nurses Association of Saskatchewan (RPNAS) had a representative attend your presentation on*

November 28, 1996. The Council has one concern to raise regarding your presentation.

A number of our members work in positions that are not described in "nurse" terms though they are required to be licensed with our Association in order to hold their positions. One example, is the title "Therapist" which involves individual and group counselling. We would hate to see some of our members fall through the cracks because their positions were not within the description of "nurse" in the final definition. We believe that if employers only are involved in defining the "nurse" group that several RPNs may not be included in the bargaining structure for Nurses.

Our Association would be willing to assist in the development of the definition of "nurse" in order to ensure that our total membership is included, not just those in nurse positions. enclosed for your information is the criteria the RPNAS uses when crediting hours worked for licensure."

ONGOING INQUIRY

Since releasing the reorganization proposal the Commission has received responses from organizations, groups and individuals. On November 29, Jim met with representatives of the SGEU to hear concerns and reaction. Last week he met with representatives of SAHO, HSAS, SGEU, SEIU, CUPE, SUN, MDS Labs, Chateau Nursing Home, Echo Lodge and Moose Jaw Pioneer Lodge employees, SRNA, SALPN, Swift Current Union Hospital Lab and X-ray technologists, RAPA, Music Therapists, Prosthetists, Orthotists and Exercise Therapists.

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Information Bulletin #11 Jan. 6, 1997

HAPPY NEW YEAR!

The Commissioner and staff would like to wish everyone a new year full of peace and prosperity. For those of you following the Julian calendar, Khristos Rodevsya!

STAFF CHANGES

Grace Marbach has left us to go to greener pastures. Her work has been greatly appreciated by the Commission. Joining us is Sheila Bissonnette, who will assist the Commission in its clerical and administrative matters. Welcome Sheila!

DRAFT REGULATIONS

Draft Regulations will be distributed for technical review and comment by the unions and employers tomorrow evening.

NORTH SASK. LAUNDRY

More information has been received on the laundry in Prince Albert. Although it is organized as a non-profit corporation, it is run more like a co-op, providing services to all 11 of its members: 10 district health boards and 1 northern hospital.

The main plant is located in Prince Albert and employs 40 full and part-time employees. It is currently running at 1/3 of its potential capacity. A satellite operation in North Battleford has also been started as a pilot project, employing 3 people. If the pilot project is successful, then other satellites in other districts may be considered.

At one time, the employees at the laundry used to be part of the CUPE local at the Victoria Union Hospital; however, there was apparently some dissatisfaction with that arrangement in the 1980's, and the employees at the laundry broke away and started their own CUPE local.

PTA/HSAS AGREEMENT

The Physical Therapists Association have made arrangements to merge their membership with the Health Sciences Association. This would give HSAS 66 more members in Regina.

MORE ON DEVOLUTION

In Bulletin #10 we told you that Saskatchewan Health has targeted April 1, 1997 to transfer two programs to health districts, those being Calder Centre and the Saskatchewan Health Aid Plan (SHAP). Plans are also in the works for one or two new health districts in the North, which may involve the transfer of some Saskatchewan Health employees in the Northern Health Services Branch.

The Commission has no other information that would suggest that any other services currently provided by central government, such as social services or justice, are going to be devolved to health districts in the future.

ONGOING INQUIRY

The Commission met with several groups and individuals regarding the Reorganization Proposal released on November 28, 1996. The input was provocative and thought provoking. We have also received many phone calls, letters, faxes and petitions. With our limited resources we are attempting to answer every letter and return every phone call.

On Dec. 13 a meeting was held to explore some ideas. Representatives from CUPE, HSA, SEIU

and SUN were in attendance. SGEU representatives chose not to attend. The Commission met with SAHO following the meeting with the unions, and contacted SGEU to outline the alternatives being discussed.

Reaction to the alternatives have been just as provocative and thought provoking as the reaction to the initial proposal.

STRONG CRITICISM

On December 28 the SGEU published an open letter to the Government of Saskatchewan in the Regina Leader Post. It reads as follows:

The Saskatchewan Government Employees' Union wants to express its profound disappointment and feelings of betrayal over the Dorsey Commission's preliminary report on union jurisdiction in the health sector.

As a union which represents about 3,500 health care workers, we know the problems caused by the restructuring of our health care system. Our members encounter them daily. We welcomed the opportunity to work on solutions. That's why we supported the establishment of the Dorsey Commission.

Our members in the health sector were promised the process would be fair and democratic. The Commission was mandated to respect the "history of trade union representation". And the guidelines required the Commission to "seek to maintain current representation". Our members were assured the purpose of the reorganization was to further the goals of health reform.

Yet in his interim report of November 28, Commissioner Jim Dorsey violated his mandate. Instead of proposing a model that supports the goals of health reform, the Commissioner recommended an elitist bargaining structure which virtually eliminates SGEU's right to represent our members in the health sector. Dorsey's proposal does not reflect the wellness model - it does not even recognize community-based health care. Instead, the Commissioner has recycled the medical model of health care, where nurses are at the top, licensed professionals are in the middle and everyone else is at the bottom. How does this proposal further the goals of health reform?

Members of our union feel betrayed. They feel angry. And they feel disillusioned by the legislative process.

Our membership is seeking major changes in the final report expected on January 15 - changes that reflect a model of union representation that supports an integrated approach to health care delivery and maintains every unions's jurisdiction in the health sector.

As the government responsible for establishing this Commission, our members hold you responsible and accountable for what happens to health care restructuring.

CONSTRUCTIVE CRITICISM

The definition of the licensed provider unit in the Reorganization Proposal provided an exhaustive list of employee occupations. Anyone employed and functioning in one of the listed occupations was included in the licensed unit. All other were included in one of the other units. The rationale, as stated in the presentation on November 28, 1996, was to provide clear lines between the various units, so that there could be as much certainty as possible in determining which employees should be included.

Dr. Ralph Nilson, Dean of the Faculty of Physical Activity Studies at the University of Regina writes:

This definition of licensed providers is exclusory in that there are a significant Number of health care professionals in Saskatchewan who would subsequently be relegated to the health care provider unit. This would be an injustice to those professionals who are equal contributing members of an interdisciplinary health care team and exceptions should be made for them. I recommend the licensed provider unit be expanded to include health care professionals who:

- are engaged in a health care field in a position involving technical proficiency and scientific knowledge
- hold a degree from a post-secondary educational institution (university or college)
- are members of a professional or quasi-professional organization dedicated to the advancement of their discipline
- exercise considerable independence of judgement and action

• and perform an important role in either the diagnosis or treatment of individuals in their care or health promotion or prevention of illness.

Graduates from the Faculty of Physical Activity Studies, particularly those employed as Recreation Therapists (RT) and Exercise Therapists (ET) possess the above professional skills, knowledge and abilities, and as such it appears appropriate that they be recognized with their colleagues (Occupational Therapists (OT), Physical Therapists (PT), Social Workers (SW) and Psychologists).

The Faculty of Physical Activity Studies recommends that recreation therapists and exercise therapists be included in the Licensed Provider Unit.

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Information Bulletin #12 Jan. 15, 1997

REGULATIONS AND REPORT DELIVERED

The Commissioner's health labour relations reorganization regulations and accompanying report were delivered to the Minister of Labour this morning. The commissioner's appointment expires January 31, 1997.

A copy of the regulations accompany this Information Bulletin.

The report will be distributed as soon as it is reprinted in sufficient copies for distribution.

REORGANIZATION HIGHLIGHTS

- three standard bargaining units:
  - health services provider
  - health support practitioner
  - nurse
- separate bargaining units for private profit employers and Regina Laundry
- total of 45 bargaining units in place of current 538
- trade unions certified by regulation for 43 of the units
- two representation votes to be held by the Labour Relations Board
  - North Central health services provider unit
  - province-wide health services practitioner unit
- all existing agreements maintained
- incidence of collective bargaining reduced from 25 to 9 or 10 depending on outcome of vote in North Central health services provider unit
- SAHO designated as exclusive employers representative organization for collective bargaining
- recognition of service as accumulated seniority for previously unrepresented employees at no cost to them
- seniority is portable into new units

THANK YOU!

The Commission sincerely thanks each of you for your patience and your candor, participation and assistance.

OFFICE CLOSES

The Commission office will close and telephone, fax and e-mail will be disconnected effective January 21, 1996. Allan Barss will continue to be available to respond to any questions or requests for information through the following means:

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Policy & Planning Division
4th Floor, 1870 Albert Street
Regina SK S4P 3V7
Phone: 787-9737 Fax: 787-7229
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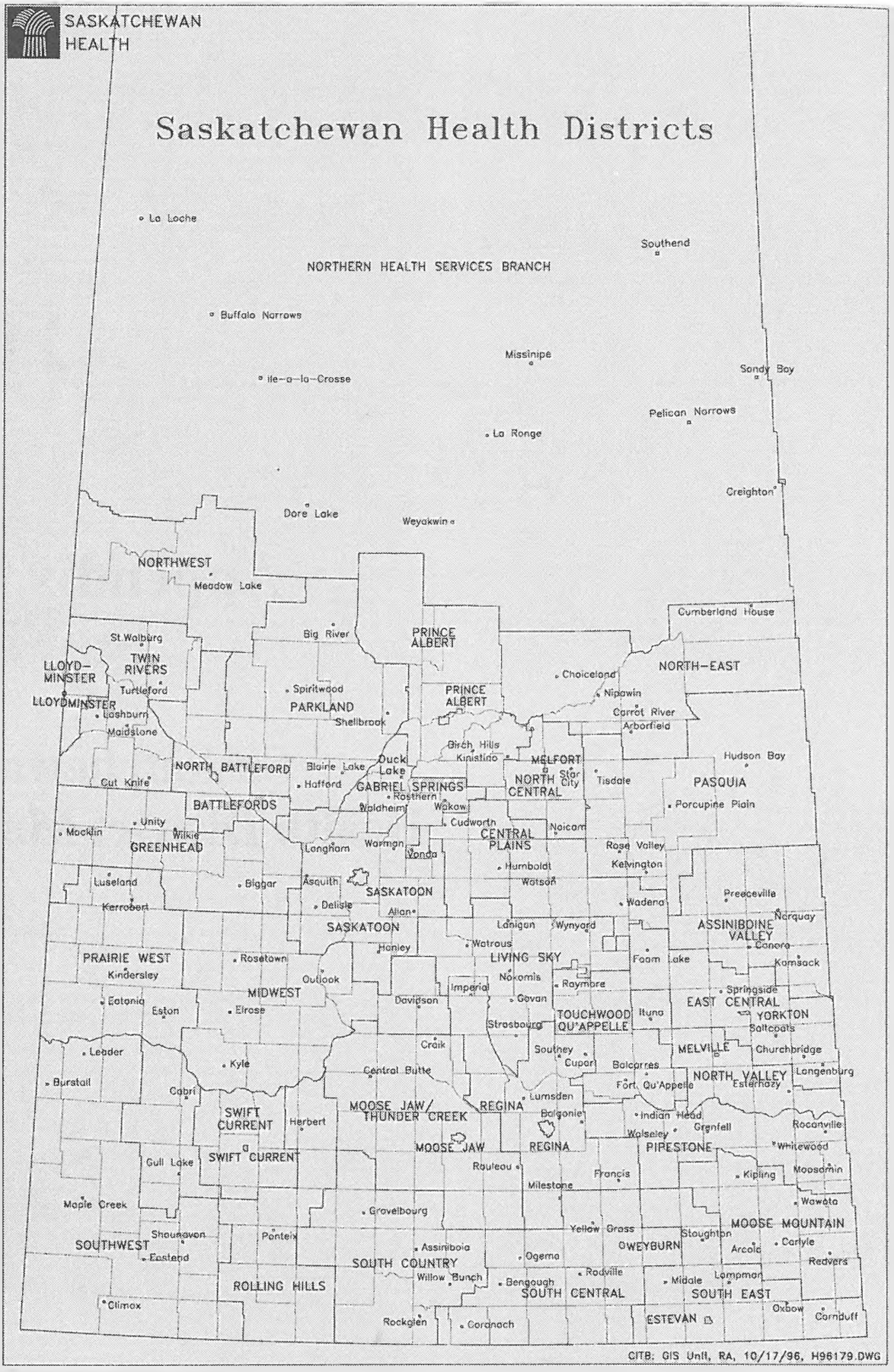
Appendix L

Saskatchewan Health District Map


SASKATCHEWAN
HEALTH
Saskatchewan Health Districts
La Loche
Southend
NORTHERN HEALTH SERVICES BRANCH
Buffalo Narrows
Missinipe
Sandy Bay
Ile-a-la-Crosse
Pelican Narrows
La Ronge
Creighton
Dore Lake
Weyakwin
NORTHWEST
Meadow Lake
Cumberland House
St.Walburg
Big River
PRINCE ALBERT
LLOYD-MINSTER
TWIN RIVERS
Turtleford
LLOYDMINSTER
Lashburn
Maidstone
Spiritwood
PARKLAND
Shellbrook
PRINCE ALBERT
Choiceland
NORTH-EAST
Nipawin
Carrot River
Arborfield
Birch Hills
Kinistino
MELFORT
Star City
Tisdale
Hudson Bay
PASQUIA
NORTH BATTLEFORD
Blaine Lake
Duck Lake
Hafford
GABRIEL SPRINGS
Rosthern
Waldheim
Wakaw
NORTH CENTRAL
Cut Knife
BATTLEFORDS
Porcupine Plain
Unity
Macklin
Wilkie
GREENHEAD
Cudworth
Naicam
CENTRAL PLAINS
Rose Valley
Kelvington
Langham
Warman
Vonda
Humboldt
Watson
Luseland
Biggar
Asquith
SASKATOON
Wadena
Preeceville
Kerrobert
Delisle
Allan
Nipawin
SASKATOON
Lanigan
Wynyard
ASSINIBOINE VALLEY
Canora
Hanley
Watrous
PRAIRIE WEST
Rosetown
LIVING SKY
Foam Lake
Kamsack
Kindersley
Outlook
Nokomis
Raymore
MIDWEST
Imperial
Springside
Eatonia
Eston
Elrose
Davidson
Govan
EAST CENTRAL
YORKTON
TOUCHWOOD QU'APPELLE
Ituna
Strasbourg
Saltcoats
Leader
Craik
Soutney
MELVILLE
Churchbridge
Kyle
Cupar
Balcarres
Central Butte
NORTH VALLEY
Langenburg
Burstall
Cabri
Fort Qu'Appelle
Esterhazy
Lumsden
SWIFT CURRENT
MOOSE JAW/ THUNDER CREEK
REGINA
Balgonie
Indian Head
Herbert
Grenfell
Roanville
Walseley
MOOSE JAW
REGINA
PIPESTONE
Whitewood
Gull Lake
SWIFT CURRENT
Rouleau
Francis
Kipling
Moosomin
Milestone
Maple Creek
Gravelbourg
Wawota
Yellow Grass
MOOSE MOUNTAIN
Shaunavon
Ponteix
Stoughton
SOUTHWEST
Assiniboia
WEYBURN
Carlyle
Eastend
SOUTH COUNTRY
Ogema
Arcola
Redvers
Willow Bunch
Rockville
Lampman
ROLLING HILLS
Bengough
Midale
SOUTH CENTRAL
SOUTH EAST
Climax
Oxbow
Carnduff
Rockglen
Coronach
ESTEVAN
CITB: GIS Unit, RA, 10/17/96, H96179.DWG

Appendix M

Employee Representation by Trade Union, Employer and Bargaining Unit

Employee Representation

HEALTH DISTRICTS:	CUPE	SEIU	SUN	SGEU	HSA	RWDSU	PSAC	PTA	RAPA	PIPS	NON UNION*	TOTAL EMPLOYEES	BARGAINING UNITS
Assiniboine Valley	422	0	133	87	0	0	0	0	0	0	27	669	19
Battelfords	931	0	176	86	0	0	0	0	0	0	28	1,221	13
Central Plains	338	104	132	16	0	0	0	0	0	0	82	672	22
East Central	725	41	289	101	0	0	0	0	0	0	80	1,236	17
Gabriel Springs	116	38	52	20	0	0	0	0	0	0	13	239	10
Greenhead	144	135	88	61	0	0	0	0	0	0	91	519	19
Living Sky	208	117	79	56	0	0	0	0	0	0	49	509	17
Lloydminster	172	0	72	8	0	0	0	0	0	0	90	342	6
Midwest	138	237	120	65	0	0	0	0	0	0	183	743	26
Moose Jaw/Thunder Creek	0	737	240	194	0	0	0	0	0	0	86	1,257	17
Moose Mountain	1	227	89	8	0	0	0	0	0	0	139	464	19
North Central	3	192	62	193	0	0	0	0	0	0	70	520	8
North Valley	357	0	118	54	0	0	0	0	0	0	40	569	14
North-East	4	305	102	5	0	0	0	0	0	0	61	477	16
Northwest	176	0	55	35	0	0	0	0	0	0	15	281	9
Parkland	215	85	124	17	0	0	0	0	0	0	201	642	22
Pasquia	268	82	126	50	0	0	0	0	0	0	50	576	21
Pipestone	69	322	114	124	0	0	0	0	0	0	146	775	26
Prairie West	204	117	115	50	0	0	0	0	0	0	86	572	19
Prince Albert	919	49	359	143	17	0	0	0	0	0	68	1,555	19
Regina	2630	387	1827	1081	148	81	0	63	52	0	185	6,454	37
Rolling Hills	58	76	51	3	0	0	0	0	0	0	143	331	15
Saskatoon	165	3447	2539	483	588	0	49	0	0	12	155	7,438	37
South Central	649	56	125	99	0	0	0	0	0	0	69	998	18
South Country	87	168	91	34	0	0	0	0	0	0	56	436	15
Southeast	312	61	183	39	0	0	0	0	0	0	113	708	13
Southwest	72	223	93	12	0	0	0	0	0	0	121	521	17
Swift Current	0	492	124	86	0	0	0	0	0	0	82	784	8
Touchwood Qu'Appelle	95	42	54	34	0	0	0	0	0	0	90	315	11
Twin Rivers	189	48	95	51	0	0	0	0	0	0	62	445	20
Northern Health Services	125	0	49	0	0	0	0	0	0	0	0	174	8
Totals:	**9,792**	**7,788**	**7,876**	**3,295**	**753**	**81**	**49**	**63**	**52**	**12**	**2,681**	**32,442**	**538**

*** Does not include employees of Affiliated Employers who are completely non-union.**

Assiniboine Valley Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union	TOTAL
Kamsack & District Nursing Home	88		9								1	98
District Board office and administration											13	13
Gateway Lodge (Canora, Norquay, Invermay)	119		10								2	131
Canora Union Hospital	53		27								3	83
Preeceville Hospital	36		9									45
Kamsack Union Hospital	59		25								7	91
Invermay Health Centre	19		14									33
Norquay Health Centre	21		13									34
Kamsack Senior Housing (Eaglestone Lodge)	27											27
The Preecevile Lions Housing Corporation Ltd.			8								1	9
Assinaboine Valley Home Care			18	76								94
Community Health				11								11
Assiniboine Road Ambulance Association Board												0
Canora Road Ambulance District Association Board												0
Kamsack Union Hospital Ambulance District Board												0
Subtotal: Number of employees employed by District:	422	0	133	87	0	0	0	0	0	0	27	669
AFFILIATED FACILITIES AND PROGRAMS:												
None												0
												0
Subtotal: Number of employees employed by Affiliates:	0	0	0	0	0	0	0	0	0	0	0	0
Total number of employees in the District:	422	0	133	87	0	0	0	0	0	0	27	669
BARGAINING UNITS	8	0	9	2	0	0	0	0	0	0	TOTAL	19

Battelfords Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union	TOTAL
Lady Minto Union Hospital	25		10								1	36
District Board office and administration											5	5
Battlefords Union Hospital	210		115								21	346
Battlefords Area Municipal Ambulance												0
Battlefords River Heights Lodge	91		23									114
Battlefords Regional Care Centre	186											186
Saskatchewan Hospital/Battlefords Mental Health Centre	386											386
Community Health				41								41
Battlefords District Home Care			19	45							1	65
Subtotal: Number of employees employed by District:	898	0	167	86	0	0	0	0	0	0	28	1179
AFFILIATED FACILITIES AND PROGRAMS:												
Societe Joseph Breton Inc. (Villa Pascal)	33		9									42
												0
Subtotal: Number of employees employed by Affiliates:	33	0	9	0	0	0	0	0	0	0	0	42
Total number of employees in the District:	**931**	**0**	**176**	**86**	**0**	**0**	**0**	**0**	**0**	**0**	**28**	**1221**
BARGAINING UNITS	6	0	5	2	0	0	0	0	0	0	**TOTAL**	**13**

Central Plains Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union	TOTAL
Leroy Union Hospital											2	2
District Board office and administration											12	12
Quill Lake Union Hospital											2	2
Spalding Health Centre		2	2									4
Wadena Union Hospital	38		19									57
Watson Health Centre		3	8									11
Cudworth Area Municiapl Road Ambulance											18	18
Humboldt Area Municiapl Road Ambulance												0
Leroy Ambulance Service											10	10
Quill Plains Ambulance												0
Shamarock Road Ambulance												0
Cudworth Nursing Home Inc.	33		7									40
Pleasant View Care Home Inc.	41		6									47
Quill Plains Centennial Lodge Inc.		64	8									72
Community Health				11								11
Central Plains Home Care				5							18	23
Subtotal: Number of employees employed by District:	112	69	50	16	0	0	0	0	0	0	62	**309**
AFFILIATED FACILITIES AND PROGRAMS:												
Humboldt and District Housing Corporation	117		15								2	134
Bethany Pioneer Village Inc.		35	6								10	51
St Michael's Hospital Of Cudworth	23		14									37
St. Elizabeth's Hospital of Humboldt	86		47								8	141
Subtotal: Number of employees employed by Affiliates:	226	35	82	0	0	0	0	0	0	0	20	**363**
Total number of employees in the District:	**338**	**104**	**132**	**16**	**0**	**0**	**0**	**0**	**0**	**0**	**82**	**672**
BARGAINING UNITS	6	4	10	2	0	0	0	0	0	0	**TOTAL**	**22**

East Central Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union	TOTAL
Foam Lake Union Hospital	22		12									34
District Board office and administration											10	10
Langenburg Health Centre/Centennial Special Care Home	4	41	4								7	56
Theodore Health Centre (Heritage Special Care Home Inc.)	24		14									38
Yorkton Regional Health Centre	510		211									721
Langenburg Road Ambulance											6	6
Churchbridge Road Ambulance											4	4
Yorkton and District Ambulance Association												0
Foam Lake Jubilee Home	60		11									71
Lakeside Manor Care Home Inc. (Saltcoats)											45	45
Anderson Lodge Incorporated	44		9									53
Community Health				34								34
East Central Home Care			28	67							8	103
Yorkton Regional Hospital Linen Services Inc.												0
Yorkton Mental Health Centre	61											61
Subtotal: Number of employees employed by District:	725	41	289	101	0	0	0	0	0	0	80	**1236**
AFFILIATED FACILITIES AND PROGRAMS:												0
None												0
Subtotal: Number of employees employed by Affiliates:	0	0	0	0	0	0	0	0	0	0	0	**0**
Total number of employees in the District:	**725**	**41**	**289**	**101**	**0**	**0**	**0**	**0**	**0**	**0**	**80**	**1236**
BARGAINING UNITS	7	1	7	2	0	0	0	0	0	0	**TOTAL**	**17**

Gabriel Springs Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-union	TOTAL
Rosthern Union Hospital	35		18									53
District Board office and administration											3	3
Wakaw Union Hospital	31		15									46
R.M. of Laird-Town of Waldheim Ambulance												0
Rosthern Union Hospital Ambulance District												0
Wakaw Area Municipal Road Ambulance District												0
Community Health				9								9
Gabriel Springs Home Care				11							9	20
Subtotal: Number of employees employed by District:	66	0	33	20	0	0	0	0	0	0	12	**131**
AFFILIATED FACILITIES AND PROGRAMS:												
Duck Lake and District Nursing Home		38	10									48
Lakeview Pioneer Lodge Inc.	50		9								1	60
Mennonite Nursing Homes Incorporated											86	86
Menno Homes of Sask. Inc.												
Subtotal: Number of employees employed by Affiliates:	50	38	19	0	0	0	0	0	0	0	87	**194**
Total number of employees in the District:	**116**	**38**	**52**	20	**0**	**0**	**0**	**0**	**0**	**0**	**99**	**325**
BARGAINING UNITS	3	1	4	2	0	0	0	0	0	0	**TOTAL**	**10**

Greenhead Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union	TOTAL
Biggar Union Hospital		33	16								1	50
District Board office and administration											3	3
Unity Union Hospital	30		13									43
Wilkie Union Hospital	35		15									50
Biggar Area Municipal Road Ambulance											23	23
Macklin Ambulance Servoce											21	21
Unity Ambulance Service											25	25
Wilkie Ambulance Service											7	7
Diamond Lodge Company Ltd.		77	10								2	89
Wilkie and District Centennial Nursing Home Company Ltd.	21		7									28
Unimac Pioneers Lodge Inc.	55		8									63
Community Health				15								15
Greenhead Home Care			8	46							9	63
												0
Subtotal: Number of employees employed by District:	141	110	77	61	0	0	0	0	0	0	91	**480**
AFFILIATED FACILITIES AND PROGRAMS:												
Golden Twilight Lodge Incorporated		25	5									30
St Joseph's Hospital of Macklin	3		6									9
Subtotal: Number of employees employed by Affiliates:	3	25	11	0	0	0	0	0	0	0	0	**39**
Total number of employees in the District:	**144**	**135**	**88**	**61**	**0**	**0**	**0**	**0**	**0**	**0**	**91**	**519**
BARGAINING UNITS	5	3	9	2	0	0	0	0	0	0	**TOTAL**	**19**

Living Sky Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union	TOTAL
Lanigan Union Hospital		36	16									52
District Board office and administration											5	5
Nokomis Health Centre (includes Puffer Special Care Home)		35	10									45
Watrous Union Hospital	37		16									53
Wynyard Union Hospital	35		12									47
Last Mountain Ambulance												0
Lanigan and District Ambulance												0
Mount Hope Road Ambulance												0
Watrous District Road Ambulance											15	15
Wynyard and District Ambulance Association												0
Last Mountain Pioneer Home Inc.	47		7									54
Manitou Lodge	41										10	51
Wynyard and District Housing Corporation	48		8									56
Community Health				10								10
Living Sky Home Care				46							19	65
Central Parkland Lodge		46	10									56
Subtotal: Number of employees employed by District:	208	117	79	56	0	0	0	0	0	0	49	**509**
AFFILIATED FACILITIES AND PROGRAMS:												
None												0
												0
Subtotal: Number of employees employed by Affiliates:	0	0	0	0	0	0	0	0	0	0	0	**0**
Total number of employees in the District:	**208**	**117**	**79**	**56**	**0**	**0**	**0**	**0**	**0**	**0**	**49**	**509**
BARGAINING UNITS	5	3	7	2	0	0	0	0	0	0	**TOTAL**	**17**

Lloydminster Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union
Lloydminster Area Municipal Road Ambulance											
District Board office and administration											33
Lloydminster & District Senior Citizens' Lodge	53		12								3
Lloydminster Hospital	112		60								23
Community Health				8							
Lloydminster Health District Home Care											31
Mental Health	7										
Subtotal: Number of employees employed by District:	172	0	72	8	0	0	0	0	0	0	90
AFFILIATED FACILITIES AND PROGRAMS:											
None											
Subtotal: Number of employees employed by Affiliates:	0	0	0	0	0	0	0	0	0	0	0
Total number of employees in the District:	**172**	**0**	**72**	**8**	**0**	**0**	**0**	**0**	**0**	**0**	**90**
BARGAINING UNITS	3	0	2	1	0	0	0	0	0	0	**TOTAL**

Midwest Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union	TOTAL
Beechy Community Health Centre		3	4									7
District Board office and administration											9	9
Davidson Union Hospital	21		10									31
Dinsmore Health Care Centre (Prairie Manor)	30		5									35
Elrose Health Centre		3										3
Kyle Health Centre		24	8									32
Lucky Lake Health Centre		32	12									44
Milden Union Hospital			2									2
Outlook Union Hospital		37	14									51
Rosetown Union Hospital and Ambulance	62		28								4	94
Beechy-Demaine Ambulance											16	16
Coteau Hills Ambulance											22	22
Davidson Municipal Road Ambulance												0
Kyle-White Bear Union Hospital Ambulance											19	19
Lucky Lake Ambulance Association											15	15
Monet-Elrose Volunteer Ambulance												0
Outlook Ambulance											8	8
Arm River Housing Corporation (Prairie View Lodge, Davidson)		44	6									50
Golden Years Lodge Housing Co. Inc.		36	9									45
Outlook and District Pioneer Home Inc.		58	15									73
Wheatbelt Centennial Lodge Inc.	25										5	30
Community Health				35								35
Midwest Home Care			7	30							85	122
Subtotal: Number of employees employed by District:	138	237	120	65	0	0	0	0	0	0	183	**743**
AFFILIATED FACILITIES AND PROGRAMS:												
None												0
												0
Subtotal: Number of employees employed by Affiliates:	0	0	0	0	0	0	0	0	0	0	0	**0**
Total number of employees in the District:	**138**	**237**	**120**	**65**	**0**	**0**	**0**	**0**	**0**	**0**	**183**	**743**
BARGAINING UNITS	4	8	12	2	0	0	0	0	0	0	**TOTAL**	**26**

Moose Jaw -Thunder Creek Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union
Central Butte Union Hospital		25	15								
District Board office and administration											4
Mosse Jaw Union Hospital		270	177								12
Central Butte and District Ambulance Association		2									
Craik Area Municipal Road Ambulance											
Moose Jaw Area Municipal Road Ambulance District Association		12									
Central Butte and District Regency Manor Inc.		36	12								
Pioneer Housing Association of Moose Jaw		69									12
Community Health				76							
Moose Jaw-Thunder Creek Home Care				118							30
Craik Community Health Centre			8								20
Subtotal: Number of employees employed by District:	0	414	212	194	0	0	0	0	0	0	78
AFFILIATED FACILITIES AND PROGRAMS:											
Extendicare Canada Inc.		105	26								
Ina Grafton Gage Home		22									
Providence Place for Holistic Health Inc.		196	2								8
Subtotal: Number of employees employed by Affiliates:	0	323	28	0	0	0	0	0	0	0	8
Total number of employees in the District:	**0**	**737**	**240**	**194**	**0**	**0**	**0**	**0**	**0**	**0**	**86**
BARGAINING UNITS	0	9	6	2	0	0	0	0	0	0	**TOTAL**

Moose Mountain Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union	TOTAL
Brock Health Centre (Arcola)		28	10								2	40
District Board office and administration											5	5
Kipling Memorial Health Centre		28	13									41
Maryfield Community Health and Social Centre											6	6
Redvers Health Centre		21	14									35
Wawota Memorial Health Centre		16	12									28
Kipling and District Road Ambulance Service											9	9
Moose Mountain Road Ambulance												0
Redvers Road Ambulance											9	9
Maryfield Road Ambulance											10	10
Wawota and District Ambulance Service											13	13
Moose Mountain Lodge Company		39	7								7	53
Willowdale Lodge Care Home		31										31
Redvers Centennial Haven Inc.		27	9									36
Wawota and District Special Care Home Inc.		37	6									43
Community Health	1			6								7
Moose Mountain Home Care			18	2							78	98
Subtotal: Number of employees employed by District:	1	227	89	8	0	0	0	0	0	0	139	**464**
AFFILIATED FACILITIES AND PROGRAMS:												
None												0
												0
Subtotal: Number of employees employed by Affiliates:	0	0	0	0	0	0	0	0	0	0	0	**0**
Total number of employees in the District:	**1**	**227**	**89**	8	0	0	0	0	0	0	**139**	**464**
BARGAINING UNITS	1	8	8	2	0	0	0	0	0	0	**TOTAL**	**19**

North Central Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union	TOTAL
Melfort Union Hospital		85	53								7	145
District Board office and administration											6	6
Melfort Union Hospital Road Ambulance												0
Melfort and District Pioneer Lodge		74	9									83
Parkland Regional Care Centre				160							1	161
Chateau Providence Inc.											46	46
North Central Home Care		33									9	42
Community Health	3			33							1	37
Subtotal: Number of employees employed by District:	3	192	62	193	0	0	0	0	0	0	70	**520**
AFFILIATED FACILITIES AND PROGRAMS:												0
None												0
Subtotal: Number of employees employed by Affiliates:	0	0	0	0	0	0	0	0	0	0	0	**0**
Total number of employees in the District:	**3**	**192**	**62**	**193**	**0**	**0**	**0**	**0**	**0**	**0**	**70**	**520**
BARGAINING UNITS	1	3	2	2	0	0	0	0	0	0	**TOTAL**	**8**

North Valley Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union
Ituna Health Care Centre	5		4								2
District Board office and administration											3
Neudorf Health and Social Centre											2
Esterhazy Area Municipal Road Ambulance											
Ituna and District Road Ambulance Association											8
Melville Area Ambulance											
Centennial Special Care Home	75		10								1
Ituna and District Pioneer Lodge	39		7								1
Community Health				10							
North Valley Home Care				44							18
Subtotal: Number of employees employed by District:	119	0	21	54	0	0	0	0	0	0	35
AFFILIATED FACILITIES AND PROGRAMS:											
St. Paul Luthern Home of Melville	123		30								4
St. Anthony's Hospital, Esterhazy	28		15								
St. Peter's Hospital, Melville	87		52								1
Subtotal: Number of employees employed by Affiliates:	238	0	97	0	0	0	0	0	0	0	5
Total number of employees in the District:	**357**	**0**	**118**	**54**	**0**	**0**	**0**	**0**	**0**	**0**	**40**
BARGAINING UNITS	6	0	6	2	0	0	0	0	0	0	**TOTAL**

North-East Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union
Arborfiled Health Centre			6								
District Board office and administration											2
Carrot River Union Hospital		20	11								1
Nipawin Union Hospital		118	45								3
Smeaton District Health Centre		3	4								
Nipawin and District Regional Ambulance											
Arborfiled Special Care Lodge Inc.		37	9								1
Pasquia Special Care Home Inc.		40	6								1
Nipawin District Nursing Home Inc.		87	18								1
Norht East Home Care											51
Community Health	4			5							
Zenon Park Community Health and Social Centre			3								1
Subtotal: Number of employees employed by District:	4	305	102	5	0	0	0	0	0	0	61
AFFILIATED FACILITIES AND PROGRAMS:											
None											
Subtotal: Number of employees employed by Affiliates:	0	0	0	0	0	0	0	0	0	0	0
Total number of employees in the District:	**4**	**305**	**102**	**5**	**0**	**0**	**0**	**0**	**0**	**0**	**61**
BARGAINING UNITS	1	6	8	1	0	0	0	0	0	0	**TOTAL**

Northwest Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union	TOTAL
District Board office and administration											2	2
Loon Lake Union Hospital	31		11									42
Meadow Lake Union Hospital	63		34									97
Beaver River Ambulance												0
Meadow Lake and District Ambulance											13	13
L. Gervais Memorial Health Centre Inc. (Goodsoil)	20		10									30
Northland Pioneers Lodge Inc.	62											62
Northwest Home Care				30								30
Community Health				5								5
												0
Subtotal: Number of employees employed by District:	176	0	55	35	0	0	0	0	0	0	15	281
AFFILIATED FACILITIES AND PROGRAMS:												
None												0
												0
Subtotal: Number of employees employed by Affiliates:	0	0	0	0	0	0	0	0	0	0	0	0
Total number of employees in the District:	**176**	**0**	**55**	**35**	**0**	**0**	**0**	**0**	**0**	**0**	**15**	**281**
BARGAINING UNITS	4	0	3	2	0	0	0	0	0	0	**TOTAL**	9

Parkland Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union
Big River Union Hospital	30		11								
District Board office and administration											6
Hafford Hospital and District Nursing Home	31		10								
Evergreen Health Centre (Leoville Union Hospital)	20		10								
Rabbit Lake Integrated Facility	18		11								
Shellbrook Union Hospital		45	13								
Spiritwood Union Hospital	30		13								
Big River Road Ambulance											
Blaine Lake and Surrounding District Ambulance Assoc.											
Shell Can Road Ambulance Association											
Rabbit Lake Area Municipal Road Ambulance											
Speers and Surrounding District Ambulance Assoc.											
Spiritwood Area Road Ambulance											
Lake-Wood Lodge Inc.	41		10								
Whispering Pine Place Inc. (Canwood)											78
Wheatland Lodge Inc.			9								59
Parkland Housing Company		40	11								
Idylwild Senior Citizens Lodge	45		13								
Community Health				12							
Parkland Home Care			13	5							58
Subtotal: Number of employees employed by District:	215	85	124	17	0	0	0	0	0	0	201
AFFILIATED FACILITIES AND PROGRAMS:											
None											
Subtotal: Number of employees employed by Affiliates:	0	0	0	0	0	0	0	0	0	0	0
Total number of employees in the District:	**215**	**85**	**124**	**17**	**0**	**0**	**0**	**0**	**0**	**0**	**201**
BARGAINING UNITS	7	2	11	2	0	0	0	0	0	0	**TOTAL**

Pasquia Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union
Hudson Bay Union Hospital	28		12								
District Board office and administration											8
Kelvington Union Hospital	25		9								
Porcupine-Carragana Union Hospital	17		13								
Rose Valley Integrated Facility	6		9								
Tisdale Union Hospital	55		29								
Hudson Bay Area Municipal Road Ambulance											8
Kelvington Municipal Road Ambulance											
Porcupine Ambulance Service											32
Tisdale Municipal Road Ambulance Association											
Hudson Bay Pioneer Lodge	28		9								
Kelvindell Lodge Company	56		6								
Red Deer Nursing Home Inc.	53		6								
Tisdale and District Housing Company Ltd.		82	20								
Community Health				11							
Pasquia Home Care			13	39							2
Subtotal: Number of employees employed by District:	268	82	126	50	0	0	0	0	0	0	50
AFFILIATED FACILITIES AND PROGRAMS:											
None											
Subtotal: Number of employees employed by Affiliates:	0	0	0	0	0	0	0	0	0	0	0
Total number of employees in the District:	**268**	**82**	**126**	**50**	**0**	**0**	**0**	**0**	**0**	**0**	**50**
BARGAINING UNITS	8	1	10	2	0	0	0	0	0	0	**TOTAL**

Pipestone Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union
Broadview Union Hospital		27	8								1
District Board office and administration											2
Grenfell Health Centrel	5		4								
Indian Head Union Hospital		26	12								
Montmarte Integrated Health Centre		22	10								1
Moosomin Union Hospital		50	24								
Wolsley Memorial Union Hospital	22		8								
Whitewood Health Centre		4	3								
Indian Head and District Ambulance											8
Moosomin District Road Ambulance Association											
Whitewood District Road Ambulance											22
Wolseley Municipal Road Ambulance											
Lakeside Home				115							1
Broadview and District Centennial Lodge Inc.		38	5								
Grenfell and District Pioneer Home	42		9								
Golden Prairie Home Ltd.		49	10								
The Eastern Saskatchewan Pioneer Lodge		68	10								1
Whitewood & District Nursing Home Inc.		38	11								1
Community Health				9							
Pipestone Home Care											109
Subtotal: Number of employees employed by District:	69	322	114	124	0	0	0	0	0	0	146
AFFILIATED FACILITIES AND PROGRAMS:											
None											
Subtotal: Number of employees employed by Affiliates:	0	0	0	0	0	0	0	0	0	0	0
Total number of employees in the District:	**69**	**322**	**114**	**124**	**0**	**0**	**0**	**0**	**0**	**0**	**146**
BARGAINING UNITS	3	9	12	2	0	0	0	0	0	0	**TOTAL**

Prairie West Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union
Dodsland Health Centre			11								
District Board office and administration											2
Eatonia Health Care Centre			9								
Eston Health Centre and Ambulance	24		7								
Kerrobert Union Hospital	32										
Kindersley Union Hospital	36		26								
Dodsland Plenty Area Municipal Ambulance											9
Luseland Ambulance											11
Kerrobert and District Road Ambulance Association											13
Kindersley and Area Municipal Road Ambulance											15
Jubilee Lodge Inc.	39		16								2
Eatonia Community Health Centre	22										
Prairie West Home Care			25	35							33
Community Health				15							
Subtotal: Number of employees employed by District:	153	0	94	50	0	0	0	0	0	0	85
AFFILIATED FACILITIES AND PROGRAMS:											
Buena Vista Lodge Inc.	26		8								
Kindersley Senior Care Inc.		117	9								1
Pioneers Haven Co. Inc.	25		4								
Subtotal: Number of employees employed by Affiliates:	51	117	21	0	0	0	0	0	0	0	1
Total number of employees in the District:	**204**	**117**	**115**	**50**	**0**	**0**	**0**	**0**	**0**	**0**	**86**
BARGAINING UNITS	7	1	9	2	0	0	0	0	0	0	**TOTAL**

Prince Albert Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union	TOTAL
Birch Hills Memorial Health Centre	3		3								9	15
District Board office and administration											11	11
Kinistino Union Hospital	27		9									36
Victoria Union Hospital (Prince Albert)	450		218		17							685
Gateway Road Ambulance												0
Northern Six Municipal Road Ambulance												0
Prince Albert Area Municipal Road Ambulance												0
Birch Hills and District Nursing Home		49										49
Kinistino and District Housing Corporation	42		7									49
Northern Housing Development (1973) Inc.	136		25								10	171
Community Health				59								59
Prince Albert District Home Care				84							31	115
Psychiatric Centre	53											53
Subtotal: Number of employees employed by District:	711	49	262	143	17	0	0	0	0	0	61	**1243**
AFFILIATED FACILITIES AND PROGRAMS:												
Mont St. Joseph Homes Inc.	73		18								1	92
Holy Family Hospital, Prince Albert	135		79								6	220
Subtotal: Number of employees employed by Affiliates:	208	0	97	0	0	0	0	0	0	0	7	**312**
Total number of employees in the District:	**919**	**49**	**359**	**143**	**17**	**0**	**0**	**0**	**0**	**0**	**68**	**1555**
BARGAINING UNITS	8	1	7	2	1	0	0	0	0	0	**TOTAL**	**19**

Regina Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union
Cupar Health Centre	2		5								1
District Board office and administration											10
Long Lake Valley Integrated Facility (Imperial)	25		13								
Cupar Area Municipal Road Ambulance											
Regina General Hospital	697		751		39						30
Pasqua Hospital	599		391		35					9	66
Wascana Rehabilitation Centre				709						43	40
Plains Health Centre	525		357		23					10	16
City of Regina (Health Workers)	110										
Community Health Services (Regina)	40			132							
Regina Hospital Laundry								81			1
Wascana Home Care			71	240	51						2
Regina Area Municipal Road Ambulance									52		
Soo Line Municipal Road Ambulance											
Thirty-Three Fourty-Eight Road Ambulance											
Subtotal: Number of employees employed by District:	1998	0	1588	1081	148	0	0	81	52	62	166
AFFILIATED FACILITIES AND PROGRAMS:											
Cupar and District Nursing Home	47		11								
Lumsden & District Heritage Home Inc.		37									7
Martin Luther Nursing Home Inc.(closed)											
The Regina Lutheran Housing Corp.	91		19								
Regina Pioneer Village Ltd.	335		88								5
Extendicare (Parkside)		175	46								
Extendicare (Elmview)		54	50								1
Extendicare (Sunset)		121									4
The Qu'Appelle Diocesan Housing Company											20
Salvation Army William Booth Special Care Home											101
Santa Maria Senior Citizen's Home Inc.	159		25							1	2
Subtotal: Number of employees employed by Affiliates:	632	387	239	0	0	0	0	0	0	1	140
Total number of employees in the District:	**2630**	**387**	**1827**	**1081**	**148**	**0**	**0**	**81**	**52**	**63**	**306**
BARGAINING UNITS	11	4	12	3	4	0	0	1	1	1	**TOTAL**

Rolling Hills Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union	TOTAL
Prairie Health Centre (Cabri)		29	10									39
District Board office and administration											5	5
Gull Lake Union Hospital		5	7									12
Herbert-Morse Union Hospital	22		10									32
Hodgeville Health Centre											2	2
Mankota and District Integrated Facility Inc.(Prairie View Health Centre)		32	8									40
Ponteix Health Centre		4	5									9
Vanguard Health Centre		6	5									11
Cabri and District Ambulance Service											14	14
Gull Lake and District Road Ambulance											9	9
Herbert-Morse Municipal Road Ambulance Service												0
Ponteix Area Municipal Road Ambulance												0
Rolling Hills Health District Home Care											112	112
Community Health				3								3
Subtotal: Number of employees employed by District:	22	76	45	3	0	0	0	0	0	0	142	**288**
AFFILIATED FACILITIES AND PROGRAMS:												
Gull Lake and District Special Care Home Inc.	36		6								1	43
Herbert Nursing Home Incorporated											33	33
Foyer St Joseph Nursing Home Inc. (Ponteix)											39	39
Subtotal: Number of employees employed by Affiliates:	36	0	6	0	0	0	0	0	0	0	73	**115**
Total number of employees in the District:	**58**	**76**	**51**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**215**	**403**
BARGAINING UNITS	2	5	7	1	0	0	0	0	0	0	**TOTAL**	**15**

Saskatoon Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union	TOTAL
Borden Community Health Centre		10	6									16
District Board office and administration											40	40
Delisle Community Health Centre			3									3
Royal University Hospital	19	947	1208		439							2613
City Hospital		550	479		120							1149
Community Health	146			108								254
Delisle Community Ambulance											11	11
River Bend Ambulance												0
Saskatoon Area Ambulance												0
Yellowhead Ambulance Area												0
Parkridge Centre		312	85									397
Saskatoon Health District Home Care			94	375								469
Subtotal: Number of employees employed by District:	165	1819	1875	483	559	0	0	0	0	0	51	**4952**
AFFILIATED FACILITIES AND PROGRAMS:												
Jubilee Residences Inc.		178	30								8	216
Saskatoon Convalescent Home		64	15									79
Sherbrooke Community Society Inc.		361	101								13	475
Saskatoon Veterans' Home						49	12					61
Spruce Manor Special Care Home Incorporated											43	43
Langham Senior Citizens Home Ltd.											21	21
Central Haven Special Care Home Inc.											60	60
Circle Drive Special Care Home Inc.											64	64
Extendicare Aged		92	14									106
Luthern Sunset Home		157	23								5	185
Oliver Lodge		91	18								8	117
Salvation Army Eventide Home		40									9	49
St Ann's Senior Citizen's Village Corporation		92	16									108
Ukranian Sisters of St. Joseph's\St Joseph's Home for Aged		48										48
Sunnyside Nursing Home											133	133
Warman Mennonite Special Care Home											29	29
St Paul's Hospital (Grey Nuns)		505	447		29						61	1042
Subtotal: Number of employees employed by Affiliates:	0	1628	664	0	29	49	12	0	0	0	454	2836
Total number of employees in the District:	**165**	**3447**	**2539**	**483**	**588**	**49**	**12**	**0**	**0**	**0**	**505**	**7788**
BARGAINING UNITS	2	14	14	2	3	1	1	0	0	0	**TOTAL**	37

South Central Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union
Bengough Health Centre		4	9								
District Board office and administration											8
Coronach District Health Centre		24	12								
Pangman Health Centre	1		11								
Weyburn Union Hospital	100		49								1
Bengough Road Ambulance											14
Coronach Area Road Ambulance											15
Pangman Road Ambulance											12
Weyburn Road Ambulance											19
Twilight Centennial Home Inc. (Bengough)		28	13								
Weyburn Mental Health Centre	64										
Sourris Valley Regional Care Centre	324										
Weyburn and District Special Care Homes Corporation	105										
Community Health				26							
South Central Home Care			20	73							
Subtotal: Number of employees employed by District:	594	56	114	99	0	0	0	0	0	0	69
AFFILIATED FACILITIES AND PROGRAMS:											
Radville And District Municipal Road Ambulance											
Marian Home/Special Care Home/Health Centre(Radville)	55		11								
Subtotal: Number of employees employed by Affiliates:	55	0	11	0	0	0	0	0	0	0	0
Total number of employees in the District:	**649**	**56**	**125**	**99**	**0**	**0**	**0**	**0**	**0**	**0**	**69**
BARGAINING UNITS	6	3	7	2	0	0	0	0	0	0	**TOTAL**

South Country Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union
Assiniboia Union Hospital		28	16								2
District Board office and administration											3
Kincaid Wellness Centre	5		1								1
Lefleche Health Centre		21	13								
Sutton-Lake Johnston Union Hospital											4
Grasslands Health Centre (Rockglen)		20	5								
Willow Bunch Union Hospital											4
Gravelbourg Municipal Road Ambulance											
South Central Road Ambulance											
Assiniboia Pioneer Lodge Inc.		99	22								
Community Health				11							
South Country Home Care			14	23							42
Subtotal: Number of employees employed by District:	5	168	71	34	0	0	0	0	0	0	56
AFFILIATED FACILITIES AND PROGRAMS:											
St. Joseph's Hospital (Grey Nuns) of Gravelbourg	82		20								
Subtotal: Number of employees employed by Affiliates:	82	0	20	0	0	0	0	0	0	0	0
Total number of employees in the District:	**87**	**168**	**91**	**34**	**0**	**0**	**0**	**0**	**0**	**0**	**56**
BARGAINING UNITS	2	4	7	2	0	0	0	0	0	0	**TOTAL**

Southeast Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union
Fillmore Health Centre		26	9								1
District Board office and administration											8
Gainsborough and Area Health Centre	26		11								2
Lampman Community Health Centre	30		10								2
Galloway Health Centre (Oxbow)	28		13								1
Borderline Road Ambulance											7
Lampman and District Road Ambulance											15
Fillmore Municipal Road Ambulance											
Oxbow Area Municipal Road Ambulance	6										
Stoughton and District Road Ambulance											18
South Eastern Saskatchewan Road Ambulance Association	7										
Estevan Regional Nursing Home	65	17	20								1
Mainprize Manor & Health Centre Inc.		18	16								2
Community Health				7							
South East Home Care			30	32							6
Subtotal: Number of employees employed by District:	162	61	109	39	0	0	0	0	0	0	63
AFFILIATED FACILITIES AND PROGRAMS:											
Border-Line Housing Company (1975) Inc.			6								50
Newhope Pioneer Lodge Inc.			8								
St. Joseph's Hospital, Estevan	150		60								
Subtotal: Number of employees employed by Affiliates:	150	0	74	0	0	0	0	0	0	0	50
Total number of employees in the District:	**312**	**61**	**183**	**39**	**0**	**0**	**0**	**0**	**0**	**0**	**113**
BARGAINING UNITS	3	2	6	2	0	0	0	0	0	0	**TOTAL**

Southwest Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union	TOTAL
Border Health Centre (Climax)		6	10									16
District Board office and administration											10	10
Eastend Wolf Willow Health Centre	40		13									53
Leader Union Hospital		19	8									27
Maple Creek Union Hospital	32		17									49
Shaunavon Union Hospital		45	15								2	62
Eastend Ambulance Division											11	11
Consul Ambulance Division											10	10
Frontier Municipal Road Ambulance												0
Richmond Ambulance Division											9	9
Leader Ambulance Division											10	10
Maple Creek Union Hospital Ambulance											12	12
Shaunavon Union Hospital Ambulance											16	16
Western Senior Citizen's Home Inc. (Leader)		33	8								1	42
Cypress Lodge Corp. (Maple Creek)		54	10								2	66
Shaunavon Special Care Inc.		66	12									78
Southwest Home Care											38	38
Community Health				12								12
												0
												0
Subtotal: Number of employees employed by District:	72	223	93	12	0	0	0	0	0	0	121	**521**
AFFILIATED FACILITIES AND PROGRAMS:												
None												0
Subtotal: Number of employees employed by Affiliates:	0	0	0	0	0	0	0	0	0	0	0	**0**
Total number of employees in the District:	**72**	**223**	**93**	**12**	**0**	**0**	**0**	**0**	**0**	**0**	**121**	**521**
BARGAINING UNITS	2	6	8	1	0	0	0	0	0	0	**TOTAL**	**17**

Swift Current Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union
Swift Current Union Hospital		188	104								33
District Board office and administration											6
Swift Current Municipal Road Ambulance											
Palliser Regional Care Centre		187									
Prairie Pioneers Lodge		47	8								
Community Health				86							
Wheatland Home Care											40
Palliser Alcohol & Drug Abuse Council Inc.											3
Subtotal: Number of employees employed by District:	0	422	112	86	0	0	0	0	0	0	82
AFFILIATED FACILITIES AND PROGRAMS:											
Chantelle Management Ltd. (Swift Current Care Centre		70	12								
Subtotal: Number of employees employed by Affiliates:	0	70	12	0	0	0	0	0	0	0	0
Total number of employees in the District:	**0**	**492**	**124**	**86**	**0**	0	**0**	0	**0**	**0**	**82**
BARGAINING UNITS	0	4	3	1	0	0	0	0	0	0	**TOTAL**

Touchwood Qu'Appelle Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union
Balcarres Union Hospital	34		14								
District Board office and administration											6
St. Joseph's Union Hospital (Lestock)	26		10								
Fort Qu'Appelle Municipal Road Ambulance											
Prairie Road Ambulance											
Touchwood Hills Road Ambulance											
Raymore and District Special Care Home Inc.		42	8								
Parkland Lodge Corp. (Balcarres)	35		6								
Qu'Appelle Valley Housing Corp.(Echo Lodge)											83
Community Health				3							
Touchwood Qu'Appelle Home Care			16	31							
Subtotal: Number of employees employed by District:	95	42	54	34	0	0	0	0	0	0	89
AFFILIATED FACILITIES AND PROGRAMS:											
Raymore Community Health and Social Centre											1
Subtotal: Number of employees employed by Affiliates:	0	0	0	0	0	0	0	0	0	0	1
Total number of employees in the District:	**95**	**42**	**54**	**34**	**0**	**0**	**0**	**0**	**0**	**0**	**90**
BARGAINING UNITS	3	1	5	2	0	0	0	0	0	0	**TOTAL**

Twin Rivers Health District

AMALGAMATED FACILITIES AND PROGRAMS:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union
Cut Knife Health Complex	7		13								
District Board office and administration											2
Maidstone Union Hospital	40		19								
Manitou Health Centre (Neilburg)	5		7								
Paradise Hill Union Hospital	30										
St. Walburg Union Hospital	3		10								
Riverside Memorial Union Hospital (Turtleford)	39		8								
Cut Knife and Area Municipal Road Ambulance											20
Maidstone Union Hospital Ambulance											27
Neilburg Ambulance											12
Northwest Ambulance District											
Cutknife and District Special Care Home Inc.		48									1
Pine Island Lodge Ltd. (Maidstone)	35		9								
Lakeland Lodge Inc. (St. Walburg)	30		11								
Turtle River Nursing Home			4								
Community Health				2							
Twin Rivers Home Care			14	49							
Subtotal: Number of employees employed by District:	189	48	95	51	0	0	0	0	0	0	62
AFFILIATED FACILITIES AND PROGRAMS: None											
Subtotal: Number of employees employed by Affiliates:	0	0	0	0	0	0	0	0	0	0	0
Total number of employees in the District:	**189**	**48**	**95**	**51**	**0**	**0**	**0**	**0**	**0**	**0**	**62**
BARGAINING UNITS	8	1	9	2	0	0	0	0	0	0	**TOTAL**

NORTHERN HEALTH

FACILITIES and PROGRAMS INCLUDED BY DEFINITION:	CUPE	SEIU	SUN	SGEU	HSA	PSAC	PIPS	RWDSU	RAPA	PTA	Non-Union	TOTAL
St. Joseph's Hospital (Ile a la Crosse)	30		10									40
District Board office and administration												0
St. Martin's Union Hospital (La Loche)	12		14									26
La Ronge Health Centre	67		13									80
Uranium City Municipal Hospital	16		12									28
Subtotal: Number of employees employed by Facilities:	125	0	49	0	0	0	0	0	0	0	0	**174**
OTHER PROGRAMS AND AGENCIES:												
Beauval Home Care Board				4								4
Buffalo Narrows Home Care Board				3								3
Creighton Home Care Board											14	14
Cumberland House Home Care Board											3	3
Deschaghe/Stoney Rapids Home Care Board											2	2
Green Lake Home Care Board				3								3
Ile a la Crosse Home Care Board				4								4
La Ronge Home Care Board			3								11	14
La Loche Home Care Board											4	4
Michel Village/St. Georges Hill Home Care Board				2								2
Pinehouse Home Care Board				3								3
Sandy Bay Home Care Board											4	4
Turner Lake Home Care Board				2								2
Wasawa, Jans Bay/Cole Bay Home Care Board											3	3
Weyakwin Home Care Board											4	4
Subtotal: Number of employees employed by other agencies:	0	0	3	21	0	0	0	0	0	0	45	**69**
Total number of employees in the District:	**125**	**0**	**52**	**21**	**0**	**0**	**0**	**0**	**0**	**0**	**45**	**243**
BARGAINING UNITS	4	0	4	0	0	0	0	0	0	0	**TOTAL**	**8**

Appendix N

Commissioner and Lieutenant Govenor-in-Council Regulations

TO THE HONOURABLE

THE LIEUTENANT GOVERNOR IN COUNCIL

The undersigned has the honour to report that:

1 Subsection 6(2) of *The Health Labour Relations Reorganization Act* provides that:

> **6**(2) The commissioner shall make regulations reorganizing labour relations between health sector employers and employees and resolving issues arising out of that reorganization and, for that purpose, may make regulations:
>
> (a) defining appropriate units for the purposes of this Act and establishing the composition of those appropriate units;
>
> (b) determining trade union representation of employees in any appropriate unit;
>
> (c) respecting the integration of employees in any appropriate unit;
>
> (d) respecting any matters the commissioner considers appropriate arising out of the integration of employees in any appropriate unit, including the integration of seniority of employees who were previously represented by a trade union and the recognition of service of employees who were not previously represented by a trade union;
>
> (e) establishing a multi-employer bargaining structure through the designation of bargaining councils and representative employers' organizations;
>
> (f) respecting the establishment of articles of association for bargaining councils and representative employers' organizations;
>
> (g) if an appropriate unit established pursuant to clause (a) consists of employees who are covered by two or more collective bargaining agreements:
>
> (i) determining which one of the collective bargaining agreements will apply to all employees in the appropriate unit; or
>
> (ii) fixing a common expiry date for all of those collective bargaining agreements;
>
> (h) delegating to the board any of the commissioner's responsibilities pursuant to this subsection that the commissioner considers appropriate, including the authority to determine any matter or thing that is to be determined or established by the commissioner in the regulations;
>
> (i) respecting any other matter or thing the commissioner considers necessary to carry out the intent of this Act.

2 Subsection 7(3) of that Act provides that:

> **7**(3) A regulation made by the commissioner pursuant to this Act may amend, vary or rescind a board order.

3 Subsection 6(5) of that Act provides that:

> **6**(5) The regulations made by the commissioner do not come into effect until they are:
>
> (a) approved by the Lieutenant Governor in Council; and
>
> (b) filed with the Registrar of Regulations in accordance with *The Regulations Act, 1989*.

4 The Commissioner appointed pursuant to that Act has made *The Health Labour Relations Reorganization (Commissioner) Regulations* as set out in the attached Schedule.

5 It is considered expedient and in the public interest to approve those regulations.

The undersigned has the honour, therefore, to recommend that Your Honour issue the Order shown below.

Recommended By: _____

Minister of Labour

Approved By: _____

President of the Executive Council

ORDER

The Honourable Lieutenant Governor in Council, on the recommendation of the Minister of Labour, pursuant to section 6 of *The Health Labour Relations Reorganization Act*, approves *The Health Labour Relations Reorganization (Commissioner) Regulations* in accordance with the attached Schedule.

_____

Lieutenant Governor

REGINA, Saskatchewan

COMMISSIONER'S ORDER

The Commissioner appointed pursuant to *The Health Labour Relations Reorganization Act*, pursuant to subsections 6(2) and 7(3) of that Act, makes *The Health Labour Relations Reorganization (Commissioner) Regulations* in accordance with the attached Schedule.

Dated at the City of Regina, this _____ day of _____, 1997.

_____

Commissioner

Certified True Copy

_____

Commissioner

SCHEDULE

Title

1 These regulations may be cited as *The Health Labour Relations Reorganization (Commissioner) Regulations*.

Interpretation

2 In these regulations:

(a) **"Act"** means *The Health Labour Relations Reorganization Act*;

(b) **"appropriate unit"** means an appropriate unit that is established pursuant to these regulations;

(c) **"district health board"** means a district health board as defined in *The Health Districts Act*;

(d) **"former appropriate unit"** means an appropriate unit covering health sector employees of a health sector employer that was determined, prior to the coming into force of these regulations:

(i) pursuant to *The Trade Union Act*; or

(ii) by voluntary recognition;

(e) **"health district"** means a health district as defined in *The Health Districts Act*;

(f) **"health sector employee"** means a health support practitioner, health services provider or nurse who is included in an appropriate unit;

(g) **"health services provider"** means an employee of a health sector employer, but does not include a health support practitioner, a nurse, a chiropodist, a chiropractor, a dentist, a duly qualified medical practitioner or an optometrist;

(h) **"health support practitioner"** means an employee of a health sector employer who:

(i) is functioning in one of the occupations listed in Table C; or

(ii) is in a position that requires, as a minimum, registration pursuant to an Act giving the exclusive right to use a title or description of an occupation listed in Table C;

but does not include a student of one of the occupations listed in Table C, or an intern or an assistant to an employee described in subclause (i) or (ii);

(i) **"nurse"** means an employee of a health sector employer who:

(i) is a registered nurse or registered psychiatric nurse; and

(ii) is functioning as a registered nurse or registered psychiatric nurse;

(j) **"registered nurse"** means an employee who is a graduate nurse or registered nurse registered pursuant to *The Registered Nurses Act, 1988*;

(k) **"registered psychiatric nurse"** means an employee who is a graduate psychiatric nurse or a registered psychiatric nurse registered pursuant to *The Registered Psychiatric Nurses Act*;

(l) **"representative employers' organization"** means the representative employers' organization designated pursuant to subsection 12(1);

(m) **"Table"** means a Table in the Appendix to these regulations.

Appropriate units for nurses

3(1) The appropriate units prescribed in this section are prescribed as the appropriate units for bargaining collectively between health sector employers and nurses.

(2) Subject to subsections (4) and (5), for each health district, there is to be one multi-employer appropriate unit respecting nurses composed of:

(a) all nurses who are employed by the district health board; and

(b) all nurses who:

(i) are employed by a health sector employer listed in Table A that operates a facility within the boundaries of that health district; and

(ii) on the day these regulations come into force, were represented by a trade union for the purposes of bargaining collectively.

(3) Subject to subsections (4) and (5), for each health sector employer listed in Table B, there is to be one appropriate unit respecting nurses composed of all nurses employed by that employer.

(4) The appropriate units mentioned in subsections (2) and (3) cease to exist one year after the coming into force of these regulations.

(5) One year after the coming into force of these regulations, there is to be one multi-employer appropriate unit respecting nurses composed of:

(a) all nurses who are employed by a district health board or by a health sector employer listed in Table B; and

(b) all nurses who:

(i) are employed by a health sector employer listed in Table A; and

(ii) on the day these regulations come into force, were represented by a trade union for the purposes of bargaining collectively.

(6) There is to be one appropriate unit respecting nurses for each of the following health sector employers composed as follows:

(a) for Extendicare (Canada) Inc. in the City of Regina, all nurses employed by Extendicare/Parkside, Extendicare/Sunset or Extendicare/Elmview;

(b) for Extendicare (Canada) Inc. in the City of Moose Jaw, all nurses employed by Extendicare/Moose Jaw;

(c) for Extendicare (Canada) Inc. in the City of Saskatoon, all nurses employed by Extendicare/Preston;

(d) for Chantelle Management Ltd. in the City of Swift Current, all nurses employed by Chantelle Management Ltd. in the City of Swift Current.

Appropriate unit for health support practitioners

4(1) The appropriate unit prescribed in this section is prescribed as the appropriate unit for bargaining collectively between health sector employers and health support practitioners.

(2) There is to be one multi-employer appropriate unit respecting health support practitioners composed of:

(a) all health support practitioners who are employed by a district health board or by a health sector employer listed in Table B; and

(b) all health support practitioners who:

(i) are employed by a health sector employer listed in Table A; and

(ii) on the day these regulations come into force, are represented by a trade union for the purposes of bargaining collectively.

Appropriate units for health services providers

5(1) The appropriate units prescribed in this section are prescribed as the appropriate units for bargaining collectively between health sector employers and health services providers.

(2) Subject to subsection (5), for each health district, there is to be one multi-employer appropriate unit respecting health services providers composed of:

(a) all health services providers who are employed by the district health board; and

(b) all health services providers who:

(i) are employed by a health sector employer listed in Table A that operates a facility within the boundaries of that health district; and

(ii) on the day these regulations come into force, were represented by a trade union for the purposes of bargaining collectively.

(3) For each health sector employer listed in Table B, there is to be one appropriate unit respecting health services providers composed of all health services providers employed by that employer.

(4) There is to be one appropriate unit respecting health services providers for each of the following health sector employers composed as follows:

(a) for Extendicare (Canada) Inc. in the City of Regina, all health services providers employed by Extendicare/Parkside, Extendicare/Sunset, Extendicare/ Elmview;

(b) for Extendicare (Canada) Inc. in the City of Moose Jaw, all health services providers employed by Extendicare/Moose Jaw;

(c) for Extendicare (Canada) Inc. in the City of Saskatoon, all health services providers employed by Extendicare/Preston;

(d) for Chantelle Management Ltd. in the City of Swift Current, all health services providers employed by Chantelle Management Ltd. in the City of Swift Current.

(5) For the laundry facility of the Regina Health District Laundry Services located, on the day these regulations come into force, at 1001 Montreal Street, Regina, Saskatchewan, there is to be one appropriate unit respecting health services providers composed of all health services providers employed at that facility by the Regina District Health Board.

Out-of-scope exclusions

6 Subject to any order of the board made pursuant to the Act, these regulations or *The Trade Union Act* and unless otherwise included pursuant to clauses 3(2)(a), 4(2)(a) and 5(2)(a), all positions that were excluded, by an order of the board or by any agreement between a trade union and an employer, from the scope of any former appropriate unit continue to be excluded from any of the appropriate units.

Trade union representation

7(1) The trade unions listed in column 2 of Table D are determined as the trade unions to represent health sector employees for the purposes of bargaining collectively with respect to the appropriate units listed in column 1 of Table D opposite the name of the trade union.

(2) As soon as possible after the coming into force of these regulations, the board shall conduct representation votes, in accordance with *The Trade Union Act*, for any appropriate unit that does not have a trade union determined pursuant to subsection (1).

(3) The board shall use the following guidelines for determining the trade unions that will appear on any ballot:

(a) any trade union that has as members 25% or more of the health sector employees included in an appropriate unit and that makes a written request to the board is entitled to be included on the ballot;

(b) written agreements that are between trade unions to merge or amalgamate or to transfer or assign jurisdiction and that are filed with the board within 30 days after the day these regulations come into force are conclusive evidence of representation rights for the purpose of determining the extent of a trade union's representation in an appropriate unit;

(c) a "no union" choice shall not appear on any ballot.

(4) If, after conducting a representation vote, no trade union receives a majority of valid votes cast, only the trade unions who received the largest and second largest number of valid votes cast on the first vote are entitled to appear on any ballot used in a subsequent vote.

(5) In the case of a representation vote respecting the health support practitioner appropriate unit, employees of the Government of Saskatchewan who would be health support practitioners if employed by a health sector employer and who are employed in the Saskatchewan Hearing Aid Plan or by the Calder Centre in Saskatoon are eligible to vote.

Requirements for board orders

8(1) Subject to subsection (2), within 60 days after the day that these regulations come into force, the board shall issue orders that are consistent with these regulations pursuant to:

(a) clause 5(a) of *The Trade Union Act*, for the purposes of sections 3 to 5; and

(b) clause 5(b) of *The Trade Union Act*, for the purposes of subsection 7(1).

(2) As soon as reasonably possible after the completion of a final representation vote required pursuant to section 7, the board shall issue orders pursuant to clauses 5(a) and (b) of *The Trade Union Act* that are consistent with these regulations and with the results of the representation vote.

(3) An order of the board made pursuant to clause 5(a) or (b) of *The Trade Union Act* that was in force prior to the day these regulations come into force and that is inconsistent with an order of the board made in compliance with this section is rescinded effective the day that the order made in compliance with this section comes into effect.

Existing collective bargaining agreements

9(1) If a health sector employee was entitled to the benefits of a collective bargaining agreement in force on the day these regulations come into force:

(a) the health sector employee remains covered, after the coming into force of these regulations, by that collective bargaining agreement; and

(b) that collective bargaining agreement applies to the health sector employee after the coming into force of these regulations until a new collective bargaining agreement is negotiated.

(2) If a trade union becomes, by or pursuant to section 7, the trade union to bargain collectively on behalf of health sector employees who were represented by a different trade union, the trade union is bound by and shall administer the collective bargaining agreement negotiated by the different trade union on behalf of all health sector employees who were covered by that collective bargaining agreement.

Local agreements continued

10 All of the following agreements are continued and continue to apply to health sector employees, with any necessary modifications required to make the agreements comply with these regulations, until the agreements expire or are amended:

(a) local agreements;

(b) transfer and merger agreements;

(c) devolution agreements;

(d) itinerant movement agreements;

(e) laboratory framework agreements;

(f) global posting agreements;

(g) agreements respecting the Saskatoon Veterans' Home.

Integration of health sector employees

11(1) Every health sector employee is entitled to retain the seniority he or she has earned in a former appropriate unit.

(2) If, following the enactment of *The Health Districts Act* and prior to the day these regulations come into force, a health sector employee lost seniority as a result of a reorganization by his or her employer requiring a transfer between former appropriate units, the health sector employee is entitled to have his or her seniority calculated under the collective bargaining agreement for the appropriate unit in which the health sector employee is placed by these regulations on the same basis that he or she would have been entitled to if he or she had earned the seniority that was lost.

(3) If a health sector employee employed by a district health board was not represented by a trade union prior to the coming into force of these regulations and, pursuant to these regulations, is included in an appropriate unit, section 36 of *The Trade Union Act* applies to the health sector employee and the health sector employee is entitled:

(a) at no cost to the health sector employee:

(i) to recognition by the representative employers' organization, every health sector employer and the trade union of his or her years of service with the health district and with any previous employer whose services were assumed by the health district; and

(ii) to include the years of service mentioned in subclause (i) to the extent and in the manner necessary to ensure that, when calculating his or her seniority, the health sector employee is placed on the same basis as other health sector employees in the appropriate unit in which the health sector employee is included;

(b) to choose whether or not he or she will join the trade union that becomes, by or pursuant to section 7, the trade union to represent the health sector employees in the appropriate unit for the purposes of bargaining collectively; and

(c) for the purposes of any union security clause contained in any collective bargaining agreement pursuant to section 36 of *The Trade Union Act*, to be considered to be a health sector employee who is not required to apply for and maintain his or her membership in the union.

(4) The representative employers' organization, every health sector employer and every trade union representing health sector employees in an appropriate unit shall recognize the entitlements given pursuant to this section to health sector employees.

(5) Any dispute respecting the interpretation, application and operation of any of the provisions of this section or the entitlements given by this section is to be resolved:

(a) by any means that the representative employers' organization and the trade union may agree to; or

(b) by arbitration in accordance with *The Trade Union Act*.

Representative employers' organization

12(1) The Saskatchewan Health Care Association, commonly known as the Saskatchewan Association of Health Organizations, is designated as the representative employers' organization for all district health boards, all health sector employers listed in Table A or Table B and all other employers whose employees are added to a multi-employer appropriate unit.

(2) Every employer mentioned in subsection (1) is to be a member of the representative employers' organization for the purposes of bargaining collectively.

One collective bargaining agreement for appropriate units represented by same trade union

13(1) Where a trade union represents health sector employees in more than one appropriate unit prescribed by section 3 or 5, the representative employers' association and the trade union shall negotiate one collective bargaining agreement that applies to all those appropriate units.

(2) For the purposes of this section, Locals 299, 333 and 336 of the Service Employees International Union are deemed to be one trade union.

Other matters

14(1) In this section, **"affiliate"** means an affiliate within the meaning of *The Health Districts Act*.

(2) Subject to subsection (3), the board shall issue any orders amending or varying the relevant appropriate units that it considers necessary if:

(a) health districts amalgamate;

(b) services are transferred between district health boards;

(c) new health districts are created;

(d) the boundaries of health districts are amended;

(e) employees of an affiliate not represented by a trade union choose to be represented by a trade union; or

(f) there are any unanticipated circumstances, including any applications before the board which were adjourned pursuant to section 9 of the Act and were not resolved by these regulations.

(3) The orders of the board issued pursuant to subsection (2) must be consistent with these regulations.

(4) The board shall decide all questions concerning who is an employee that are not resolved by a health sector employer and a trade union that represents health sector employees.

(5) The board shall decide all questions pursuant to clause 5(l) of *The Trade Union Act*.

Coming into force

16 These regulations come into force on the day on which they are filed with the Registrar of Regulations.

Appendix

TABLE A
[subsections 3(2), 3(5), 4(2) and 5(2) and subsection 12(1)]

Bethany Pioneer Village Inc.
Buena Vista Lodge Inc.
Cupar and District Nursing Home Inc.
Duck Lake and District Nursing Home Inc.
Golden Twilight Lodge Incorporated
Jubilee Residences Inc.
Holy Family Hospital, Prince Albert
Humboldt and District Housing Corporation
Kindersley Senior Care Inc.
Lakeview Pioneer Lodge Inc.
Lumsden & District Heritage Home Inc.
Lutheran Sunset Home of Saskatoon
Mont St. Joseph Home Inc.
Newhope Pioneer Lodge Incorporated
Oliver Lodge
Pioneers Haven Co. Inc.
Providence Place for Holistic Health Inc.
Radville Marian Health Centre
Regina Pioneer Village Ltd.
Santa Maria Senior Citizens Home Inc.
Saskatoon Convalescent Home
Saskatoon Veterans' Home
Sherbrooke Community Society Inc.
Societe Joseph Breton Inc. (Villa Pascal)
St. Ann's Senior Citizens' Village Corporation
St. Anthony's Hospital Inc.
St. Elizabeth's Hospital of Humboldt
St. Joseph's Hospital (Grey Nuns) of Gravelbourg
St. Joseph's Hospital of Estevan
St. Joseph's Hospital of Macklin
St. Michael's Hospital of Cudworth
St. Paul Lutheran Home of Melville
St. Paul's Hospital (Grey Nuns) of Saskatoon
St. Peter's Hospital, Melville
The Border-Line Housing Company (1975) Inc.
The Regina Lutheran Housing Corporation
The Salvation Army for the purposes of operating the Salvation Army Eventide Home of Saskatoon
Ukrainian Sisters of St. Joseph of Saskatoon

TABLE B

[*subsections 3(3), 3(5), 4(2) and 5(3) and subsection 12(1)*]

La Ronge Health Centre
St. Joseph's Hospital (Ile a la Crosse)
St. Martin's Union Hospital (La Loche)
Uranium City Municipal Hospital

TABLE C

[*Clause 2(h)*]

Addiction Counsellor/Therapist
Adjunctive Therapist
Assessor/Coordinator
Audiologist
Certified Prosthetist
Certified Orthotist
Dental Hygienest
Dental Therapist
Dietitian
Emergency Medical Technician
Exercise/Conditioning Therapist
Health Educator
Infection Control Officer
Mental Health Therapist
Music Therapist
Nutritionist
Occupational Therapist
Ophthalmic Dispenser
Orthoptist
Paramedic
Perfusionist
Pharmacist
Physical Therapist
Psychologist
Psychometrician
Public Health Inspector
Recreation Therapist
Respiratory Therapist
Social Worker
Speech Language Pathologist

TABLE D
[*subsection 7(1)*]

Column 1 Appropriate Unit	Column 2 Trade Union
Nurses: All nurse units prescribed by section 3.	Saskatchewan Union of Nurses (SUN)
Health Services Providers: All health services provider units prescribed by subsection 5(3):	Canadian Union of Public Employees (CUPE)
The health services provider units prescribed by clauses 5(4)(a) and (b):	Service Employees' Union Local No. 299, chartered by the Service Employees' International Union (SEIU)
The health services provider unit prescribed by clause 5(4)(c):	Service Employees' Union Local No. 333, chartered by the Service Employees' International Union (SEIU)
The health services provider unit prescribed by clause 5(4)(d):	Service Employees' Union Local No. 336, chartered by the Service Employees' International Union (SEIU)
The health services provider units prescribed by subsection 5(2) for the following health districts: **Assiniboine Valley** **Battlefords** **Central Plains** **East Central** **Gabriel Springs** **Lloydminster** **North Valley** **North West** **Parkland** **Pasquia** **Prairie West** **Prince Albert** **Regina** **South Central** **South Country** **South East** **Touchwood Qu'Appelle** **Twin Rivers**	

Canadian Union of Public Employees (CUPE)

The health services provider units prescribed by subsection 5(2) for the following health districts: **Moose Jaw/Thunder Creek** **Moose Mountain** **Pipestone**	Service Employees' Union Local No. 299, chartered by the Service Employees' International Union (SEIU)
The health services provider units prescribed by subsection 5(2) for the following health districts: **Greenhead** **Living Sky** **Midwest** **North-East** **Saskatoon**	Service Employees' Union Local No. 333, chartered by the Service Employees' International Union (SEIU)
The health services provider units prescribed by subsection 5(2) for the following health districts: **Rolling Hills** **Southwest** **Swift Current**	Service Employees' Union Local No. 336, chartered by the Service Employees' International Union (SEIU)
The health services provider unit prescribed by subsection 5(5):	Saskatchewan Joint Board, Retail, Wholesale and Department Store Union, Local 568 (RWDSU)

TO THE HONOURABLE

THE LIEUTENANT GOVERNOR IN COUNCIL

The undersigned has the honour to report that:

1 Clauses 6(6)(a)and (b) of *The Health Labour Relations Reorganization Act* provides that:

> 6(6) The Lieutenant Governor in Council may make regulations:
> (a) defining, enlarging or restricting the meaning of any word or phrase used in this Act but not defined in this Act;
> (b) subject to subsection (7), prescribing a person as a health sector employer.

2 Subsection 6(7) of that Act provides that:

> 6(7) The Lieutenant Governor in Council shall make a regulations pursuant to clause (6)(b) only on the recommendation of the commissioner.

3 The commissioner has recommended that regulations be made designating a certain person as a health sector employer.

4 It is considered expedient and in the public interest to make regulations for the purposes of the Act.

The undersigned has the honour, therefore, to recommend that Your Honour issue the Order shown below.

Recommended By: _____

Minister of Labour

Approved By: _____

President of the Executive Council

ORDER

The Honourable Lieutenant Governor in Council, on the recommendation of the Minister of Labour, pursuant to subsection 6(6) of *The Health Labour Relations Reorganization Act*, makes *The Health Labour Relations Reorganization (Definitions) Regulations* in accordance with the attached Schedule.

Lieutenant Governor

REGINA, Saskatchewan

SCHEDULE

Title

1 These regulations may be cited as *The Health Labour Relations Reorganization (Definitions) Regulations.*

Interpretation

2 In these regulations, **"Act"** means *The Health Labour Relations Reorganization Act.*

Health sector employer

3 For the purposes of the Act, La Ronge Health Centre is prescribed as a health sector employer.

Appropriate units

4 For the purposes of the Act, **"appropriate unit"** includes a unit of employees of two or more health sector employers.

Coming into force

5 These regulations come into force on the day on which they are filed with the Registrar of Regulations.

Notes

Notes

Notes

Notes