

The Impact on Organized Labour of the
Health and Social Services Delivery Improvement Act:
A Case Study

By

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B.S.W., University of Victoria, 1985

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of

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ABSTRACT

This case study is specifically concerned with the implementation and impact of the *Health and Social Services Delivery Improvement Act* (Bill 29-2002) upon unions and the workers who deliver health care services in one health authority in British Columbia. The Act eliminated or reduced a number of union roles, and workers' rights and benefits previously achieved through decades of collective bargaining.

Qualitative, face-to-face interviews with four health care union leaders or designates combined with documentary analysis and literature reviewed were the methods employed to collect data.

This study documents four major findings: 1. The legislation impacted all workers facing programme and facility closures but in particular support workers, mainly women, who were contracted out who also lost pay equity gains established through collective bargaining; 2. Amidst the government ideology and dogma of the public policy shift with contracting out there were initial reports of organizational impacts in health facilities with reduced morale, increased workload, a division between workers and reduced quality of service to patients and residents; 3. Unions experienced legislative interference in their role and described this as “union busting” in neo-liberal times of health care restructuring; 4. Unions employed several democratic mechanisms to resist and forged alliances to strengthen their resistance.

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Debra Gillespie
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DEDICATION

This work is dedicated to the memory of my father, Edward, who was a great study of the political economy and its impact on citizens. Together with my mother, Charlotte (a mother to all) raised their five children to seek out the truth, stand together with others on social justice issues and to care for family, friends, neighbours and others. I have always benefited from this grounding and hold it close to my heart.

Glossary of Industrial Relations Terms

Bargaining Agent:

Establishment of a bargaining unit triggers the appropriate unions, as designated by the BC Labour Relations Board (BCLRB), to compete to secure the right to bargain for the workers. Workers will vote to join the appropriate union to represent them as their bargaining agent in collective bargaining and contract enforcement. Health employers in BC have a bargaining agent called Health Employers Association of BC (HEABC). See also Bargaining Association.

Bargaining Association:

In 1996, the NDP government following the Dorsey Commission, implemented bargaining associations with the Health Sector Labour Relations in the amended Health Authorities Act (1996). This legislated unions, who represent similar occupations to form five provincial councils or bargaining associations to represent workers for the purposes of collective bargaining and other policy labour relations issues. The lead union is the union with the majority of members in the association. For example, HEU is the lead union in the bargaining association for the health services and support workers with BCGEU, BCNU, HSA and various trade unions of IBEW, USWA, IUOE, IBPAT, CSWU, UBCJA and UAJAP&P in the same association. See also Figure One in Chapter Five.

Bargaining Unit:

A group of employees in the workplace designated by the B.C Labour Relations Board to be represented by a union. For example, general support workers have long been established by BCLRB as a bargaining unit in health facilities generally represented by HEU but sometimes by BCGEU. Collectives of workers or a union may challenge the BCLRB designation claiming the workers designation belongs in another union. The colloquial term for a union dispute of jurisdiction is sometimes called raiding. Health care is one of the most highly unionized sectors in Canada with B.C in 2000, having the highest rate of unionization at 78 per cent of workers unionized in health facilities (Akyeampong, 2000).

Bumping:

A colloquial term to describe a process whereby a unionized displaced or laid off worker may exercise their seniority rights to maintain employment by displacing a junior worker from their job who is on the same seniority list under the same collective agreement. A bumping chain is started where the senior, displaced worker is permitted to exercise their seniority rights against another less senior worker. Bill 29 temporarily altered bumping provisions between 2002 and December 2005, legislating senior displaced workers to only bump those workers with under five years seniority.

Certification:

The process whereby the labour relations board designates a union as the bargaining agent for a group of workers following a majority vote of support by the workers.

Collective Agreements:

Are legally binding contracts governing terms and conditions of employment including wages and benefits, which employers and unions negotiate for a specific term. Collective agreements mean workers have rights. Workers generally have an opportunity to ratify the agreement by a democratic vote, unless imposed by legislation. The term of the agreement usually ranges from two to three years. It is during the expiry of the term of a collective agreement that workers generally have the legal right to engage in job action. See also essential service levels.

Contracting Out:

A transfer of work from the unionized workforce to an outside contractor. In the public sector this is considered by many to be privatization (Fuller, 1997; Jackson, 2005; Starr, 1987).

Corporatist:

Is a term that is synonymous with tripartism whereby unions, corporations, and government collaborate to the point union independence to negotiate and advocate on behalf of workers is diminished. See also partnership agreements.

Dovetailed Seniority:

A process whereby an expanded or single dovetailed seniority list for each bargaining unit represented by a bargaining association for each service delivery area identified in the BCLRB decision B274/2002. For example, in VIHA two geographic areas are identified for purposes of job postings and bumping: a. north and central; and b. south. This term resulted out of a BCLRB arbitration decision brought forth by the health science professional bargaining association as the result of HEABC's interpretation of Bill 29. The process determined in the arbitration award resulted in health authority employers producing lists of junior employees from the various unions in the bargaining association, which a displaced senior employee may bump. For example, a CUPE health science professional may now bump a HSA worker listed on the dovetailed seniority list.

Employment Security Labour Force Adjustment (ESLA):

ESLA was a provision in all health care workers collective agreements stemming out of the recommendations of Vince Ready, an Industrial Inquiry Commissioner, on May 8, 1996. The job security provisions operated by the HLAA were voided by Bill 29-2002. See also Health Labour Adjustment Agency (HLAA).

Essential Services:

Health care is designated by law, as an essential service requiring unions to establish with employers an essential number of workers required to preventing serious harm to the public. Much newspeak is made about strikes impacting productivity however; empirical data shows that this amounts to "one-tenth of 1% of total working time" (Jackson, 2005:147).

Health Employers Association of BC (HEABC): The *Public Sectors Employers Act* (1996), legislated by the NDP government that all health facilities would be represented by HEABC in matters of bargaining and industrial relations.

Health Labour Adjustment Agency (HLAA):

HLAA formed out of the Health Labour Accord of 1993 administered the job security programme outlined in the Accord and ESLA of 1996. Provincially funded and operated to support health care workers during an anticipated time of restructuring and labour force adjustment. HLAA provided funds for skills upgrading, training, wage protection for those workers who were displaced due to closures or downsizing, province wide job matches to new or vacant positions for displaced workers, a lengthy period of working while on severance as well as provision for early retirement top up monies for workers close to retirement. Estimated costs of ESLA were \$35 million over three years province wide for all unions. See also Employment Security Labour Force Adjustment (ESLA).

Industrial Relations:

A global term that refers to relations between organized labour and unorganized labour, employers and government.

International Labour Organization (ILO):

Is an agency of the United Nations (UN) that seeks to promote fair and equitable labour practices and working conditions. There are “177 nations (including Canada) who are member States of the ILO” (Fudge & Brewin, 2005:82). A key function of the ILO is to promote international adoption of labour standards through the Conventions, which member States have ratified. These Conventions and the ILO hold no legal power but instead use “...moral suasion” as a key strategy (Fudge & Brewin, 2005:85). Canada and all provinces and territories ratified in 1972 convention No. 87, Freedom of Association and Protection of the Right to Organize (Adams, 2005). Canada has yet to sign on to Convention No. 98, the Right to Organize and Collective Bargaining. The unions have complained to the ILO Committee on Freedom of Association on the majority of the labour legislation enacted between 2001 and 2004 by the BC Liberal Government. The Committee has consistently found the BC Government to be in violation of the UN Convention No. 87, Freedom of Association (Steward & Ohmart, 2004).

Labour Relations Board:

A board established under the B.C Labour Relations Act that administers labour relations law which includes union certifications, essential service levels and investigations of complaints of labour practice in relation to contracts or collective bargaining.

Partnership Agreements:

Is the term used to describe the written agreement between Compass Group Corporation (Morrison and Crothal) and the IWA local 1-234 which guarantees workers wages and benefits will remain at a pre-determined level, therefore ensuring profits to the corporation. It also has a no job action or strike clause. Health authorities have performance agreements with the provincial government, mainly drawn around specific provincial health priorities but also around financial budget targets.

Pay Equity:

A strategy or programme to implement equal pay for equal work. The basic premise is that wages should be based on job duties not on worker characteristics such as gender. Legislation, public policy and collective agreements are strategies that achieve pay equity.

Red Circling:

Is an accepted industrial relations term used to describe a wage protection process in the event of restructuring or alteration in job rates. The Paramedical agreement Article 10.04 (b) states, “an employee assigned to a lower rated position shall continue to be paid at the employee’s current rate of pay until the rate of pay in the new position equals or exceeds it” (H.S.A April 1, 2004 to 2006). Red circling is a freeze at the current rate of pay prior to displacement. Green circling includes red circling (wage protection) plus continuation of future wage increases as if the worker were still in the position the worker no longer occupies.

Request for Proposals (RFP):

Is the process of public procurement health facilities engage in where specific details of a service required by the health authority is open for a tendering or bidding process whereby any business or corporation may submit a business proposal consisting of a financial plan to provide the service. It is law in BC that capital project contracts over \$25,000 must be put to public tender or RFP. Since 2001, other service operations such as support work have been placed into the RFP processes.

Successorship:

A practice entrenched in Section 35 of the BC Labour Relations Code, which outlines the process in the event of a business unit that is sold or transferred. The law allows for unionized workers covered by a collective agreement to have their bargaining agent (union) and collective agreement designated as successor, therefore reducing the impact to workers during change. Bill 29 struck down the right of successorship for health sector workers and their unions. Successorship was of no force in the event a health sector employer decided to contract out specific services to a private contractor rendering union successorship and collective agreements void.

Union Decertification:

A process whereby a majority vote of workers in a union may apply to the BC Labour Relations Board to decertify from their bargaining agent (union). At the point of decertification, workers may opt to join another union or remain non-unionized. Since the enactment of Bill 29-2002 some BCGEU and HEU members in care facilities decertified from their union in hopes of protecting their jobs from contracting out (White, 2004; Muzin, 2004).

Chapter One: Introduction to Study

I was born and raised in Victoria, British Columbia, Canada in an environment that was and still is passionate about truth telling and truth seeking, especially connected to social justice issues. Health care as a social justice issue is a hot topic for our family. Our mother has experienced the effects of recently de-listed health care services and suffered from reductions the Provincial Government enacted through the Medical Services Plan reducing Pharmacare coverage. We have family currently living in residential care facilities where contracted out support services are in place and have experienced a father whose death at home required much unpaid family members' time to support home care. All of these experiences are forms of privatization. As a family, we come from a place of knowing what it means in British Columbia to be recipients of health care. Furthermore, my siblings, our friends and I are insiders in health care; all workers, all come from a place of knowing. We see the changes implemented since the B.C Liberals came to power in May 2001 with an unprecedented electoral majority. We hear the rhetoric through the stories and incidents reported in the media, through government and employers' condemnation of health care workers' wages and hear the varying fiscal budget crises reported by the Province, Federal and local health authorities. Most importantly, we hear the priorities of increasing investment opportunities to business partners and international markets.

Privatization (or further privatization of health care), ideologies, fiscal imperatives and policies that facilitate contracting out are framed as a social justice agenda worthy of further inquiry. It is with this position, background, knowledge and

experience that public policy supporting health care privatization by way of contracting out became the focus of this case study.

Less than a year into the B.C Provincial Government's mandate of 2001, sweeping reforms to public policies and programmes were being implemented at a rapid pace. The justification for these reforms was mainly about fiscal accountability based on a three year projected estimate of provincial debt (McMartin, 2002). Included in these reforms were health care budgets and public sector workers. On January 28, 2002, the government brought into effect the *Health and Social Services Delivery Improvement Act* (Bill 29-2002) combined with the *Health Sector Labour Adjustment Regulations* (Regulations 39-2002). This legislation is the policy this case study pivots on.

The Act (more commonly referred to as Bill 29) eliminated or limited a number of unionized workers' collective agreement provisions previously achieved through collective bargaining. Some of these lost rights or provisions included elimination of protection from privatization, also known as contracting out, limitations on seniority (displacement and bumping rights) and employment security. Bill 29-2002 defines the majority of health care workers (who are women) in acute and facility care as "non-clinical" and therefore employers may contracting out their jobs. These definitions in the Act appear complex and confusing. For example, a physiotherapist, a profession designated under the *Health Professions Act*, based in an acute care hospital working with patients occupying in-patient beds would be considered "clinical" under Bill 29 and therefore protected from privatization. However, rehabilitation physiotherapists, based in an acute care site working with clients in outpatient services, would be defined as "non-

clinical” by Bill 29 and at risk for privatization. These types of designations and definitions are confusing to the public, workers, unions and possibly employers.

The Provincial Government, in announcing the Act, noted health sector employers could contract out “non-clinical” support services such as laundry, security, housekeeping and food services. However the legislation was broad based and may be applied to the majority of unionized workers in various health sectors. The Act had the potential to alter the delivery of public not-for-profit health care in B.C and the security of the workers who support it.

The conceptual framework for the research was guided by a need to study changing public policy, specifically the legislation passed in the legislature by a majority government, without public debate. I was interested in how legislators gave workers and unions rights and how governments take these rights away in the legislative snap of the fingers. I wanted to look at why this Act appeared to draw a line in the sand between the government and organized labour by reducing union roles and influence. I wanted to understand contracting out as part of health care privatization. Table One outlines the health care privatization framework for the purpose of this thesis.

Table One: Health Care Privatization Framework

<ul style="list-style-type: none"> • Government disengagement of funding public programmes resulting in the public privately paying e.g. de-listed health services from provincial insurance scheme.
<ul style="list-style-type: none"> • Government de-regulating entry into delivery of direct health services creating opportunities for private-for-profit entities e.g. outpatient blood collection (labs), surgery and diagnostic services.
<ul style="list-style-type: none"> • Government reduced social spending by cost-shifting budget reductions onto the unpaid caregivers e.g. reduced home support requiring family and friends to provide.
<ul style="list-style-type: none"> • Government disengagement of capital infrastructure, funding and service delivery shifting to the corporate sector by entering into public-private partnerships (P3s).
<ul style="list-style-type: none"> • Government re-regulating health and labour policies through legislation to allow for bidding by private-for-profit corporations to manage and deliver services in hospitals, facilities e.g. contracting out.
<ul style="list-style-type: none"> • Government, media, corporations and employers framing the discourse and practices in health care to reflect business or market practices e.g. programme development=business case; procedures/protocols=business processes; clients=health care consumers.

(Adapted from Armstrong, et al, 2001; Fuller, C, 1998; Starr, 1987, 1990).

As a social worker, part of my initial framework was to explore how the Act impacted on the discipline of social work. However, Bill 29-2002 impacted all workers and the initial concept was rejected for the following reasons:

1. large provincial businesses and international corporations were already operating in other provinces before Bill 29-2002 was enacted offering for-profit private services for security, health records, laundry, maintenance, grounds keeping, clerical, housekeeping and food services (Armstrong, et al, 2001). Currently, many professional disciplines working in health care are not employed by large corporations; in fact, many are in short supply such as pharmacists, registered nurses and physical therapists;
2. in 2002, health authorities in B.C already had begun to contract out service work such as grounds keeping, security and health records transcription and by the end of 2002 some were announcing requests for proposals (RFPs) for laundry, cleaning and food services;

3. the framework was advanced by linking the legislation to the political and economic agenda, of neo-liberal ideological (defined in Chapter Two) and economic policy direction.

This thesis was written from a labour perspective. While government and employer rationales with respect to key actions are included, this work is not documented from those perspectives. My values, beliefs and assumptions are discussed later in this chapter. This decision was also influenced by the reality that little is documented in the Canadian literature from the union or worker position on contracting out worker's (womens') jobs in health care (Armstrong, et al, 2001; Fuller, C, 2001 & 2003; Jackson, 2005).

This case study was focused on the public policy shift from the 1990s during a period of health care reform and restructuring when protection for workers from contracting out was entrenched in legislation and collective agreements to 2002 when this protection was reversed. New legislation, provincial and federal health care funding restraints and notions in media that there were no other options but to reduce overpaid support workers' wages led to the belief that balanced budgets or cost containment could only be achieved by contracting out thousands of unionized workers in the Province of British Columbia. The two research questions that guided the period of study between January 28, 2002 until December 31, 2004 were:

1. How was the *Health and Social Services Improvement Delivery Act* (Bill 29-2002) operationalized in one health authority in British Columbia?

2. How have health care unions and their membership representing most at risk “non-clinical” service workers (as defined by the Act) experienced the impact of the *Health and Social Services Delivery Improvement Act*?

Inherent in the conceptual framework, research questions, and methodology, but not always explicitly stated, are the values, beliefs and assumptions of the researcher (Merriam, 1989). A social worker for over 20 years as both a clinician and supervisor, I am currently employed with the Vancouver Island Health Authority. I frequently use health services and have been in an increased position of privately paying for recently de-listed services and medications from B.C’s medical insurance scheme. I am a member and union activist of the Health Sciences Association. I define myself as a worker, one who must sell her skills and knowledge to an employer in exchange for money (income). My hats are layered and woven with structural social work values and beliefs as categorized by Mullaly (1993, 1997). These values and beliefs include: 1. social beliefs that all citizens are entitled to have their human rights upheld by a democratic state; 2. political democracy means meaningful citizen participation in all levels of government and non-government areas including policy development and implementation; 3. economic beliefs about equitable and fair distribution of resources; 4. social priorities must be the basis of economic and public policy; 5. social constructs are rooted in political and macro-economic ideology and structures and can change; and lastly 6. worker rights are human rights, which collectivities of citizens can advocate for and are worthy of inclusion on the social justice agenda.

The initial assumptions in 2002 were rooted in my experience as a worker and my values and beliefs prior to commencement of the study. They were: 1. the provincial

government had embarked on a direct attack against organized labour and the unionized workers; 2. health care workers are predominately women; therefore Bill 29-2002 was inherently discriminatory and an attempt to further marginalize women; 3. health care workers feel undervalued in the workplace for many reasons and the introduction of Bill 29-2002 has contributed to this; 4. the B.C Liberal government's ideological and political agenda was that private for-profit health care is more efficient than public not-for-profit health care; 5. the government was diligently committing resources to create a non-government presence in public policy and programmes; 6. the B.C Liberal regime was constructing crisis in the B.C health care system by under-funding, making it impossible to run efficient services to meet the public need, thereby creating the public perception that the only option for health authorities is to privatize by way of contracting out.

Chapter two discusses the economic, political and ideological context leading up to Bill 29-2002 alongside other labour policies enacted by way of the Legislature. Chapter three provides an overview of the literature on cornerstone Canadian health care reports, privatization and contracting out. Chapter four presents the case study methodology and methods, which include interviews, literature and documentary analysis. Chapter five and six document the data collected and discusses the results. Chapter seven and the postscript conclude this study on policy implementation and the impacts to unions and workers.

Chapter Two: Context

Case study research on public policy often involves details of the political, economic and ideological context during which the policy or legislation was developed (Burnham, et al, 2004; Majzark, 1984). The first section of the chapter is a discussion of the dominant ideology, neo-liberalism. The second section outlines the last three decades in British Columbia focusing on health and labour policy expanding and retreating from programmes and workers. It provides a backdrop to the enactment of Bill 29-2002. Lastly, the main tenets of the *Health and Social Services Delivery Improvement Act* are discussed as well as other temporary and permanently restrictive legal measures that were implemented in this new era to limit worker and union roles and rights.

Neo-Liberalism in Canada

Neo-liberalism is a political economic ideology tied to the capitalist economic market (Atasy & Carroll, 2003; Brodie, 1996a, 1996b; Carroll, 2005; Brownlee, 2005; Dorrien, 1993; Leyes & Panitch, 2001; McEwan, 1999). Clarke described it as the “business agenda” of transnationals or businesses and the “free trade agenda” of neo-liberal governments (2003:204). The neo-liberal discourse is seductive and convincing. Market phrases such as, ‘individual rights’, ‘freedom to choose’, ‘personal responsibility’, ‘customer choice’, ‘flexibility’, ‘competition in a global market for sustainability’, ‘fiscal accountability’, have crept into our everyday lives (Barlow, 1999; Hay, 1999). As Armitage explains, neo-liberalism is anti-social welfare and pro-business (2003). All are opposed to the liberal or social welfare notion that health care emerged from during the Keynesian Welfare State (KWS) or post WWII era, (MacDonald, 1999; McEwan, 1999; Shield & Evans, 1994; Rachlis, 2004a).

The KWS had its base in social liberalism, individualism and collectivism. One KWS attraction was that it would maintain an orderly workforce and control class conflict by redistribution of capital and by providing for those who were temporarily not able to participate in modes of production (Hay, 1999). This redistribution of taxes was committed to “social protectionism” where federal and provincial social welfare policies and programmes evolved (Hay, 1999:57). In Canada, social liberalism has been organized as the foundation of worker or labour political parties such as the Co-operative Commonwealth Federation (CCF) and later the New Democratic Party (NDP) which were modes of furthering rights of liberal democracy and citizenship (Carroll & Little, 2001; Barlow, 1999; Panitch & Leys, 2001; Panitch & Swartz, 2003). The social welfare era was marked with liberalism or liberal shared values that supported development of the public policies and programmes outlined by Armitage as; “1. concern for the individual; 2. faith in humanity; 3. equity; 4. equality; 5. community; 6. diversity; and 7. democracy” (2003:4). Social welfare policies and programmes such as public health care, education, welfare, and universal guaranteed income insurance schemes developed out of this economic and ideological paradigm.

Neo-liberalism is an economic ideology born out of economic liberalism, which claims the market, not the state is the fairest arbitrar of money distribution. The key tenets of neo-liberalism are “deregulation”, “privatization” and “economic liberalization” (McEwan, 1999:4). These tenets become the foundation of political and economic conditions, curtailing social welfare expenditures, unions’ role and restructuring macro-economic policies (Brodie, 1996a; McEwan, 1999; Jackson, 2003 & 2005). Neo-liberal policy-making is informed by the liberal contention that “economic growth will be the

most rapid when the movement of goods, services and capital is unimpeded by government regulations” (McEwan, 1999:31). Armitage in discussing the welfare state explains the neo-liberal position of “dismantlement”, “incremental restrictions” and “deunionization and privatization” (1988:252).

The revitalized B.C Liberal Party is a blend of Reform, Social Credit and Liberal Party members (Panitch & Swartz, 2003). Conservative Socred political parties have been pro-business and anti-labour since the 1930s (Panitch & Swartz, 2003). The B.C Liberal Party position rests on the presumption that the unemployed are lazy, social welfare is overly generous and that the remedy for these perceived situations is by implementing neo-liberal policies that cut social programmes, reduce labour standards and shift activities to market-based solutions (Laird, 1998; Panitch & Swartz, 2003). The neo-liberal position also adopted is that unions are greedy and public service workers are lazy and overpaid for what they do. The press releases in January 2002 on Bill 29-2002 from the Liberal Government frame this by stating legislation had to be implemented to reduce unions’ powerbase and high union wages (Ministry of Skills, Development and Labour, 2002b:2). Neo-liberals describe labour unions as “parochial, old-fashioned and unrealistic” (Carroll, 2003:45). Conservative or neo-liberal economists and the corporate sector adhere to notions whereby high rates of unionization, strong employment standards protections and high taxes are all damaging to global economies (Bluestone & Bennett, 2001). These ideas translate into labour policies which seek to reduce wages and benefits from the workers in order to ensure higher levels of profit, resulting in tensions between the interests of business or government and the declining bargaining power in the labour market (Fudge & Brewin, 2005; Panitch & Swartz, 2003; Saad-Fiho & Johnson, 2005).

Trade unions and workers are curbed by de-regulation to control costs of labour for profit making, and citizens experience reduced social protections through limits to social welfare programmes (Fuller, 2001; Carroll & Ratner, 2005; Jackson, 2005; Panitch & Swartz, 2003). Privatization of services, programmes, crown corporations and land is a key strategy in the neo-liberal project (Starr, 1987, 1990). The constructs of debt crisis and debt reduction are off-loaded to the minds of individual citizens. This process of fiscalization is used to increase international trade and allow the government to retreat from the social safety net to privatize social programmes and to reduce the role of trade unions and deregulate workers rights (Brodie, 1996a; Carroll & Ratner, 2005; Fudge & Brewin, 2005; Jackson, 2005; McEwan, 1999; Panitch & Swartz, 2003; Rice & Prince, 2000).

In Canada, neo-liberalism did not occur overnight. Several corporate and policy think-tank alliances were formed to successfully challenge notions of entitlements and rights in a social democracy (Barlow 1999:20). Brodie adds, “changing public expectations about citizenship entitlements, the collective provision of social needs, and the efficacy of the welfare state has been a critical victory for neo-liberalism” (1996b:131). It was during the 1980s that the federal government took on the role of educating citizens and stated that, “as a consequence of new economic, fiscal and global realities, social policy has to facilitate and assist the occupational, industrial, and often geographic relocation that new economies require of the current generation of Canadians” (Prince & Rice, 2000:91). Brodie explained this insidious creeping of neo-liberal ideology and policy in the 1980s:

An uncompromising neo-liberal worldview came to dominate the Mulroney government’s front benches after its re-election in 1988 and the

implementation of the Canada-US free trade agreement in 1989. Throughout the late 1980s, the Mulroney government had used mounting federal deficits as a rationale for cutting back the welfare state. These changes were the beginning of the end of what proved to be a relatively short-lived experiment in collectivization of social responsibility in Canada. By the early 1990s, the Conservatives' attack was directly linked to making Canada more 'competitive' –primarily by forfeiting economic terrain to the private sector (Brodie, 1996a:6).

In the 1980s, the Social Credit government in B.C implemented several neo-liberal policies to reduce social welfare programmes and workers' rights and jobs; the federal government began its assault on public programmes and workers by withdrawal of funds (Carroll, 2005; Fudge & Brewin, 2005; Panitch & Swartz, 2003). Panitch and Swartz describe this massive retrenchment of workers and unions rights and roles as "permanent exceptionalism"; policy changes were first implemented as exceptions due to the economy but eventually achieved permanent status (2003:7).

The Business Council on National Issues (BCNI) formed in 1977, renamed in 2001, The Canadian Council of Chief Executives (CCCE). Brownlee described this as a "...corporate offensive of the 1970's" which was a response to the decline in economic growth (2005:75).

Thomas d'Aquino became the head of the CCCE in 1981 and continued in power until his recent retirement. D'Aquino, as cited in Newman, exemplifies the agenda of neo-liberal economic and political hegemony propagated by the business elite aided by corporate media:

If you ask yourself, in which period since 1900 has Canada's business community had the most influence on public policy, I would say it was in the last 20 years. Look at what we stand for and look at what all the governments, all the major parties...have done, and what they want to do. They have adopted the agendas we've been fighting for in the past few decades (1998:151).

At the time Chrétien became Prime Minister, d'Aquino described the CCCE's activity as follows, "we took [the deficit reduction] campaign in hand, and we scared the hell out of people. We said it over and over again for so long that people began to believe the deficit was really wicked" (as cited in Newman, 1998:159). As Prince and Rice (2000) describe the fiscalization discourse began to move citizens away from any collective responsibility for social welfare. We have been lead to believe that we cannot afford health care or other social programmes. As citizens we have also learned that health care will only be sustainable if we keep unions and workers in check through reforms such as de-regulating their rights and roles and marketization of social programmes, benchmarking them to the for-profit private sector (Jackson, 2005; Rice & Prince, 2000; Saad-Filho & Johnson, 2005). Saad-Filho and Johnson assert public sector reforms have as the base, "the systematic use of state power to impose (financial) market imperatives" (2005:3).

Albo and Crow assert three "common pressures" for labour unions and workers present in neo-liberalism (2005:12). The first pressure described by Albo and Crow is the "economic slowdown". This has employers restructuring workplaces by lay-offs, moving to a leaner model of staffing. Programmes and services are closed and there is a generally more "flexible" and temporary workplace with "non-standard" work arrangements and wage compression (2005:13). This strategy began in the 1980's and widened "...gaps between the share of value taken by capital and that taken by workers" (p. 13).

The second pressure Albo and Crow explain is in the form of "flexible labour market policies" where "disincentives to work" such as employment insurance and other welfare programmes are reduced, creating uncertainty and a hungry worker who will

work for any wage regardless of the conditions of work (p.13). In Canada and British Columbia, we have seen changes from unemployment insurance to employment insurance as well as limits placed on accessing income assistance programmes such as welfare (reduced by 30%). These policies are also strongly allied with the portrayal of out-of-control unions, generous public sector workers wages and the claim as one of the root causes of the fiscal crisis (Fudge & Brewin, 2005; Jackson, 2005; Panitch & Swartz, 2003). Evidence of this in B.C is seen in the New Era documents, fiscal and core services review, media releases and ministry annual reports (discussed in the next two sections of this chapter). British Columbians have experienced the power of the provincial government's use of legislation to change the Labour Code and Employment Standards Act. Further legislative changes removed the right to strike, imposed collective agreements and altered collective agreement rights. They also removed barriers to privatization in the health care sector.

The third pressure Albo and Crow describe is the “internalization” of capital leverage for employers where workers wages are tied to global trade deals (2005:13). They further explain: “transnational corporations (TNCs)...have used this increased leverage through threats of capital flight, as well as the expansion of international production networks, which allow production to be moved to wage zones [such as Mexico]” (P.130).

The next section discusses three decades of health and labour policy provincially and nationally.

Political Economic Backdrop

The 1980s – The Neo-Liberal Creep and Black Thursday in British Columbia

Until 1982, British Columbia under the Social Credit regime had experienced economic growth with up to 20 percent of total revenues derived from natural resources (McMartin, 2002:21). Global economic recession emerged, commodity prices fell and B.C's natural resources only produced approximately "10 percent of total revenues" (McMartin, 2002:21). The Socreds responded to the capital crisis claiming B.C could not afford the social safety net and "implemented drastic cuts to social programmes" (Armitage, 1988:227) and to the public sector workers (Panitch & Swartz, 2003). The budget of 1983 became known as "Black Thursday" (Panitch & Swartz, 2003). B.C took the lead in implementing a "wage restraint program" in 1982, which, Panitch and Swartz claim, "...represent[ed] the most sustained assault on trade union rights in Canada" (2003:38). The Socred's implemented a barrage of legislated changes to labour policy, which imposed wage freezes, limitations on the role of a union in collective bargaining, involuntary continuation of collective agreements, labour code and employment standards amendments that resulted in massive layoffs of public sector workers (Fudge & Brewin, 2005; Panitch & Swartz, 2003).

Labour's response was to stand in solidarity by escalating to a daylong general strike. The government temporarily backed off but continued to implement temporary and permanent restrictive measures against labour (Fudge & Brewin, 2005; Panitch & Swartz, 2003). Carroll and Ratner observed that B.C under the Socred regime "...implement[ed] Canada's first comprehensive neo-liberal initiative..." (1989:29). Boardman, et al., concluded in the 1980s that B.C was the first province in Canada to

engage in privatization of Crown corporations (2003). The government went on a spending spree by hosting the Expo 1986 venture. Health care and social services experienced a funding diet for the remainder of the 1980's (British Columbia Health Association, 1990). Despite reported provincial budget surpluses in 1988 and 1989 the Socreds continued to squeeze the public health care system and promoted privatization initiatives (Fuller, 1998, 2003).

By 1988, with mounting debt and deficits the Federal government response was similar to B.C, they implemented wage freezes to public sector workers of six and five per cent, limiting public sector workers' right to strike and "implement[ed] permanent legislation that restricted trade unions" (Panitch & Swartz, 2003:32). Federal responsibility to health care and education began its decline in 1977 with the change in the 50-50 cost sharing arrangement with the provinces. The Established Programmes Financing Act (EPF) was passed "...signaling a decreased role" by divesture in federal standards and policies letting provinces allocate money without accountability measures in place (Fuller, 1998:71).

The Canada Health Act passed in 1984 tying a portion of the EPF funding to provincial adherence to five criteria of public-administration, universality, portability, reasonable access and insurance of health services. In 1984, the Federal Progressive Conservatives (previously Trudeau's Liberals also introduced cuts) began a series of cuts in the EPF transfer payments commencing in 1985, 1990 to 1992 which amounted to approximately "...\$37 billion reduction..." to the provinces for health care (Fuller, 1998:75).

In 1988, the Progressive Conservatives under Mulroney completed the Canada-United States Free Trade Agreement (CUFTA) also known as the Free Trade Agreement (FTA). Coming into effect January 1, 1989 the Agreement increased Canada's "market integration with the United States" (Faux, 2001:2). Global economic recession hit and Canada "slid" into an economic recession (Panitch & Swartz, 2003:97). Claims were made that the FTA would increase workers' wages and quality of jobs and the economic boom would continue to support social programmes (Campbell, 2001; Jackson, 2003; Torjman, 2001). The Federal government developed a fiscal restraint program against social programmes and public sector workers and implemented a series of legislation and Orders-in-Council (Panitch & Swartz, 2003). This included back-to-work provisions, suspension of right to strike, wage freezes, and limiting collective bargaining (Fudge & Brewin, 2005; Jackson, 2005; Panitch & Swartz, 2003).

The 1990s - The British Columbia Freak

By 1990, the B.C. Socreds, after reporting two consecutive years of a surplus budget and forecasting a continuous pattern of prosperity, ordered a Royal Commission on health care and cost containment lead by Justice Seaton. The New Democrats were elected to office November 1991 after 15 years of the Social Credit regime, just as another global economic recession was commencing (McMartin, 2002). However, the provincial economy grew faster than the rest of the country, due to stimulation from the building boom, infrastructure construction and population growth (McMartin, 2002). This growth lasted until the mid 1990's (McMartin, 2002; Panitch & Swartz, 2003).

In 1991, the Royal Commission concluded with the report *Closer to Home*, the Report on Health Care and Costs (Ministry of Health Responsible for Seniors, 1991).

The overall fiscal recommendation was one of rationalization by using current resources more efficiently. This was to be accomplished by shifting funding from the traditional and more costly areas of acute and facility care to the community (Ministry of Health Responsible for Seniors, 1991). The political challenge for the NDP was to demonstrate a balanced approach to its constituents and the business sector and they embarked on a campaign of camouflaging the Socred government initiative into a progressive or social democratic reform scheme. New Directions for a Healthy British Columbia (1993) became the health reform policy direction. Vince Ready, an industrial relations commissioner, explained the public policy direction in the 1990's as focusing reforms on cost containment and improved health care delivery through initiatives such as regionalization, amalgamations, mergers, restructuring and closures (Ministry of Labour of British Columbia, 1996).

Alongside the withdrawal of federal health dollars, the NDP initiated reform with health care administration by creating 102 Regional Health Boards (RHBs) and Community Health Councils (CHCs) between 1993 and 1996. The other major reform as mentioned above was to shift funding, workers and health care services out of hospitals and into the community. The announcement of the closing of Shaughnessy Hospital in Vancouver in 1992 was the first attempt at shifting acute care resources (350 acute care beds), 1700 staff and associated funds to other types of facilities and the community (Ministry of Labour of B.C, 1996).

In May, 1993 due to an estimated 10 per cent workforce reduction in B.C hospitals, HSA, HEU and BCNU with mediator Vince Ready, brokered an agreement with the government known as the Health Labour Accord (Ministry of Labour of B.C,

1996). In the forefront of health care restructuring, this agreement secured funds for job security, extended periods of severance, created provincial seniority for bumping purposes, retraining initiatives, provincial job matching services and top up monies for those displaced employees close to early retirement age. These job security provisions would be managed by the newly formed, Health Labour Adjustment Agency (HLAA).

The Health Accord expired in March 1996 and job security provisions known as The Employment Security and Labour Force Adjustment Agreement (ESLA) were re-negotiated with the government. The deal came at a cost to workers only receiving 1.5% wage increase, and a three-year term collective agreement in exchange for job security. This job security language between government and unions was described as being one of the most progressive provisions available to health care workers throughout Canada and the United States (Health Canada, 1997). Collective agreement language stemming out of the Health Accord and ESLA also included barriers to privatization. An example of this language included, “the employer will not contract out bargaining unit work that will result in the lay-off of employees” (Paramedical Collective Agreement, 1996:24). Legislation was enacted to prevent contracting out. Bill 45-1993, the *Health Authorities Act* of 1993, Section 3.3 stated, “...that health services in British Columbia continued to be provided on a predominately not for profit basis” (p.3).

By 1996, B.C was facing significant and continued funding cuts for health care from the Federal Liberals amounting to an additional loss of \$797 million for 1997 and 1998 (Minister of Labour of B.C, 1996). Privatization and profit making in B.C was on the rise, ranging from the opening of the first private for profit Cambie Surgical Centre in Vancouver to increasing the number of for-profit out patient labs (Fuller, 1998).

At the outset of the NDP rise to power, the Federal Liberals, claiming budget deficits and expanding debt, began their retreat from health care, education and social services by passing Bill C-69 (Shan, 1994). In 1993, the FTA was expanded to include Mexico becoming the North America Free Trade Agreement (NAFTA). As with the FTA, NAFTA was billed as "...rising productivity and rising incomes" (Campbell, 2001:22). However, underlying these trade agreements were the arguments that for Canada to be more competitive in the world market "...lower taxes, lower social spending and more flexible labour markets" were required (Jackson, 2005:203). The 1990s saw the federal government reduce spending on programmes from "42.9% to 33.6%" of gross domestic product (GDP) (Jackson, 2005:207). Nationally, unemployment in the 1990s averaged "9.6%...higher than any other decade since the 1930s" (Campbell, 2001:22). Indeed, the promise of trade agreements did not bolster wages or improve jobs for workers. Campbell, in citing a federal government empirical research study, notes between 1989 and 1997 "...Canada's trade boom resulted in a net reduction of 276,000 jobs" (2001:23). The National Union of Public General Employees summarizes the impacts to workers and jobs in the private sector as the result of NAFTA and expanding international markets:

As we entered the 1990s, Canadian business and industry faced more competitive pressures with the growth of corporate globalization and the free flow of international capital. To meet the growing demands of competitiveness in an increasing global economy, the private sector engaged in major restructuring of the workforces. Lean production, the objective of most of this restructuring, resulted in a smaller, more flexible and lower paid workforce. With the opening up of global markets through international trade deals, we have increasingly been confronted with Canadian jobs relocating to low wage countries that have low union density and little regulation governing labour relations (2004:7).

In the wake of NAFTA, the policy of cuts to the social safety net and public sector downsizing was part of rethinking the role of government in the new era of trade liberalization. By 1995, the Federal Liberal government entrenched the shift away from “collectivities of social responsibility under the pretense of protecting the future viability of the social safety net” (MacDonald, 1999:76). They did this by introducing the Canada Health and Social Transfer (CHST) to replace both the Canadian Assistance Plan (CAP) for social welfare programmes and the EPF for health and education, marking a dramatic reduction in overall cash transfers to the provinces (Fuller, 1998; MacDonald, 1999; Shan, 1994; Torjman, 2001). The CHST was a single block funding scheme to pay for health care, education and social services with no strings attached for allocation of funds to each programme and the workers who deliver the service (MacDonald, 1999; Torjman, 2001). Federal budget deficit cuts resulted in the CHST being reduced by about one-third in absolute dollars (Hobson & St-Hilaire, 2000). Cuts to social programmes resulted in a loss of worker jobs. During this period the Mulroney Conservative government engaged in privatization in the industrial sectors, such as Petro-Canada and Canadian National Railway, which produced revenues for several years totaling over “...\$10 billion” (Boardman, et al, 2003:131).

Despite British Columbia’s attempts to protect workers’ rights and benefits, creating a labour friendly status during neo-liberal times of federal and global economic recession and expanding U.S health care markets was difficult. The NDP succumbed to federal and business pressures. Carroll and Ratner explained the NDP decade of rule involving a shift from inclusion of social interest groups to a “business lens” and concern as to how business would react to new policy and programme initiatives (2005:19).

Legislation, which paled in comparison to other provinces, was enacted by the NDP, which ranged from back-to-work, limiting right to strike, limiting role of unions in collective bargaining, imposing collective agreements and wage restrictions. Panitch and Swartz describe this era of NDP, social democratic rule in neo-liberal times as, "...an important testament to the role coercion [of workers and unions] continued to occupy even within the framework of NDP reforms" (2003:204). In the 1990s, the NDP government demonstrated leadership in health care and industrial relations. Contracting out of health care workers' jobs did not occur in B.C due to the protections entrenched in legislation and collective agreements. This was a different scene to that in the provinces of Ontario, Manitoba, Saskatchewan, Alberta, and Newfoundland where contracting out was initiated as part of a larger scheme of privatization (Armstrong, et al, 2001).

The New Millennium – Another Neo-Liberal Creep and Black Sunday

Towards the end of the NDP regime, its relationship with labour unions and the public was rocky at best. Labour was making public announcements of withdrawal of political support especially after the government had legislated workers in the education system back-to-work in 2000 (Panitch & Swartz, 2003). Despite the reduction of funding from the federal government, the NDP continued to record budget surpluses and in their final fiscal year recorded revenues of over \$24 billion with a \$1.6 billion surplus (McMartin, 2002). McMartin reported, "...the New Democrats were able to make a small payment on our seemingly ever-growing provincial debt, marking just the third time in the past 30 years that B.C's debt actually declined" (2002:21). Just prior to the defeat of the NDP, the federal government began increasing transfer monies back to the provinces, but many claim this was not sufficient to compensate what was removed

during the previous two decades (Armstrong et al, 2001; Hobson & St-Hilaire, 2000). However, the business or market interest of the Canadian Council of Chief Executives (CCCE), CD Howe and Fraser Institutes were and still are lobbying for a complete withdrawal of CHT and CST (formerly CHST) claiming it creates fiscal imbalances (Brownlee, 2005; Poshman & Tapp, 2005).

May 2001 started the beginning of the B.C Liberal New Era by an election giving them 77 out of 79 seats, an overwhelming majority. The B.C Liberals campaign alleged: “high taxes, over regulation and hostile business policies have driven workers and employers out of our province” and promised to reverse this trend with “...the right attitude, policies and taxation environment” (B.C Liberal Party, 2001:10).

First was the fiscal review, which claimed fiscal crisis due to NDP mismanagement of revenues and linking this to costly social programmes and high public sector wages. However, the Auditor General’s report soon countered this. Political pundit, Shreck noted, “Mr. Strelieff [Auditor General] shows in his report that in the five year period ended March 31, 2001 the economy in BC grew more than did the government’s net liabilities” (2002a:1). The government made an about face to support the fiscal crisis strategy and shifted focus to “projected estimates for the next three fiscal years...” which included the newly implemented tax cut creating a \$3.8 billion deficit (McMartin, 2002:22).

The deficit projections were used to justify significant funding cuts and reductions to social welfare programmes including health care. The 2002 budget announced the pay policy on public sector workers’ wage increases to be zero over the next three years (Fuller, C, & Stephens, S, 2004). This was rationalized by fiscal pressures and the

message that the public sector was already overpaid. McMartin, a political consultant who worked for the Progressive Conservative and Social Credit governments, explained the governments' strategy:

Whether or not Premier Campbell is right in making sizable reductions to the provincial public service and government programs, it's questionable that he claims he was forced to do so because he inherited a structural deficit from the NDP. Having the mandate and the legislative authority to implement his government's fiscal and other policies, he need not blame his predecessors for his own policy priorities, nor need he fabricate a fictitious inherited structural deficit as an excuse to do so (2002:21).

In tandem with the fiscal review was the Core Services Review (CSR) implemented in June 2001 (Government of British Columbia, 2001). The CSR outlined a doctrine of neo-liberal governing and economic policy objectives, which included reduced public spending, privatization and de-regulation (Government of British Columbia, 2001). The main purpose of this review was to "rethink government" in the provision of services and programmes to ensure those "non-essential" will be "eliminated" or shifted for the purpose of fiscal accountability (Government of British Columbia, 2001:3). Each Minister was asked to employ a series of five tests, in a phased timeline, to ensure their ministry was implementing the governments' mandate outlined in the New Era document.

The first test called the "Public Interest Test" was for ministers to determine whether "...the mandate, program, activity or business unit continues to serve a compelling public interest" (2001:5). Public was never defined leaving the question whether it was unionized workers, elderly, women, corporations, or markets? The second test called the "Affordability Test" asked Ministers to assess whether the "package of programs, activities or business units is affordable within the current fiscal environment"

(p. 5). Again, in this obscure language it is unclear if it pertains to unionized workers wages, women, the poor, residential care versus assisted living, medical services insurance for eye exams, physiotherapy, or women's centres and law centres. The third test refers to the "effectiveness" and "role of government". It asks Ministers, "Are we doing the right thing? Is there a legitimate role for the provincial government in this program, activity or business unit?" (p. 5). This was primarily targeted at the relocation or marketing of public sector services to private sector markets. The crux of this test was the ideological, political and economic position of government intervention in the collectivities of the citizenry whether it be unionized workers, children, the poor and frail elderly or those in need of medical care. The fourth test of "efficiency" asked Ministers "Are the current organizational and service delivery models the most efficient way to manage and deliver the programs, activity or business unit?" (p.5). Efficiency appeared dependent on legislation (Bill 29-2002) that was designed to promote contracting out of unionized workers jobs to transnational corporations (TNCs). The fifth test sought "accountability" and asks Ministers "Are the current organizational and service delivery models the most effective way to account for program activity or business unit performance?" (p.5). It is unclear to whom the accountability is for. Was it for unionized workers who are citizens or was it accountability to markets in liberalizing the economy? Shortly, after the review the Ministry of Health Services and Ministry of Health Planning initiated performance contracts with health authorities that established performance measures to ensure fiscal and public accountability (Ministry of Health Planning, 2002; Ministry of Health Services, 2002).

The Core Services Review further advised Ministers that they “may also want to refer to the work of previous initiatives and will need to factor in the deregulation agenda” (2001:5). The government justified the CSR assessment criteria as being based on similar tests administered by other provincial and federal government ministries linking it to the broader global trend rooted in neo-liberal economic policies. In conducting the CSR between July and October 2001, ministers were provided alternate “service delivery options” that included “elimination” “reduction”, “consolidation”, “redesign”, “transfer to the voluntary or private sector”, “alternate service delivery” or “regulatory approaches” and “cost recovery mechanisms” (2001:11). Ministers could choose a public consultation process as part of the CSR.

For health care the public consultation process began on, August 27, 2001. The Select Standing Committee on Health was reconvened by the Legislative Assembly with a mandate to “examine, inquire into and make recommendation...to ensure the government expenditures on health care services are sustainable” (2001:3). The committee consisted of eleven Members of the Legislative Assembly (MLA); one of the eleven was NDP and all others were from the Liberal Party. The committee looked at four specific points: 1. sustainability; 2. short and medium term management and cost containment solutions; 3. improvements as well as improvements to health outcomes; and 4. other areas determined by the Standing Committee (2001). The Committee’s recommendations included a category on privatization. It recommended the government investigate capital financing schemes with public-private partnerships. The Standing Committee further recommended the B.C government explore which health care services could be delivered as a public-private or sole private venture (2001).

Following the fiscal, core service review and public consultation, Bill 29-2002 was enacted. Organized labour dubbed the date as “Black Sunday” reminiscent of anti-labour laws from the 1980s. The government news release on January 25, 2002 criticized the previous NDP government for placing “...union interests ahead of patients...” promising Bill 29-2002 would bring better management by “...focusing resources on core services” and placing “...the interests of patients first” (Ministry of Skills Development and Labour, 2002a:1). The government’s media backgrounder outlined six benefits of Bill 29-2002 to patients which were primarily aimed at curbing costs, providing newly formed health authorities with the mandate to “manage” health care and to “expedite restructuring initiatives” (Ministry of Skills Development and Labour, 2002b: 1). The government stated the legislation was developed to address two major problems of “management” and “sustainability” (Ministry of Skills Development and Labour, 2002b:2). The management problem was primarily linked to organized labour’s “...rigid collective agreements...” containing provisions such as employment security, bumping rights and reassignment of workers which are costly and cumbersome to implement (2002b:2). The sustainability issue was directed at cost containment noting health spending has grown “twice as fast as the economy” and the projections to 2005 would see health consume 43 per cent of the provincial budget (Ministry of Skills Development and Labour, 2002b: 2). Organized labour costs were listed as consuming up to “80%” of the health budget with support staff having wages “...30% higher than the rest of Canada” (2002b:2).

In the Annual Reports for the 2001-2002 fiscal year, the Ministers of Health Services and Health Planning cite workers’ wages accounting for “...80 per cent of

health care costs...” and this statement preceded the paragraph which explained the costs for health care, “...have been growing three times faster than the growth of the economy” (p.2). The 2001/02 annual reports of the Ministries of Health Services, Health Planning and Skills Development and Labour all refer to the recent implementation of Bill 29-2002 as a “major tool for change” to provide employers with “flexibility” and promised that it would “...provide the same level of services and quality of services in a much more cost-effective manner” (2002:3,6,43,45).

By late 2002, the Vancouver Island Health Authority (VIHA) along with other health authorities, were announcing budget shortfalls of millions of dollars. These budget shortfalls were in part related to recent wage increases of public sector workers and increased Medical Services Plan (MSP) rates which the Provincial Government (imposed and negotiated) was not willing to fund, citing economic rationalizations related to escalating projected provincial debt and the need for fiscal accountability (McMartin, 2002). The government held Health Authorities accountable through performance contracts and adherence to the budgets provided them.

In the following statement, VIHA described their cost pressures and the intent to accommodate them by dealing with their unionized workforce:

Bill 29 has allowed Health Authorities [and affiliate sites] the option, under certain conditions, to contract out support services to the private sector in order to preserve available funding for core health services. Fiscal reality necessitates that this be pursued aggressively [...] This fiscal years funding allocation included an increase of \$19.4 million. However, VIHA experienced additional cost pressures this fiscal year of \$43 million related to the cost of union wage agreements, benefit increases [increased MSP rates], inflationary and new technology costs. These pressures must be accommodated by this Redesign plan (2003:4).

Legislation specific to workers and unions, enacted during 2001 and 2004 is reviewed in the next section.

The Legislation: How Much Legislation Does it Take to Get the Message Across?

The question that subtitles this section is linked to the volume (fourteen acts) of legislation enacted by the B.C Liberal regime between 2001 and 2004. Other labour legislation, that impacted unions' and workers' rights and benefits will be discussed. The *Health and Social Services Delivery Improvement Act* (Bill 29-2002) was passed quickly. It came into force three days (January 28, 2002) after a first reading as Bill 29 before the legislature. The Health Sector Labour Adjustment Regulations 2002 were finalized by Order in Council February 2002. The government announced to British Columbians that Bill 29 would provide the flexibility required by the six newly formed health authorities (December 2001) to implement necessary health care reform if B.C was to have an affordable and sustainable health care system (Ministry of Skills Labour and Development, 2002b). Whereas the government may have stated the legislation was to produce "flexibility" to restructure health care by way of contracting out non-clinical services, it impacted all workers' collective agreement provisions whether they were contracted out or not. The Act provided the legal right to privatize "non-clinical" unionized jobs in the health sector as defined by the Act, through contracting out initiatives. It also removed barriers to contracting out by voiding previous legislation and provisions in collective agreements.

Bill 29 is a key piece of legislation, which facilitates health care restructuring by moving "functions or services within a worksite to another worksite within a region or to another region or to another health sector employer...including...partnerships or joint

ventures with other health sector employers or subsidiaries” (Sec 4.1). The worker “may” be transferred, without notice, by the employer to another worksite, multiple worksites, or transferred with a health service; however, in the case of the latter there is no explicit fiduciary responsibility on the part of the employer to offer this job security to the worker (Sec 4.3).

Sections 5 and 6 of the Act remove all barriers to privatization, enabling employers to contract out non-clinical services, as defined by the Act as outlined in the Regulations. These sections voided previous legislation and negotiations as outlined in the *Health Authority Act* 1993, and collective agreement language limiting an employer’s option of contracting out services in the health sector. Furthermore, section 6.4 explicitly stated, “a provision in a collective agreement requiring an employer to consult with a trade union prior to contracting outside of the collective agreement for the provision of non-clinical services is void”. Previously the Health Accord, eventually evolved into the Employment Security and Labour Force Adjustment Agreement (ESLA), required employers and unions to discuss health care restructuring initiatives that impacted worker job security.

Non-clinical workers in the Act are defined as “...services other than medical, diagnostic, or therapeutic services provided by a designated health service profession to a person who is currently admitted to a bed in an inpatient unit in an acute care hospital, and includes any other services designated by regulation” (Sec 6.1). Very few health care workers fit this narrow definition, as many are not directly assigned to in-patient acute care beds. Furthermore, this definition excluded all support workers, such as clerical, housekeeping, food service, laundry and security workers as well as direct clinical

workers such as dietitians, social workers, medical radiation technologists, ultrasound sonographers and many others. This definition excluded all staff who work in emergency wards, out-patient acute care services and residential care facilities where clients are not defined as in-patients.

Section 6 removed unions' long standing right of successorship by banning the Labour Board of B.C from declaring contractor employers, such as Compass or Sedexo as successor employers thereby transferring the union's certification of the workers to another union or non-union entity. Section 6(3) also limited the Labour Board's traditional role as defined in the Labour Code in declaring employees of the contractors to be employees of the health sector employer, again denying union successorship to represent those workers under the union's certification.

Sections 7 and 8 of the Act voided all previously negotiated job security provisions in place to support the transition of workers during times of health care restructuring. These sections terminated the Health Labour Adjustment Agency (HLAA) that administered the Employment Security and Labourforce Adjustment (ESLA). It also reduced severance entitlements to less than prescribed in the *Employment Standards Act*, recently amended in May 2002. Section 8.9 directed remaining funds from the HLAA to be placed in the *Health Special Account Act*.

Section 9 restricted and temporarily suspended long established worker bumping rights until December 31, 2005. This section restricted workers' bumping rights by differentiating bumping options if a worker had been employed less or more than five years. It also limited workers' notice period of lay-off, shortens time frames for bumping and limits the amount of times a worker may bump to secure a job. Section 10 voided

any collective agreement provision or attempts of a trade union, employer, arbitrator of B.C Labour Relations Board to alter or negotiate any provision that “...conflicts or is inconsistent...” with the Act (Sec. 10). This legislative restriction on future negotiations was critical for organized labour’s role in representing their members in collective bargaining.

Part three of the Act turns its attention to the social service or community sector where four unions represent workers whose employers are represented by the Community Social Service Employers’ Association (CESEA). Sections 12, 13, and 14 voided the Public Sector Accord, equity adjustments and employment security provisions.

Finally, the Act reached into current collective agreements that were negotiated or imposed in 2001 by the government or through the employer’s bargaining agent, HEABC. Griffin-Cohen and Cohen (2004) in citing expert witnesses for the health care unions’ B.C Supreme Court challenge found that Bill 29 may be the first occurrence of legislative interference in Canada with a current term of collective agreements.

Bill 29-2002 voided many provisions achieved through years of past collective bargaining, voided current collective agreement provisions and placed restrictions on future collective bargaining. The Act may be viewed within the context of neo-liberalism, economic globalization and the barrage of legislation enacted during 2001 to 2004 that reduced and eliminated unions’ role and workers’ rights and benefits in B.C. This other legislation is summarized in Table Two.

Table Two: Other Legislation Enacted in B.C Altering Labour Rights from 2001 to 2004

Legislation	Date	Main Tenets
Bill 2-2001, <i>Health Care Continuation Act</i> .	June 19, 2001	Ceases legal job action of BCNU & HSA. Orders a cooling off period.
Bill 13-2001, <i>Greater Vancouver Transit Services Settlement Act</i> .	August 1, 2001	Ceases legal job action, imposes back-to-work orders and contract settlement provisions.
Bill 15-2001, <i>Health Care Services Collective Agreement Act</i> .	August 9, 2001	Imposes collective agreements including wage settlements upon BCNU & Health Science Professionals.
Bill 16-2001, <i>The Miscellaneous Statutes Amendment Act</i> .	August 16, 2001	voids amendments to the B.C Human Rights Code to prevent discrimination in payment of wages.
Bill 18-2001, <i>Skills Development and Labour Statutes Amendments Act</i> .	August 16, 2001	Prohibits teachers right to strike, mandating 100% essential service. Outlaws sectoral bargaining.
Bill 22-2001, <i>Skills Development and Fair Wage Repeal Act</i> .	August 21, 2001	Repeals previous legislation that required public work contracts to exclusively hire trade union workers.
Bill 27-2002, <i>Education Services Collective Agreement Act</i> .	January 27, 2002	Legislates a collective agreement on public school teachers.
Bill 28-2002, <i>Public Educators Flexibility and Choice Act</i> .	January 27, 2002	Permits contracting out of teachers and support worker. Removes job security.
Bill 48-2002, <i>Employment Standards Act</i> .	May 30, 2002	Reduces protections from employer misuse of overtime. Removes previous child labour standards. Excludes farm workers from overtime limits. Lowers minimum wage to \$6 per hour training wage for first 500 hours. Excludes unionized workers from the minimum standards.
Bill 18-2003, <i>Coastal Ferry Act</i> .	March 26, 2003	Converts B.C Ferries from a crown to a private corporation.
Bill 94-2003, <i>Health Sector Partnership Agreement Act</i> .	November 27, 2003	Limits employee rights of successorship in a union with a contractor employer providing services to the health sector. Potential to facilitate union-free work sectors.
Bill 95-2003, <i>Railways and Ferries Bargaining Association Act</i> .	November 27, 2003	Intervenes in the ferry worker's bargaining.
Bill 37-2004, <i>Health Sector (Facilities Subsector) Collective Agreement Act</i> .	April 28, 2004	Imposes a collective agreement on HEU & BCGEU including 11% wage roll back, increased hours of work (36 to 37.5). Alterations were mediated to include cap on contracting out jobs and severance money.

Like Bill 29-2002, these thirteen acts of legislation have a clear message.

Workers' and unions' rights have been curtailed or eliminated to promote the neo-liberal agenda by reducing labour costs and labour rights, thereby attracting business to B.C and limiting the governments' social responsibilities. Some of the legislation ranges from

being permanent (Bill 29, Bill 94) to temporarily restrictive (Bills 2, 15, 37). When looking at the gender picture, the B.C Liberals receive a failing grade. The majority of the public sector legislation is geared towards limiting or removing rights of women. Women represent over 80% of the workforce in education and health care sectors, which are also long standing traditional areas of women's employment (Armstrong et al, 2001; Creese & Strong-Boag, 2005; 2004; Fuller & Stephens, 2004; Griffin-Cohen and Cohen, 2004). Creese and Strong-Boag state the "Liberals have tossed equality and justice overboard" (2005:32). Fudge and Brewin document over 100 pieces of labour legislation enacted across Canada since the 1980s, which limit or curtail worker rights and a union's role in representing workers. This links the B.C trend to a broader neo-liberal, de-regulation and labour policy agenda in Canada.

Summary

The legislative authority of the B.C Liberal regime wasted no time in achieving the following:

- curtailed union roles in representing workers in collective bargaining;
- limited union successorship;
- eliminated or amending worker rights with back to work legislation;
- suspended the right to strike;
- involuntarily extended collective agreements;
- imposed wage settlements and collective agreements;
- reduced or eliminated previously negotiated collective agreement rights and legislation implemented by the NDP;

- temporarily removed the right of health care workers to organize in a union of their choice.

The *Health and Social Service Delivery Improvement Act* was one tool of governing for the B.C Liberal Government, mass media and corporations to fulfill the neo-liberal agenda of reduced social spending, deregulation and privatization through contracting out. Legislation of the volume and pace adopted by the B.C Liberal regime was purposeful and repressive. It was also consistent with the national and international labour relations scene in the globalized market economy.

Further linkages to the context and underpinnings of the policy shift in Bill 29-2002 are covered in the subsequent literature review. Chapter three reviews key Canadian health care policy reports and other literature focusing on privatization, profit making and contracting out in the public sector.

Chapter Three: Literature Review

Since 2000, three Canadian cornerstone reports have contributed to the debate and public policy of sustainability, protection, expansion and restructuring of Medicare.

Following the discussion of these reports, literature specific to defining public health care privatization, profit making and contracting out is reviewed.

Canadian Health Policy Reports

The three major government sponsored reports reviewed are: 1. A Framework for Reform, Report of the Premier's Advisory Council on Health for Alberta, frequently referred to as the Mazankowski report, chaired by the former Deputy Prime Minister, Don Mazankowski; 2. The Health of Canadians –The Federal Role by the Standing Senate Committee on Social Affairs, Science and Technology, also known as the Kirby Report, chaired by Senator Michael Kirby; 3. Building on Values, The Future of Health Care in Canada by the Royal Commission, known as the Romanow Report, by the former Saskatchewan Premier Roy Romanow. These reports contain opposing conclusions about Medicare's financial sustainability and how it should be reformed.

The Mazankowski Report

The Alberta Premier's Advisory Council report established "... changes in how we should organize and deliver health services..." (p. 5) and recommended "fundamental changes in how we pay for health services" (p. 4). The Council asserted that without these changes Alberta's health care system is not fiscally sustainable. In particular, the Council concluded, "that the current health care system is not sustainable if it is solely funded from provincial and federal government budgets" (p. 53). The report went on to outline a "range" of private sources of funding to reform the health care system, namely,

by “allowing privately funded and privately delivered health services” and “expanding supplementary or private insurance” (p. 54). From this stance, the report described the serious flaws of Canada’s health care system as an “unregulated monopoly” (p. 4). The Council further criticized the “system [a]s by government, paid for by government....it’s a command and control systemthat doesn’t work” (p. 21). The Council recommended, “[w]e need to seriously look at expanding the role of the private sector in delivering insured health services” (p. 25).

The Council’s recommendations allow for an expansion of private, for-profit health care-at the expense of the publicly funded and administered system. The report suggested Medicare coverage be reduced and few, new services be publicly funded. The solutions offered are that de-listed services or treatments could be paid for privately. The Mazankowski report recommended fundamental and permanent changes to Medicare, particularly in the areas of increasing commercialization or privatization, by stating “as long as insured health care services are publicly funded and standards are in place, it should make no difference if services are delivered in public, private [for-profit] or not-for-profit [private] facilities” (p. 51). To this end, the Council recommended increasing “choice” and “competition” by “unbundling the system” which would “expand the number of suppliers delivering health care services” (p. 48). The report went on to outline the devolution of health care by expounding the benefits of “unbundling” as it relates to decreased role for government:

Rather than have government act as the insurer, provider and evaluator of health services, the various function could be broken up. The role of government could focus more on setting overall direction and allocating funding to health authorities (p. 24).

The report did not address the issue of contracting out of workers jobs to for-profit service delivery entities. However in the 1990's contracting out of hospital support workers' jobs for for-profit multinationals occurred (Armstrong et al, 2001). Vivone, in commenting on the report states, "privatization is already rampant in health care [in Alberta]" (2002:2). The report recommended health authorities be given increased power to directly or indirectly provide all services with public or private for-profit providers by way of agreements or contracts.

The Kirby Report

The Standing Senate Committee on Social Affairs, Science and Technology consisted of eleven senators who conducted a two-year review of Canadian health care as well as other countries health care systems. Criticism surrounded Senator Kirby, chair, as he sat on the Board of Directors of Extendicare, a for-profit company delivering nursing home care and long term care (Canadian Labour Congress, 2002:1). At the outset, while the report called for infusion of five billion dollars of new federal money it claimed that "no amount of new money will make the current system sustainable over the long term" and recommends changes to the structure and functioning of the system (p. 20). The Committee further recommended a system of "service based funding" where hospitals or providers would be funded based on type and volume of service provided (p. 32). The rationale for this is to target hospitals to specialize and to encourage high efficiency. The committee stated this system would lead to "hospitals becoming more independent from government", thereby reducing the size of government departments leading to a further reduction of public servants (p. 38). The report stated this new funding model may be applied to any combination of owner-operator model of service delivery by explaining

how, “[s]uch an institution could be either publicly owned or owned by a private not-for-profit or for-profit organization” (p. 39). The Committee further described this fundamental shift to a market or commercial competitive model by explaining how underachieving hospitals can adjust their practices:

Hospitals will adjust their service mix in order to earn the highest possible returns consistent with meeting the needs of the population they serve. Hospitals will be encouraged to specialize in those services they can do best, and those for which the rates of remuneration are most attractive, they will reduce to the point of not providing those low-volume services that are not appropriately funded for (p. 40).

The Senate Committee flatly rejected literature and research critical of for-profit delivery by asserting that “[g]iven the evidence in the literature, the committee believes that leaving the *Canada Health Act* as it currently is –which meant permitting private-for-profit hospitals or clinics to operate under Medicare (since such institutions are not currently prohibited under the Act) –will not, as some critics maintain, weaken or destroy the health care system as we know it now” (p. 57).

The Committee supported any mixed delivery model of funding (private or public) and health service delivery. It further recommended expanding the *Canada Health Act* to include the provision of home care services to provide support for “post-acute home care” (p. 151). The report did not specifically address the area of contracting out of support services such as housekeeping, laundry, dietary, maintenance or security usually provided in-house in hospitals and facilities. However, contracting out of these services had already begun in several provinces across the country (Armstrong, et al, 2001).

The Romanow Report

The Federal Royal Commission's mandate was to recommend "the long term sustainability of universally accessible, publicly funded health system" (p.1). The report rejected claims that the current system was in crisis and not sustainable and states the following:

Our health care system is adequately meeting our needs. Canada's health outcomes compare favorably with other countries and evidence suggests that we are doing a good job in addressing the various factors that impact on overall health. But there is room for improvement (p.xxiii).

The Commission discussed the under-funding issue with the federal government's cash transfer having been reduced from 47 per cent of hospital and physician expenditures, to less than 15 percent by the late 1990s it recommended an infusion of several billion dollars. The Commission stated, "the federal government has successfully removed the risk of growing health expenditures to the provinces" (p. 67).

The Commission was clear "...that direct health care services should be delivered in public and not-for-profit health care services" (p. 7). The report rejected claims that for-profit delivery is the path to take by explaining how for-profit entities profit off the back of the not-for-profit public sector:

In effect, these [for-profit, private] facilities 'cream-off' those services that can be easily and more inexpensively provided on a volume basis, such as cataract surgery or hernia repair. This leaves the public system to provide the more complicated and expensive services from which it is more difficult to control cost per case. But if something goes wrong with a patient after discharge from a private facility[...]the public system is required to provide a 'back-up' to the private facilities to ensure quality care (p. 7).

The Commission further pointed to the research on the different “quality outcomes” in the United States where non-profit delivery has better outcomes than for-profit delivery (p. 7). The report does review specific areas of concern regarding current privatization practices, trends towards for-profit private health care and drew attention to trade treaty implications that may open Canada up for penalties or risk of international competition and control of the health care system. Romanow consulted trade treaty lawyers and stated there was a “strong consensus that the existing single-payer monopoly of Canada’s health care system is not subject to a challenge under NAFTA” (p. 237). The report directly discussed contracting out of health care workers jobs. While the Commission appeared to reject further increases to health care privatization it did spend time defining the differences, levels of complexity and the priorities between “direct health care services such as medical, diagnostic and surgical care...” and “ancillary services such as food preparation, cleaning and maintenance” (p.6). In this endeavor, the report went on to explain that these ancillary or non-direct care staff, are more easily monitored for quality control and can be easily replaced, by “...competitors in the same business to whom hospitals can turn for laundry, or food services if their current contractor is unsatisfactory” (p. 7). The Commission offered the following explanation of public approval of contracting out hospital and facility support workers jobs to for-profit entities:

An increasing proportion of ancillary services provided in Canada’s not-for-profit hospitals are now contracted out to for-profit corporations. Canadians seem to find this role for private sector companies acceptable. ... (p. 6).

In Saskatchewan under the Romanow NDP regime, back to work legislation was enacted as was contracting out of hospital support workers (Haiven & Haiven, 2002; Willson & Howard, 2001).

Summary

All three health care reports took positions on private financing and for-profit delivery. Both Mazankowski and Kirby regarded the Canadian health care system as an opportunity for private ventures. Both maintain that in order to sustain a health care system it must be reformed by marketization and further profit making. Mazankowski recommends a complete shift by devolving government role and increasing private for-profit sector delivery. The Kirby report advocated maintaining a publicly financed system and infusing federal dollars but supported a marketization approach inclusive of competition and private for-profit delivery. Romanow, like Tommy Douglas, echoed Canadian citizen's defense of Medicare and recommended solidifying key values and principles of a publicly funded not-for-profit delivery system. The Commission further recommended expanding publicly insured services and cautions against for-profit hospital models because of NAFTA. However, Romanow conceded to a trend already in place since the decade of the 1990s. The report supported expanding the private for-profit sector role in the provision of support services such as housekeeping, laundry, food, security and maintenance. What was not evident in the report were references to impacts on workers and impacts on the quality of service or the true costs of contracting out.

Further literature specific to health care privatization and profit making is reviewed next.

Defining Privatization and the Canadian Health Care System

The concept of privatization as it relates to health care is complex. Many of us would not be able to describe what is private and public health care because Canadians are assimilated into a mix of health care delivery that relies on private and public sector provision of service and funding. Starr defines the concept of privatization as a "...shift from publicly to privately provided goods and services" (1990:125). Policies that encourage this shift are discussed by Starr (1990) and Armstrong and Armstrong (2001a) and include: 1. the cessation of public programmes and disengagement of government from specific kinds of responsibilities such as delisting health services and consequent off-loading of costs to citizens or shifting previously paid for services such as home care to the unpaid care giver in the home; 2. sale of public assets such as crown lands and corporations; 3. financing private provision of services, for example, through contracting out; 4. government deregulating entry into activities that were previously a public monopoly by creating opportunities for private-for-profit health service providers by enacting legislation such as, Bill 29-2002. Many authors describe the Canadian health care system as a legislated public monopoly because the provincial governments are the sole provider of the service (Armstrong, 2001; Flood, 1999; Fuller, 1998; Globerman & Vining, 1998; Sanger and Sinclair, 2004). Private insurance plans cannot reimburse hospitals, medical practitioners or patients for provincially insured services. The provincial governments are responsible for administering health care in order to receive funding through the Canada Health Transfer (CHT formerly the CHST).

Most health care in Canada while publicly funded was never free of private sector participation. Nothing in the *Canada Health Act* prevents private individuals or entities

whether for-profit or non-profit from delivering the insured services (Fuller, 1998; Flood, 1999). Medicare is an insurance scheme, which is publicly funded but mainly non-government delivered by independent doctors, professionals and private, not-for-profit hospitals and facilities (Armstrong, 2001; Flood, 1999; Fuller, 1998). Fuller (1998) and Flood (1999) explain the majority of hospitals are operated by non-profit societies. Until the royal assent of the *Health Authorities Act* (1993) in British Columbia, hospitals operated under the *Societies Act* (British Columbia Health Association, 1990). All provincially insured services whether provided by a non-profit or for-profit entity invoice the government and/or provincial insurance plan directly for the fixed fee established by provincial legislation; no additional fee may be billed to the patient or government.

The provincial insurance plan does not include coverage for certain health care services. Examples of private pay health care in B.C are the de-listed services (from the provincial insurance scheme) such as eye exams with optometrists, out-patient physical therapy, massage, chiropractic and podiatry therapies and medications purchased at community pharmacies. Fiscal cuts to home care services resulting in unpaid caregiving, primarily by women, leads to more privately purchased care (Armstrong & Armstrong, 2001a; Fuller, 1998; Fuller, C & Stephens, S, 2004). The mixture of non-profit and for-profit entities providing health care services had its roots during the development of medicare (Barlow, 1999; Fuller, 1998). An example, in the area of diagnostic and laboratory blood services, is provided from the literature on the competition for health care dollars. In 1994, the NDP commissioned the Kilshaw Report on diagnostic services comparing B.C with several other provinces that relied on privatized, for-profit out-patient laboratory blood testing. The results demonstrated that this practice resulted in

higher per capita costs than public non-profit labs (Kilshaw, 1993). Kilshaw recommended B.C adopt a model to encourage the public to increase usage in the non-profit hospitals or community based labs as a cost containment measure (Kilshaw, 1993). It failed to be implemented due to corporate pressure placed on the government (Thiink Group, 2002). The Medical Services Commission in B.C evolved in the 1990s and it controls licenses for all laboratory blood collection sites and according to Fuller (2001c) has stated it favours private, for-profit licensed labs. Private, for-profit labs expanded exponentially in B.C in the 1990s (Fuller, 1998). Fuller provides the fiscal details of what is at stake:

In 1996-97, \$54.7 million was paid in lab fees to hospitals for out-patient services, compared to \$117.4 million paid to private companies in B.C. From 1992-93 to 1996-97, billings for outpatient lab services grew by four per cent in the hospital sector and by 22 per cent in the private sector. Up to 80 per cent of private sector outpatient lab services are used to provide a relatively short list of routine services [as opposed to complicated, labour intensive ones conducted in hospitals] (2001:304).

While this example from the literature provides the amount of money and profits to be made in health care, they are all consistent with the *Canada Health Act*. Sanger and Sinclair state the erosion and increased marketization of health care is constructed by way of “chronic underfunding” and altering the culture of medicare “...by steady, incremental commercialization” (2004:17). Gratzner supports saving health care by introducing market strategies of private payment to make Canadians more responsible as they “shop” for the best deal which will curb misuse due to the current “free” nature of the public system (1999:175). In contrast to Gratzner’s opinions of promoting responsible use by citizens, is Armstrong et al (2001) who maintain Canadians are responsible to the point of paying for no longer insured services or providing them as the unpaid and invisible

caregivers in home care situation. Barlow strongly defends Medicare as “...a fundamental right of citizenship” which is paid for by citizens by way of redistribution of taxes (2002:4).

Contracting out literature is reviewed in the next section.

Privatization – Contracting Out

Canadian literature on outsourcing or contracting out public sector health care workers jobs is sparse. Sources were expanded to include literature from the United States, European Union and Canada.

Starr observed in the United States that advocates of contracting out or “partial privatization” demonstrate “...an undue tenderness toward private contractors ...and their history of cost overruns and an undue hostility toward public employees ...and their history of wage increases” (1990:128). While Starr (1990) found some evidence that private entities report lower costs, there are areas to consider prior to contracting out a service. Four areas of concern for Starr are:

- empirical studies show little in the way of costs differences between public and private provision of services;
- differences with public versus for-private operations which gain profits and reduce costs in the provision of social programmes by “creaming” of clients to private institutions who can afford higher costs of service (p. 129);
- literature lacks data on the quality of contracted out service provided, making it difficult to assess if the cost reductions are the result of increased efficiency or “deteriorating quality” (p. 129);

- lower costs are achieved by reduced worker wages and benefits and there is an increase in part time jobs. Starr states:

Privatization enables governments to cut wages and break unions; it is a means of imposing losses on public employees. If it enables governments to reduce services and allows providers to skim off the best clients, it is a means of imposing losses on beneficiaries. Neither of these ways of reducing costs has anything to do with improvements in efficiency. Perhaps the public wants wages and benefits cut. If so, voters and legislators should do so with their eyes open (1990:129).

Bailey (1987) who is not opposed to privatization as public policy, would agree with Starr's findings and forewarnings, but adds that public entities and policy makers need to be aware of additional concerns. Bailey cites these concerns as:

- the increased and continuing need to regulate contracted out services for protection of the public;
- vendor availability and economies of scale where if something goes awry with one vendor another may not be available to take over or if too many vendors exist in one geographic location the "economies of scale may be lost..." (p. 149);
- there are costs attached to transitioning to a private contractor, which are seldom noted in literature. Bailey discusses these costs as difficult to estimate but "... could far outweigh the potential benefits of privatization" (p. 149);
- compliance to the contract, by the vendor, in the interest of maintaining quality and protection of the public, Bailey cautions this "... will require a managerial unit to oversee vendor actions –another hidden cost of privatization" (p. 150);
- should contracting out fail in the private sector, the public sector will be expected to take back this responsibility of service provision –all leading to more costs and the disruption of service –"a nonfiscal cost borne by clients ..." (p.150).

Bailey concludes that generally citizens do not “subject the things they hold most valuable to the market” (p. 151). Bailey further states “... privatization may provide a good tool for the public manager and add an interesting dimension to the political discourse, the concept –even after eventual clarification –will not offer as much as its advocates claim” (1987:152).

Wilner (1999) discussed the social welfare consequences of privatization and cited the examples of Sweden in the 1980s where women workers in the public sector experienced wage inequalities related to contracting out. Parker (2003) in discussing privatization in the European Union (EU) noted the impacts on social welfare to wages, risks of unemployment and work environment. Parker cited the “gainers” in privatization as investors, financial institutions, management consultants, politicians and multinational corporations (2003:124). Parker’s list of “losers” includes trade unions and categories of workers more at risk for “...unemployment and wages cuts...” (p. 124). Parker notes the workers at risk of privatization tend to have lower education levels and fewer skills (2003). Higher skilled and educated workers tend to be at low risk of contracting out (Parker, 2003). Parker finds that “...issues to do with power and control in social welfare terms either are secondary issues in the literature or, much more frequently, are ignored altogether” (2003:125). By 2003, Boardman, et al in examining “medium term” privatization trends in Canada predicted that most privatization will occur in B.C with B.C Hydro, B.C Ferry, railroads, liquor, ICBC vehicle insurance and health care (2003:152). However, Boardman, et al note “...any reduction in publicly funded, universal, free health services will be controversial” (2003:152).

Armstrong and Armstrong noted in 2001b, if health care literature or research is being conducted in Canada on impacts of privatization to women it "...is not publicly available" and concluded their work was "...more about what we do not know than it is about what we have evidence to support" (p.164). Armstrong and Armstrong turned to evidence in the private sector of declines of worker morale and productivity linked to "constant change" (2001b:171). They found the Ontario health care system contracted out food, housekeeping, laundry, clerical and laboratory reconstructing them as "hotel services" which "distances them from health care and relocated them as private sector concerns" (2001b:176). In Ontario, Armstrong and Armstrong found that empirical data on cost savings and quality control was not evident in the decision to contract out (p.176). Armstrong and Armstrong concluded Canadian research on health care contracting out was virtually non-existent and, while unions do studies on contracting out, specific impacts to women workers were not identified (2001b). Furthermore, they found that privatization produces savings by shifting unionized jobs with wage and benefit protections away from women to lower wages with little to no benefits. In 2001, Armstrong, et al, concluded a gap existed in the Canadian health care privatization literature and research with respect to impacts to women as care recipients and as paid and unpaid caregivers.

Botting (2001), noted the loss in 1996 of worker's jobs in Newfoundland health facilities to contracting out of food, laundry and housekeeping as a cost saving measures where the majority of workers effected were women who were paid lower wages by the private company. Botting (2001) referred to personal communication with a nurses union consultant on the impacts of contracting out to workers who remained on the job. These

impacts were “...high levels of stress, increased workload, rapid changes with little input from frontline workers, understaffing, and workplace health and safety issues” (Botting, 2001:76). Brodie discussed the restructuring of social welfare noted that women withstand the worst of structural adjustment policies, which seek to reduce the public sector (1996b). Citing empirical data from developing countries, Brodie found privatization brings pay equity gains for women to a standstill (1996b).

Willson and Howard, in 2001, cited examples of contracting out in Manitoba and Saskatchewan in the 1990s of health support workers jobs in food, laundry, cleaning, and homecare; however no specific data was available. Willson and Howard concluded, “[w]omen are disproportionately affected by change in health policy because women comprise the majority of paid workers, care recipients and unpaid workers in the health care system” (2001:247).

Fuller supported this notion and explained that contracting out produces cost savings by lowering worker wages, eliminating health and welfare benefits and preventing unionization (1998, 2001). In 2004, Fuller and Stephens discuss the negative impacts to women’s income and security in B.C as the result of downsizing and employment policy changes, naming poverty as the number one concern (2004). Lowe found in Canada that the goal of ongoing restructuring of the workplace and the labour market is to increase productivity and competition as opposed to a worker-centred agenda of good jobs (2000). Jackson noted the trends in the labour market and employment relationships are downsizing, contracting out of those jobs redefined as non-core, such as hospital support workers, and increased flexibility of hours of work resulting in increased overtime, part time jobs or contract employment (2005).

Summary

Canadian health policy reports reviewed offered a range of recommendations for Medicare's financial sustainability. The options ranged from increasing private-for-profit involvement to limiting further privatization. While Romanow's report specifically addressed the policy and practice of contracting out in health care and public acceptance of it the report missed the mark in producing data that speaks to the impacts on workers and to the clients receiving these services.

Literature was reviewed in defining privatization and the relevance to the Canadian scene. Canadian contracting out literature for health care is limited and expanding the review to include U.S and the European Union all concur that public sector contracting out is privatization. The evidence to date on contracting out is that most often cost savings are produced from reductions of worker wages and benefits.

Case study methodology, and three methods of data collection are discussed in the following chapter.

Chapter Four: Methodology and Methods

Key to any research is an explanation of what the researcher did and how she arrived at her findings. The following discusses the methodological choice of case study design to fit the exploratory research questions concerned with public policy. Triangulation methods of data gathering by reviewing literature, interviews and documentary analysis are further discussed. The site of the study is VIHA and the participants are the four main health care unions in British Columbia. Ethical considerations are reviewed. A discussion of data gathering follows with four challenges the researcher faced. The chapter concludes with a review of how data was organized for the purposes of the discussion.

The Research Questions

The research questions were refined at several points in the initial exploration of information and feasibility phases. This involved reviewing union websites, newspaper articles and the legislation. The questions are designed to explore and gather data on the impact and experience of health care unions and workers with implementation of health and labour policy. The questions are: 1. How has the *Health and Social Services Delivery Improvement Act* (Bill 29-2002) been operationalized in one health authority in British Columbia?; and 2. How did health care unions and their membership representing most at risk ‘non-clinical’ service workers (as defined by the Act) experience the impact of the *Health and Social Services Delivery Improvement Act*? These questions underpinned the methodology research design, and methods utilized to gather data.

Case Study Design

In the initial phase of matching the questions and purpose of research with a methodology, the work of Majzark (1984) on policy research provided a base of knowledge for design. Majzark explained, "...policy research operates at the boundaries of research methodology, there is no single, comprehensive methodology for doing the technical analysis of policy research" (1984:58). However, case study methodology is frequently used in public policy research (Burnham, et al, 2004; Hall, et al, 1975; Majzark, 1984;). Majzark (1984) offers five guidelines for designing a research study on policy: 1. use a combination of methods; 2. research methodology that allows for flexibility as the research unfolds; 3. methodology is selected based on fit with research questions; 4. utilize existing data to increase efficiency; and 5. methodology reflects the political environment.

A qualitative, exploratory intensive single case study methodology was deemed the right fit for the research questions. Yin (1989) supports this design as appropriate because the research question is of the "how" type rather than of the "what", "how much", or "how many" type (p.18). Yin defined the case study strategy as one that "investigates a contemporary phenomenon within its real life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used" (1989:23). This design's unique strength is its ability to deal with a variety of evidence collected through various methods (Yin, 1989; Merriam, 1988; Majzark, 1984; Stake, 1998). The other feature of a qualitative case study design is the flexibility and efficacy for design decisions to be refined and developed as the study proceeded. The design was altered during the proposal and data

collection phase. For example, unions were to be interviewed at two points in time but due to the schedules of participants, it was reduced to one interview. Near the end of the study period and due to an illness of one participant, the data collection period was extended from October 2004 to December 2004. As well, if a participant expressed a need due to schedules to do the interview over the telephone, the design flexibility allowed for this request. Another alteration to the design occurred during the interviews when the participants referenced myself to contact union legal or research departments for specific details. This was accommodated for by the flexibility of the case study design. The other contribution or benefit of the case study design in public policy research is the ability to "...develo[p] recommendations concerning the future implementation of policy options" (Majzark, 1984:63). Merriam (1988) notes that qualitative, case study research is an ideal design for understanding and interpreting various phenomena.

Many authors discuss the need of researchers to address the many criticisms that surround the case study strategy (Burnham et al, 2004; Hall, et al, 1975; Merriam, 1988; Stake, 1998; Yin, 1989). One of the criticisms is lack of rigor, specifically, as it relates to scientific generalizations. As a single qualitative case study, drawing on the experiences of four unions representing thousands of workers in one region in British Columbia, impacted by implementation of health care privatization legislation, the initial goal of this thesis was not to generalize the data gathered to a global level. Instead, the intention was to document the impacts on organized labour of a policy implementation during 2002 and 2004.

Stake explains that in qualitative, case study research, “naturalistic generalizations are conclusions arrived at through personal engagement in life’s affairs or by vicarious experience so well constructed that the person feels as if it happened to themselves” (1995:85). However, union leaders or their designate connected what was occurring in VIHA to other experiences of contracting out in other parts of B.C and nationally. The data reported were condensed but the use of specific quotes from interviews and the comparisons of various stages of the legislation being implemented in other health authorities in B.C leads to a path of generalizability. The description of the case studied is detailed and therefore the transferability of these data to other health care unions, workers and contracting out legislation is possible if only to be used as a guide to mitigate negative impacts of similar public policy shifts.

Validity of data reported has been a common ethical and scientific concern of case studies (Denzin & Lincoln, 1998). This was overcome by employing three methods of data collection, one-to-one, semi-structured purposive interviews, literature reviews and documentary analysis of primary, secondary and tertiary sources. This strategy of multiple data gathering methods is known as triangulation or “cross checking” data which increases validity (Burnham et al, 2004:31). Bryman (2001) also supports the principle of triangulation in studying social phenomena. Case study design is intended to be rich in amount of data collected as a way to provide understanding of public policy implementation within the political, ideological and economic context during the period of study. However, this volume of data obtained from interviews and documents is so lengthy, and detailed that busy policy makers or health authorities do not have time to read all the details. This was corrected by categorizing data into themes specific to the

researchable questions. However, it is ethically and morally challenging to limit data provided by busy union leaders whose members were losing their jobs or experiencing negative impacts as the result of a shift in public policy.

Many of the primary, secondary and tertiary documents and literature reviewed were incorporated into the chapters on context and discussion. Validity was upheld by the use of these methods. The accounts of the four unions combined with other documents provide the reader with the opportunity to assess the accuracy, completeness and perspective taken (Stake, 1995). Another strategy for increasing validity of the case study in policy research is to provide copies of the transcripts, discussions and/or analysis of the data to participants to cross check data and interpretation of data at various stages in the research process (Denzin & Lincoln, 1998; Creswell, 1998; Merriam, 1988 and Yin, 1994). Stake notes in his research experience that he usually received little back from the interviewees in terms of feedback or additional data (1995). Devine notes, "...qualitative research tends to be valid" (1995:146). The strategy of checking back with participants was not adopted as it took nearly a year to obtain one interview with busy union leaders. It was determined, that lengthy waiting times with possibly prodding for feedback was not feasible for the purposes of this study. Furthermore, union leaders, or their designates were interviewed separately and data gathered demonstrated similar experiences of the impact of Bill 29-2002. This lead to a strong sense of validity of the findings.

Methods

Three traditional methods of data gathering were utilized in this case study. Qualitative, face-to-face, semi-structured, purposive elite interviews with union leaders or

designates combined with documentary analysis and literature reviewed were the methods employed. Elite interviewing is a technique that, “can be used whenever it is appropriate to treat a respondent as an expert about the topic in hand” (Leech, 2002:663). Elites can therefore be politicians, legislators, government bureaucrats, chief executive officers and union leaders.

Elite interviews was decided upon in the proposal and ethical application to the University of Victoria Human Subjects Review Committee (HREC) when initial letters of support for the study were sought from the four main health care unions. See Appendix One for the template of the initial letter mailed to unions. Participant selection will be discussed later in this chapter. At this stage, some unions and their research or legal departments expressed concern whether I would want to directly talk to members at the worksite who may be facing job loss or those who may have forgotten the key tenets of Bill 29-2002. They were also concerned about whether the research would compare union versus government responses and what my standpoint was on the legislation. It appeared to this researcher that unions were in a defensive and cautious position within the current political environment. It was decided that, given the experience under the B.C Liberal regime, a more respectful and possibly more successful strategy would be to provide union presidents control of direct interview or ask them to designate a person or a group of union representatives to be interviewed. Union presidents are elected representatives of thousands of workers across B.C. They come from the ‘rank and file’ and have expert knowledge of their membership, the union as an entity and local and provincial labour relations issues.

Elite interviews are not without challenges. Burnham, et al, (2004) describe the difficulties as: 1. deciding on which elites to be interviewed; 2. getting access to leaders who have busy schedules and may not prioritize student research; 3. busy leaders may not have the time to prioritize to designate someone else or may bring others into the interview without the interviewers knowledge before hand; 4. preparing for the interview means the interviewer must have enough knowledge and understanding of the issues to engage in informed conversations with the participant. Finally, it is noted that researchers should rely on more than one method of collecting data when engaging in elite interviews (Bryman, 2001; Hertz and Imber, 1995). Details of the challenges experienced with data collection using union leaders will be discussed later in this chapter.

Authors and researchers document cautions for inexperienced student researchers conducting interviews with willing and knowledgeable participants on a variety of research issues and topics (Denzin & Lincoln, 1998; Kirby & McKenna, 1989 ; Kvale, 1997; Merriam, 1988). Issues of sensitivity, respect, empathy, understanding the principles of confidentiality, knowledge of power imbalances between a researcher and participant and basic interview skills are some of the concerns with student case study researchers. The consultative support from my supervisor assisted in reducing the concerns during the initial phase of pre-interview preparation and post interview debriefing. These concerns were satisfied by the experiences and credentials of the investigator, myself. The investigator has twenty years practice as a registered social worker with the British Columbia Board of Registration for Social Workers (BCBRSW) (bound by a professional code of ethics) in health care. The investigator is also

experienced in interviews and conversations for the purpose of gathering data and assessments with clients but not in research. It is understood that protection of the public and ethical research applies whether the principal investigator is a student social worker conducting research or a practicing social worker with the public.

The other methods utilized for data gathering and validation purposes was reviewing the literature and documentary analysis. Documentary analysis is one method used extensively in policy research (Majzark, 1984; Burnham, et al, 2004; Lowe, 1997; Harrison, 2001). It is sometimes referred to as “unobtrusive measures” (Kirby & McKenna, 1989:84). Primary, secondary and tertiary (as defined by Burnham, et al, 2004) sources of information were utilized. The sources include historical and present day context of ideology and political economic environment relevant to the research questions. To this end, a variety of documents were reviewed for the purposes of gathering data to produce a chain of events, context, additional information, interpretation and cross checking of data provided from the qualitative interview method. The interview guide was developed specifically to aid in the collection of data related to the research questions. It contained questions that evolved from my assumptions (disclosed in chapter one), documents relevant to the legislation and the unions’ public statements. Essentially, the guide was focused on specific themes and categories, but it was a guide and the unions had the option to discuss other issues.

The Case Study

This thesis is a case study of the implementation and impacts of legislation shifting health care and labour policy towards privatization through contracting out of workers’ jobs. The study was bound by time (January 28, 2002 to December 31, 2004),

by geography (one health authority in British Columbia, the Vancouver Island Health Authority) and the experience of the participants (four main health care unions representing health care workers). The site of the study was the Vancouver Island Health Authority (VIHA). VIHA had been formed by in 2001 by the newly elected liberal government. Their mandate is to govern, plan and deliver services in B.C. VIHA was part of a major restructuring of health care administration by the provincial government which saw six Health Authorities formed, five Regional and one Provincial Authority for specialized services.

The geographic boundary of VIHA encompasses all of Vancouver Island the Gulf and Discovery Islands and the mainland communities north of Powell River and south of Rivers Inlet (VIHA, 2003). VIHA manages a budget of over a billion dollars and directly operates thousands of acute, residential, assisted living and mental health beds (VIHA, 2003). The authority also funds through the Ministry of Health Services approximately 3000 beds with contracted or affiliate residential care facilities (VIHA, 2003). There are approximately 16,000 employees, many would belong to one of the 14 unions certified to represent workers in the sites. The governance model consists of a nine member board of directors, a chief executive office and senior executives who oversee a variety of programmes and services.

The study is specifically concerned with the implementation and impact of the *Health and Social Services Delivery Improvement Act* upon health care unions and the workers who deliver health care services. The health care union's main offices are in Vancouver and Burnaby with some local offices in Victoria. These unions represent members who work in VIHA operated and contracted sites.

Selection of Participants

The decision to approach union presidents rather than the general membership was related to some union's initial response and concerns expressed to the letter seeking support for research on Bill 29-2002. Despite the letter noting my position as a union activist worker in VIHA, my view of the legislation and reassurance the unions were not consenting to participate, concerns were raised. Some union representatives from their legal and research departments made telephone contact to discuss the research design, methodology and methods of data collection. One union also went the next step to contact local union activists (who informed me) in VIHA to be reassured of my integrity. All four unions provided letters of support, which were enclosed in the application to the University of Victoria Human Subjects Research Ethics Committee.

Union presidents were then asked to participate or designate others to participate in two semi-structured, face-to-face taped interviews. The unions therefore had control over participant selection and whether to contribute to the research study. The unions chosen to participate were the four unions (HEU, BCGEU, HSABC and BCNU) representing the majority of health care workers employed in facility and community health sectors whose jobs were most at risk of being privatized through implementation of Bill 29-2002. Three union presidents chose to be interviewed with one president (HSA) also including their director of labour relations. The BCGEU president designated a former union member whose job had been eliminated due to privatization and had become an employee of the union.

Ethical Considerations

The purpose, benefits, research design, data gathering methods, participant selection and rights, the initial letter of support and responses, covering letter, consent form, interview guide and thesis outline were reviewed by the University of Victoria Human Research Ethics Committee (HREC). The application for approval to proceed was granted for May 2003 to May 2004 with no concerns expressed or revisions recommended (see Appendix Three). An application for extension post May 2004 was granted due to difficulty in obtaining interviews.

The commitment to ethics was consistently reflected in written documents provided to volunteer participants and in the data gathering process. Initially, following the approval to proceed with the study, the four union presidents were couriered June 2003, a package of information which included a letter of introduction, purpose and benefits of the study, participant consent form, interview guide and the thesis outline (see Appendix Two). This information included statements of the voluntary, unpaid nature of participation, purpose and perceived benefits of the study, rights to anonymity if so requested, confidentiality, control of 'off-the-record' data and consent to tape recording. It also included participants the right withdrawal from the study at any point in time, flexibility to include additional data, as well as contacts at the University if there were concerns about the study or my conduct.

The letter of introduction, consent form and interview guide were reviewed prior to the commencement of the interview with the audio recorder not operating. The interview process was explained and participants were given the opportunity to discuss relevant issues, concerns or information before taping began. The participants were also

informed of the need to indicate ‘off-the-record’ statements or to request the recorder be turned off at any point in the interview prior to commencement of the interview. The second interview held one year later, followed the same process. Audiocassette tapes and transcripts will be shredded 6 months later completion of the thesis and final approval from graduate admissions is received. I did not apply to the VIHA Research and Ethics Committee to conduct research in the health authority. As a VIHA employee, judicious caution was followed to exclude data from my worksite unless it was publicly available through VIHA’s website, media or journal sources.

Data Gathering

Two methods of collecting data from a variety of sources were utilized: five audio taped, semi-structured elite interviews with voluntary participants and analysis of literature and primary, secondary and tertiary documents.

Following the couriered package to union presidents, direct telephone contact was made to them, their assistants or designates to establish interview times and locations. This rendered one interview scheduled for September 2003 with HEU. The other union presidents either had busy schedules or did not return the messages. This was a significant challenge of the select elite interviews process. This was eventually overcome and interviews were obtained. However, the original design of conducting two interviews with each participant was altered. Tentative interviews with the non-responding union presidents were scheduled for April 2004. However union collective agreements were expiring by April 2004 and negotiations combined with a prolonged job action delayed these interviews. Finally with deadline pressures the approach taken was to contact the assistants to the presidents of the three unions (HSA, BCNU and BCGEU)

and to prod and negotiate with them. The original couriered package was faxed to the assistants to review with their union presidents along with a schedule and deadline for the data gathering part of the research. This persistence and flexible approach produced an agreement to participate with a scheduled time frame.

The second major challenge was for the interviewer to be well versed in collective agreement language (benefits and rights), knowledgeable of the key tenets of Bill 29-2002 and health care privatization, as well as union role. This preparation entailed review of union websites, available literature, collective agreements, the legislation, and media reports. This process of preparation enabled me to feel confident of my abilities to conduct competent, meaningful interviews.

The third significant challenge for myself occurred during the interviews. Busy union leaders came to the interview with a myriad of labour relations and global issues related and not related to the interview guide. For example, a discussion of union raiding began one interview or partway through another global issues of privatization of natural resources ensued. All of these issues are of interest to me, but it is data not related to the study and therefore not included in this thesis.

Interviews ranged from 1 hour to 1.5 hours in time and were conducted at a location and date of the participants choice. Interviews took place in Vancouver, Burnaby and Victoria. During the interview, notes were taken to reference unanswered questions and to document information for follow up. Participants deferred answers to specific questions on legal and member loss to researchers or legal counsel, which required additional time to gather this data. Some unions did not have exact numbers tracked and so this portion of the design was eliminated. Union leaders or their

designated representative was provided every opportunity to add additional information.

HEU was the only union interviewed twice.

Documentary analysis consisted of a review of “...primary, secondary, and tertiary sources” as defined by Burnham et al, (2004:82). This assisted in preparation of the interview guide, the actual interview, context setting and data analysis. Documents and literature obtained and reviewed ranged in data from the 1990’s to the period of study ending on December 31, 2004. The documents reviewed are listed in Table Three.

Table Three: Documents Reviewed

Primary	Secondary	Tertiary
BC Core Services Review	Health Authority websites and publications	Journal articles
Auditor General Reports		Canadian Labour Congress
Ministries of Health Services, Planning and Skills Labour and Development Annual Reports	Newspaper Articles from Times Colonist, Vancouver Sun, Province, Georgia Strait, News Group. Media releases	Publications and research from CCPA, Caledon and Fraser Institutes, National Union of Public General Employees, BC Federation of Labour
BC Industrial Commissioner Reports on job security BC Health Accord	Government healthcare reports or reviews from 1990 to 2002 such as Closer to Home, Patients First, New Directions	Books specific to contracting out, labour unions, workers, privatization, and political context.
Union collective agreements spanning from 1990 to 2004	BCHA reports and submissions to Royal Commission – Closer to Home	Journals or books related to NAFTA, FTA, MAI, GATTs – free trade
BC Labour Board Arbitration Awards	Union newsletter articles, websites and bulletins	
Tentative Framework Agreements	Federal Senate Committee health report	
BC legislation ranging from 1990’s to 2004	Alberta’s health review	
VIHA redesign plan 2001-2003	Royal Commission on The Future of Health Care in Canada	

Data Analysis

Dealing with interview and documentary data generally encompasses two steps. The first step is to summarize and organize the data. The second step is to analyze the data to discern common experiences of themes. The interview was focused on specific topics and themes as reflected in the guide. The data from the interviews and documents

were organized. An initial step involved writing ‘the story’ of the policy implementation and impact of it. The five interviews yielded over 400 pages of transcription, which were cross-referenced twice with the original audiotapes to ensure all data were recorded in the transcripts. Data was not always obtainable on exact numbers of jobs lost to contracting out so the initial design of organizing this into a table was abandoned. These transcripts were photocopied to provide a working copy for notes and coding purposes. Field notes were incorporated into this coding process. Coding involved naming and categorizing the experiences of the unions through in-depth examination of the data. These steps became crucial and the analysis included milling, absorbing, re-reading, sorting, and constructing the data from the documents and interviews. Coding and categorizing data into a significantly reduced amount of reportable data is a challenging and rewarding experience.

Themes emerged by way of triangulation of data from documents and the four unions and workers experiences. Just at the point of engagement with the detail, the reality of ‘letting go’ some of the detail is also an ethical judgment. For example, I found myself asking, ‘How can I exclude what one busy union president stated was important to the membership but does not relate directly to the study?’. The available data was categorized and reported into themes that emerged from the interview guide and what the participants stated were significant to the union and the membership. Data was documented into four separate union experiences. It is important to note each union and the membership did not experience Bill 29-2002 identically, the themes vary between the unions. Data also varied dependent upon the union leader versus non-leader designated

who did not have similar access to information. This is the reality of conducting research, however, there were more similar impacts noted than not.

The discussion of the data re-organized the themes and linked this data directly back to the research questions rooted in worker and union experiences with implementation of legislation. The discussion takes a critical perspective and incorporates the literature and the documents reviewed. Documents and literature were reviewed for relevancy to the topic of workers, unions, health care privatization (contracting out), political, economic, legal, ideological, historical and current day context, as well as piecing the experiences together for validation purposes. The four major findings can be traced to the data gathered and the discussions of it. Chapter Five to follow, reports the data gathered from the union interviews and Chapter Six discusses the results of the study.

Chapter Five: Case Study Results

Introduction

The period of study commenced January 28, 2002 and ended on December 30, 2004. Table Four profiles each union interviewed between 2003 and 2004.

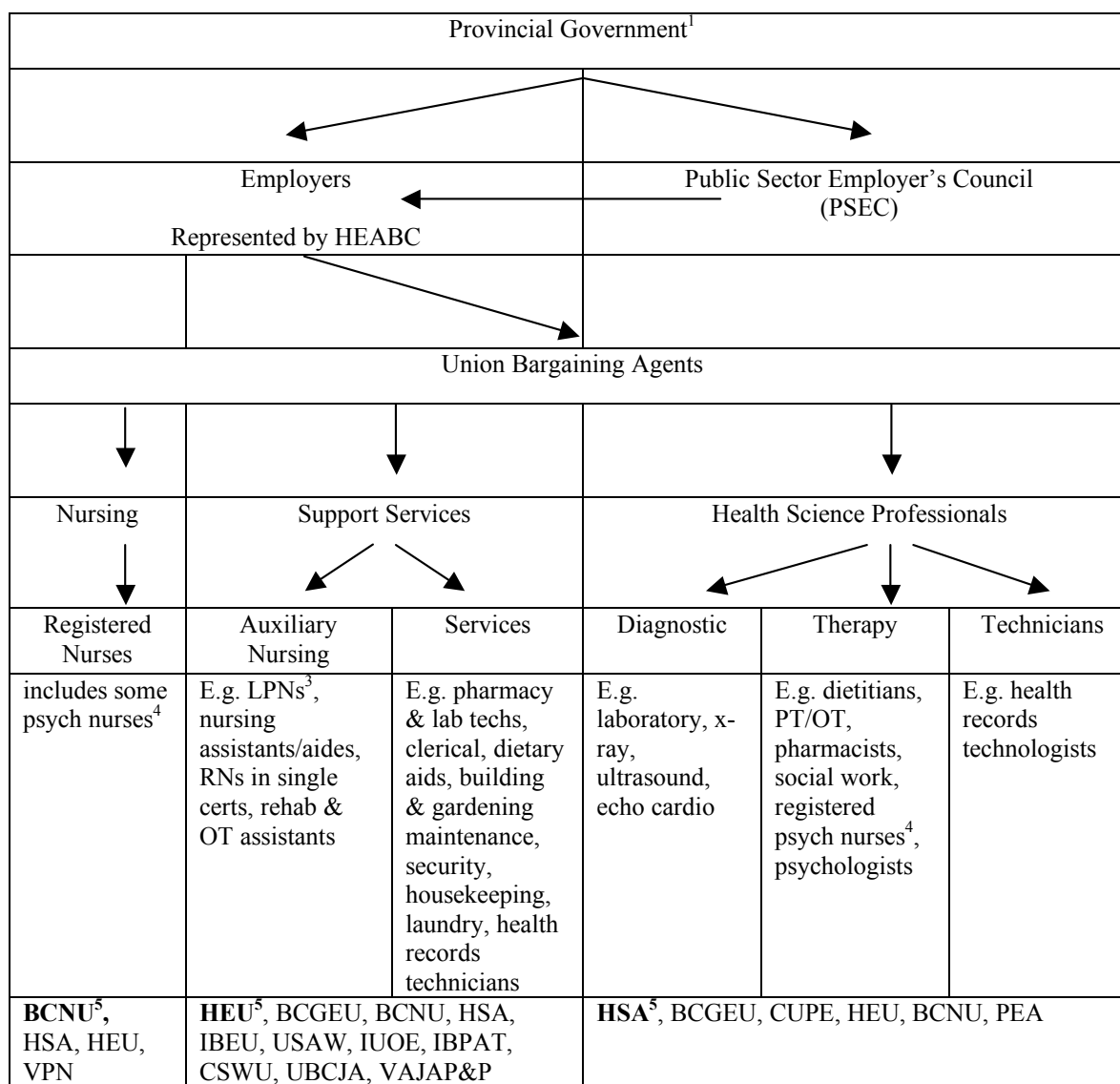
Table Four: Profile of Unions Interviewed 2003-2004

Union	Incorporation Date	Approximate Total Membership	% of Women in Union	% Potentially Impacted by Bill 29-2002
BCNU	1946 RNABC 1981 BCNU	24,000	98%	100%
BCGEU	1942 BCEA 1974 BCGEU	60,000 20,000 (12,000 in Health; 8,000 in community)	80%	100% of 20,000
HEU	1946	46,000	87%	100%
HSA	1971	14,000	80%	100%

In gathering data from the unions on impacts to their membership or organization, it is important to distinguish the complexities of limiting worker impacts within one health authority. For example, Bill 29 legislated changes to health sector collective agreements province-wide. Union responses to questions on worker and union impacts were reported generally and not consistently to VIHA, the site of investigation for the research.

Each of the unions are organized on the basis of a certification by the B.C Labour Relations Board, which appoints them as the bargaining agent to represent specific groups of workers. In B.C, the NDP government in the 1990s organized bargaining around specific groups of workers and unions to form bargaining associations for collective bargaining and negotiating purposes. Figure One summarizes the collective bargaining structure in B.C.

Figure 1
Collective Bargaining Structure and Bargaining Agents for Health Care
in British Columbia



¹ Provincial government enacts legislation to restrict/end strikes and sets wages and benefits in collective agreements; establishes pay, labour relations and health care policy. It has been directly involved in health care bargaining since 2001.

² HEABC represents health care employers, however it takes direction from government through PSEC.

³ Majority of LPNs are represented by HEU.

⁴ Majority of Psych nurses are members of HSA, however, the main bargaining agent is BCNU.

⁵ Bold lettering indicates lead union in bargaining.

The data from each of the unions was reported in four union specific sections. As previously noted in the methodology chapter, each union did not report identical experiences with Bill 29-2002 but there were a significant amount of similar experiences. For example, HSA reported no membership loss with contracting out, while HEU and BCGEU reported a different experience. Other differences the researcher attributed to timing of the interview and interviewee. HEU's interview in 2004 followed the tumultuous industrial relations with the government imposing a collective agreement (included BCGEU), a long protracted strike resulted in a compromise and members became upset with their union. The BCGEU designate, a laid off worker and now a union staffer did not have the same overall knowledge but the personal experiences produced rich data. In this case website material and conversations verified the impacts were similar to other unions. The varying categories of data are organized as impacts to union and workers with separate categories noting various strategies of resistance to Bill 29. All unions considered the policy change of contracting out to be a form of health care privatization.

The Hospital Employees Union (HEU)

The Hospital Employees Union's (HEU) founded out of the Vancouver Municipal and Regional Employee's Union, which was essentially a merger of women's and men's unions from CUPE local 15 in the health care sector. HEU, an affiliate of CUPE national also represents the health sector of CUPE in B.C. Fred Muzin, president of HEU was interviewed on September 20, 2003 and September 15, 2004. Muzin stated HEU is the largest health care union in British Columbia. In 2003, HEU had already begun to experience membership loss through privatization initiatives including contracting out of

support staff in the Fraser and Vancouver Coastal Health Authorities. Exact numbers of member losses was not available at the time of the interviews. HEU's president and the executive council are elected from the general membership.

The disciplines within HEU cover a broad range of workers. These include Licensed Practical Nurses, Registered Nurses (sites where HEU has full certification for workers employed at a site occurring mainly in rural locations), dietary aids, laundry, housekeeping, security, groundskeepers, clerical workers, health record transcriptionists and plant for maintenance. Muzin stated that this broad base has its "...advantages and challenges". The themes that emerged from the interview data were impacts to the union, union busting, employer options, impacts to workers, strategies of resistance to prevent job loss and privatization and union strengths and solidarity.

Impact on HEU

HEU stated they received no formal notification that Bill 29 was going to be introduced in the legislature. Muzin reported "...there were a few rumours on the Thursday that they were thinking of introducing some sort of legislation to deal with health care...". There was an emergency weekend session called to pass Bills 27 and 28 to get the schools back in. By 11 p.m. on Sunday, January 27, 2002, Bill 29-2002 had been introduced, passed the readings and had become the Health and Social Services Delivery Improvement Act by 5 a.m. "...when most of us were sleeping including the MLA's". HEU is not aware of any process of public consultation or having an opportunity to provide input into the tenets of Bill 29. Muzin, however, does believe the Health Employers Association of British Columbia (HEABC) and the Fraser Institute were involved with the development of Bill 29 with the government. Muzin stated he

cannot produce specific data but links his claim to the attitude of organizations and special interest groups in bargaining. He referred to articles published by the Fraser Institute (years ago) and media that diminished the skill set of hospital support workers in food, laundry and cleaning to that of regular hospitality workers therefore devaluing and justifying wage reductions. Muzin stated these groups tend to have negative attitudes toward unions and unionized workers.

Union successorship was described by Muzin as "...a loss to the traditional role of the union and to workers, when we can no longer represent them in health care...". HEU explained Bill 29 "blocked" the union from being a successor union to workers employed by private contractors such as Compass. "Bill 29 quite clearly rescinds the part of the Health Authorities Act and Labour Code that allowed a union to follow the workers". In a further attempt to "block" HEU from representing workers they have traditionally represented, Compass and Sedexo "...have been entering into partnership agreements with IWA [the International Wood and Allied Support Workers Local 1-3567], a union local that will not fight for health care workers...". By the 2004 interview, Muzin reported this agreement had been signed by Compass and the IWA. Workers were expected to sign a union card first with IWA before Compass would hire them. Muzin stated this will guarantee VIHA budget savings and Compass will maintain profits by "keeping workers at low wages with no benefits such as sick time and pensions....". The loss of the long standing significant role of bargaining on behalf of members Muzin stated was another assault on unions. HEU noted that decades of negotiations have taken place in good faith and Bill 29-2002 "wiped it out".

“Union Busting”

With respect to Bill 29 Muzin acknowledged in 2003 that there would be implications and impacts for other unions such as BCGEU. However, he stated that HEU is the target. Muzin referred to the wording of the Act where it only protects those health care disciplines that are assigned to an in-patient bed in an acute care hospital, which excludes all HEU workers. HEU received a leaked copy of the Minster’s briefing document in the 2002 budget and it is noted that the government was budgeting and planning to privatize 20,000 HEU members positions. Muzin links their union as a target to the election where NDP defeated the Liberals in 1996 stating HEU was involved in the election and has always been politically active.

HEU claimed that Bill 29 was introduced not only to privatize health care but to destroy HEU, the largest health care union in B.C. Muzin stated the act was implemented as a form of “union busting” and acknowledged all health care unions are experiencing this. Muzin referred to the Premier’s year-end statement where he diverted from his printed remarks to make public negative comments about HEU. Muzin stated HEU and their members are a clear and “vilified” target.

By 2004 Muzin reported that the government and some health authorities have “vilified” HEU. The union, executive and members were feeling the brunt of privatization, losses of collective agreement rights through Bill 29, a legislated collective agreement in 2004 which included wage cuts and other significant losses to save members jobs.

Employer Options: Decertify, Close or Privatize

HEU outlined several available options to the employer exercised to reduce budget deficits. These options included union decertification, outright closures of facilities, lay offs and privatization of support services.

Some affiliates representing publicly and privately operated facilities in each health authority went to the workers to explain that if they decertified from the union and took wage reductions, they would be hired back and would not lose their jobs through privatization. Muzin stated that this process of decertification occurs where employers who wanted to keep their employees saw no other fiscal options. Decertification did not occur in sites directly operated by VIHA. Decisions by health authorities across the province to close residential and acute care facilities also occurred. VIHA did close the Gorge Road Hospital and Sandringham (private hospital was converted to another use).

Contracting out was the main option chosen by most employers in at least three health authorities. Muzin stated that the Vancouver Coastal and Fraser Health Authorities introduced privatization at a rapid pace. Not many could understand the rationale other than statements made of budget shortfalls. Muzin stated he had difficulty believing that the Federal and Provincial Governments were not able to adequately fund health care when they seem to be able to fund other priorities including war activity. HEU pointed out the mounting research in other parts of Canada and the world that outlines privatization of health care does not save money. Muzin referred to areas in Great Britain, which have returned to the public models of delivery for greater fiscal efficiency, local control and improved delivery of service.

According to Muzin, VIHA began a gradual process of privatization by contracting out groundskeepers, security, and medical record transcriptionists, "... it appeared to be resisting the government's agenda to push privatization". HEU and VIHA were attempting negotiations under section 54 of the Labour Code to keep their members employed but they were not able to agree. Muzin believes VIHA's budget deficit forced further privatization of housekeeping, laundry, and food services.

Impact on Workers

Muzin reported in 2003 and 2004 several impacts to workers as the result of the introduction and implementation of Bill 29. These impacts included job loss impacting financial security, emotional responses (grief, anger, fear, disbelief), internalized stress and feeling devalued to lost or reduced collective agreement rights (including job security, pay equity and limited seniority rights).

Job Loss through Privatization

By September 20, 2003, Muzin reported that HEU membership had experienced minimal job loss in VIHA as the result of privatization. Security services, groundskeepers and health record transcriptionist had been privatized in some sites or were in the process of contracting out. Compared to several thousand jobs lost to privatization in other health authorities such as Fraser and Vancouver Coastal Health Authorities, HEU considered these losses minimal. Muzin stated, "the Vancouver Island Health Authority started off fairly slow because I don't think they are convinced philosophically that privatization is the way to go". However, by the time of the 2003 interview VIHA had initiated requests for proposals for foodservices, housekeeping and laundry for acute care and residential care sites in south and central island. By June

2004, approximately 1200 workers had received their lay off notices and were continuing to work. Muzin notes, "...some will lose their homes because they can't afford the rent or mortgage". These HEU members continued working and were in the process of deciding to bump another worker, accept lay off notice and take any pay-out monies while looking for work elsewhere. This included the option of being hired back with Compass making as much as 40 percent less per hour with few benefits. Muzin explained these workers were banned from forming a group and trying to bid on any of the VIHA contracts as Bill 29 made it illegal to do so.

By the September 2004 interview, VIHA had contracted out some medical record transcription services, groundskeepers, security, and negotiated and awarded a 5-year term contract to the US based multinational corporation Compass Group, and its subsidiaries Morrison's (food service) and Crothall (laundry and housekeeping). Food services were contracted out in the following VIHA operated sites: Royal Jubilee, Victoria General, Saanich Peninsula, Juan de Fuca (Glengarry, Priory, Aberdeen and Mt. Tolmie) and Queen Alexandra Centre for Children's Hospitals. Housekeeping and laundry services were also contracted out at the same sites with four additional sites, Cowichan District Hospital (including Cairnsmore Place) and Nanaimo Regional General Hospital (including Dufferin Place). The total loss of workers classified as casuals, part time or full time in VIHA operated sites was approximately 1200. VIHA affiliate facilities that contracted out HEU members were Central Care Home, Mt. Edwards Court, Sunset Lodge and Beacon Hill Villa. This adds approximately another 300 workers to the previous total. Exact numbers of HEU lost jobs at affiliate sites was not available during the study period. Muzin stated the magnitude of privatization for HEU

support workers was lower in VIHA than in other health authorities such as Fraser and Vancouver Coastal Health Authorities.

Muzin directly attributed the rationale for contracting out to Provincial Government under-funding. “VIHA have been resisting but now it looks like they’re being squeezed to comply with political direction”.

Social - Emotional Impacts

Muzin reported in 2003 and 2004 a range of emotional impacts HEU workers were experiencing as the result of losing their jobs or seeing their fellow workers losing theirs. Muzin commended the membership who, while knowing they are losing their jobs, were continuing to focus on providing service to the patients and residents. The emotional impacts reported were: disbelief, betrayal, feeling devalued, internalized stress, anger, resentment and fear.

Initially many HEU members were in disbelief that in 2002 the Provincial government would cancel the benefits and rights negotiated in 2001. Furthermore, they didn’t believe that the government alongside the health authorities would privatize their jobs and services because as Muzin described, “...there’s still patients and residents and my services are required; now they realize all the underpinnings...” (2003). Alongside disbelief were the additional feelings of betrayal from government, employers and to some extent the union. By 2004, HEU members were holding their union accountable for job loss and wage rollbacks.

Muzin in 2003 and 2004 reported members feeling devalued. He explained, “the government and employers have gone to great lengths to make workers feel devalued in health care –to rationalize taking money out of members pockets to pay for debt”. HEU

went on to describe the process of workers who have worked for years with knowledge and skills on how to clean an operating room, "...are suddenly informed someone can do it for 40% less per hour so you're out the door".

Muzin commented on the seriousness of the situation where their members are put in the position of continuing to work at sites where lay off notices have been given or their co-workers were being contracted out:

And what that's going to do is it internalizes unbelievable amounts of stress that eventually this society is going to have to pay for. There is going to be huge medical costs, the amount of frustration. The amount of people that feel totally deceived and violated by employers and people they worked very close with for year. The deep-seated resentment is unbelievable... Bill 29 has given them [employers] a tool to be very powerful, to be even more Draconian. So for instance, they lay off housekeepers, they get sixty of them in a room, and say we're contracting our your work you're going to be out of work even though you've been here twenty, thirty years, now go back to work. This is the level of concern they have for these people (2003).

In VIHA workers were provided with a thousand dollars for retraining, access to the employee assistance program for counseling, support on how to create resumes and do job searches and had the option of staying on the casual list for other work. Muzin described this as a "crisis management" approach to minimizing impact to his membership. HEU had reports of instances of workers expressing anger, crying at work, functioning in a state of shock as well as booking off on medical leave. In addition, many others are working in fear of possible job loss and feel intimidated to speak up on any issues of concern. Muzin reported, "it's a strategy of fear and uncertainty". All of these emotions are part of a process that Muzin maintained could have been prevented had the employer and government looked at other options. In September 2004, it was too early in this privatization process for HEU to know the long-term impacts to the workers.

Combined with emotional impacts HEU reported their members have experienced many financial losses related to removal of collective agreement provisions.

Lost Collective Agreement Provisions and Benefits

The Act not only provided a structure that facilitated privatization, it also removed other collective agreement rights and benefits previously negotiated in the collective bargaining process. These lost rights and benefits are important to the workers.

Employment security, removed by Bill 29-2002 resulted in workers losing wage protection, relocation to other vacancies in the province, retraining initiatives and a longer period of severance while continuing to work. Muzin reported the funds for these job security provisions over a 3-year contract amounted to \$35 million. This resulted in all health care unions falling back on section 54 of the Labour Code of BC that required specific notice period for laid off employees as well as discussions between the union and employer on the labour adjustment to take place. Muzin further explained the job security provisions and workers opportunity to participate in the privatization proposals, included in ESLA had been eliminated:

If they [employer] were thinking of contracting out they had to provide copies of the tenders and the documents to people in-house so they could bid, and if they could demonstrate that they could do it more efficiently...They [the government] specifically wrote that out in Bill 29. They said, we're basically not interested in the skill of the workforce having anything to do with health care, because we want to privatize.

Bumping rights linked to accumulated seniority, which HEU had negotiated 30 years ago, were removed by the Act. Bill 29 limited this provision in the collective agreements by allowing employees with more than 5 years seniority to bump someone with less than 5 years seniority. If there were jobs remaining in the regions that laid-off

workers were qualified to do, they would often be part time or less desirable shifts that senior employees would have worked years to avoid.

Collective bargaining is a key and fundamental right or entitlement of workers organized in a union. Bill 29 removed several collective agreement provisions such as pay equity, job security and seniority. Muzin questioned:

How are we going to achieve collective agreements in the future when the government violates and breaks legal contracts...it's beyond me how we're going to meet that challenge in the future years. Why would anybody enter into an agreement that doesn't mean anything?"

Collective bargaining was described as a loss for both the union and the workers.

The loss of decent wages with the hourly wage rate dropping between \$9 to \$10.50 per hour for support workers was of particular concern for Muzin. These wage reductions are linked to pay equity losses that HEU struggled to achieve for women in the 1960's. In 1992, Muzin reported HEU workers went on strike for equal pay for equal value to improve the wages of working women. He explained:

I believe this government is absolutely and totally opposed to pay equity and economic justice for women. I don't think they have any respect for the work that women do and I think it is part of their agenda. Because certainly in the public sector, that has been the area where women have been able to a greater extent than in the private sector, to achieve economic justice. And so, I think they want to get rid of any responsibility, any civil society community governmental responsibility for citizens... You know marginalize women, get them out of the workforce, but it's to re-establish the historical role of women that rolls back women's rights, economic justice over forty years.

Muzin states this loss of a decent wage primarily for women as support workers in health care, is a form of wage discrimination.

Strategies of Resistance

HEU has established several costly strategies to prevent or reduce privatization of jobs. Together with other health care unions, the B.C. Federation of Labour, Canadian Labour Congress and CUPE National they submitted complaints to the United Nations International Labour Organization (ILO). Muzin reported that the ILO did sanction (not legally binding) the B.C Provincial Government for violation of fundamental worker's and women's rights, but the government had little response.

HEU joined by other health care unions launched a court challenge asserting Bill 29-2002 violation of the Canadian Charter of Rights and Freedoms. The B.C Supreme Court has denied this challenge and it will eventually proceed to the Supreme Court of Canada. This is a lengthy process and as Muzin explained the law operates at varying rates depending on "...whether you are bosses or whether you are workers".

HEU increased their involvement with various community groups or "social justice partners". These groups are the anti-poverty groups, B.C Coalition of People with Disabilities, Health Coalition, seniors and other community action groups. The union used funds and resources to educate the public and union members through press releases and public rallies about the impacts of Bill 29 and privatization. Muzin stated that the media was not always interested in this issue. Member education included direct mail out, surveys, polls, union steward education, website and bulletins distributed and posted on union bulletin boards in the workplace. By September 2004, Muzin acknowledged that communication to their membership needed to be improved so that all members know exactly what is going on before it is reported in the media. This was partially in

response to the job action taken by HEU in 2004 where members were not able to readily access information before the media was reporting it.

In an effort to reduce what HEU learned in 2002 was the provincial goal of privatizing over 10,000 full-time equivalent jobs, the union attempted to negotiate wage reductions with the government. The resultant agreement amounted to increasing the work week from 36 hours to 37.5 hours, giving up cost-of-living increases and pay equity totaling 4.4%, reducing paid vacation leave, reducing wages in certain job areas up to \$1 per hour and extending the 2001 contract until 2006. The deal included capping contracting out of 5000 jobs province-wide, including severance provisions. This document was known as the Tentative Framework Agreement. This agreement was presented to a vote of provincial membership and was rejected by 57%. Muzin stated there were two main reasons why this was rejected: 1. not all members believed jobs would be privatized and therefore were not willing to accept a wage cut; and 2. members no longer trusted the government to honor agreements. HEU's next strategy of attempting to negotiate similar agreements with affiliate employers met with opposition by the Hospital Employers Association of B.C. (HEABC). HEU reported that HEABC backed off this position. Muzin stated that some of the employers said, "I really value my staff and if you'll help me with my budget problem I'm willing to come to an agreement...". HEU successfully reached agreements with smaller affiliate facilities in the Vancouver Island Health Authority such as Mt. St. Mary's in Victoria and St. Joseph's in Comox. HEU was in active negotiations with Sunset Lodge Facility, Central Care Home and Mt. Edward Court in Victoria when suddenly the employers decided to contract out. HEU did not know how much the Vancouver Island Health Authority or

HEABC had influenced the decisions of the affiliates. However, as VIHA distributes operating funds to affiliate care facilities significant influence is assumed.

HEU was actively dedicating resources to organize workers to join the HEU (decertify from IWA local I-3567) who now work for Compass. The strategy was an attempt to gain back union membership and represent workers by a union which traditionally represents health care workers.

HEU, alongside B.C Federation of Labour, was educating members about the upcoming 2005 provincial election on issues that affect their lives and the lives of their family. The goal was to have members vote. HEU also sponsored members through paid union leave to work on campaigns or to run as a candidate in the upcoming 2005 election.

Union Strengths: Gradual Re-Building of Solidarity

Muzin believed with HEU developing separate agreements with facilities negotiating wage concessions which resulted in members ratifying the agreements (previously rejected) that this was an example of part of the process of re-building solidarity amongst the membership. He stated this represented as an example of people moving away from individual concerns to collective concern for others. Muzin explained this hope in 2003:

They are seeing that if they don't help out the other members of the team, that they become increasingly vulnerable and so they're prepared to share some of the pain. And I think like any difficult time or crisis, I think the solidarity will be much enhanced. I think we'll be a stronger union, but it's going to be very painful.

In 2004, Muzin further cited the example of their recent illegal job action to protest the governments imposed contract and felt there was more of a feeling that, "...we are in this

together”. Muzin reported that during the strike action, both HEU and BCGEU received more public support than the government anticipated.

By the 2004 interview, HEU had experienced an imposed collective agreement where the government was rolling back wages by approximately 15%. Legal and illegal job action resulted in a mediated agreement (with the BCFED) to wage rollbacks and capping privatization of their members jobs (and BCGEU) to 600 between 2004 and 2006. Muzin reported members were angry, grieving, betrayed by the government and employers, and had turned these emotions towards the union. Muzin noted the beginning phase of re-building solidarity was the overwhelming support from the public, other unions, and social justice partners.

Muzin ended the 2004 interview with this statement of the on-going struggle of union resistance:

Well, some people think that the current situation is very, very bad and that the government may be trying to get rid of the Hospital Employees Union. We’ve been around for sixty years. It is never easy when you’re advocating for workers. It is never been easy being an HEU member. We have had decades of struggle...It is never easy and we will be around tomorrow.

British Columbia Nurses Union (BCNU)

The British Columbia Nurses Union (BCNU) obtained union certification in 1981 to represent nurses. Previously RNABC held the union certification and collectively bargained on behalf of members from 1946 until 1981.

BCNU has an elected union president, currently Debra MacPherson, and an elected executive council. They are affiliated with the Canadian Federation of Nurses Union as well as B.C Federation of Labour. MacPherson noted that Bill 29 had the

potential to impact all nurses. Nurses who work in ambulatory and outpatient areas in acute care, community and residential settings, are defined as “non-clinical” by Bill 29-2202 and could be contracted out. Major themes that surfaced from the MacPherson interview (held on September 22, 2004) were; the target, impacts on BCNU, impacts on nurses, reduced quality of work environment, and strategies of resistance.

The Target

BCNU acknowledged while they have concerns about contracting out of nurses it has been primarily HEU and BCGEU support workers who have lost their jobs. Nurses were not the main target. “There was some sense that it might have been the HEU and ...—the desire, to reduce wages of support workers”. In discussing privatization, McPherson stated that the greatest amount of privatization had been with HEU workers province wide and noted the impacts privatization of support workers had on nurses.

Impact on BCNU

The main impacts felt by the union were financial and a sense of frustration from the lack of consultation.

Financial and human resources of the union were used to support all campaigns, town halls, rallies, member and public education, arbitrations and court challenges. BCNU stated that not only were the unions spending significant amounts of money but so were the health authorities, HEABC and the provincial government in arbitrations and court challenges. McPherson stated, “...so that’s tax dollars that could be going to patient care...”

BCNU believed the overall lack of consultation with the Provincial Government on Bill 29 was a complete reversal of labour relations practices prior to Bill 29-2002. It

was noted that many employers were not willing to engage in consultation. McPherson stated, “Our employers seem to now believe that because the Government will legislate an end to all of their problems, that they need not consult, they need not negotiate, and that they have absolute right, kind of like absolute rule in the ancient English Law to do whatever they want with their workers without any consultation or regard for their professional status or knowledge or skills”. Bill 29 voided the job security provisions, which compelled employers to consult with unions on labour force adjustments such as restructuring to mitigate job loss and other adverse impacts.

MacPherson discussed the legislation and its ideological basis as an attack against the role of the union. Alongside these impacts MacPherson stated the union, on behalf of members, lost the right to bargain on collective agreement issues noted in Bill 29.

Impact on Nurses

A number of impacts were discussed. These were, lost collective agreement rights, loss of jobs, employer options, the target or goal of legislation, quality of work environment, destabilization of the health care team, demoralization and low morale.

As with the other health care unions BCNU members lost many rights that had been negotiated over the decades. Some of these lost rights were job security, seniority provisions related to bumping rights, union successorship, and the right to be represented in collective bargaining.

Bill 29 removed the job security provisions and altered bumping rights, which limited a nurse’s ability to locate a job using their seniority rights. This was further complicated in small facilities which were either closed or had too few nursing positions to preclude bumping. HLAA (job security programme), which previously would have

matched the RN to vacant positions elsewhere in the health authority or province, was no longer in existence. This programme at a time of nursing shortages, also benefited employers with labour shortages. At Sunset Lodge, an affiliate facility in VIHA, RNs had to look for work elsewhere without seniority benefits, vacation allowance or sick banks which historically they could carry to their new place of work.

Successorship is a significant loss to nurses. McPherson explained that, if a private facility owner sells to another owner or if a health facility decided to contract out workers, the union had no legal right to continue representing members in that work place. McPherson believed Bill 29-2002 is rooted in an ideology of the government towards women. She stated, “it seems to be an unmitigated attack on the work places of women, where women have managed to make good strides in terms of equalizing wages and having strong representation around their working conditions; it’s a disempowering thing”.

BCNU estimated that by September 2004 (within VIHA) somewhere between 100 and 200 Registered Nurses had lost their jobs. This mainly occurred in residential care facilities that closed or replaced RNs with LPNs. Very few BCNU positions were lost due to privatization. Job loss occurred primarily in privately operated affiliate facilities for which VIHA provides the operating funds. In this estimate, McPherson included the Gorge Road Hospital closure. Job losses amongst nurses on Vancouver Island were lower than in the Interior Health and Fraser Health Authorities.

Affiliate employers and health authorities used workplace restructuring, privatization or closures of some acute and residential care facilities to contain costs and balance their budgets.

BCNU stated while the Act may have been intended to facilitate contracting out of support staff the language as to its effect on nurses is vague. Ambulatory care and long-term care facility nurses are most at risk. In 2004, BCNU asked Colin Hansen Minister of Health, about the privatization of emergency departments. He stated this could occur because they are considered outpatient services. McPherson stated research studies which compare cost efficiencies and outcomes between the private and public sector indicate a lack of support for the privatization direction the government is moving toward. BCNU finds this contrary to the government's practice of using data and evidence to support their programmes. BCNU was beginning to see a few examples in VIHA (primarily with small affiliate facilities contracting out RN's such as Sunset Lodge and other residential care facilities) of using private nursing agencies to fill vacant shifts. McPherson stated VIHA was one of the last health authorities to begin contracting out and wondered if this delay was related to their Chief Executive Officer's attempt to pursue other options with the budget.

McPherson comments on economic factors driving the BC Liberal's agenda of privatizing some sectors of health care and links it to examples from Britain. "And what we saw in Great Britain, the public system was under-funded to the point of crumbling resulting in privatization of health care".

Quality of Work Environment

With other areas of British Columbia initiating privatization earlier than VIHA, BCNU was able to report on some of these impacts to nurses employed within VIHA. In the implementation phase of contracting out support workers in VIHA, BCNU reported

impacts of declining quality of work environment, reduced collaboration and inefficiencies.

McPherson reported incidents of reduced health care team collaboration and cohesiveness because RNs and other professionals were working alongside the contracted employees. In Royal Columbian Hospital, Sodexo, a multinational corporation based in France, had been contracted by the health authority to provide support services. The RNs in the emergency wards had to call a dispatcher at Sodexo to locate another cleaner. With the health authority no longer the direct employer, RNs and other professionals were not allowed to direct the work of the support staff.

McPherson stated that the contracting out of services had created inefficiencies and will continue to create inefficiencies like the previous example. These inefficiencies also created increased workload for nurses. BCNU further stated that inefficiencies in the work environment by privatization have seen RNs and clients, "...taking the secondary brunt". The primary brunt are the workers who lost their jobs or were hired back at 40% of the previous wage earned.

This blend of public and privatized workers further impacted RNs working in a collaborative team environment. McPherson reported in VIHA as well as Vancouver Coastal Health Authority memos circulated by employers to staff advising they could no longer share in celebrations (e.g. potluck meals) with the contracted out employees. At Saanich Peninsula Hospital, staff were advised not to have on-site, pot-luck parties for support staff losing their jobs to privatization. McPherson summarized this as an employer strategy that keeps workers apart, "...from supporting each other and building relationships and from organizing".

Social and emotional impacts to nurses, from contracting out or the possibility of it plus work place restructuring with LPNs replacing RNs, were surfacing to the attention of BCNU. Job loss combined with an unstable workplace contributed to low morale amongst nurses. McPherson stated that loss of control over nurse's work environment (not being able to deliver quality care) was also a contributing factor to low morale. Another effect of privatization that has occurred in other health authorities and was beginning to surface in VIHA (as they privatize support worker's jobs) as the "...disruption of the team and loss of collaboration...". BCNU stated this disruption also contributes to low morale.

Strategies of Resistance

The British Columbia Nurses Union (BCNU) engaged in numerous strategies to protect their members' jobs against privatization. These strategies ranged from membership and public education, joining community coalitions and the labour movement as well as negotiating directly with the government and receptive employers. BCNU used their resources and funds to support these strategies and to pursue arbitrations and the Supreme Court challenge. BCNU notes the unexpected benefit that has emerged as the result these actions. McPherson explained that few nurses had known the experience and long struggles of the union movement over the decades to obtain certain rights, wages and benefits. It was reported that many nurses see the union as an organizing body to whom they pay money and expect the union to provide services to them. Bill 29-2002 has caused "members to understand that they are part of a struggle that impacts on them directly and intimately, because it impacts on their ability to deliver

care; it's not just about the money". The strength that emerged from these strategies was the realization that nurses have power to engage the public in a dialogue on key issues.

BCNU's first strategy was to educate members about the potential impact of Bill 29 and health care privatization. They did this by having experts from the United States, Great Britain and Canada present to their membership. Their goals were to ensure: 1. that membership understood why BCNU was going to be taking issue with the legislation and privatization of health care; and 2. for RNs to understand how this legislation applied directly to them. McPherson explained, "a lot of Registered Nurses went around and said, that's not for us, that's for HEU". In educating their members about the impacts of privatization and structural changes in staff mixes, BCNU undertook Professional Responsibility Campaigns at the worksites including the filing of reports or grievances to employers about "working and practice conditions". These campaigns were implemented in VIHA in 2004 in response to the privatization of support services and minimal contracting out of RNs in affiliate facilities.

The union's second approach was to educate or inform the public of BCNU's concerns by way of campaigns, rallies, press releases and town hall meetings. In Vancouver, various media releases were employed to inform the public of operating rooms not properly cleaned by private contractors. However, MacPherson stated the media chose not to cover all the issues brought forward. McPherson stated, "I don't think the public really understands what privatization means...and that's a challenge for us". BCNU campaigned in Victoria against the lay offs and privatization of staff at Sunset Lodge, a VIHA affiliate care facility.

BCNU worked with other health care unions on the Supreme Court challenge on the constitutionality of Bill 29 with respect to the Canadian Charter of Rights and Freedoms. BCNU also forged alliances with various community coalitions in mobilizing public awareness with the message, "...battles around health care are not battles that one group or another can win on their own".

McPherson explained the negotiating strategy in preventing job loss, "...we had to work hard to try and convince employers that it's in their best interest to retain skilled qualified nurses". BCNU also did this in response to employers laying off RNs and replacing them with lower waged Licensed Practical Nurses (LPNs). McPherson outlined that with small, single certification affiliate facilities that were closed or planning privatization, BCNU was able to negotiate and locate other employment for the workers within the health authority. Some employers were receptive to this due to the shortage of nurses in health care. The union was not successful with this approach during the reorganization of Sunset Lodge, an affiliate of VIHA. This resulted in those laid off RNs having to look for work at other facilities. They were not able to carry their benefits and seniority with them.

McPherson stated not all employers were willing to enter into discussion on issues related to Bill 29 or general workforce adjustments. BCNU then found themselves with increased grievances proceeding to arbitration because many employers were not willing to resolve issues within the workplace. This was a change from previous practice across all health authorities. BCNU found the best strategy in response to Bill 29 and the continued threat of privatization was to negotiate directly with the government. These negotiations centred on their collective agreement settled in 2004 and with issues related

to public versus private health care. McPherson described negotiations with the Hospital Employers Association of British Columbia (HEABC) and government to be “treacherous”. BCNU had to create a positive environment by acknowledging the government’s bottom line related to wage increases and by putting forth other issues affecting RNs. By September 2004, McPherson noted that BCNU met with Premier Campbell and Minister of Health, Colin Hansen prior to the First Ministers Meeting to discuss health initiatives, nursing shortages and privatization of health care. McPherson stated that while BCNU claimed that contracting out of acute care services such as surgeries was not necessary because there is “unused capacity within the public system...”, the premier challenged BCNU to provide data.

British Columbia Government Services Employees Union (BCGEU)

The British Columbia Government Services Employees Union includes workers employed both by government and private organizations who receive the majority of their operating funding from government. BCGEU also has some private sector certifications in hotels, casinos, credit unions and other establishments. BCGEU’s leadership consists of a president and board of directors/executive council elected by the members.

BCGEU stated 20,000 of their total membership could be affected by Bill 29. Twelve thousand of the 20,000 are employed in the health care facilities sector and 8,000 of these are employed in the community health services sector covering two separate collective agreements where HEU or HSA are the lead negotiating unions. Jackie White was designated by George Heyman, president of the BCGEU to be interviewed on November 15, 2004. Jackie was a displaced worker from a Victoria care facility where her job was contracted out. White was currently employed by BCGEU.

Themes that emerged from the interview were: impacts to union (consultation, union busting and the target), impacts to workers and employer choices of decertification, closure or privatization and strategies of resistance to prevent privatization.

Consultation

White stated that BCGEU or the public was not notified or consulted on Bill 29's content or intent before the government introduced it. White, who was a representative on the bargaining committee in 2001 for the Health Services component, recalls similar features of Bill 29 being raised by HEABC on behalf of the employers. White was not able to provide specific details but she did recall HEABC wanting to limit bumping rights, to increase the ability to move workers where the employer needed them and to reduce rights and benefits.

Union Busting and the Target

BCGEU stated that the legislation was aimed not only at supporting an ideology of privatization and balancing budgets by reducing labour costs but essentially at "union busting" with specifically HEU. BCGEU based this assertion on the fact that HEU experienced more job loss due to privatization than any other health care union. However, White also points out that BCGEU has less members working in health and community facilities than HEU does.

Support workers jobs were targeted for privatization. White stated that the target or goal was to advance the agenda of privatization by forcing contracting out. White explained the organization of this goal:

The decline in services that is inevitable when you bring profit into any worksite, or at least certainly in general terms. You often see that the productivity decreases, the actual quality of the work that's being done inevitably decreases as well. So, by having that decline happen, then it

decreases the confidence that the public has in the public health care system, and so it just opens the door even wider to privatization.

In terms of “union busting”, White explained that the Provincial Government “...has made it abundantly clear that unions are villains, blaming us for budget deficits due to high wages that are not justified...and unions cannot continue in B.C...”.

Impact on Workers

BCGEU described a number of impacts to their members. Impacts ranged from loss to workers, loss of cohesive teams reduced mentorship, social-emotional impacts of demoralization, stress, anger and employer options.

Losses or harm to workers are significant. These include job loss, reduced wages and benefits, a sense of insecurity and an erosion of teamwork. White described that some of their members who lost their jobs experienced financial hardship and had to rely on employment insurance and income assistance to support their families. Those workers who had difficulty finding work were older women, immigrant women and workers who did not have all the required qualifications. Some of the women are immigrants or women who learned on the job, trained by fellow employees. Some workers rehired by private contractors have taken wage cuts of nearly 40% and lost extended health, dental and sick bank benefits as well as pensions. These wage cuts meant some workers had to work two jobs. White was laid off due to privatization initiatives in an affiliate care facility. She had to move as she could no longer afford the rent where she was.

Loss of a sense of security was described by White as including workers no longer knowing what to expect next, financial insecurity and the sense that next day

might be the last day of employment. She stated this loss of security created an increased sense of “..fear and intimidation amongst the workers”:

They never know on any given day that they go to work that they’re going to get pinked slipped. So, it’s very hard to plan your life, and it affects the morale. Affects the ability how you’re able to, you know, provide service to the residents and patients that you look after.

White experienced this on Thanksgiving Day in October of 2003. When she received a Thanksgiving card from her employer, expressing how grateful they were for the good work of all staff. This stood in contradiction to the employer’s memo on the same day in the staff communication book apologizing for needing to contract out their jobs (and that a letter would be mailed to their homes).

BCGEU stated the quality of work environment is impacted by privatization.

White stated BCGEU members used to have fun at work, but fun was no longer experienced by those left behind or the new private contractor employees. These workers entering the worksite reported to a separate supervisor. No longer was there a sense that they all work for the same purpose and employer. White stated they had witnessed the effects of low wages through high staff turnover. Long-term employees mentoring of new employees was significantly reduced. White felt this lack of continuity was particularly important when it came to caring for the frail elderly. White expressed concern that housekeepers and food service staff not only performed particular tasks but also watch out for and assist residents. Other health care teams relied on this style of working together. However, BCGEU reported this division of some staff having separate reporting relationships created a division at work that further resulted in a workplace with

poor staff cohesion and low morale for workers. BCGEU reported this has led to a destabilization of the workers and could ultimately impact care of residents and patients.

BCGEU stated their membership has been demeaned and demoralized through the implementation of Bill 29 and the process of privatization. Workers have reported feeling high levels of stress and anger.

White discussed the impact of “stripping away how one defines oneself...” as a particular type of person at work. It removed a part of how an individual defines oneself and it can be a demoralizing process. BCGEU described the implementation of privatization through the Act, as a “...direct attack on unionized workers...” and results in, “...demoralizing and devaluing the work our sector does within the health care system”. White explained that the health authorities and government’s public statements that many of their jobs are comparable to the hospitality industry and justifies paying lower wages:

So, it further divides workers and employers on economic lines. And, as I was saying, the workers have taken some major decreases in pay and benefits. So, when workers are subjected to that sort of low wage ghetto, and they feel that that don’t have any rights as employees, certainly, no right to be able to speak out if there is something that’s not working well, because I have seen that happen a lot. Anyone who speaks out is just terminated. So, it has [...] the demoralizing effect.

BCGEU reports privatizing workers jobs was confusing on many levels to the workers who received compliments from clients with statements like, “...I could never do your job for a million dollars...”. White stated the media releases, employer and government statements that turn the workers’ jobs into not being worth what they are paid for created a further experience of devaluation and demoralization.

Workers in their last few weeks of work were expected to train and orient new hires from private contractors. White described this process as another cause of being demoralized, creating stress. Workers at risk of privatization reported high levels of stress in the work environment associated with potential loss of work and income.

Anger was a common emotional response. White described many workers have expressed this to her or other union activists. White shared a personal response:

I would say I was impacted more greatly than I expected I would have been. It's still very painful for me. I still feel—I feel really, like my anger comes from the fact that we did good work, and we do good work, and for somebody to be able to do this because a piece of Government legislation allowed them to, is just wrong, and I can't let go of that.

Employer Options

BCGEU experienced similar losses of members in VIHA and other health authorities related to the process of decertification, and privatization of certain occupations within care facilities. They did not experience facility closures.

White explained that within VIHA and other health authorities, employers in privately and publicly operated affiliate care facilities approached the workers to explain if they decertified from BCGEU they would be able to keep their jobs. Facility administrators never contacted the union to negotiate wage concessions to keep these workers employed. This occurred in Nanaimo where 40 workers decertified and their jobs were contracted out.

BCGEU reported in November 2004 that two affiliate facilities in VIHA chose to contract out their workers. This amounted to approximately 50 lost jobs. The occupations included Licensed Practical Nurses and nursing assistants, maintenance, food services, laundry and cleaners. The two affiliate facilities in VIHA were Craigdarroch

Care Home and Sidney Care Facility where the majority of their operating budget is provided by VIHA. These two facilities operate for profit within the public health care system. White noted there were section 54 hearings at the Labour Board, concerning the inadequacy of the notice period given to laid off employees under the Labour Code, White heard these employers explain, "...costs of wages and benefits were impacting [their] profit margin".

In comparison, White stated that the privatization BCGEU experienced in VIHA was low compared to the Fraser and Vancouver Coastal Health Authorities where by November 2004, over 400 jobs were lost due to privatization and others (unknown totals) lost to decertification. White's final comments on the causes and effects of privatization are:

It's been a year, that the [private] companies contracts have been out there, and I'm not entirely convinced that the employers are actually happy with having to conduct business that way. But they have been left with no option under the budget – restricted funding...And I hope at some point in time someone finds the sense to go back and look at how the effect that Bill 29 has had before anymore devastation is done.

Strategies of Resistance

White described a number of costly strategies BCGEU implemented in response to the Act. These strategies included collaborating alongside other unions, public and worker education, negotiating with government and individual employers and increasing democratic participation.

BCGEU, along with other health care unions, launched a Supreme Court challenge to the legislation on the grounds that it violated the Charter of Rights and Freedoms (under provisions that protect the security of the person and freedom of association, equality for women). These unions together with British Columbia

Federation of Labour (BCFED), the Canadian Labour Congress (CLC) and their affiliation to the National Union of Public General Employees (NUPGE) engaged in public awareness campaigns. As well, BCGEU joined in the complaints to the International Labour Organization of the United Nations. White did not have details of the UN or court challenge.

White stated BCGEU engaged in public awareness campaigns and claimed this was effective in VIHA on the Saanich Peninsula where the privately operated Sidney Care facility was contracting out jobs of its members. This campaign did not prevent the privatization. White believed it was because, "...some employers are ideologically bent on privatizing and another piece of it too is, they simply find it a way to get rid of the union". BCGEU participated in rallies around the province and did a number of press releases, not all of which were reported in the media.

In 2002, member education occurred within weeks of the introduction of the Act. However, by the time jobs were being privatized in 2003 many members had forgotten or did not believe the full extent of Bill 29-2002.

BCGEU entered into negotiations directly with HEABC and the Provincial Government resulting in the Tentative Framework Agreement. HEU and BCGEU membership did not ratify this agreement. The next step for BCGEU in 2003 was to negotiate with employers who had expressed a position, "...not wanting to contract out their workers, but because of funding freezes, felt they had no other options". They used the Tentative Framework Agreement as a template to negotiate local agreements with affiliate employers in VIHA and other health authorities to prevent job loss and privatization. "The workers felt at the time that rather than see their job go completely,

that they would be willing to take those concessions such as wage roll backs, reduced vacation, etcetera”.

Entering into contract negotiations in the spring of 2004, BCGEU had a clear mandate from their membership, “... to do whatever we could to save their jobs”. The agreement struck between labour and the government in the 2004 facility support sector labour dispute around Bill 37-2004 included BCGEU.

BCGEU recognized the need to increase their members participation in municipal, provincial and federal elections. They began a campaign alongside B.C Federation of Labour and other health care unions to educate members on the importance of political participation.

BCGEU’s first goal was to link legislation such as Bill 29 to a political process their members would want to be part of. Secondly, they encouraged members to register to vote and thirdly, created a campaign titled, “Member to Member”. This third campaign involved union stewards visiting the worksites and talking to the membership about the importance of voting and providing information on the issues. White explained, “I think by doing that one-to-one contact, we’re reminded that we are part of a much larger collective, and that if, you know, we work together we can win”.

The Health Sciences Association of British Columbia (HSABC or HSA)

The Health Sciences Association of British Columbia (HSA) union represents over 100 disciplines called health science professionals including dietitians, pharmacists, psychologists, physical and occupational therapists, social workers, laboratory technologist and psychiatric nurses. Most of these professionals work in diagnostic,

treatment and rehabilitation areas of health care. HSA has a governing Board of Directors elected from the membership.

In 2001, HSA was the first union to defy the newly elected B.C Liberals by establishing a two-day illegal picket line (no history of this type of action) across the province in protest to the *Health Care Continuation Act* (Bill 2-2001). The act legislated an end to job action of BCNU and HSA where no picket lines had previously been set up. Other health care unions did not support this illegal action as their contracts had been settled or were under negotiations. HSA received much public and media support. HSA was taken to B.C Supreme Court and no fines or penalties were levied against the union as the picket lines had been withdrawn noting they respected the courts.

The interview was conducted on September 22, 2004 with President Cindy Stewart and Ron Ohmart, Executive Director of Labour Relations. Themes from the data collected were impacts to union (consultation, union busting, financial, collective bargaining), impacts to members (loss collective agreement provisions, quality of work environment, job loss) and strategies of resistance. While the specific focus is with VIHA, the union responses also covered the provincial perspective.

Impact on HSA

Impacts to HSA are in the areas of consultation, union busting, financial, and dramatically reduced influence in collective bargaining.

Consultation

In terms of Bill 29, H.S.A was not consulted nor were they aware of any formal public consultation prior to the legislation. Stewart stated, “looking back there were some signals around job security provisions but the extent to the reach of the actual

stripping, no inkling [it would be] as far reaching and the implications would be so severe”. Stewart explained:

The process was a big problem in terms of no heads up, no consultation, no kind of justification, at least for our contract. And when we put those questions to the decision-makers directly; What is it? What problem are you solving with our collective agreement that required you to introduce Bill 29? They could not give us an answer.

Union Busting, Privatization and Reform

HSA stated its union membership was not the primary target. By September 2004, HSA realized that the majority of privatized workers were HEU members and to a lesser extent BCGEU. Stewart stated health care unions were the general target. “It’s hard not to say that one of the effects, if it wasn’t an outright goal of Bill 29, was union busting”. Stewart further added that the legislation undermined the role of unions in the collective bargaining process and removed various rights and obligations negotiated over decades of collective agreements.

The third underlying goal of the legislation Stewart mentioned is the “support for privatization”. The government removed legislative and collective agreement barriers that were deemed “anti-privatization” which prevented employers pursuing that option. HSA reported that the government stated that removal of various barriers would “...facilitate meaningful health reform”. HSA believed the lack of consultation through Bill 29 was a backlash from the previous decade of enforced consultation. HSA observed that some employers didn’t actively consult with the union and in fact actively worked against the mandated consultation in the Health Labour Accord. Ohmart stated the government, “...could have achieved those flexibility goals for health reform without the kind of atom bomb or crowbar and...could have done some tweaking to have

circumvented those barriers instead of doing what they did with Bill 29”. Stewart and Ohmart stated HSA was not opposed to the introduction of “appropriate” health reform and previously submitted provincial recommendations on laboratory reforms to keep outpatient labs public and thereby retain the profits in the public system. They felt these types of reforms are about improving the delivery of health and social services. Stewart asserted, “...undermining unions and/or privatizing services is not about improving the delivery of health and social services...”.

Financial Losses

Stewart and Ohmart described the costs incurred for increased litigation as the result of HEABC’s interpretation of Bill 29. “Union resources, hundreds of thousands of union members funds as well as tax payer dollars, were being wasted on litigation due to HEABC’s interpretation of the issues out of Bill 29, [...] these were resources, time, energy, money that were diverted away from health care and people”.

Collective Bargaining

Stewart stated with Bill 29 becoming law and imposing changes to collective agreements, one of the ideological goals of the Act was limiting the long-standing role of the union. Stewart described it as “...the undermining and the loss of rights of the role of unions with collective bargaining in representing, and having the ability to represent the interests of their members”. HSA considered this to be one of the most significant impacts to the unions and a loss for members. Ohmart explained that since the implementation of Bill 29 in 2002 it had impacted future bargaining. The legislation reduced members’ and union’s expectations during bargaining in 2004 and described the

process as “...having a gun pointed to your head”. HSA further stated the legislation did not allow unions to renegotiate outside of the Bill 29 provisions.

Impact on Workers

Stewart stated Bill 29 broadly impacted every HSA member because it targeted specific groups and health sectors that may be privatized (such as residential care or disciplines not specifically assigned to direct care or in-patient in acute care) but it affected other rights in the collective agreement related to health care restructuring. “Well there is certainly the potential for a lot of negative impacts depending on how the tools contained within Bill 29 are used”.

HSA described numerous impacts to their membership as the direct and indirect result of the legislation and implementation. These impacts, whether temporary or permanent, included a loss of collective agreement provisions such as employment security, bumping, red circling, melded seniority and regional postings, reduced income losses, social-emotional impacts (fear, grief) reduced quality of work environment and job losses related to restructuring.

Lost Collective Agreement Provisions

HSA stated that the removal of the employment security provisions negotiated over a decade ago were problematic to workers as well as employers. Stewart explained that the legislation removed a proven, workable process for employers, which also served to reduce worker impact during labour force change. During times of labour adjustments or restructuring initiatives, each party knew a process and a role. Ohmart stated, “it was also recognized that our employees were in short supply, so you had a mechanism by which you could ensure [...] you didn’t lose valuable people in a region or province”.

Employers and unions would have violated the law if they attempted to negotiate an employment security process outside of Bill 29.

The Act altered the long held right of bumping. Stewart explained how problematic this is to workers during a time of restructuring in the workplace. “We found specifically long service employees were detrimentally affected by Bill 29 because of the rules that they outlined around bumping”.

HSA noted that red circling (wage protection), melded or dovetailed seniority and regional postings were all areas that HEABC stated no longer existed in collective agreements because Bill 29 was silent on these provisions. The arbitrator for the labour board ruled in the unions’ favor noting the long-standing practice of these areas (previous to Bill 29-2002). Ohmart stated “while HEABC conceded that the health authorities were the successor employer and the certifications and contracts could continue, they did not fundamentally agree that [the six newly formed] health authority operated sites could have employees on one seniority list impacting bumping and job posting rights”.

HSA reported that the loss of the employment security provisions (ESLA) meant workers who were being displaced due to budget and restructuring lost significant amounts of wages. “They lost a years salary; they had a year of job security and that was reduced to four weeks”.

HSA reported that the legislation had the effect of lowering wages and impacted the collective bargaining process in 2004. Ohmart explained:

The climate of fear that they have created amongst the employees, it has one—one benefit for the employer, the government; it did drive down wages, it did drive down expectations, it did make people afraid to say, well, hey, you owe me—this money for overtime. Because they were afraid of losing their jobs[....]Bargaining had our members saying just protect our jobs, we’ll do anything.

HSA noticed collective bargaining in 2004 was impacted by the threat of privatization in the workplace and created concessionary contracts with reduced wages. They also found that members' job security "eclipsed " financial concerns with wages.

Social-Emotional and Quality of Work Environment

HSA reported that the legislation and the accompanying restructuring and privatization initiatives impacted their members negatively. These negative impacts are social-emotional and a reduced quality of work environment.

HSA found that morale in both the health and social service sectors was low. The union attributed this to the experience of co-workers seeing HEU and BCGEU members being privatized and the realization that their own jobs could be privatized. The union was beginning to hear reports from their members at VIHA where privatization of HEU workers jobs had begun. Their members grieved the loss of the HEU members they have worked alongside as much as 20 years. Stewart explained, "...It's depressing, it's made people angry, frustrated and truly has affected morale...".

Ohmart discussed these emotional impacts and work productivity referring to research by Dr. Marie Campbell in the 1990's from the multi-site hospital previously known as the Juan de Fuca Hospitals in Victoria. It was a continuous quality initiative in patient focused care where the hospital wanted this new initiative documented in research. Ohmart reported the Chief Executive Officer did not agree with the results and ceased the distribution of the research. Ohmart recalled:

The researcher said only people who feel secure about themselves and about their situation, are in a position to provide quality care. And as soon as you threaten their job, their productivity, and ability to care for someone else became compromised because they were too busy worrying

about themselves to think about somebody else[...]So you don't have a confident well-paid person, in the mental state to direct energies into the person under their care. If there are concerns about their job, they're discussing it with their co-workers and so on.

Ohmart believed that the privatization and job loss fear reduced productivity. He acknowledged that research has not been conducted in this area and it may be difficult to measure.

Stewart reported that while members did not lose their jobs to privatization they were experiencing difficulties in the workplace. Significant impacts from other areas of B.C, which they expected may occur in VIHA were identified by the union as, quality of work environment, and worker's pride in their work environment. These impacts relate to inability to direct the work of the contracted out workers; increased workload and receiving patient complaints. Ohmart stated that the complaints members reported included reduced security on psychiatric wards, increased workload related to increased patient complaints with food and cleanliness. Infection control concerns emerged in the Vancouver area. HSA reported that inefficient use of staff time resulted from having to contact a call centre or a supervisor to request a cleaner remove spilled body fluids. Ohmart explained, "...it's more difficult to deal with patients when patients are getting crappy food instead of decent food...". Stewart reported how HSA members have pride in their work and workplace and this pride is diminished with cleanliness and food issues.

Restructuring and Privatization

HSA members experienced job loss with workplace restructuring. In VIHA, HSA members were displaced or lost jobs related to facility closure or programme restructuring (referred to as the paramedical cuts), linked directly to Health Authority budget deficits. No jobs were lost to contracting out. HSA believed that government

funding to VIHA was intentionally lower than required to maintain current levels of services. Recovering costs by reducing labour costs certainly helps balance the budget.

While HSA felt that their members were not vulnerable to contracting out, they cautioned Bill 29 as being able to be applied at anytime in the future.

Strategies of Resistance

Stewart and Ohmart outlined a “multi-pronged” three to five year strategic plan in response to Bill 29 and discussed the challenges, “...how do we position ourselves during this time of a hostile political climate?”. Ohmart explained they “...litigated, negotiated and established relationships where appropriate”. These strategies included meeting with decision makers and employers, pursuing arbitrations and litigation, joining with other unions for public education, as well as educating and supporting members.

Shortly after the Act was proclaimed, HSA met with the Ministers of Labour and Health, HEABC and employers. Stewart and Ohmart then began meeting with each health authority, as “... the people that would chose to use this tool or not...we needed to protect our members”. Ohmart claimed this labour relations approach was successful once the employer was willing to cooperate with them. “Our collective agreement over the years developed in response to health care amalgamations and regionalization and already had room for a lot of flexibility, a lot of options...we didn’t see Bill 29 coming, we saw on-going consolidation and restructuring”.

Alongside this negotiating strategy was one of on-going work and development of good labour relations with all employers. Ohmart explained their message to employers was powerful and effective:

So you know, labour peace does count for something; you know, in terms of your productivity. And that—that’s a pretty good message and---and

most of the employers, VIHA, in particular, were receptive to that message, and avoided using the—the full impact of Bill 29.

HSA utilized the strategy of open discussions with employers to acknowledge their awareness of the budget limits but also to advise them on the implications and consequences of privatization. Stewart stated they were able to remind employers that some of the services (physiotherapy, pharmacy) their membership provide could be more costly if contracted from the private sector. HSA discussed the issue of Bill 29 defining most workers as ‘non-clinical’. Examples of these disciplines would be hospital laboratory and x-ray technologists and workers in residential care facilities such as dietitians, social workers, occupational, recreational and physical therapists. They also discussed liability issues stemming from contracted out workers where the health authority is not the direct employer or supervisor of the work and losing control of quality. Finally, HSA raised with employers the experiences they had observed of Health Authorities losing control in the workplace with privatization.

HSA engaged in similar strategies as other health care unions in terms of legal actions, arbitrations with HEABC at the Labour Board and filing complaints to the United Nations regarding Bill 2 -2001, Bill 15-2001 and Bill 29-2002. These complaints were filed through their national union, NUPGE working with the Canadian Labour Congress and lodged with the Committee on Freedom of Association of the International Labour Organization of the UN. Stewart commented, “we all like to crow when we’re number one in the U.N’s eyes, and here the U.N, through one of its agencies, has condemned Canada, and the B.C government in their arrogance studiously ignored that”.

HSA is the only bargaining association to file a Tort claim against HEABC. Stewart explained the basis of this claim, (under appeal in September 2004), “we were in collective bargaining when Bill 29 was being drafted, they had an obligation to raise issues through the collective bargaining process, and they were in breach of their duties to do that”.

HSA has not signed onto the Canadian Charter challenge against the government of BC, but dedicated financial resources to support the action. Stewart explained HSA was not able to demonstrate the same level of damages to their membership as other unions.

HSA did proceed with several litigations known as arbitrations against HEABC. Ohmart explained that HEABC was reaching into sections of the collective agreement on areas that Bill 29 did not explicitly contemplate within the language of the Act or the regulations. HSA pursued three arbitrations (red circling, regional posting and sec. 35(5) of the Labour Code on successorship with seniority lists) before the BC Labour Board which were successful.

HSA alongside other health care unions and national union affiliations participated in rallies, media releases and public awareness campaigns. Stewart explained the importance of these initiatives, “because you need public condemnation of the impacts to workers and society”. Stewart and Ohmart stated one of their strengths is the membership talking directly with the media and public about what they do and their concerns with health care. The union has found this is successful in making an impact with the public, politicians and media. Stewart outlined encouraging members to use the

power of their vote for the upcoming municipal and provincial elections. Multiple methods were employed to keep members and union activists educated.

HSA employed a conservative strategy when using the media to showcase issues and impacts of Bill 29:

We could get headlines trashing VIHA or other health authorities, but when it comes to how are we going to manage all these layoffs with the paramedical budget cuts, you know what VIHA is going to do. Let me see, I got this Bill 29 here, and I can just beat you to a pulp. And let's see, you just embarrassed me in the Times-Colonist... What is the employer going to do after being embarrassed in the Times-Colonist? They're going to use Bill 29. We might have got a headline but then it may have cost us jobs. And so, we were very careful to never point the finger at the employer or health authority. We did understand that sometimes people were put into a position that maybe necessarily didn't believe in, but had to do as the reality of their job and the service they wanted to provide. And so we tried to be sensitive to that and give them—meet with them. What is it that you really need? What do you have to do? What are you really trying to accomplish here? We know you've got some budget problems, that you didn't create, but on the other hand, we're here to represent our members and try to minimize the negative impacts on them.

Stewart's final comment on privatization of health care is about an outcome, "...the constant pressure on the health system creating incentives for privatization...is disturbing". Stewart explained further her concerns about the loss of a publicly funded, operated system and the constructed need for privatization, "...they've done a masterful job, by altering the hard core Canadian value [of health care entitlement] by denying access and limiting services".

Summary

Each union reported on union and membership experiences and impacts of the implementation of Bill 29-2002. Themes varied amongst the unions, which are representative of the range of impacts, priorities of the leader at the time of the

interview(s), and differences between interviewing busy union leaders and a non-union leader. HEU and BCGEU were the most impacted by contracting out. BCNU and HSA experienced different impacts of the legislation related to reduce collective agreement rights during times of health care restructuring. All four unions engaged in strategies of resistance and reported a variety of successes with hope their political campaigns would alter the majority seats in the legislature for the upcoming 2005 election.

Chapter six will discuss the four union and worker's experiences of implementation and impacts of Bill 29-2002.

Chapter Six: Discussion of Results

The following discussion arises out of the data obtained from the four health care unions during the period January 2002 to December 2004. Much of the unions' observations and analysis focussed on the economic, political context for increased privatization of support services and workers. The three main areas of discussion are: 1. implementation of Bill 29 in the Vancouver Island Health Authority; 2. its impact on unions and; 3. its impact on workers.

Implementation of Bill 29 in the Vancouver Island Health Authority

Implementation of Bill 29 in the Vancouver Island Health Authority (VIHA) occurred in several ways during the period of study. This discussion will focus specifically on union reports of job loss through contracting out. It also includes available data on job loss through closures and union decertification. Other data, while linked to the implementation of the Act such as temporary or permanent loss of collective agreement rights, will be discussed in the section, "Impact on Workers" and "Impact on Unions". While VIHA does not directly operate affiliate facilities, they do control the operating and capital monies for them (similar to the funding relationship the government has with VIHA). Limited data related to contracting out of workers at affiliate sites is included.

White of the BCGEU reported approximately 90 members lost their job due to contracting out and decertification in affiliate facilities. The majority of these workers

were women. Fifty of these members were contracted out and approximately 40 lost their jobs post decertification as they were eventually contracted out. White stated this number was small compared to the overall total numbers of job lost in the rest of B.C. However, White further reported these numbers were still low in comparison to HEU.

MacPherson of BCNU reported approximately 100 to 200 nurses lost their jobs. However, this total included the Gorge Road Hospital (GRH) closure in Victoria, which was not the result of Bill 29. These numbers also included affiliate and amalgamate facilities where RNs were replaced with lower waged licensed practical nurses.

HSA reported no job loss in 2004 through contracting out in VIHA owned or affiliate residential care facilities. While members were impacted by job loss from restructuring initiatives related to budget deficits, the total number of members remained stable in the union.

Muzin of HEU reported in 2004 an entirely different picture for support workers in VIHA operated and affiliate sites. This occurred after VIHA and HEU had undergone discussions pursuant to Section 54 of the Labour Relations Code, which involved negotiating alternatives to contracting out and labour adjustment strategies. It was not disclosed publicly as to what the 'deal-breaker' was between VIHA and HEU. VIHA described in their redesign plan their desire to pursue contracting out to reduce labour costs to meet budget requirements established by the provincial government. In VIHA sites, approximately 1200 jobs were lost due to contracting out in security, gardening, food, laundry, and housekeeping services. Additionally, approximately 300 HEU and 90 BCGEU jobs were contracted out at six affiliate residential care sites. HEU experienced

the highest amount of workers contracted out. The majority of workers who lost their jobs were women. Refer to Table Five for the list of job losses.

Table Five: Job Losses between 2002 and 2004 in VIHA Amalgamate and Affiliate Facilities to Contracting Out¹

UNION	SERVICES	FACILITIES	TOTAL NUMBER OF JOBS LOST
HEU	Housekeeping, laundry, food services, gardening, security, health record transcriptionists (at some sites)	Royal Jubilee Hospital, Victoria General Hospital, Cowichan District Hospital, Aberdeen, Glengarry, Mt. Tolmie, and Priory Care Hospitals, Queen Alexandra Centre for Children's Hospital, Nanaimo Regional General Hospital, Cairnsmore Place, Dufferin Place, Mt. Edward Court, Sunset Lodge, Central Care Home, Beacon Hill Villa	1500
HSA	Health Science Professionals	0	0
BCGEU	Housekeeping, laundry, food services, resident care attendants	Sidney Care Facility, Craigdarroch Care Home, Nanaimo Facility	90
BCNU	Registered Nurses	Sunset Lodge	<10

¹ Workers in all unions lost jobs to decertification, facility and programme closures, and replacement of RNs with LPNs. This data is not included in this table.

All unions by 2004 made varying statements on their labour relations with VIHA. Generally, the unions did not believe VIHA was ideologically supportive of contracting out or privatization. However, it was felt that Rick Roger, CEO of VIHA, was pressured politically to comply and needed to balance the Authority's budget. The following quote in the Victoria Times Colonist newspaper illustrates the unions understanding of Mr. Roger's difficult decision. Mr. Roger's comment occurred at his resignation from the Health Authority:

When contract negotiations with the Hospital Employees' Union fumbled and more than 1000 people lost their jobs because housekeeping and dietary contracts were awarded to a private company for a projected cost savings of \$50 million over five years—Rogers said he felt sick. 'I know I did everything I could to put a different package together[...]'The

consequences for staff that I've worked with for damn-near two decades has troubled me to no end. I don't think I've had a sound and thorough night's sleep since this started' (Harnett, October 2, 2004).

While VIHA anticipated saving \$50 million over five years through contracting out initiatives, observers caution against this estimate (Bailey, 1987; Fuller, C, 2003; Starr, 1990). Contracting out often results in other costs not factored into original estimates. Owners incur administrative costs related to their ongoing supervision, auditing of contracts and performance and pursuing remedies when performance falls below the standard (Bailey, 1987; Fuller, C, 2003). As well, there may be costs to a health authority when "lower wages paid to workers translates into poorer training and higher staff turnover, ultimately jeopardizing patient safety" (Fuller, C, 2003:6). These costs to VIHA were not available and are difficult to compute in any case.

Contracting out of support workers jobs to for-profit corporations occurred in the previous decade in other parts of Canada and internationally, linking the B.C experience to a broader trend of restructuring of unionized public sector workers in health care (Armstrong et al, 2001; Bailey, 1997; Fuller, et al, 2004; Fuller & Stephens, 2004; Saad-Fiho & Johnson, 2005; Starr, 1990). In Canada, there has been ongoing restructuring of workers with the intent to promote productivity and competitiveness, as opposed to decent jobs for workers (Lowe, 2000). Common forms of restructuring are downsizing, contracting out of jobs that are redefined as non-core, and creating a flexible worker by increasing part-time, casual and overtime hours (Jackson, 2005). The unions reported increased workloads, resulting from under-trained, high turnover contract employees, and increased complaints from clients. These impacts are discussed in the section titled 'Impact on Workers'.

Impact on Unions

The *Health and Social Services Delivery Improvement Act*, and the interpretation by HEABC impacted all four unions and their members, workers in hospitals and health facilities. There were four main areas of concern. These were: 1. elimination of the unions' right of successorship; 2. financial costs to unions; 3. limiting the unions' long standing role in consultation; and 4. limiting the role in collective bargaining on behalf of their membership.

On the issue of successorship, Bill 29 initially prevented the unions from automatically representing non-clinical workers who become employed by a private contractor. In VIHA, this meant HEU could not automatically represent the newly hired workers of Compass, a private, for-profit corporation. At the time of the 2004 interview Muzin noted HEU would be attempting to organize these workers back into HEU. This had recently been achieved in other health authorities with workers employed by private corporations some of whom had been organized the union local of IWA Local 1-3567. This union had a partnership or corporatist agreement with employers to keep wages and benefits to a minimum. Therefore, Bill 29-2002 did not entirely block the unions from representing contracted out health sector employees, but it imposed a barrier. However when combined with the *Health Sector Partnership Act* (post Bill 29) there was a stronger legal barrier to organizing contracted out workers in any union. This companion Act to Bill 29-2002, allowed private corporations to lay-off unionized workers hiring them back the next day as a non-unionized worker potentially creating a union-free work zone. The new 2003 legislation has yet to be tested in B.C. Issues of successorship and the significance to workers are discussed in the section 'Impact on Workers'.

Financial costs to the unions were of concern. First, with contracting out to private corporations, HEU and BCGEU lost members. The loss of members translated into less member dues and thereby less income for the unions. Second, unions described spending hundreds of thousands of dollars on litigation mainly in the area of arbitrations and the courts. HSA contended that arbitrations were sought due to HEABC's interpretation of Bill 29, which in all cases the Labour Board ruled in favour of the unions (Steward & Ohmart, 2004). Thirdly, unions employed several costly strategies of resistance to increase worker democratic participation, educate both members and the public on privatization. They also attempted to negotiate wage concessions or restructuring initiatives with VIHA operated and contracted (affiliate) facility employers. Lastly, they cooperated with the broader labour movement on health care privatization issues. This activity was linked to saving jobs, preventing further job loss, preserving the fundamental principles of freedom of association and the right to collective bargaining in a neo-liberal environment.

The four unions reported Bill 29 primarily targeted HEU and to a lesser extent BCGEU and their members. They also reported the government and HEABC's intention was to "bust the unions" (MacPherson, 2004; Muzin, 2003; Steward & Ohmart, 2004; White, 2004). Several sections of the Act support the unions claim of legislative interference with their role. Section 6 reduced the automatic right of unions successorship in representing newly hired contracted out workers (previously discussed). Section 6.4 removed the mandatory mechanism for employers to engage in consultation in relation to contracting out services and workers. Sections 4, 7, 8 and 9 all reduced or eliminated collective agreement provisions obtained through past and current collective

bargaining. Section 10 effectively halted any future collective bargaining by making it illegal to negotiate outside of the Act.

Bill 29 fundamentally restricted collective bargaining, which represents one of the most significant roles of unions (Jackson, 2005; Panitch & Swartz, 2003). Collective bargaining is considered by many to be consistent with principles of freedom of association in the Canadian Charter of Rights but to date not upheld at the Supreme Court of Canada (Adams, 2005, Fudge & Brewin, 2005). The International Labour Organization (ILO) of the United Nations received several complaints from B.C.'s health care unions on Bill 29-2002 and other labour legislation. The ILO's 2003 response includes the following key passage:

The Committee also points out that repeated recourse to legislative restrictions on collective bargaining can only, in the long term, prejudice and destabilize the labour relations climate if the legislator frequently intervenes to suspend or terminate the exercise of rights recognized for unions and their members. Moreover, this may have a detrimental effect on workers' interests in unionization, since members and potential members could consider it useless to join an organization the main objective of which is to represent its members in collective bargaining, if the results of bargaining are constantly cancelled by law. The Committee also hopes that, in future, full, frank and meaningful consultations will be held with representative organizations in all instances where workers' rights of freedom of association and collective bargaining are at stake.... (2003:17).

The provincial government's response to the ILO's position was to describe the complaints as, "...fundamentally frivolous, vexatious mostly driven by political motivation and completely without merit" (ILO, 2003:8). Furthermore, the government cited budget deficits, rising health and education costs, public sector wage settlements (which the government either negotiated or imposed) that exceeded private sector increases, escalating job action that posed a threat to the public. The government claimed

its mandate for fiscal responsibility, deficit and debt reduction required such legislation (ILO, 2003). The government's response to the ILO also claimed their public consultation process "Patients First" as further rationale for Bill 29 (ILO, 2003). The unions were particularly concerned about lack of consultation prior to the legislation and their skepticism through previous government and/or employer actions, which showed little or no interest in meaningful consultation with fixed agendas and pre-determined outcomes. The government with its overwhelming electoral majority had carte blanche to do as it wished.

Limiting a union's role through legislation is an increasingly Canadian experience linked to neo-liberalism, which includes increasing privatization (Adams, 2005; Armstrong et al, 2001a; Botting, 2001; Fudge & Brewin, 2005; Panitch & Swartz, 2003). In Britain, under Thatcher, where health care privatization was introduced in the 1980's, a reduction in the role and power of trade unions was linked to a cut back on social welfare spending and state support of privatization (Doern et al, 1998; Leyes, 2001; Parker, 2003; Pollock 2004;). Neo-liberal economists and the private sector believe that high rates of unionization, strong employment standards protections and high taxes are all damaging to global economies. Economists Bluestone and Harrison examined experiences in twenty different developed countries over four periods and found no data to support this ideology (2001). Aidt and Tzannatus (2003) conducted a significant study for the World Bank, which found little support for the neo-liberal view that unions have negative impacts on growth or job creation. Goodman et al (1998) further explained that prior to the Thatcher regime (1979) in Britain 75% of all workers were affiliated with unions (1998). The Thatcher government withdrew support for collective bargaining,

passed laws to limit the role of trade unions as well as encouraging employers to ignore unions to achieve their market goals (Goodman, et al, 1998). Globally, in developing and developed countries collective bargaining or collective agreements are being restricted (Adams, 2005; Fudge & Brewin, 2005; Panitch & Swartz, 2003; International Labour Organization, 2000).

Brodie explains the neo-liberal practices of designating groups, such as unions, as a special interest group, "...with positions and motivations that are unrepresentative of and potentially antagonistic to those of 'ordinary Canadians'" (1996b:140). Unions and their membership are referred to as greedy, lazy and overpaid, behaviors contrary to current economic global realities. A reduced role and influence for organized labour is a key component of a neo-liberal agenda. De-regulation, reduced social spending and privatization are also key components of the neo-liberal agenda which coincidentally affect or rely upon declining organized labour. Panitch and Swartz (2003) explain workers and unions have a subordinate role to capital. Whereas the post-war era established organized labour rights to worker's "material interests" in capitalism, the neo-liberal era (since the 1980s) is much less concerned with labour rights (Panitch & Swartz, 2003:31). The neo-liberal era reverses post-war concepts of labour by reducing or eliminating collective bargaining, wages and benefits (Panitch & Swartz, 2003).

Unions participate locally, nationally and internationally in matters of social justice and are a form of resistance to a neo-liberal ideology (Freeman & Medoff, 1984; Jackson, 2005). Navarro, in his analysis of national health programmes stated, "the major social force behind the establishment of a national health program has been the labour movement (and its political instruments—the socialist parties) in its pursuit of the

welfare state” (1989:390). He discussed four areas of health care for which organized labour in developed countries have lobbied for (1989). Table six compares Navarro’s (1989) four areas to key actions of the B.C Liberal Government.

Table Six: Comparison of Organized Labour Lobby with Health Care versus B.C Government Actions (2001 to 2004)

Organized Labour Lobby (Navarro, 1989)	B. C. Liberal Government Actions
<ul style="list-style-type: none"> • Universalization of public health care • Participation of labour movement in the direction of the health care system • State responsibility for the management of funds • Financial support of health care by a system of taxation 	<ul style="list-style-type: none"> • Moving away from declining scope universal health care coverage by inducing substitution through private pay options (de-listed services) • Structurally reduce role of labour’s participation, consultation and collective bargaining by mechanisms of legislation • Creation of partnership agreements between unions, governments and employers to curb union influence and independence • Amalgamated health authorities to manage funds and deliver services • Selective privatization of health services through contracting out non-clinical labour force • Tax reductions which justify reduced social welfare funding

Labour’s role with the universal health care lobby is significant for the unionized and non-unionized workforce. In many ways, union collective bargaining for health and dental insurance benefits for their membership is a replacement for or second best option to universal access to these social welfare programmes.

“Unions are organizations that define, promote and fight for the collective interests and rights of workers or a group of workers, especially in relation to employers, but also in relation to governments, the media and other social groups” (Jackson,

2005:144). In B.C, the phrase “Six Bucks Sucks” was coined and promoted by all unions with the B.C Federation of Labour’s Campaign B.C in response to reducing the minimum training wage to \$6.00 per hour. Unions have also protested the privatization of B.C Hydro and spoke out against tax reductions, which impact funding of social programmes for all citizens. In response to B.C’s anti-labour legislation and HSA and BCGEU’s complaints to their national union, NUPGE launched a campaign titled, “Labour Rights are Human Rights”. This campaign was a significant force with the Canadian Labour Congress and in the complaints against B.C’s labour laws to the United Nations. There are many examples of organized labour’s public resistance to current neo-liberal policies and practices. Health care unions employed several costly strategies of resistance. The benefit of this was the awareness that the membership (health care workers) have influence with the public on matters of health care and privatization.

Legislation such as Bill 29 was clearly designed to curtail the role and influence of organized labour (Fudge & Brewin, 2005; Panitch & Swartz, 2003). This legislation is part of a broader pattern of legislation in Canada (Fudge & Brewin, 2005). Since 1980, over 150 pieces of legislation have been enacted in Canada to limit or reduce the role of unions and worker rights (Adams, 2005; Fudge & Brewin, 2005; Panitch & Swartz, 2003). Limiting the role and influence of unions through legislation is seen as a necessary structural pre-condition to increasing privatization in health care. Labour relations were substantially shifted to the detriment of unions and their members in an unprecedented manner. Governments, of which one party has an overwhelming majority, are clearly more able to enact legislation consistent with their policies. Union busting through legislation was a common theme expressed by union representatives.

Impact on Workers

In British Columbia (as elsewhere in Canada), health care work is largely women's work (Armstrong & Armstrong, 2001a; Baines, et al, 1993; Fuller, 2001; Griffin-Cohen and Cohen, 2004). Unions report women in the health sector make up between 80% (BCGEU and HSA) to 85% (HEU) and 98% (BCNU) of their membership. This context is salient in discussing particular impacts to workers where women experience the brunt of health reform policies, which is ideologically driven towards market solutions in the form of privatization by way of contracting out workers (Armstrong & Armstrong, 2001a; Fuller et al, 2003).

Impacts on workers reported by unions as the result of the implementation of Bill 29-2002 were described as harmful and sometimes devastating. The impacts to be discussed are social-emotional, quality of work environment and loss of collective agreement provisions.

Social-Emotional Impacts

All four unions reported emotional stress for their members due to the privatization initiatives or the perceived threat of privatization of their jobs. This occurred to workers who lost their jobs and to those who kept their jobs. The social-emotional impacts reported ranged from grief, disbelief, betrayal, feelings of distrust, stress, feeling devalued, demoralized, anger, low morale, and fear.

Grief, reported by all four unions, was a common response in relation to experiencing job loss as well as for those workers witnessing the loss of co-workers and the realization the work environment was changing. Disbelief, betrayal and distrust were emotional responses reported by HEU of their member's reactions to losing their jobs or

seeing their co-workers lose their jobs. The disbelief and betrayal was compounded with what they perceived were essential and valued jobs now being contracted out by an employer whom they had committed to and relied on income in exchange for labour.

Stress, anger and resentment were additional powerful emotions reported by HEU and BCGEU by workers who were losing their jobs. HEU and BCGEU warned of the costs to society of the effects the emotions described have on a person's health. BCGEU and HEU reported workers who were on medical leave and struggling with "deep-seated" anger in response to losing their job. While HEU reported VIHA offered support to HEU employees losing their jobs no unions reported support for workers continuing to work in an environment undergoing significant restructuring.

Low morale, demoralization and devaluing were reported by all unions in the study as consequences of the provincial government's restructuring. HEU and BCGEU reported workers whose jobs were contracted out felt devalued and demoralized. HEU and BCGEU members heard key messages that the market rate for 'hospitality' workers was 40% lower than health sector wage rates that they were overpaid and a correction was necessary.

Demoralization was articulated by White of BCGEU as a process of "...stripping away how one defines oneself..." when experiencing loss of definition of self in the loss of a job through contracting out (2004). White goes further to link this experience of ideas and messages as acceptable rationales for the legislation to balance budgets (2004). For workers left behind, HSA reported their members feeling demoralized in a post-privatization workplace with unclean environments and patient complaints about "bad

food” (Stewart & Ohmart, 2004). This is consistent with other worker experiences in Canada (Botting, 2001; Stinson, et al, 2005).

Low morale has been cited as a consequence to public sector employees converting to the corporate private sector (Armstrong, et al, 2001a; Botting, 2001; Stinson, et al, 2005). Demoralization equates with low morale. Armstrong and Armstrong reports, “there is a growing body of evidence from the private sector indicating that both worker morale and innovation suffer from downsizing, mergers and constant change, while money may not be saved in the long run” (2001a:171).

Fear of further privatization was a constant destabilizing thought amongst workers. Workers were afraid to speak up about issues in the workplace for fear of losing their job (Muzin, 2003; Stewart & Ohmart, 2004; White, 2004). Workers intentionally did not claim overtime for fear that additional costs would lead to contracting out (Stewart & Ohmart, 2004). Workers were silenced about other concerns for fear their professional discipline could be targeted or placed at risk for contracting out. Initial media reports quoted Health Minister Colin Hansen who indicated a range of up to 50,000 workers including support workers, medical technology, laboratory, nurses, kidney care wards could be contracted out leaving much uncertainty for most workers about their jobs (Beatty, 2002; Lavoie, 2002). Workers were silenced in bargaining demands for 2004 wage increases other than to request their unions do everything they could to protect their jobs from privatization currently or in the future (Muzin, 2004; Stewart & Ohmart, 2004; White, 2004).

Fear and anxiety about one’s job is generally accepted as counter-productive to a healthy work environment. Ready, an Industrial Inquiry Commissioner of B.C, in

deliberations on matters of “worker anxiety” and job security in health reform noted the following, “the most productive and motivated workers is one who feels satisfied and not threatened” (Ministry of Labour, 1996:3).

While not related to the issue of contracting out, fear of consequences to voice the truth is prevalent elsewhere in VIHA. Noteworthy is the comment on fear of consequences from participant affiliate facilities and employees of VIHA as cited in the Capital Regional District’s review of assisted living undertaken in 2004. The report notes the following:

It was also not uncommon in this review for agencies contracted to VIHA to ask that their comments not be identified. There seemed to be a sense of potential unwelcome consequences of providing comments unfavorable to VIHA” (Health Facilities Planning, 2005:92).

Quality of Work Environment

During and after privatization was implemented, the work environment was reported to have deteriorated, with decreased productivity, reduced team cohesion, and increased workload.

My work experience over the last 20 years suggests that productivity is influenced by the quality of the social environment. BCNU and HSA cited the blend of VIHA and private contracted employees created workplace inefficiencies, which are difficult to measure. VIHA is not the employer of private contractor employees and therefore, cannot direct or correct their work.

All unions reported the difficulties of mixing private contract and public employees and how this lessened team cohesion. Unions reported workers who work in acute and facility care rely on knowing their regular food service, housekeeper, laundry and security workers. Support staff has invaluable information about patients and

residents, which assist in overall care. The quality of the support staff plays an important part in functioning of the health care team (MacPherson, 2004; Muzin, 2004; Steward & Ohmart, 2004; White, 2004). These relationships were weakened with contracting out. Along with higher staff turnover in the private contracted employee group, health care team cohesion is also weakened.

Unions reported lack of team cohesion associated with high staff turnover of contracted employees (Newsgroup, 2004). Unions also reported a growing sense of division between workers, public and private and increased workload as the result of privatization. Unions expressed concern that this destabilization not only impacts workers but also could ultimately impact the care of patients and residents (Muzin, 2003, 2004; MacPherson, 2004, Steward & Ohmart, 2004; White, 2004).

The examples previously discussed of reported inefficiencies, declining care team cohesion and increased complaints from the clients were linked to reports of workers experiencing increased workload.

BCNU reported nurses experiencing increased workloads associated with the complications of inexperienced support workers and their high turnover. By November 2004, within the period of study, after hearing numerous reports from social workers, dietitians, and speech language pathologists (in VIHA), HSA went to the media. The complaints about food quality, lack of food and unsafe diet textures meant social workers and dietitians were spending up to 50% of their time hearing complaints, attempting to resolve them or referring them elsewhere. This reduced the amount of time devoted to patients and residents. HSA stated, "... it's affecting their ability to do their jobs" (News Group, 2004:1A). They further mentioned the loss of long-time, experienced, capable

employees and their replacement by inexperienced staff, prone to higher staff rates of turnover (News Group, 2004). In response, the vice president of Morrison's Healthcare Food Services (a subsidiary of Compass) acknowledged staff turnover but stated, "...a certain amount of turnover is to be expected during times of major change" (News Group 2004:1A).

The social-emotional and workplace impacts of privatization are of concern when factoring data from other sources. Pacific Blue Cross, the private insurance company that covers extended health and dental benefits of health and facility care employees, reported escalating claims and costs for certain medication. In 2004 and 2005, Pacific Blue Cross reported that out of the top 10 costly drugs used by health care workers in British Columbia, the highest use is for antidepressants (Pacific Blue Cross, 2006). The data informs that one-third of all health care workers took anti-depressants or 14% higher than the general population (Pacific Blue Cross, 2006).

Further adding to the discussion of healthy workplace is the report of the Auditor General of British Columbia. The Auditor General's report of 2003 discussed the attributes of a healthy work environment and job satisfaction. The attributes noted in the report are: 1. demands fit the resources of the person; 2. a high level of basic predictability; 3. good social support; 4. meaningful work; 5. high level of influence at work ; and 6. balance between efforts and rewards (2003:20). The Auditor General focused specifically on health care workers in the 2004 commenting as follows:

If the health authorities are to fulfill government's expectations of putting patients first; they must ensure that the work environment supports health care workers in their efforts to provide the best patient care possible. Such supports include protecting workers from undue stress and risks (2004:2).

In 2004, unions were more likely to report that the opposite was occurring in health care environments. VIHA was the first health authority to be reviewed by the Auditor General in 2004. VIHA responded to the review stating, “the [...] Board has adopted a policy specifically focused on providing employees with a work environment that is free from injury and work-related illnesses (2004:97). This VIHA quote is biased in favour of physical dimensions of health, ignoring behavioral or emotional factors. Various restructuring options implemented by VIHA appear to question whether the policy was implemented in the form of a good quality work environment.

While unions were expressing concerns on the impacts to workers, the work environment, and potential impacts to clients, further media reports during the study were beginning to trickle in if only for the sound bite effect. In 2004, a daughter and wife of an 85 year old veteran complained about the lack of acute care beds and had to spend days lying on a stretcher in the hallways of the emergency room. They also commented on the poor quality of food and how, “...it was so tough he couldn’t have eaten it”... (Harnett, 2004:6). In another article, “complaints of heart attack victims being fed hamburgers, diabetics served white bread and white rice and dirty bed linens in hallways...” relate to the privatization of hospital support services (Harnett, 2004:13). In 2004, it is questionable in VIHA whether these complaints concur with the Auditor General’s observations (previously noted) on the importance of these to both patients and workers (2004).

Loss of Collective Agreement Provisions

Workers who lost their jobs due to contracting out or experienced other forms of health care restructuring were disadvantaged by changes imposed by Bill 29 (or HEABC

interpretations of it), which altered or removed collective agreement provisions. Job loss, the prospect of job loss and/or a significant income loss is amongst the most damaging consequences for any worker. Discussion of the impact of job loss was included in the section on ‘social-emotional impacts’. This section will examine the effects of dramatic changes in collective agreement provisions including: contracting out, red circling, regional job postings, successorship, seniority (bumping rights), melded seniority, job security and pay equity.

Contracting Out

Prior to Bill 29, legislation and negotiated union contracts (previously discussed in Chapter two) actively discouraged contracting out. The *Health Authorities Act* (1993) combined with ‘no contracting out’ clauses embedded in collective agreements ensured contracting out (and the termination or lay-off of workers) did not occur. Bill 29-2002, Section 5 enables health authorities to contract out non-clinical services (2002). These legislative and policy changes were significant elements in health care restructuring. Privatization of support service workers and the lowering of wages were for cost containment.

Red Circling and Regional Postings

Eliminating red circling (wage protection) and the availability of regional postings were not specifically addressed in legislation. However, as Stewart and Ohmart explained, it was implemented in VIHA through HEABC’s interpretation and instruction to employers on Bill 29. This action temporarily occurred until suspended by the B.C Labour Board award, in favour of the unions appellant. In some cases, workers waited for nearly two years with wages owed paid from red circling (wage protection) (Stewart

& Ohmart, 2004). Regional postings were a by-product of the application of regional seniority provisions in place but a ruling in the union's favour at the B.C Labour Relations Board needed to occur (Stewart & Ohmart, 2004). This provision is significant when job losses occur, especially with the removal of job security provisions by Bill 29 (ESLA).

Successorship

The elimination of the right of union successorship is a key tenet of Bill 29. Loss of union successorship or the ability of the union to maintain its certification to represent workers in the same workplace being privatized is significant. When jobs are contracted out or new operators take over running a facility, there is diminished role and/or power of organized labour in the labour-management relationship (Griffin-Cohen & Cohen, 2004; Fudge & Brewin, 2005; Fuller & Stephens, 2004; International Labour Organization, 2003). This diminished power enables management, acting on behalf of government owners, to impose significant cost reductions (income and benefit loss), job loss and a workplace suffused with stress, threat of job loss and often reduced services (Armstrong & Armstrong, 2001b; Fudge & Brewin, 2005; International Labour Organization, 2003). Compass Group Canada, a multinational corporation, based in Britain operating Morrison and Crothall, signed a partnership agreement with the International Wood and Allied Workers Local 1-3567 which included terms of working conditions, continuation of set wage rates, and guaranteed job action (Griffin-Cohen & Cohen 2004; Muzin, 2003). These multinational corporations rely on a non-unionized workforce or agreements with unions characterized by low wages and little or no benefits (Griffin-Cohen & Cohen 2004; Muzin 2003; White, 2004;). These savings on labour costs improves profits. Loss

of successorship has occurred throughout Canada and in other parts of the world (Adams, 2005; Armstrong & Armstrong, 2001b; Camfield, 2005; Fudge & Brewin, 2005; International Labour Organization, 2002). This links the legislation to a global trend of restructuring the public sector and unions (Camfield, 2005; International Labour Organization, 2002).

Seniority and Bumping Rights

Bill 29 suspended (until December 2005) long-standing, seniority and bumping rights, which limited work options during a time of restructuring. For BCGEU and HEU members who were losing their jobs due to contracting out, they could apply their seniority to bump another worker with less than five years seniority. Many HEU workers with appropriate job skills in VIHA operated sites had few options to bump other employees because of the predominance of long-term employees (Muzin, 2003).

The option of utilizing a dovetailed seniority list under section 35(5) of the *Labour Relations Code* for these members within the VIHA amalgamated sites was challenged by HEABC at the BC Labour Relations Board (BCLRB June 28, 2002). HSA, as the lead union of the bargaining association argued effectively that successorship meant: 1. VIHA and other health authorities operating various sites would continue to be named as the single employer; therefore, the continuation of successorship of collective agreements would remain intact and; 2. that regional or dovetailed seniority lists should be created within sections of a region to allow for displaced and senior employees to use the limited bumping provisions outlined in Bill 29 to secure employment in their community, close to home (BCLRB No. B232 June 28: 2002). The BCLRB decision in 2002 in rejecting HEABC's arguments stated the following:

We observed that while seniority is not a statutory right, it is nonetheless one of the most important, if not the most important, right that the trade union movement has been able to win for its members in its modern day history. The importance of seniority and the concerns that a threat to seniority unleashes cannot be overstated.[...]To facilitate the movement of services and employees Bill 29[...]removes collective agreement barriers to layoffs and limits bumping....However, Bill 29 does not define “seniority” or a “seniority list”. We also conclude Bill 29 does not limit the Board’s powers under section 35(5) to make adjustments to the seniority lists (p. 4-8).

For BCGEU, HEU and BCNU in affiliate sites of VIHA dovetailed seniority lists were eliminated. This meant that employees facing termination due to contracting out had very few options, particularly if they did not possess the qualifications to bump others. HSA and BCNU identified this limitation of seniority linked to bumping rights to be problematic for their membership who were not the targets of contracting out but experienced job loss due to restructuring initiatives related to budget shortfalls.

The legislation ‘sunset clause’ returns workers to their former bumping rights in December 2005. This clause in Bill 29 appeared to exist to reduce massive amounts of bumping triggered by large amounts of lay offs. Therefore, it was an intended legislative strategy to temporarily reduce rights during a systematic restructuring of the health sector workforce on the grounds of cost savings.

Job Security

The legislative removal of job security found in the Employment Security and Labour Force Adjustment Agreement (ESLA) was identified by all unions as another negative economic impact on workers whether they were contracted out or lost their job due to reorganization or closure. Ready noted the intent of ESLA was, “...to establish a labour adjustment transitional process including harmonious mutually beneficial relationships with all parties. The goal is to improve the health care system for the

benefits of all....” (Ministry of Labour of B.C, 1996: 2). This removal resulted in several impacts:

- workers experienced income loss by employers being able to avoid the extended severance period (progressive job adjustment process);
- the resources of the HLAA were lost in matching displaced workers with vacancies across the province meant immediate or eventual access to employment. HSA and BCNU explained this also benefited employers where professional disciplines in short supply such as nurses, pharmacists or physiotherapists could be directed to vacancies available in the province;
- removal of retraining funding to enable job mobility. For example if a cleaner, laid off due to her job being contracted out, wanted to become a medical records transcriptionists or ward clerk (both in short supply), the previous system provided a severance period during which the cleaner could apply for assistance to support retraining;
- workers close to retirement no longer had pension top-up monies to minimize pensions reductions if this was the workers only option.

Job security provisions were negotiated between the unions and government in the 1990’s and appeared to reflect the shared value of a stable, effective workforce. While Health Canada in 1997 boasted this as the most progressive job security in North America, the newly elected B.C Liberals moved quickly to liquidate it (1997). Media or government reports were not available to explain where the savings from the removal of this lost provision ESLA were assigned. Bill 29 does state the ESLA funding was shifted

to “...the Health Special Account Act” (2002). It is estimated that this job security provision was worth \$35 million over a contract period (Muzin, 2003).

The removal of job security provisions is clearly a plank in the government’s move to privatize the workforce. Privatization is accompanied by the loss of a public work force, mainly women and significant erosion of workers rights and benefits.

This was very different for the health science professionals who lost their jobs due to closures or restructuring. HSA reported that while severance provisions were significantly reduced most members eventually found work elsewhere. Health science professionals are more qualified, in short supply and therefore largely irreplaceable. The same could be said for nurses. They are in short supply, provincially, nationally and internationally. The most serious effects they would have suffered are lost employment security provisions, seniority rights, and portable benefits if they could not find work within VIHA or an affiliate site.

The story for laundry, housekeepers and food service workers is one of loss. They had fewer options other than to accept re-employment in the health care sector at wages 40% less than pre-Bill 29 or find employment in other private sector areas. The workers, some with families to support, had to take on additional jobs to make ends meet (Muzin, 2003, White, 2004). Women are particularly vulnerable to dislocation with reduced chances of retraining on significantly reduced incomes (Armstrong & Armstrong, 2001a; Creese and Strong-Boag, 2005; Fuller & Stephens, 2004; Griffin-Cohen & Cohen, 2004).

Pay Equity

The majority of health support workers (women) in the food services, housekeeping and laundry were viewed as having no greater skills or qualifications required of similar workers in the hospitality industry. The comparison of these workers to hotel workers is connected to a national and international trend (Haiven & Haiven, 2002). This concept justified contracting out to private corporations and their hiring of replacement workers paid approximately 40% less than public employees –lower health system costs ensued (Armstrong & Armstrong, 2001b; Fuller 2001; Fuller, S, & Stephens, L, 2004; Griffin-Cohen & Cohen, 2004; Government of Canada, 2002). Muzin cited the Fraser Institute in the mid 1990's for a report, which concludes hospital support workers were overpaid, compared to the hospitality industry (2003). Other political analysts including Vaughn Palmer joined in with the position that these “non-professional” support workers were overpaid and were draining the health budgets of money that could be redistributed to direct care (as cited in Griffin-Cohen & Cohen, 2004:22). The B.C Medical Association also joined in encouraging privatization of support services to contain costs (as cited in Griffin-Cohen & Cohen, 2004). The Romanow Commission stated that Canadians appear to accept contracting out of food services, cleaning, housekeeping, maintenance and laundry to the for-profit sector. The Commission however neglected to explain that the money saved is at the expense of worker's income (2002). Fuller explains, “outsourcing companies achieve their cost savings almost entirely by reducing the cost of labour: maintaining low wages and benefits and fighting attempts to unionize” (2001:302). The rationale provided by VIHA to contract out support staff was budget shortfalls of \$42.5 million. Local media reported

that VIHA could save 10 million dollars a year by contracting out support staff (Patterson, 2004; Harnett, 2004). The picture is clear; budgets are balanced in part on the backs of support workers of whom over 80% are women. In this privatization scheme, workers and their wages are treated as a commodity – devalued and laid off for lesser-valued private replacement workers. Further clarification from BCGEU and HEU shows that some of these workers are immigrants, single parents with children or older workers without formal educational certificates who learned on the job skills or with partners who also work in similar work environments. Bill 29-2002 hit these vulnerable workers hard (Muzin, 2003, 2004; White, 2004).

HEU reported that privatization “...stripped away decades of struggle for pay equity to improve women’s wages in health care...” (Muzin 2003). Equal pay for work of equal value also known as pay equity was negotiated into collective agreement wage schedules in the 1960’s. Discontinued in the 70’s and 80’s, HEU and other public sector unions went on strike in 1992 to restore pay equity (Muzin, 2004). This action resulted in over 90% of union members receiving increased wages for pay equity (Griffin-Cohen & Cohen, 2004). This trend of improving pay equity for women continued in the 1990’s under the NDP’s Pay Equity Framework policy.

In 1995, the government introduced the Public-Sector Employers Council on Pay Equity Policy Framework. Pay equity was a recommendation from the Royal Commission, *Closer to Home* (1992). This policy direction was implemented to address long-standing devaluation of women in the public sector (Panitch & Swartz, 2003). Traditionally, public sector workers have been defined as direct, government employees; health care workers are not included in this definition (Fuller & Stephens, 2004). While

the framework was not intended for health care, unions used this document as a template to negotiate pay equity gains for women support workers (Fuller & Stephens, 2004; Griffin-Cohen & Cohen, 2004).

Muzin reported in 2003 and 2004 the wages for food, housekeeping and laundry workers ranged from \$17.00 to \$19.00 per hour depending on seniority and job classification. Muzin further reported that while many criticized these wages as too high, he maintained it was a fair wage for the type of work and conditions in the hospital and facility sector (2003). Compass Group, the multinational corporation based in Britain, with its Subsidiaries Morrison (food services) and Crothall (housekeeping and laundry) paid workers in VIHA sites between approximately \$9.00 and \$10.50 per hour with little or no benefits (Harnett, 2004b). This amounted to approximately 40% less money. Some HEU members were expected to be hired by Compass but Muzin did not expect many because these companies did not want HEU workers to reorganize back into HEU (Muzin, 2004).

Muzin in 2003 reported that pay equity losses for women constituted a form of wage discrimination. This discrimination was created through Bill 29-2002 enabling Health Authorities to reduce their budget deficits, which included unfunded wage settlements in 2001. This occurred at the same time the newly elected Liberal Government had enacted tax cuts and reduced social funding and programmes (Creese & Strong-Boag, 2005). Combined with budget shortfalls and the message that support workers were over-paid compared to their equivalent in the private sector enabled the government to act against organized labour. Pay equity losses for women in health support jobs combined with limited sick leave provisions, holiday entitlement and

pensions created serious economic losses for women (Botting, 2001; Griffin-Cohen & Cohen, 2004; Muzin, 2003).

The government's 2002 introduction of Bill 29 effectively "...turned back the clock..." on pay equity gains for women (Muzin, 2003). At the same time, it established a task force to determine feasibility of creating pay equity legislation for the private sector. The 2002 Task Force stated, "there is no dispute that substantial sex-based wage disparities (also referred to as gender pay gaps) exist in British Columbia and across Canada, that they adversely effect women in a number of ways" (Iyer, 2002:i). How ironic that the Task Force would provide this analysis at the same time as government was instituting discriminatory policies in the public sector.

Full economic impacts to former HEU or BCGEU members were not available from the unions during the period of study. However, White stated that BCGEU were already seeing former members living on welfare and employment insurance. White also noted some members had to work two jobs to support their family (2004). Muzin stated some would lose their homes (2004).

The devaluation of these worker's jobs, through comparison with the hospitality sector or household domestic tasks, is a negative message for women. The message appears to suggest that health support staff is traditional women's work with little of no market value (Armstrong & Armstrong, 2001a; Baines, et al, 1993; Fuller 2000).

This shift in public and labour policy through the implementation of legislation promoting privatization has therefore had negative consequences for workers and especially for women who make up the majority of workers in health care. Unionized public sector jobs have been a significant source of better paying jobs with benefits for

women (Jackson, 2005). These jobs reduce poverty, economic dependence, thereby enhancing the ability of women to have options (Jackson, 2005). The loss of years of pay equity for support workers resulting in low wages represents what could be categorized as a race-to-the-bottom for poverty (Armstrong & Armstrong, 2001b; Botting 2001; Brodie, 1996b; Creese & Strong-Boag, 2004; Griffin-Cohen & Cohen, 2004; Rachlis, 2004b).

Summary

The B.C Liberal government enacted an immediate and significant policy shift through tax and budget cuts under the guise of fiscal imperatives. Bill 29-2002 deregulated all barriers to privatization in law and collective agreements previously put in place in the 1990s. The Act empowered health employers to contract out work to private for-profit corporations, not bound by successorship of unions or collective agreements. Performance contracts initiated by the government held VIHA accountable for the budget deficit of over \$50 million, partially created by the provincial government's refusal to fund the government's legislated and negotiated wage settlements and increased medical services rates. Speculation from unions of VIHA's ideological opposition to contracting out workers was consistent with local media releases and VIHA's redesign plan. VIHA pursued options to prevent contracting out with HEU but in the end, they failed.

VIHA operated and contracted (affiliate) facilities laid-off approximately 1600 support workers from housekeeping, laundry, security, grounds keeping and food services to meet their budget targets. Bill 29's removal of job security and bumping provisions was a significant precursor to privatization. The government's agenda to advance privatization combined with their inability or refusal to fund VIHA's (health

authorities) budget deficits, meant that the removal of job security provisions to reduced labour costs were inevitable.

Over 80 per cent of hospital and facility support workers are women. Notions of these workers redefined in legislation as non-core or “non-clinical” or hospitality comparable to a hotel worker provided the rationale to reduce wages and benefits. These women, through their unions, had made significant gains in pay equity that through one piece of legislation was gone. Wages for workers of private corporations is currently 40 per cent less with little or no health and welfare benefits akin to structured wage inequality. Privatization for women in health care has serious consequences.

This shift in B.C represents a trend in provincial and national labour relations from one of “consent to coercion” where social democratic labour policies representing “consent” moved to neo-liberal policies representing “coercion” (Panitch & Swartz, 2003:7). Panitch and Swartz describe the BC Liberal government’s aggressive attack on unionized workers and unions in implementing the neo-liberal policy as follows: “This inauspicious beginning to the new century in B.C, with a government going even further against labour than Harris had dared in Ontario, or Klein in Alberta, dashed any hope the Canadian Labour movement might have had for a respite from the assault it had been having for so long” (2003:208).

Chapter seven to follow concludes the thesis. A postscript follows.

Chapter Seven: Conclusion

Privatization of health care includes contracting out of services and workers' jobs to the for-profit corporate sector where wages are lower and little or no benefits (extended health or pensions) exist. In neo-liberal times this policy direction is constructed as a fiscal imperative that is common sense and reasonable to sustain our beloved health care system by curbing greedy unions and worker's wages. In the 1990s, a labour friendly B.C government implemented policy (legislation and collective agreement language), which protected workers from contracting out and pursued other options to federal under-funding. The turn of events in 2002 by the enactment of Bill 29-2002 led to my interest as a health care worker and as a union activist as to how this was going to be implemented and experienced. The purpose of this case study was to identify and describe the implementation of the *Health and Social Services Delivery Improvement Act* on health sector unions and their membership; the workers who deliver the care and services.

Research involving citizens and their lives is never a linear process. This case study was no exception. Participants were 'in the midst' of implementation with loss of rights, roles, jobs and a sense of politically "treacherous times" (MacPherson, 2004; Stewart & Ohmart, 2004). The research questions became contextualized and clearer in the process of doing the study.

1. How was the *Health and Social Services Delivery Improvement Act* (Bill 29-2002) operationalized in one health authority in British Columbia?

2. How did health care unions and their membership representing most at risk “non-clinical” service workers (as defined by the Act) experience the impact of the *Health and Social Services Delivery Improvement Act*?

These questions directly link to the debate in Canada over preserving or restructuring the public not-for-profit health care system. These debates include ideological, political and economic contexts. These guide policy direction with governments, legislators, media, corporations, employers, unions, health care workers and citizens. Bill 29-2002 and the Regulations removed many freely negotiated collective agreement rights of workers and impacted on the role of organized labour.

During the data collection phase, this study was hampered by challenges to the method of face-to-face interviews with busy unions leaders. It is impossible to know if other methods such as a survey would have been responded to, but it would not have produced the richness of the data eventually collected by tape recorded interviews. Case studies have been widely criticized as yielding volumes of data and being too lengthy for policy makers to access in an efficient manner (Burnham, et al, 2004). This study followed a similar pattern. In an attempt to be thorough, summarizing and excluding reportable data was a challenge, which an experienced researcher may have handled differently. The critical approach in the discussion section focused on the research questions while thorough there is no claim to completeness.

My bias and competing interests as a researcher were declared in Chapter One. While this study is sympathetic to organized labour some will claim it is related to my role as a union activist. But these criticisms must also factor in my values and beliefs as a social worker which include opposition to privatization of social programmes, being

defined by the legislation as “non-clinical”, my direct experience as a caregiver and my three aunts living in residential care with contracted out services. These are some of the strengths of this research and, as such, an acknowledged limitation of this study. Another researcher, depending on their standpoint may approach the data and discussion with an opposing perspective.

It was at the point of re-organizing and sifting through the transcripts that I queried the amount of questions posed, yet I find I have more questions. Does one ever know the right amount of questions to ask? While generalizability was not a goal of this case study design, unions made several comparisons to similarities in implementation and impacts with other health authorities in B.C and contracting out both nationally and globally. Impact on union roles was a province-wide experience and similar legislative interference nationally and internationally was reported by authors (Adams, 2005; Fudge & Brewin, 2005; Griffin-Cohen & Cohen, 2004; Goodman, et, al, 1998; Jackson, 2005; Panitch & Swartz, 2003; Starr, 1987). All unions reported that worker and organizational impacts were similar to contracting out implemented in other regions of B.C.

Part of the purpose of this study was to explore and document impacts in one health authority. In some respects, this study of policy implementation may have been less cumbersome data wise if it had been completed retrospectively where implementation and impacts may have been more easily accessible from unions and websites. However, the initial impacts and insights of implementation may not have been recalled with such detail and passion as what is captured in this body of research.

Major Findings

Major findings to be discussed are “union busting” in the era of public sector restructuring, workers, mainly women, who absorb the brunt of labour policy changes, organizational impacts and union agency.

“Union Busting” in Public Sector Restructuring

Majority governments are clearly able to enact legislation consistent with their policies. This study documents that the B.C Liberals with the overwhelming majority had carte blanche to enact Bill 29-2002 plus 13 other anti-labour laws that cancelled out years of collective bargaining and union roles. Unions described this as “union busting”. Bill 29-2002 contained three key legislative forces that significantly reduced the role of unions. The Act blocked the transferability of union representation to contracted out workers in a health facility. It removed a key industrial relations mechanism (consultation) in discussing labour force adjustments between unions, employers and government to mitigate negative worker impacts. Finally, Bill 29-2002 interfered with past collective agreement provisions, invalidated existing 2001 ones and restricted future collective bargaining.

Labour relations were substantially shifted to the detriment of unions and their members in an unprecedented manner. Reduced social spending, privatization and deregulation are planks for the B.C Government. These three neo-liberal components also rely on reduced role and influence for organized labour, which Bill 29-2002 achieved. This B.C experience is not unique. Across Canada, over 150 pieces of legislation have been documented by Brewin and Fudge (2004) creating a decline in organized labour’s influence and role in collective bargaining (Adams, 2005; Brewin & Fudge, 2004;

Panitch & Swartz, 2003). This finding is consistent with literature and research nationally and internationally on restructuring in the public sector in a globalized economy (Brownlee, 2005; Brodie, 1996; Griffin-Cohen & Cohen, 2004; Jackson, 2005; Rice & Prince, 2000).

Women Bear the Brunt of Health and Labour Policy Shift

This study documented that 80 to 98% of health care workers in B.C are women, which is consistent with Canadian health care literature and research (Armstrong, et al, 2001; Fuller, C & Stephens, S, 2004; Griffin-Cohen & Cohen, 2004, Jackson, 2005). All workers experienced some impacts, but women bore the brunt. Support workers (80% to 85% women) were redefined by the government as “non-clinical” and diminished their skill set to that of regular hospitality workers, therefore devaluing and justifying wage and benefit reductions. Laid off women support workers lost a decade of pay equity gains with jobs now valued at a 40% wage reduction. The legislation also had a universal impact as it applied to the majority of workers in other labour force adjustments with facility and programme closures. Other workers, who remained on the job, experienced the aftermath of the Bill 29 implementation.

Hospital support workers were contracted out, facilitating wage and benefit cuts to reduce health authority deficits. U.S, European and Canadian literature demonstrates that contracting out almost entirely relies on reducing worker wages and benefits to cut costs (Bailey, 1987; Fuller, C, 1998, 2001, 2003; Griffin-Cohen & Cohen, 2004; Jackson, 2005; Starr, 1987). The privatization of support workers undermines the economic security of large numbers of workers, mainly women. Jackson, a Canadian economist, documents that laid off women have reduced chances of retraining on significantly

reduced incomes making it less likely to secure a job with a living wage, leaving them at risk for poverty (2005). Restructuring of costs in the health care system by significantly reducing incomes and benefits for support staff creates ‘winners’ and ‘losers’. The ‘winners’ are the for-profit corporations, government and employers and the ‘losers’ are the workers, mainly women. These actions are shortsighted. The potential to increase poverty to laid off workers or newly hired workers at lower wages may result in costs to health care and the social welfare system. These increased costs may not surface to the public’s attention for some time.

Organizational Impacts

While all unions reported their belief in VIHA’s opposition to contracting out, the government’s refusal to fund a \$50 million deficit forced their hand. Human resources, people caring for people and the fundamentals of cleanliness and decent food are paramount in health care. This study documented initial union, worker and client (media) reports that suggest these were in decline. Health care staff relies on good working relationships with support staff that also interact and directly support patients and residents. This mixture of Compass private contracted employees and VIHA employees lessened team cohesion and morale. For workers remaining, reports of increased workload were related to working with inexperienced contracted workers, high staff turnover and increased patient and resident complaints (requiring time to resolve). The impacts and further reports of quality control complaints with inedible, inconsistent food and dirty buildings demonstrate how the health authority and affiliate employers lost direct control over their operations. This data questions whether the B.C Government’s

2002 promise that Bill 29 would provide the “same level” and “quality of service” is more rhetoric than promise (Ministry of Skills Development and Labour, 2002b:2).

Most of these concerns were validated in media reports from patients, residents and unions. Many authors noted these types of consequences are hidden costs to privatization and are seldom calculated or reported on (Armstrong, et al, 2001; Bailey, 1987; Fuller, C, 1998, 2001; Starr, 1987). Unions warned of these consequences (Stewart and Ohmart, 2004).

In 2004, the Auditor General of B.C recommended that if the government was to fulfill their promise of “Putting Patients First” then health care workers must work in an environment that is conducive to that goal (2004:2). The documented impacts in this study raise doubt as to whether the government or health authorities were able to fulfill the platform of providing good health care by “putting patients first”, (Ministry of Skills, Development and Labour, 2002a:1). The ideology and dogma of the government have driven this public policy choice but it is blind to the impacts on humans. The B.C Government introduced this legislation in 2002 announcing it would address two major problems in health care, “management” and “sustainability” (Ministry of Skills, Development and Labour, 2002b:1). It seems they may have increased problems of health management by introducing privatization of workers.

Government and corporate goals of a flexible low cost workforce are much more about the bottom line than caring for humans. While the B.C Liberal Government’s media release in 2002 claimed the “NDP placed union interests ahead of patients”, this researcher questions if the B.C Liberal’s have placed business interests ahead of patients (Ministry of Skills Development and Labour, 2002a:1).

Union Agency, Union Strength

Each union reported on their resistance strategies during tumultuous labour relations in B.C. The membership stepped up to the plate and spoke to their neighbours, friends, family, media and M.L.As specifically with their concerns and experiences with Bill 29-2002 and health care privatization. Health care workers, rather than relying on their union leaders, realized they could have an impact with the public and public policy debate.

Health care workers take direct care of citizens in hospitals and care facilities. The public knows this and supports them and the government underestimated this support. This was evidenced in pre Bill 29-2002 illegal strike of HSA and in 2004 with HEU and BCGEU. The government further underestimated these women's health care unions and the extent they would engage in the democratic mechanisms available to resist the government's agenda. Unions forged alliances with community social action groups and with the broader provincial and national labour movement. Unions initiated labour board arbitration hearings, court action, and launched several complaints to the United Nations as well as encouraged members to vote and participate in the 2005 municipal and provincial elections. The unions continue to lobby for the organized and the unorganized.

The agency and role of unions could be considered a key measuring stick for industrial democracy in Canadian society. Attempts to reduce the role of representing the collective voice of workers will continue with neo-liberal governance. However, as long as there are power differentials between workers, employers, governments and reduced social welfare programmes, unions will have agency and a power base. Furthermore,

there may be a political price to be paid by a government when increasing privatization of health care, legislating reduced role and influence of organized labour and ignoring the ILO rulings of the United Nations.

Contributions

This research contributes to the existing body of knowledge and research in Canada on industrial relations in health care. It also demonstrated how health and labour policy changes impact unions and workers, mainly women, who support the public sector of care. At best, this research may inform the caring state, employer, politician, citizen, and media as to the negative and costly consequences and to pursue alternate options to collective agreement interference and contracting out. The data may be used as a guide to mitigate negative impacts with public policy shifts of this nature. Unions are already informed; it may provide further evidence in their pursuit of resistance against the neo-liberal agenda of privatization. This study does begin to inform concerned policy makers on policy development and implementation gone wrong.

Finally, this study contributes to societal recognition of how legislation impacts Canadian citizens, who are members in a union and health care workers (women) by documenting, contextualizing and giving voice to their experience in a body of research. Workers were silenced out of fear for their jobs, and future collective bargaining. Many health authorities have strict muzzling or communication policies concerning how employees speak out in the public sphere about their work environment. Unions reported that press releases on the issues and impacts of Bill 29-2002 were largely ignored by media adding to a veneer of silence. The Romanow Commission noted there was general acceptance of contracting out hospital support workers, but neglected to document impact

on workers and clients. The voice of the unions representing over 100 thousand health care workers and the data speaks for itself. Those who read it will have their own reactions depending on their standpoint, but as a union activist in various worksites, a client of health care and as a niece of three aunts living in facilities with contracted out support workers, I know the reality.

Suggestions for Future Research

Future research collaborating with unions and workers is a vital part of any study in industrial relations. Canadian research on impacts of health care privatization (contracting out) is lacking (Armstrong, et al, 2001; Fuller, C, 1997, 2001; Rachlis, 2000). Research that studies and evaluates the true fiscal costs of contracting out including the transition, implementation, administration, health care professionals clinical time dealing with complaints, plus the human costs to clients and workers would be an invaluable contribution to the political and policy arena. Research of this focus is imperative given the government claims of improved health care delivery.

My new awareness of the notions and language used in neo-liberal times regarding marketization, fiscalization of social programmes, public sector workers and unions contributed to my understanding of these constructs. Research involving critical methods of discourse analysis of these notions may provide further awareness for public sector workers and unions of the space these constructs occupy in citizen's lives.

Learning and Final Comments

I learned that public sector reform is not simply a policy choice but a deeper process of restructuring capitalism (Jackson, 2005; Panitch & Swartz, 2003). This process redefines the relations between State and global capitalism (Brodie, 1996;

Brownlee, 2005; Rice & Prince, 2000). This is an important implication for public health sector workers and unions. The many difficulties workers and unions experience don't just stem from a bad policy choice but from capital restructuring (Carroll & Ratner, 2005). This has been evolving in Canada for nearly three decades regardless of which political regime was in power (Carroll & Ratner, 2005). Respite from the new reality of neo-liberalism is not expected to ease up (Carroll & Ratner, 2005; Panitch & Swartz, 2003). I am convinced more than ever that privatization of public sector programmes and jobs is a social justice issue worthy of continued resistance.

In the short run health care workers lost much more than they or their unions bargained for. In the long run these actions could come back to haunt the public as important support services deteriorate under private sector employers and increased poverty of workers drives up health care and other social service use. In addition, in the long run citizens must decide how we value and compensate the workers who care for us in a publicly funded not-for-profit health care system. Ultimately, citizens must decide whether policy choices should focus on attracting business or attracting health care workers to a not-for-profit system of care.

Postscript to Study

Several relevant events have occurred since the end of the period of study on December 31, 2004; the story and experiences are still unfolding.

In 2005, the provincial IWA local 1-3567, representing Compass workers was absorbed by the Steelworkers union (Knox, 2006). The contracted out support workers won the right at the labour board to vote to join an appropriate union. HEU became the successful bargaining agent of the contracted out workers in VIHA. HEU on behalf of these workers is currently in bargaining with Compass Group pursuing a collective agreement that includes wage and health benefit increases.

By June 2005, with complaints of "...inedible food and dirty rooms..." Sunset Lodge cancelled its contract with Compass Group, the company providing housekeeping and food services (Lavoie, 2005a:A1). Several complaints were reported to the Times Colonist of poor food quality, dirty facilities and high staff turnover in VIHA operated sites (Cowan, 2005; Lavoie, 2005b). My aunts, who reside in three care facilities where food, laundry and housekeeping are contracted out, tell us that the food is "horrible", dirt appears to be mounting and that there are high staff turnover possibly related to low wages not matching the demands of the job. In 2006, my mother's post surgical experience in hospital included a failure to deliver food to her and a contracted worker stating she was unable to order food while RNs claimed they had done so. When the food arrived 30 minutes later she could not cut the meat and neither could I. I then privately purchased food from a local restaurant so my mother would have something nourishing. Initially, VIHA minimized the extent of these kinds of problems, and after

considerable public pressure, acknowledged the problems and promised to resolve them (Harnett, 2005, Lavoie, 2005c).

By December 2005, VIHA announced in a regional labour management meeting they would not be pursuing further contracting out of support workers jobs (Avery, 2006, personnel communication). In the summer of 2006, the government of B.C conducted province-wide housekeeping and food services audits, which included client survey participation; the results of this study have not been released in the government websites or media (my aunt participated). The May 2005 provincial election resulted in significant seats lost by the Liberals. Without data, one can only speculate that all the anti-labour legislation impacting many B.C families as well as the far-reaching cuts to social programmes that these actions had some impact on these lost B.C Liberal seats.

In 2006, the provincial government dangled a billion dollar budget surplus carrot including signing bonuses for all public-sector unions and physicians to ratify collective agreements by specified dates. The government claimed that if unions did not adhere to the deadlines the billion-dollar surplus would be absorbed by the fiscal year end to pay the debt. McMartin states the unions “capitulated” believing Finance Minister, Taylor’s rhetoric before the media release of the 2005-06 year end of a “3.9 billion-dollar” surplus (2006:1).

In the fall of 2006 the B.C Government announced their ‘Conversation on Health’ to sustain health care as there has been a 40 per cent increase in health spending since 2000 (Willcocks, 2006; Whitcombe, 2006). The government is excluding all health care workers in this second public consultation, but will hold private forums with a limited number of participants (Health Sciences Association, 2006). November 2006, the

government announced deficit projections from 2007 to 2010 predicting all provincial health authorities cumulative debt to be "... over one billion dollars..." (Kines, 2006:A1). The government did not meet their mandate of efficiency targets to contain costs. If this is an accurate government budget projection then it does not appear that contracting out workers reduced budget deficits.

In 2005, the health care unions constitutional court challenge, Charter of Rights and Freedoms to Section 2 (d), freedom of association (right to collective bargain) and Section 15, right to equality (rolling back pay equity gains for women) was granted leave of the Supreme Court of B.C by the Supreme Court of Canada to hear the merits of the union's arguments in February 2006 (Headley, 2006). The long awaited announcement was handed down on June 8, 2007 with a landmark six to one decision upholding collective bargaining as a Charter right and that sections of Bill 29-2002 were ruled unconstitutional, giving the provincial government 12 months to rectify these violations. The Court did not support the union's argument of discrimination based on gender. In rejecting the union's claim, the Court decided that Bill 29-2002 targeted job functions but not the worker's characteristics or gender. Nor did the Court support the claim of union loss of successorship, stating the Act did not entirely block this activity. The Supreme Court decided that the B.C Liberal Government engaged in "...substantial interference..." with collective bargaining (2007:40). The Supreme Court stated:

[Bill 29-2002] interfered with the process of collective bargaining, either by disregarding past collective bargaining, by pre-emptively undermining future processes of collective bargaining, or both... These provisions [contracting out, lay offs and bumping] deal with matters central to the freedom of association and amount to substantial interference... Although the government was facing a situation of exigency, the measures it adopted constituted a virtual denial of the s.2(d) right to a process of good faith bargaining and consultation (2007:40).

The Court rejected the government's argument that the legislation was necessary to ensure continued health care delivery, noting there were other options available and that they did not engage in "...meaningful consultation with the union" (2007:45). The Court said:

This was an important and significant piece of labour legislation which had the potential to affect the rights of employees dramatically and unusually. Yet, it was adopted rapidly with full knowledge that the unions were strongly opposed to many of the provisions, and without consideration of alternative ways to achieve the government objective, and without explanation of the government's choices (2007:45).

This decision impacts all unions, employers and governments across Canada. On August 2, 2007, the provincial government announced the appointment of associate deputy minister Paul Straszak to navigate discussion between the government and unions, a first step in the direction of the Court's 12-month timeframe. However, the resolution may be found somewhere between the need to secure votes in the May 2009 provincial election combined with the issues health authorities face with contracted out services.

Insiders and outsiders to labour organizations see the space that exists within the tensions of global market capitalism and hold up hope with producing probable strategies for a renewal of labour and citizen rights and a re-emergence of social democracy rooted in liberal values (Coburn, 2003; Jackson, 2003 & 2005; Panitch & Swartz, 2003). It will take commitment within the space in each of us to build international solidarity in the form of transnational social movements inclusive of citizens who are members of trade unions, anti-racist, ecology and feminist movements inclusive of a hegemony situated in liberal values and beliefs (Armitage, 2003; Carroll & Ratner, 2005; Carroll & Tolstoy, 2003; Panitch & Swartz, 2003; Starr, 2007).

APPENDIX ONE

Debra Gillespie
 [ADDRESS]
 Phone/Fax: [number]

[DATE]

[UNION & CONTACT NAME]
 [ADDRESS]

By Fax: [NUMBER] (original to follow in mail)

Dear [PRESIDENT NAME],

Re: Student Research on Bill 29

I am a graduate student in the School of Social Work at the University of Victoria (UVIC). I am focusing my thesis work on the Health and Social Services Delivery Improvement Act (Bill 29-2002). The title of my thesis project is *“Improved Health Care Delivery or Paving the Road to Privatization? – The Health and Social Services Delivery Improvement Act: A Case Study.”* I have chosen this topic for my thesis as I believe this is a significant social policy shift and I view it as an attack against unions, unionized workers and the public health care system. I am also a union activist, employed in the Vancouver Island Health Authority and am a member of the Health Sciences Association.

Presently, I am preparing for the UVIC ethical review and require a letter of approval from you as the president on behalf of your union that you support this student thesis study by expressing a willingness to have me do the study. By providing me with this letter you are in no way consenting to participating in the study, only to supporting my study. After the UVIC Ethics Committee grants its final approval I would then be providing you with additional information on the study, a consent form and interview guide consisting of questions you or your designate may chose to answer.

Specifically, my research will be:

1. Examining the Act (Bill 29-2002) in terms of the political and economic context, its origins, policy direction, goals and legal aspects;
2. Tracking incidents of privatization of the “non-direct” (as defined by Bill 29) health services in acute and facility care in British Columbia with particular emphasis on implementation of the Act in the Vancouver Island Health Authority (VIHA);

(2)

3. Examining how this Act or social policy reform fits within the discourse of economic liberalism in the Canadian context;
4. Documenting the impact of Bill 29 on those unions whose members' jobs are most at risk of privatization (or are being privatized) and their membership.

My study will include interviewing you or a designate specifically about the implementation of Bill 29 in VIHA and its impact to your union and membership. While I am focusing on one health authority, I will also be considering the impact in this region within the context of other health authorities in British Columbia. My plan is to create a listing of services and occupations throughout B.C which are being privatized or are targeted for privatization.

If you would like to discuss this with me please do not hesitate to call me at work [number] or home [number]. I look forward to receiving your letter by March 31, 2003 supporting my student research and thank you for your consideration.

Yours truly,

Debra Gillespie

APPENDIX TWO

Debra Gillespie
[ADDRESS]

[DATE]

[UNION & CONTACT NAME]

Dear [NAME]

Re: Introduction to Bill 29 Study: *Improved Health Care Delivery or Paving the Road to Privatization? The Health and Social Services Delivery Improvement Act: A Case Study.*

Further to receiving your letter supporting or approving the inclusion of your union and membership in my social work graduate thesis study, I have received approval from the University of Victoria ethical review to proceed. The main purpose of this research is to examine the Health and Social Services Delivery Improvement Act (Bill 29-2002) within the provincial and federal political and economic context, while documenting specific incidents of privatization and its impact as experienced by unions with most at risk members (to privatization) in the Vancouver Island Health Authority (VIHA).

You have been selected to consider participating as an elected leader and representative of your union. Specifically, your union represents a large number of members whose work is defined as 'non-clinical' in acute and/or facility care by Bill 29 and whose jobs are at risk or are in the process of being privatized in British Columbia. I intend to focus on the incidents and impacts of privatization in the Vancouver Island Health Authority and will be investigating how this compares to the rest of your membership throughout British Columbia. Please review the attached consent form, interview guide and thesis outline and decide whether you, a designate or any combination of participants from your union could provide the information I am seeking for my thesis study.

I believe research regarding Bill 29-2002 and the impact to your union and your membership is important because it links the experience of unions who represent health care workers in British Columbia to the current Canadian debate on maintaining a publicly funded health care system.

-2-

The potential benefits of your participation in this research include: 1. contributing to a body of knowledge on health reform, privatization and its impact on unionized workers who support our public health care system; 2. specific research on Bill 29-2002 will contribute to developing a knowledge base and could form the basis of other research in this topic area; and, 3. this research contributes to societal recognition of how legislation impacts unions and the workers and further documents, give voice to their experience in a body of research.

If you or your designate agree to participate it will be without financial compensation. Your participation will include two one and a half hour audio taped interviews, spaced eight to ten months apart at a location that is convenient for you. In my final written thesis I am also planning to include a provincial overview that tracks the health care services and occupational groups which are being targeted for privatization and would appreciate information that you are able to provide in this regard. Any other resource materials such as research, reports, and articles which would assist me in my research and education would be appreciated.

I do not anticipate any inconveniences to you or your designate by participating in this study. I am the sole data gatherer and have no intention of using it for commercial purposes. Dissemination of the results will be documented in my thesis and there may be opportunities to publish an article, present at a public forum, convention or conference. Upon your request, a copy of the thesis will be provided to your union.

If you have any questions or concerns about this study please contact me at home [number] or work [number] or contact either of the following individuals: University of Victoria Supervisor, Dr. Andrew Armitage (250-721-8333); or, the Associate Vice President of Research (250-472-4362).

Please review the enclosed consent form, interview guide and thesis outline which will assist you in determining whether you or someone you designate would agree to participate. I will contact you in the next few weeks to establish a time to meet to review participation in the study. Thank you for your time and consideration.

Yours very truly,

Debra Gillespie
Principal Investigator
Enclosures - 3

PARTICIPANT CONSENT FORM

For voluntary, unpaid participation in Debra Gillespie's graduate social work student thesis titled: *Improved Health Care Delivery or Paving the Road to Privatization? The Health and Social Services Delivery Improvement Act: A Case Study.*

The purpose and objectives have been outlined in the letter of introduction enclosed with this consent form.

I understand and agree to the following:

1. To participate in two, one and a half hour audio taped interviews at a time and location which is convenient for me spaced over the course of 8 to 12 months;
2. To consider providing non-confidential information, reports and research including but not limited to incidents of privatization specific to health care services and members occupational groups, and Bill 29's impact to the union and its membership;
3. There are no known or potential risks to me. However if I identify any known or potential risks, I understand the principal investigator and I will discuss how to minimize these risks in consultation with her thesis supervisor.
4. If I agree to participate and change my mind at any point, I can withdraw from the study without explanation, prejudice or negative consequences;
5. If I withdraw from the study, data from the interviews; reports, written information and research will be included in the final thesis report. However, I maintain the right to have these deleted from the study as well as any non-public information including field notes, audio tapes, transcriptions and union documents;
6. To the best of my knowledge the principal investigator, Debra Gillespie, has no known authority or power over me;
7. The letter of introduction and this consent form can be reviewed at any point during the study and will be reviewed prior to the commencement of the second interview;
8. My identity as an elected union leader or representative of my union in a public role will not be anonymous in the study and in the final written thesis. While I do not anticipate requiring anonymity I reserve the right to have my identity protected or disguised as linked to specific data and generally made in statements with no designation other than to the union I represent.
9. All information provided will be kept in a secure location in the investigator's home office and will only be shared with the supervisory committee and in the final completion of the written thesis;
10. It is my responsibility to identify "off the record" verbal or written information which I do not want included in the final written thesis;

11. Upon completion of the written thesis and defense and final approval the principal investigator, Debra Gillespie, will destroy all audio tapes, field notes, transcriptions, and any other confidential identifying data by way of shredding.

Any questions or concerns about this study should be directed to any one of the following: The principal investigator Debra Gillespie at home [number] or work [number].

The University of Victoria supervisor is Dr. Andrew Armitage (250-721-8333).

You may also verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice President of Research at (250-472-4362)

My signature below indicates that I understand the conditions of participation in this study as outlined in the letter of introduction and on this consent form and that I have had the opportunity to have my questions answered by the principal investigator, Debra Gillespie.

Name of Participant (please print) _____

Signature _____ Date _____

FOLLOW UP INTERVIEW

Review of Consent

Name of Participant (please print) _____

Signature _____ Date _____

A COPY OF THIS CONSENT WILL BE LEFT WITH YOU AND A COPY WILL BE RETAINED BY THE PRINCIPAL INVESTIGATOR

INTERVIEW GUIDE

Union Demographics

1. How long has your union been in existence?
2. What is your total membership?
3. How many members could potentially be affected by Bill 29?
4. What percentage of this total are women?

Background on Implementation of the Health and Social Services Improvement Delivery Act (Bill 29-2002)

1. Did your union receive either formal or informal notification of its contents or intent before Bill 29 was introduced in the legislature?
2. Are you aware of unions or the public being consulted or given the opportunity to provide input regarding Bill 29 before its introduction?
3. All unions affected by Bill 29-2002 have made public statements condemning it; please list four or five specific concerns you have with Bill 29.
4. What do you see as the primary goals or policy direction of Bill 29?
5. Do you believe these goals are related to improving the delivery of health and social services?

Impact of the Implementation of Bill 29 in the Vancouver Island Health Authority, specifically regarding privatization of services and/or occupations

1. Since January 28, 2002, which specific occupations in your union have been privatized in VIHA?
2. Since January 28, 2002, which Requests for Proposals have been advertised and not awarded?
3. How many members have you lost in VIHA due to privatization since January 28, 2002?
4. How does this compare to the loss of membership in other health authorities in BC?
5. How many of your members have been able to successfully secure jobs in other service areas by exercising their reduced seniority and bumping rights?
6. How are privatization and the threat of privatization of your members' jobs impacting the workplace? (E.g. morale, people leaving and looking for jobs elsewhere as they know they will be bumped or privatized, etc)?
How has the implementation of the Act impacted on labour relations with VIHA? (e.g. increased grievances, arbitrations, increased meetings to negotiate on behalf of members).
7. How does the level of privatization of services in VIHA compare with other regions in BC?

8. I am preparing a table or chart to include in my final written thesis and I was hoping to include a listing of all occupations which have been privatized and cross referencing them with the affected union and the five health authorities in British Columbia. I understand all unions are tracking incidents of privatization where members' jobs are lost, would you be able to share specifics of this on an ongoing basis?

Union Response to the Implementation of Bill 29

1. What strategies has your union developed or undertaken to challenge the Health and Social Services Delivery Improvement Act - Bill 29-2002? (e.g. solidarity with other unions, working with BC Fed, CLC, public awareness, education, research, rallies, member education, court challenges)
2. Please share any non-confidential information on the court applications, human rights challenges with UN, etc and the basis for these challenges.
3. Identify two strengths of your union and your membership that have emerged since the implementation of Bill 29.

Additional Information

1. Is there other information you would like to add that we have not covered on this specific topic of privatization?

THESIS OUTLINE

TITLE: Improved Health Care Delivery or Paving the Road to Privatization? The Health and Social Services Delivery Improvement Act: A Case Study.

INTRODUCTION

Interest
Background
Issue
Research Question

POLITICAL CONTEXT

Politics; British Columbia, Federal, NAFTA, GATS, Globalization/US Influence
Ideology: Economic Liberalism
Financial/Economic
Legislation: The Act(s)

LITERATURE REVIEW

Health Policy: cornerstone reports; Kirby, Romanow, Mazankowski
Policy Change
Policy Implementation
Health Care Privatization

METHODOLOGY

Case study including time line for benchmark events of privatization
Key face-to-face interviews with union leaders or their designates
University of Victoria Human Subjects Ethical Review

CASE STUDY

Description of geographic boundaries, time frame limits, and sector of health care system
Critical events time line of incidents of privatization
Interview results: participants commentary on events

DISCUSSION OF CASE STUDY

Discussion in the context of the literature, political scene and research question(s)

CONCLUSION

Answer to research question(s)
Critical analysis of methodology
Changes of view/perspective
Suggestions for future research

APPENDIX THREE



University
of Victoria

University of Victoria - Human Research Ethics Committee

Certificate of Approval

<u>Principal Investigator</u> Debra Gillespie Graduate Student	<u>Department/School</u> SOCW	<u>Supervisor</u> Dr. Andrew Armitage
<u>Co-Investigator(s):</u>		
<u>Title:</u> Improved Health Care Delivery or Paving the Road to Privatization? The Health and Social Services Delivery Improvement Act: A Case Study		
<u>Project No.</u> 157-03	<u>Approval Date</u> 15-May-03	<u>Start Date</u> 15-May-03
		<u>End Date</u> 14-May-04

Certification

This is to certify that the University of Victoria Ethics Review Committee on Research and other Activities Involving Human Subjects has examined the research proposal and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Subjects.

J. Howard Brunt
Associate Vice-President, Research

This Certificate of Approval is valid for the above term provided there is no change in the procedures. Extensions/minor amendments may be granted upon receipt of "Request for Continuing Review or Amendment of an Approved Project" form.

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Human Research Ethics Committee Certificate of Approval

<u>Principal Investigator</u> Debra Gillespie Graduate Student <u>Co-Investigator(s):</u>	<u>Department/School</u> SOCW	<u>Supervisor</u> Dr. Andrew Armitage	
<u>Project Title:</u> Improved Health Care Delivery or Paving the Road to Privatization? The Health and Social Services Delivery			
<u>Protocol No.</u> 189-04	<u>Approval Date</u> 14-Jun-04	<u>Start Date</u> 08-Jul-03	<u>End Date</u> 13-Jun-05

Certification

This certifies that the UVic Human Research Ethics Committee has examined this research protocol and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Subjects.

Dr. Martin Taylor
Vice-President, Research

This Certificate of Approval is valid for the above term provided there is no change in the procedures. Extensions or minor amendments may be granted upon receipt of "Request for Continuing Review or Amendment of an Approved Project" form.

189-04 Gillespie, Debra

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