The Ontario Hospital Bargaining Review Committee

REPORT ON STRUCTURE

AND BARGAINING

FOR CUPE ONTARIO HOSPITAL WORKERS

FEBRUARY

1982

COMMITTEE MEMBERS

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INTRODUCTION

The Ontario Hospital Bargaining Review Committee was established as the result of a motion adopted in May 1981 at the Health Care Workers' Conference held in Windsor. The motion cited the need for a better bargaining structure for hospital workers, and called for the election of a committee which would study bargaining structure, receive input from locals in the seven regions of the province, and make recommendations for change.

The seven elected committee members met for the first time on September 17, 1981 in Ottawa. Sister Grace Hartman addressed the committee, informing us that she had assigned four of her National office staff the task of investigating the hospital bargaining situation in Ontario in order to report back to her. She asked the committee to work with these four staff persons, and to accept their assistance in conducting a review of hospital bargaining. Consequently, further meetings of the Bargaining Review Committee were attended by Brothers "Lofty" MacMillan, Gil Levine, Fred Tabachnick, and Randy Sykes.

We began our work by discussing various problem areas in central bargaining by relating them to our present structure. We noted that in almost all other provinces, hospital locals had joined together to form Councils of Unions with direct local union input. Such Councils feature a central decision-making body and an elected executive charged with the responsibility of carrying out those decisions.

Noting that the concept of a Council of Hospital Unions had been endorsed by a previous Health Care Workers' Conference, we decided that we should investigate the matter further. We asked the National Office staff to provide us with information on the various provincial hospital Councils for our next meeting.

After additional discussion of the Council concept, we reached a concensus that we should propose a Council structure for Ontario's hospital workers. Using the by-laws of existing Provincial Councils as working documents and making alterations and additions to suit our needs here in Ontario, we began the task of building a proposed structure for an Ontario Council of Hospital Unions.

Sister Hartman had directed her National staff to conduct a "tour" of the Province in order to have direct discussions with local leaders, members, and staff representatives. The Committee decided to attach its chairman, Brother Paul Barry, to the tour, as it would provide us with the opportunity to get the same type of input for our work. A basic outline of the proposed structure was complete in time for the tour, and it was discussed with the 48 local unions (representing over 80% of our hospital membership), as well as a number of staff representatives, who made submissions to the tour committee. We would like to point out that the cost of this tour was borne by the National Office.

Most of the feedback received from the locals is contained in the body of this report, but suffice it to say that the Council

concept received very significant support, and many new views and ideas were made to us.

As we continued with our meetings, a number of "detail" items became more concrete, and we discussed many matters of principle and proposals for policies of the Council regarding administrative activities and responsibilities, as well as policies for conducting negotiations (mostly as a result of input received on the tour).

This report fairly represents a summary of what we heard, what we did, and what we recommend. Improvements and additions are, of course in the hands of the hospital locals. Indeed, the very concept itself must be accepted by the membership in order to become a reality. We feel that the "realities" that we faced in our last round of bargaining indicate that these charges are long overdue, and we make our recommendations unanimously in that spirit.

We wish to express our sincerest thanks to Sister Grace Hartman, whose constant support and encouragement was essential to the success of our Committee. We also thank Brothers MacMillan, Levine, Sykes and Tabachnick for their invaluable assistance, as well as Sister Cathy MacQuarrie, chairperson of the H.C.W.C.C., for her contribution to our work.

STRUCTURE

BACKGROUND

1. The major responsibility of the Hospital Bargaining Review Committee was to examine the present structure under which collective bargaining for Ontario hospital locals takes place, and to recommend necessary changes.

2. The idea of building a new structure for Ontario hospital bargaining is not new. On the contrary, it has been a constant topic of discussion virtually since the inception of central bargaining. Certainly, in the past three years the need for structural change has become obvious, and at least two committees have been appointed to study the matter.

3. The root of the structural problem can be traced back to the 1974-76 period when the bargaining situation was in a state of flux. Prior to 1974, all bargaining was conducted on a hospital-by-hospital basis. During 1974, some areas began to bargain regionally, notably Metro Toronto and the Sudbury areas. During that period we believed that regional bargaining would become the established system across the province, as a step eventually leading to full provincial bargaining. As a result, we established a structure in Ontario hospitals based on seven regions (indeed, for a time, there was an eighth "region" consisting of paramedic locals).

4. However, regional bargaining never did become established. Partially as a result of the 1974 Johnston Commission, the OHA and CUPE agreed to move directly to province-wide or "central" bargaining on a wide range of monetary issues. The first round of central bargaining took place in 1976, and we are about to enter the fifth round in mid-1982.

5. Despite the fact that province-wide bargaining became the reality, our Union never adapted its structure to suit the new situation. We have remained without a central, provincial decision-making body for our hospital locals. Decision-making power now rests solely with the seven regions, with each region having an equal vote on any matter. Essentially, what we have now in Ontario is a federation of seven regions.

6. The present structure, with its lack of a central authority, has caused a multitude of problems over the years - problems too numerous to outline in any detail. Some examples can be cited for illustration purposes.

7. First, the regions, which are deemed to have equal authority, contain vastly differing numbers of locals and members. Two of the regions are very large (Metro Toronto and Eastern Ontario) while two others are extremely small (Western and Northwest). The Toronto region has approximately 10 times the membership as the Northwest region, yet they have equal status when a vote of

the regions is taken. This wide difference in size and circumstance of regions tends to be a highly divisive factor.

8. Secondly, regions often make decisions which bind their central bargaining committee representatives without having heard from other regions, staff or our elected leaders. This has often led to members coming to central bargaining committee meetings "with their hands tied". The region has made a decision which binds its representative, who may be convinced that such a decision is wrong after he has heard the views of the other committee members and staff involved. Also, regions do not necessarily always receive the same information on which to base their decisions. We do not have at present a good communications system for hospital locals, and the information received by regions is almost always second or third hand from their committee representative and/or staff representative.

9. There is also considerable confusion over how to bring locals together in a central place and what authority such a meeting has. At various times, we have had "mini-conferences", presidents' meetings, HCWCC Conferences, etc., but none of these has any constitutional authority. Their decisions are not binding and can apparently be altered or ignored by locals, regions, bargaining committee members, staff, etc. without consequence.

10. Financial problems have also plagued some of the regions. Regions 1 and 7 (Western and Northwest) simply do not have an adequate membership base to support the required financing. A Region's treasury essentially depends on the number and size of hospitals contained in the Region, and on its distance from Toronto.

11. Another serious problem stems from the fact that there is no "permanent" central decision-making group. The Central Bargaining Committee can make certain decisions when it is constituted, but there are transitional times between contracts when the Bargaining Committee is being gradually replaced or re-elected at a series of regional meetings. This situation, which has existed for many months at a time, leaves a gap in decision-making authority.

12. Last year's strike highlighted the structural problems and emphasized the urgency of their resolution. In fact, in its report to the 1981 HCWCC Conference in Windsor, the Central Bargaining Committee made "Structure" its very first recommendation for change. That report, which was adopted by the Conference, made the following statement on structure:

> "Our Structure: At the Health Care Workers' Conference in Ottawa, we all approved and endorsed a new structure which introduced the creation of a council of hospital unions, retaining the seven regions, and ensuring that local autonomy would be protected, but organized in such a way as to provide a more

> disciplined and rational means of making, and abiding by, decisions. As it stands now, our president's meetings and mini-conferences have no constitutional authority, no rules concerning the number and entitlement of delegates, and our bargaining committee is not even structured in such a way as to provide for the election of a chairperson. We feel that the implementation of the approved new structure would go a long way toward cleaning up our act, and we would recommend that the necessary by-law changes be made without undue delay."

13. These views have essentially been supported by the three hospital co-ordinators who have struggled with the need for structural change since the mid - 1970's. Brothers Edwards, Douglas and Brown all had strong views regarding the inappropriateness of the present structure and the difficulties it causes.

14. Even more importantly, these views indeed are shared by the local unions, as is evidenced by last month's "tour" by members of our Review Committee. The Committee interviewed 48 hospital locals representing over 80 per cent of the total membership and found virtually unanimous support for the new structure being proposed.

15. The Council of Hospital Unions structure which the Committee is proposing will provide a democratically-controlled central decision-making body, and should put to rest any confusion about who is in charge of bargaining for hospital workers in this province. The structure is simple, with the affiliated local unions having direct, delegate input into the Council, which then elects its

Executive and Bargaining Committee. Policy decisions rest with the Council, while implementation and administration is the function of the Executive.

16. It must be emphasized that the sole function of the Council is to co-ordinate bargaining. Its mandate does not extend to education or political/legislative action, so there should not be any overlap or conflict with either the Division or its jurisdictional group, the HCWCC.

17. The proposed Council structure is, with some variations, consistent with the pattern adopted by CUPE hospital locals in most other provinces. There is no other province which lacks a central decision-making authority, or which vests such authority in geographic regions. The Bargaining Review Committee studied the structure existing in each of the other provinces, and adapted the appropriate methods and structures to suit Ontario's individual situation.

18. The Hospital Bargaining Review Committee is unanimous in its desire to move forward immediately with implementation of the Council of Hospital Unions. Having discussed the matter in depth with locals representing over 80 per cent of the membership, we believe that this desire also fully represents the wishes of the local unions.

VIEWS EXPRESSED BY LOCAL UNIONS

1. There was a clear consensus that the present structure is not working and that changes have to be made now before the growing alienation and hostility advance any further.

2. The Committee's proposed outline for a Council of Hospital Unions was received favourably by all Locals, and was greeted enthusiastically by the majority. Any negative or hesitant comments were of the "looks good on paper, but..." type.

3. Most Locals favoured the "representation by population" formula presented to them, although some argued for all locals to be entitled to the same fixed number of delegates.

4. There was a consensus that the Council's by-laws should clearly define the duties and responsibilities of the Executive vis-à-vis the Co-ordinator. The Co-ordinator should be the negotiator. Administrative and decision-making powers should rest with the Council and the Executive.

5. Most Locals indicated that they would financially support a proper funding scheme for the Council. Some support was given for a per capita linked to a percentage of the average hospital wage, so that it would rise automatically each year. There was near-unanimous support for the proposal that all per capita be paid directly to the Council, with the Regions becoming self-financing

on the basis that meets their particular needs.

6. Several Locals suggested that the Council might provide financial assistance to small and remote locals which find it difficult to send delegates to Council meetings. One suggestion was that Council funding could be set at a level high enough so that the Council itself would finance the cost of one delegate attending from each Local. If the Local is entitled to more than one delegate, the Local would be responsible for financing all remaining delegates.

7. Several Locals stressed the need that some sort of impeachment or recall process be written into the by-laws, so that the Local Union delegates could replace Executive Officers in mid-term if they are not satisfactorily fulfilling their functions.

8. A few Locals expressed the view that the Council would obviate the need for a Health Care Workers' Co-ordinating Committee, so the H.C.W.C.C. should be eliminated. The Committee pointed out that this would have to be a matter to be dealt with by the Ontario Division, since the H.C.W.C.C. is a jurisdictional group of the Division.

9. The Locals were clearly pleased to receive the Committee's proposals, as well as to learn that it is our aim to have the new structure in place before the next round of bargaining begins.

COMMITTEE RECOMMENDATIONS

1. The Committee recommends to the Ontario hospital local unions that they meet in convention to found the Ontario Council of Hospital Unions.

2. The Committee further recommends the adoption of the proposed Council By-Laws and financing structure.

HIGHLIGHTS OF PROPOSED COUNCIL BY-LAWS

1. Purpose of the Council

The purpose of the Council is to act as a provincial decision-making structure regarding collective bargaining for CUPE Ontario hospital local unions. Locals will have direct, delegate input into the Council. The Council structure will provide clear lines of authority, responsibility and accountability. The Council will negotiate and/or co-ordinate negotiations on a province-wide basis on behalf of affiliated hospital local unions.

2. Role of Regions

Regions, or "Areas" as we are proposing to rename them, will continue to exist as co-ordinating and information-sharing bodies for the locals in the seven areas. However, they will no longer have direct decision-making responsibility in terms of the central bargaining process, as there will be direct input from the local union into the provincial Council.

3. Affiliation

Affiliation to the Council will be open to all hospital local unions, including central laundries, central food services, and subcontracted units. The only pre-condition of affiliation will be a requirement that the local union have passed a resolution indicating its willingness to participate in central bargaining. Those local unions which have passed such a resolution, but who are prevented from participating

in central bargaining by decision of their management, will nevertheless be permitted to affiliate to the Council.

4. Representation

Representation at Council meetings shall be based on the following formula:

Up to 100	members	- 1 delegate
101 to 300	members	- 2 delegates
301 to 500	members	- 3 delegates
501 to 700	members	- 4 delegates
701 to 1000	members	- 5 delegates
1001 or more	members	- 6 delegates

The formula is based on the hospital membership only of composite locals. If all local unions sent their full allotment of delegates, the Council meetings would be comprised of approximately 175 delegates.

5. Council Meetings

The Council will hold an Annual Meeting in March of each year. Other meetings shall be at the call of the Council Executive, or upon written petition of at least 25% of affiliated locals. Council meetings would be called, for example, to develop and ratify central bargaining proposals, to receive reports (if necessary) from the Bargaining Committee and to give the Committee direction, to discuss any "final offer" from the Employer and to recommend its acceptance or rejection to the local unions, and so on.

6. Council Executive

At the Annual Meeting in alternate years the Council shall elect its Executive. The Executive will consist of a President, a Secretary-Treasurer, and seven (7) Area Vice-Presidents. The President and Secretary-Treasurer shall be elected at large, and the Area Vice-Presidents shall be elected by their area caucuses. The term of office of the Executive shall be two years. At the first meeting of the Council Executive following the election of officers, the Executive shall designate one of the Area Vice-Presidents to act as First Vice-President for the ensuing term.

7. Executive Committee

The Executive Committee of the Council shall consist of the President, the First Vice-President and the Secretary-Treasurer. Its purpose shall be to act on matters of urgency when it is not practical to call a meeting of the full Council Executive.

8. Bargaining Committee

The Bargaining Committee shall consist of the full Council Executive. The President shall act as Chairperson of the Negotiating Committee.

9. Financing

The Council's affiliation fee shall be based on the formula of 1/10 of 1% per month of the average monthly hospital wage rate, to be payable quarterly in advance on June 1, September 1,

December 1 and March 1. The initial quarterly payment shall be $1.35 per member per month, payable on June 1, 1982. A revised affiliation fee shall become effective for the next quarterly period following each negotiated adjustment to the average monthly hospital wage rate.

BARGAINING

BACKGROUND

1. The Committee considered various aspects of the present bargaining process and found it to be in need of change in a number of areas.

2. The members of the Committee are unanimous in our endorsation of the concept of central bargaining. Clearly, the present system has faults, but we should attempt to correct them and move forward, not fall backward into chaotic individual bargaining.

3. Perhaps the most serious and difficult question facing us is how to achieve greater standardization of our collective agreements without sacrificing the "Superior Benefits" some locals have previously negotiated.

4. A simple statement that "all superior benefits shall be protected" is not an adequate response to this difficult problem. Unless we are prepared to abandon our drive for further standardization, we have to recognize that it is impossible, as long as we are strait-jacketed by compulsory arbitration, to ensure that the very best clause will become the standard clause. The Committee has devoted a great deal of time and thought to developing a recommendation in this area.

5. A considerable part of the superior benefits problem relates to the difficulty in identifying what exactly are the superior benefits in each agreement. This can be partially answered by devoting more research time in preparation for bargaining.

However, there will always remain the fact that different individuals or groups may come to different conclusions as to whether or not one clause is superior to another.

6. The Committee is very concerned about the present inadequate method of negotiating and resolving "local issues". First, there is often considerable confusion over the distinction between "central" and "local", particularly since one aspect of a clause may be central, while the remainder of the clause is local. Secondly, the present system of forwarding unresolved issues on to the central table seems to often work to our disadvantage in that local unions feel pressured by the central parties to drop their local demands or to dispose of them quickly. Thirdly, the present requirement that all local issues at a given hospital be resolved before the central settlement is implemented applies tremendous pressure on the local union executives to drop their demands so that the members won't have to wait for their retroactive pay. These factors have combined to produce highly unsatisfactory local bargaining results for a large number of our local unions.

7. Generally speaking, the Committee is concerned that many locals are frustrated by the central bargaining process and have lost a degree of confidence in the ability of the union to meet the challenges we face in this area. We must pay particular attention to the area of internal communications in this regard. Good two-

way communications must be established between the local unions and the central negotiating committee. The local unions must know what is happening at all stages of negotiations, and must feel a part of the process.

VIEWS OF THE LOCAL UNIONS

1. Despite some strong concerns in several areas, nearly all Locals are committed to the continuance and expansion of central bargaining.

2. Few indicated that they no longer wanted to participate, although many (probably a majority) said they would participate only if certain conditions were fulfilled.

3. The major conditions for participation mentioned were:

   (a) change of Co-ordinator

   (b) commitment to preservation of superior benefits

   (c) establishment of a proper decision-making structure

4. The preservation of superior benefits was stated to be a key factor by a large number of Locals. Several indicated that they felt they have lost ground in too many areas as a result of central bargaining (for example, the Sudbury hospitals' "booking off" clause and double time and a half for overtime on paid holidays).

5. Most recognized, however, the desirability of moving toward more standardized language and benefits, and perhaps eventually toward a "master agreement". Therefore, it seems clear that there has to be a resolution or accommodation of the serious problem of recognizing superior benefits while moving toward

standardization. Most locals indicated that they could perhaps accept a loss of certain clauses if the overall settlement package provided for substantial gains in other areas. Partial answers to this problem can probably be found by an effort to identify the serious "superior benefits" in each agreement and to establish a close relationship between the negotiators and the local committees so issues can be discussed rationally as they arise.

6. Many locals expressed concern over the lack of a clear understanding of which issues are "central" and which are "local". Often part of a clause will be central, and the other part local. This perceived lack of clarity leads to a frustrating process whereby Hospital employers refuse to deal with many issues at the local table because they claim they are central. The usual result is that such issues are sent up to the central table and are subsequently returned back to the local parties - a very frustrating process for the locals.

7. The opinions on the value of local issue bargaining varied considerably from local to local. A large number seemed to be able to deal on a reasonable basis with their Hospitals, with a number of beneficial changes to contract language. Many others believe that local bargaining is a complete waste of time, since their hospitals will not give ground on anything whatsoever. A common complaint was that the hospitals are proposing so many take-aways

at the local table that our locals wind up feeling fortunate if they manage to maintain the status quo.

8. The question of how local issues should be resolved was discussed at length. Here again, opinion was divided. About half the locals prefer to remain with the present system, whereby unresolved local issues are referred to the central table and, if necessary, arbitrated by a "central" Board. Some mentioned that it is often helpful to bring the issues before "outside" parties, because they are not so impaired by the attitudes, likes and dislikes which govern the relationship between the local parties. They also may be able to fit a local issue into some broader overall pattern that they have developed or are developing in other parts of the province.

9. On the other hand, roughly an equal number of locals would prefer to scrap the present system in favour of retaining and resolving all local issues at the local level, without reference to the central table. The commonest complaint is that once the central negotiating teams become involved, the locals lose some control over their issues and indeed often feel pressured by the central table to drop such issues. Some also contend that the Union's central team may not understand the local's issues or their importance to the local - the tendency is to view them as "minor" and an impediment to an overall settlement. Therefore, a substantial number of locals would prefer to deal with local

issues strictly at the local level, with reference to individual local boards of arbitration if necessary.

10. An item on which there was virtual unanimity was the contention that settlement of local issues, however it is done, should not hold up the implementation of the central settlement - or at the very least, the retroactive pay. The present system results in tremendous pressure on the local executives to drop their local issues so that the members will not have to wait for their retroactive pay.

11. Most local unions react favourably to the concept of a "master agreement", with many being very enthusiastic about it. No serious principled opposition was raised.

12. However, there was strong concern voiced over the issue of "superior benefits". Clearly, the price of a master agreement cannot be wholesale giveaway of the good and protective language that some of the locals have been able to establish over the years.

COMMITTEE RECOMMENDATIONS

1. The Council should adopt a policy clearly endorsing the concept that central bargaining should not result in any Local Union being forced to accept a reduction in benefits or inferior contract language without the local's prior knowledge and agreement. As a general rule, the Council's Bargaining Committee would not agree to any such loss of benefits or language whatsoever. However, situations may arise where a "trade-off" might be advantageous in order to secure a substantial improvement for the majority. In such situations, any such trade-offs should only be accepted where agreed to by the affected local union officers in advance of any agreement at the central table.

2. In order to identify "superior benefits", the Committee recommends that the Council request the CUPE Research Department to establish, in consultation with the Co-ordinator, a computer data bank which would store all CUPE hospital agreement clauses on the issues being negotiated centrally. Such computer data bank should be accessible by portable terminal from the location in which bargaining is taking place.

3. The Committee further recommends that each Area Vice-President member be assigned the responsibility of researching and becoming fully familiar with the collective agreements in the area he/she represents.

4. The Bargaining Committee and the O.H.A. should jointly issue definitions of "central issues" which are as clear and precise as possible. The Bargaining Committee should also approach the O.H.A. regarding the possibility of having the two central committees "screen" all local issue proposals in advance of local issue bargaining, in order to prevent any disagreements as to the local or central nature of any proposal.

5. The Memorandum of Conditions to Bargain should provide for local issues to be negotiated and arbitrated at the local level exclusively, without the intervention of the central committees.

6. Regardless of what methods are used to resolve local issues, the Bargaining Committee should attempt to ensure that the implementation of the central settlement or award is not delayed by the failure to have resolved local issues at individual hospitals.

7. Central bargaining must not be carried on in a secretive manner. On the contrary, the Bargaining Committee should report regularly to the Locals regarding the progress of negotiations, and should provide as much concrete information as is possible. Locals should be encouraged to transmit their views on any issues to the Bargaining Committee through the member representing their area.

INTERNAL COMMUNICATIONS

BACKGROUND

1. Poor internal communications seem to have plagued Ontario hospital central bargaining since its inception. This past round of bargaining was particularly poor in this regard, and it ultimately was a significant factor in our inability to effectively utilize the strike weapon.

2. There is apparently no system of communications whatsoever. Communications filter out from the central source, sometimes through staff, sometimes through bargaining committee members, but messages sent are often not received at the local union level. Locals constantly complain of being in the dark as to the progress of central bargaining, and this dramatically increases their frustration with and alienation from central bargaining.

3. Tens of thousands of dollars are spent on printed material which often does not even get distributed to the local unions, let alone to the membership. After the strike, the Ontario Regional Office still had dozens of boxes of undistributed leaflets.

4. The failure to receive information seems particularly acute in the smaller cities and towns. Also, since much communication is

by word-of-mouth from one local president to the next, locals which are relatively inactive and who do not seek out information are often completely out of touch.

5. Other than the Co-ordinator, it appears that no individuals or groups take any responsibility for communications, nor is there any follow-up or accountability for such communications.

6. The Committee believes that it is imperative that a proper internal communications system be established. The viability of any group is almost always linked to its ability to communicate among its constituent parts and individual members. Unless we can communicate clearly and regularly with each other and with our staff, all our efforts will be severely hampered and probably doomed to failure.

VIEWS OF THE LOCAL UNIONS

1. It was a virtually unanimous view that communications during the past round of bargaining and strike were extremely poor to non-existent. The Locals stated that they were largely "in the dark" during both negotiations and the strike, with virtually no information coming from "Toronto" (the central table). Many Locals said they had to rely on the Globe and Mail or their local media for information about what was going on at the provincial level.

2. It appears that there was a near-total communications break-down during the strike. Neither Locals nor staff in the field got regular or reliable information from the central table. Many Locals complained that what little information they did get was highly confusing and often inaccurate and contradictory regarding the true situation of the strike in some areas. It appears that CUPE entered what was probably the most significant strike battle in its history without having any kind of communications system to let the generals know what the infantry was doing, and vice-versa. Needless to say, steps must be taken to ensure that this never happens again.

3. A considerable number of Locals did not get all the print materials which were made available in the two-month period prior to the strike. We were not able to ascribe any particular cause to what appears to be an appalling situation, except for the fact that

there is no system of accountability established at any level to ensure that jobs actually got done. The situation was probably even worse than we heard during the tour, since most of the "non-urban" Locals did not appear before our Committee. We are, however, convinced that the distribution system to the non-urban areas was far worse than it was in the larger cities.

4. The Locals all support the idea of a regular provincial newsletter for hospital workers, to be published year-round, not just during bargaining. Such a newsletter would probably be a strong binding force for our widely-scattered and different-sized Locals.

5. Most Locals approved of the concept of "communicators" and special courses for them, but felt that they were of little value last time because of lack of follow-up.

6. As much as possible, all print materials must be produced in English and French. Some concern was raised about poor French translations of our English material. Regarding other languages commonly used by our members (Italian, Portuguese, Greek, Chinese), some Locals believe it is important to have at least some multilingual communications, while others believe it would be a waste of time and money. The latter contend that if the members want to read about the Union, they will either struggle through the English themselves or seek assistance from a fellow worker or family member.

7. Some locals believe that staff have not taken an active enough role in developing and ensuring adequate communications for hospital workers. Some see responsibility for communications as falling largely on the staff, while others believe the rank-and-file should assume primary responsibility in this area.

COMMITTEE RECOMMENDATIONS

1. One of the Council's highest priorities must be to establish a viable communications system. Persons, both rank-and-file members and staff, must be given specific responsibilities over areas and tasks, and be held accountable for carrying out such responsibilities. The system should be designed to take into account all the different types of communications which may be involved - e.g. a provincial newsletter, printed leaflets, buttons, bargaining committee reports, communications from the Council to the Locals and vice-versa, communications from the Co-ordinator to the Locals and vice-versa. Particular attention should be paid to assisting locals to develop good distribution systems within their own local union.

2. As soon as possible following the Council's Founding Convention, the Council Executive should hold a meeting with the Provincial Co-ordinator, the Regional Co-ordinators, and the Public Relations Department to design such a communications system.

3. While the Staff should be fully utilized in ensuring good communications, ultimate control and responsibility should rest with the elected officers of the Council and the Local Unions. In particular, the Council's Area Vice-Presidents should take on the major responsibility for ensuring proper flow of communications both within their area and between their area and the central bodies.

4. The Council should as soon as possible establish a regular newsletter which would be published six to eight times per year. The purpose of the publication would be to share information among local unions themselves, as well as with the National Union and staff. Each local union would be asked to assign one interested member to act as a "reporter" for that local, and the reporter would submit material to the newsletter editor whenever noteworthy situations occurred in the local union (e.g. - new units organized, contracting-out, layoffs, closure of beds, expansions, new technology, etc. etc.) A provincial newsletter editor would be appointed to work closely with the P.R. Department, the Council Executive and the Co-ordinator.

ROLE AND UTILIZATION OF STAFF

BACKGROUND

1. The Committee is concerned that we have not devoted adequate consideration to the role we expect our staff to play, and, as a result, have not fully and effectively utilized the staff resources which are made available to us by the national union.

2. In particular, it is our view that we are not making the best use of our full-time Co-ordinator. The absence of a viable rank-and-file decision-making structure has resulted in the Co-ordinator having to assume a wide variety of duties which could and should be the responsibility of the local leaders.

3. It appears that many of the area staff representatives often are not fully aware of the developments that are taking place within the hospital field. Staff meet very infrequently and there is often a lack of communications in the field. This makes it particularly difficult for those local unions who tend to rely on their staff representative for information regarding central bargaining.

4. The experience of the last round of bargaining up to an including the strike showed that the membership had largely lost effective control over the decision-making process. Structures and policies must be developed to ensure that democratic control is firmly vested with the membership and its elected leaders, not with the staff.

many of the administrative duties he now undertakes, such as arranging meetings and conferences, keeping the books, handling financial transactions etc. The Locals believe he should be strictly a negotiator of central issues and, perhaps, a co-ordinator of local issues bargaining. Relieving him of all the other duties would give him more time to build better contact with the Locals and to do a better job at preparing for negotiations.

aspects relating to hospital bargaining. These staff members should meet and consult regularly, and work with the Council Executive in providing leadership in hospital bargaining.

6. All Staff Representatives servicing hospital local unions should, if at all possible attend all meetings of the Council of Hospital Unions. The Council should ask the Ontario Regional Director to assign high priority to this request.

7. The Co-ordinator should develop a short orientation program for newly-hired staff representatives,and for staff representatives who have not previously serviced hospital locals. The orientation should familiarize staff representatives with the history of central bargaining, the structure of bargaining, the Council of Hospital Unions, and with the policies and priorities adopted by the Council. The Council should request the Regional Director to ensure that all newly-hired staff representatives spend sufficient orientation time with the Co-ordinator within two months after they are hired.

8. The Co-ordinator and the Council should fully utilize the services of the National Departments, particularly Research and Public Relations. The Council should request that research assistance be made available at all times immediately prior to and including bargaining and that, if possible, a researcher be assigned as a member of the union bargaining team.