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Strikes in the health sector: A policy analysis

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**STRIKES IN THE HEALTH SECTOR: A POLICY
ANALYSIS**

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*Te Whare Wānanga
o te Ūpoko o te Ika a Māui*



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I INTRODUCTION

The right to strike is guaranteed by international law and bestowed upon all employees.¹ From the mid 20th century, it has been used as a legitimate method of defending the social and economic interests of workers and only in exceptional circumstances will the right to strike be removed. Yet political and moral debate seizes New Zealand over the ability of health sector workers to engage in industrial action. A war of words has developed when doctors down their scalpels and stethoscopes and when nurses, radiographers and food and cleaning services exercise this right. What should be a process of negotiation between two parties over the renewal or creation of a collective agreement is complicated as patients and their families are drawn into the debate. The severe impact of strikes on a vulnerable section of society, the sick and the weak, has led to public outcry and a call for legislative change.

This paper examines the debate as to whether the right to strike in the health sector should be maintained. Consideration is given to the main arguments put forward on each side of the debate, to the validity of the debate in light of the Employment Relations Act 2000 (ERA) and to possible legislative alternatives. An international comparison is used to demonstrate New Zealand's position internationally and to determine whether the correct balance has been struck between guaranteeing a fundamental human right and ensuring the health and safety of a nation.

II THE DEBATE: A RIGHT TO STRIKE OR NOT?

A Introduction

Since the ERA replaced the Employment Contracts Act 1990 (ECA), the rate of stoppages has dropped by nearly 20 percent. However, the problem nowadays is not so much the number of strikes but more who is striking. A relative shift in union density to 68 per cent in the public sector has meant that strikes, which were once the domain of

¹ The right to strike is not set out explicitly in ILO Conventions and Recommendations. "The right to strike is, however, mentioned incidentally in a Convention and in a Recommendation. The Abolition of Forced Labour Convention, 1957 (No 105), prohibits the use of forced or compulsory labour "as a punishment for having participated in strikes" (Article 1, subparagraph (d); and the Voluntary Conciliation and Arbitration Recommendation, 1951 (No 92), first mentions strikes in paragraphs 4 and 6, then states in paragraph 7 that no provision it contains "may be interpreted as limiting, in any way whatsoever, the right to strike" (ILO, 1996b, p 89 and 1996a, p 660)." Bernard Gernigon, Alberto Otero and Horacio Guido *ILO Principles Concerning The Right To Strike* (International Labour Organization, Switzerland, 1998) 7, n 1. The right to strike is also preserved in the International Covenant on Social, Economic and Cultural Rights, art 8(1)(d).

private sector workers in large scale factory and transport employment, have now moved to become prevalent in both the education and health sector. As a consequence there has arisen a perennial debate as to whether health sector employees should be able to strike. Industrial Action in this sector is always met with a great deal of controversy and comment not only by the public and District Health Boards (DBHs) but from within the medical profession itself. Conflicting opinions have been voiced, some arguing that medical strikes are unethical while other advocate that the need for improvement in conditions justifies such action.²

B A Ban on Strikes in the Health Sector? Is a Law Change the Solution?

Calls for the Government to intervene in the strike-ridden health sector are commonplace. Christchurch-based Health Cuts Hurt wants to see fully funded arbitration, like that used to settle a secondary school teachers' dispute in 2002, replace the current law.³ Such groups make strong arguments.⁴ Since June 2006, hospitals have been hit by strikes by junior doctors, nurses, orderlies and food and service cleaners. Consequently, an estimated 1800 planned operations in Canterbury have been disrupted. Health Cuts Hurt spokeswoman Eleanor Carter said patients face an "appalling" situation.⁵ Waiting lists in some parts of the North Island have stretched to 18 weeks which in some cases has forced health boards to fly patients to Australia for treatment.⁶

The chairman of the Medical Council, Professor John Campbell, has also called for a ban on strikes in the health sector.⁷ He argues that industrial action is totally unsatisfactory and other methods need to be considered. Pay issues can be resolved through arbitration and that strikes are a markedly dangerous and ineffective alternative. Each time industrial action is taken there is an increase in uncertainty of diagnoses, management and of risk. Professor Campbell noted that while it is unclear that the cumulative effect of health sector strikes and decisions made by clinicians during the

² Frank Frizelle "Is it Ethical for Doctors to Strike?" (2006) 119(1236) *New Zealand Medical Journal*.

³ It is important to note that arbitration used in the teachers' strikes was voluntary arbitration. Health Cuts hurts wants compulsory arbitration imposed of a similar structure to that used during the teachers strike.

⁴ Kamala Hayman "Government Action Called For" (18 January 2007) *The Press* Christchurch 4.

⁵ *Ibid.*

⁶ Kamala Hayman "Longer Wait Blamed on Unions" (16 January 2007) *The Press* Christchurch 2.

⁷ NZPA "Ban on Strike by Health Workers Only Way Forward" (29 November 2006) *NZPA* Wellington.

strikes had led to any deaths, this possibility cannot be ruled out.⁸ Canterbury DHB voted for a ban on strikes this year. The Medical Council and the Orthopaedic Association have both suggested that health workers be subject to compulsory arbitration.⁹ Various reasons have been cited to justify such a law change.

1 Delayed treatment

The exclusion from treatment of many patients under patient safety provisions naturally bears the consequence of delays in the delivery of essential treatment and therapy. For example, many cancer patients are deprived of appropriate, timely access to radiotherapy treatment. During radiographer strikes in November 2006, any patient with cancer in Category A or B, that are the more serious forms of cancer, received his/her treatment within a "good practice framework". However, in Auckland and Wellington some category C patients, with "less serious" forms of cancer, had their treatment delayed to an extent that some had to be offered treatment in Australia.¹⁰ Category C patients can wait up to 18 weeks to start treatment; the recommended time is between four to six weeks. Jill Lane, the Hutt Valley DHB spokesperson noted that contingency planning and the effects of industrial action has resulted in the "need to treat those people that have the highest clinical need and at this particular moment women with breast cancer" and other less serious forms of cancer "don't meet that need."¹¹ Delays in treatment caused by strikes increase stress in both patients and their families. It is unclear whether delays in medical treatment have caused any worsening of patients' medical conditions and no deaths have occurred due to industrial action. However delays have prompted comment that during strikes, New Zealand's health care system is "a third world health system."¹²

2 Economic cost of strikes

Industrial action appears to have caused lasting damage from which health systems struggle to recover, has been very costly in both the short and long term and has not accomplished what the management or unions have sought to achieve. In 2006 the number of days lost by hospital strikes ballooned to 11500 compared to just 1700 in

⁸ Ibid.

⁹ Hayman, "Government Action Called For", above n 4.

¹⁰ Hon Pete Hodgson (14 November 2006) 635 NZPD 6409.

¹¹ "Cancer Patients Get More Bad News" (8 June 2006) *One News* Auckland www.tvnz.co.nz (accessed 20 August 2007).

¹² Ibid, quoted from Breast Cancer Foundation spokesperson Dr Belinda Scott.

2000.¹³ Increasing dependence on locums has been seen throughout the western world, particularly in the context of industrial action. Although standard form employment contracts set a minimum locum rate of \$45 an hour for house officers and \$60 an hour for registrars, actual pay ranges between \$70 and \$120 an hour. It is estimated that locum doctors have taken \$10 million of the Canterbury's health budget this year and nationally it is predicted the cost will be over \$100 million.¹⁴ This differential demonstrates a marked difference between employer's hopes and the true market rates of employing replacement workers.

3 *The blame game*

Political comment is expected and National has led the attack on the ERA legislative scheme. In 2006 National's Industrial Relations spokesman, Wayne Mapp, accused the Ministers of Labour and Health of "simply sitting on their hands while the health sector is increasingly paralysed by strikes."¹⁵ The ERA amendments in 2004 have been blamed for having a multimillion-dollar impact on the economy. It is ironic, however, that under the ERA, strikes in the health sector have decreased, suggesting comparatively less cost compared to under the ECA.

The Government itself has put pressure on the unions by attributing blame. Helen Clark, speaking on National Radio on 4 December 2006 commented that all strikes undertaken by junior doctors, radiation technologists, radiographers and medical laboratory workers had been organised by the same person, Dr Deborah Powell, and noted that other unions within the sector were more willing to negotiate.¹⁶ Opposition comment is common, accusing union leaders and members of union of having no concern for the impact of such industrial action on families in need of medical care.¹⁷

4 *General public comment*

The public has also voiced their frustration and attributed blame. In light of a radiographers' strike in January this year, the Anglican Church commented that it is

¹³ "Health Sector Disruptions Escalate" (26 April 2007) *Newstalk ZB Auckland* www.tvnz.co.nz (accessed 20 August 2007).

¹⁴ Kamala Hayman "Relief Doctors Costing Millions" (14 June 2007) *The Press Christchurch* www.stuff.co.nz (accessed 20 August 2007).

¹⁵ Wayne Mapp, New Zealand National Party "Time for Minister to Act on Health Strikes" (15 November 2006) Press Release.

¹⁶ It is important to note that Mrs Powell was also involved in many influential strikes under the ECA.

¹⁷ Mapp, above n 15.

time striking radiation therapists stopped endangering lives. The Dean of Holy Trinity Cathedral in Auckland, Bishop Richard Randerson, says families will not be forgiving if loved ones die because of the strikes and that the health system is failing people if it allows strike action over a pay claim to impact on peoples' lives.¹⁸ It is the delicacy of and public interest in the health sector that leads to blame being directed at individuals involved or parties to the dispute. However, simply because the public shows animosity towards strikes and blames those striking workers does not mean that the right to strike should be legislatively removed.

5 *Are patients being used as pawns? Do strikes impact on those they are intended to?*

While strikes aim to cripple the employer, those who are most affected are the patients themselves. DHBs and the public alike both claim that unions are willing to sacrifice patients to achieve unions' aims. The transfer of patients due to industrial action has been shown to result in relocation anxiety, a well-recognised phenomenon where patients are taken out of an environment where they are comfortable and have trust in the staff and have to build up trust anew.¹⁹ The delays caused by strikes also cause distress in the families of patients. In a study that measured the effects of strikes on the families of intensive care patients, it was shown that industrial action caused measurable distress and anxiety to the relatives involved.²⁰ In light of this study it was concluded that industrial conflict must be resolved through negotiation if at all possible. At every level, health sector employees have a responsibility to avoid strike action.²¹ However, it must be noted that strike action is considered a measure of last resort by unions and is only employed after all other possible means to conclude an agreement have been fully explored and utilised. Negative consequences in relation to third parties are simply unavoidable when the right to strike is exercised in any industry.

¹⁸ "Church Wants to End Radiation Row" (10 January 2007) *Newstalk ZB* Auckland www.tvnz.co.nz (accessed 21 August 2007).

¹⁹ P Johnson "Rural Peoples' Experience of Critical Illness Involving Inter-hospital Transportation: a Qualitative Study" (1999) 12(1) *Australian Critical Care* 12-16.

²⁰ Peter Dzendrowskyj, Geoff Shaw and Lucy Johnston "Effects of Nursing Industrial Action on relatives of Intensive Care Patients: A 16-month Follow-up" (2004) 117(1205) *New Zealand Medical Journal*.

²¹ *Ibid*, 12.

6 *Other reasons to ban strikes in the health sector*

Reasons given by those against strikes in the health sector were published in 1986 and are still restated by many today. These include:²²

- a. Strikes could result in unavoidable suffering and death;
- b. It would be a breach of the fiduciary duty doctors have towards their patients;
- c. It would be against the Code of Ethics many health sector workers have sworn to;
- d. It would amount to "holding to ransom" a weak and vulnerable segment of the population for material gain;
- e. It would shatter the image of doctors as selfless healers; and
- f. Doctors are already overpaid and strike action is greed.

C Why Strikes in the Health Sector Should Remain Legal

Opposition to strikes in the health sector is met with forceful argument for the right to be maintained. It is argued that the whole point of industrial action is that it creates a very difficult situation for an employer who is unwilling to reach a satisfactory settlement during the course of normal collective bargaining. Its purpose is to bring an unwilling employer back to the table and to a settlement. There are already statutory restrictions on the right to strike, both general and specific to the health sector. Further legal restriction of the right to strike would not only decrease the bargaining power of unions but would also breach international principles of labour law.

1 International principles

From its second meeting in 1952, the Committee on Freedom of Association, a subset of the International Labour Office (ILO), has declared strike action to be a right bestowed upon all employees.²³ The right to strike is a human right guaranteed by international law and is generally reflected in the laws of democratic countries. This right is exercised by health professionals in accordance with ethical standards of their professional and international organisations. Although used only when absolutely

²² PS Sachdev "Doctors' Strike – an Ethical Justification" 99 (1986) *New Zealand Medical Journal* 412-4.

²³ Gernigon, Odero and Horacio, above n 1, 11.

necessary, the right to take effective strike action is viewed as fundamental by many health sector organisations and their members world-wide.²⁴

2 *Balancing out bargaining power*

It is vital that unions are able to act to ensure that the salaries and conditions of health sector employees are good enough to attract people into this essential service. In order to do so, freedom of association must be guaranteed and the right to strike must be legislatively available. Employers naturally have greater bargaining power and if collective bargaining reaches an impasse, there must be a means available of breaking the deadlock. If medical professionals are unable to strike, this significantly decreases their bargaining power and therefore preventing the obtainment of more favourable employment conditions. If industrial action is legislatively prevented, this would destroy a system where workers' collective right to exert economic pressure creates a balance of bargaining power between employers and employees.²⁵

3 *Public notice prior to and during industrial action*

The ERA envisages a publicity campaign so that the issues raised by industrial action are sufficiently understood by the public, thus ensuring a wide range of support. Awareness of resource issues minimises some of the concerns the public may have when industrial action does occur. Suggestions are generally given to the public to seek alternative health care at a facility unaffected by the strike combined with the establishment of a plan to provide essential services during the period of industrial action. During a strike the principles upheld by health sector employees include:²⁶

1. Ensuring minimum level of disruption to the general public;
2. The delivery of essential health services to a reduced patient population;
3. Crisis intervention by health professional for the preservation of life;
4. Ongoing health care to assure the survival of those unable to care for themselves;
5. Therapeutic services without which life would be jeopardised; and

²⁴ New Zealand Nurses Organisation "Submission to the Transport and Industrial Relations Select Committee on the Employment Relations Amendment Bill 2004".

²⁵ Chris White "Workchoices: Removing the Choice to Strike" (2005) 56 *Journal of Australian Political Economy* 66, 76.

²⁶ International Council of Nurses *Guidelines on Essential Services During Labour Conflict* (International Council of Nurses, Geneva, 2004) 5.

6. Health services necessary for urgent diagnostic procedures required to obtain information on potentially life-threatening conditions.

D Conclusion

Wage increases generally require government funding and often governments will use public sector pay restraint as a political tool to keep budgets under control. Therefore, government strategy plays a major role in determining whether union demands will be met. It is of paramount importance that, if possible such political policy can be challenged. Both sides of the debate put forward credible and convincing arguments. In light of this, the right to strike needs to be balanced with the paramount concern of patient safety, preservation of life and prevention of permanent disability. At the forefront must be patient safety in the event of a strike while at the same time ensuring the principle of the right to strike is not undermined.

III THE CURRENT LEGISLATION

A Introduction

In 1991 the ECA introduced a policy that promoted individual contracts. Strikes remained legal but the ability for ministerial interference was reduced and provisions concerning compulsory intervention were removed. This was in stark contrast to New Zealand's first statutory framework that promoted a desire to avoid the destructive consequences of industrial conflict by providing a process that required employers and trade unions to resolve their difference through the institutional framework of conciliation and arbitration.²⁷ While the ERA emphasised collective bargaining as the norm for collective settlements and provided stronger recognition of unions, it maintains comparatively minimal intervention with regards to strikes.

B Lawful Strikes

Under section 83 of the ERA, for a strike to be lawful it must not be classified as unlawful under section 86.²⁸ The strike must relate to bargaining for either a collective

²⁷ Hon Margaret Wilson "The Employment Relations Act: A framework for a fairer way" in Erling Rasmussen (ed) *Employment Relationships: New Zealand's Employment Relations Act* (Auckland University Press, Auckland, 2004) 10.

²⁸ Employment Relations Act 2000, s 86(1)(a)-(g) sets out when a strike will be unlawful; note that s 83 also applies to lockouts.

agreement that will bind each of the employees concerned,²⁹ or relate to bargaining with regard to an aspect of a collective agreement in respect of which the right to strike is available under a declaration made by the court under section 192(c).³⁰ Participation in a strike will also be lawful if the employees who strike have reasonable grounds for believing that the strike is justified on the grounds of safety or health.³¹

C Essential Services

Under the ERA the obligation to give notice depends partially on whether the proposed strike or lockout is being undertaken by employees employed in, or an employer engaged in, an essential service. As defined by the ILO, an "essential service" is one in which "the interruption of which would endanger the life, personal safety or health of the whole or part of the population."³² The New Zealand legislative scheme conforms to this and is based, at last in part, on the apparent assumption that any strike or lockout in an essential service will cause disruption of a kind which is contrary to the public interest. As the public health sector falls within Schedule 1(11) of the ERA, industrial is first governed by the essential services provisions in sections 90-92 of the Act. The obligation to give notice of a strike or lockout applies only if the proposed strike or lockout "will affect the public interest, including (without limitation) public health or safety."³³

1 Public interest requirement

The ERA inserts the criterion of "public interest" as a prerequisite to the application of the special notice provisions. This criterion did not previously exist under the ECA where the essential service provisions were applicable provided that the striking union fell within Schedule 3 of the Act. Under the ERA a strike or lockout will be in the public interest:³⁴

Where the matter directly or indirectly affects a significant number of people or where a matter will have significant effects. Whether a matter is in the

²⁹ Employment Relations Act 2000, s 83(b)(1).

³⁰ Employment Relations Act 2000, s 83(b)(ii).

³¹ Employment Relations Act 2000, s 84.

³² Gernigon, Odero and Horacio, above n 1, 20.

³³ Employment Relations Act 2000, ss 90(2) and 91(2).

³⁴ Department of Labour "Report to the Employment and Accident Insurance Legislation Committee on the Employment Relations Bill 2000" (June 2004) 104.

public interest has to be considered on a case by case basis depending on the circumstances of the matter.

In the case of the public health sector, it is unlikely that a strike will not fall under public interest. Ensuring seamless service delivery in this sector is clearly a matter constantly in the public eye and is of the utmost importance to patients and their families.

2 Notice requirement

Under section 90(2) if the proposed strike will affect the public interest, including public safety or health,³⁵ and if it relates to bargaining under section 83(b),³⁶ the requirements under section 90(1)(b) of the Act must be complied with. No employee in an essential service may strike without giving notice to their employer and the chief executive of their intention to strike within 28 days before the date of commencement.³⁷ The courts have noted that the ERA notice provisions must be strictly adhered to.³⁸ Furthermore, under section 90(1) no employee may strike unless the strike is lawful under sections 83 or 84.

Under section 90(3) the notice required by section 90(1)(b)(i) must be no less than 14 days in advance in the case of a strike within the public health sector. The notice must also specify the nature of the proposed strike, the place or places where it will occur and the date on which the strike will begin. Upon receipt of such notice, the chief executive is obliged by section 92 to “ensure that mediation services are provided as soon as possible to the parties to the proposed strike or lockout for the purpose of assisting the parties to avoid industrial action.”

³⁵ Employment Relations Act 2000, s 90(2)(a).

³⁶ Employment Relations Act 2000, s 90(2)(b).

³⁷ Employment Relations Act 2000, s 90(1)(b)(i).

³⁸ The Labour Court once pointed out that the provisions of what is now s 90 are mandatory and that Parliament intended the section to be applied strictly (*Air NZ Ltd v NZ Air Line Pilots Assn* [1987] NZILR 742).

3 *Mediation*

Section 92 places an obligation on the chief executive to provide mediation services, rather than obliging the parties to attempt mediation within the notice period.³⁹ This service is provided by the Department of Labour through their mediation service. No coercive powers are given to the chief executive if parties themselves are unwilling to mediate, however, the duty of good faith under section 4 requires the parties to adopt a co-operative approach to a mediated settlement of the issues giving rise to the proposed industrial action.⁴⁰

D *Schedule 1B Code of Good Faith*

Strikes or lockouts inevitably raise concerns for patients' safety and well-being. To help alleviate such concerns, section 100D provides for and regulates a Code of Good Faith for the Public Health Sector (the Code).⁴¹ The Code was a joint venture between the New Zealand Council of Trade Unions and District Health Boards New Zealand and was agreed to supplement existing mechanisms under the ERA. It was enacted in 2004 and is contained in schedule 1B of the Act. Its provisions sit along side the essential service provisions and both are applied when issues arise concerning industrial action in the public health sector. Under section 100D the Code does not limit the application of the duty of good faith contained in section 4. Accordingly, it is a breach of good faith for a person to whom the Code applies to fail to comply with it⁴² and unlike other codes developed under Part 8A which serve only as a guide for the specified institutions, the Code is directly enforceable.

1 Purpose

The Code was agreed as a response to the high level of public criticism invariably attached to industrial action in the health sector. The aim was to provide a legislative method in order to minimise the disruptive effects of industrial action while ensuring adequate employment protection was available to employees.⁴³ It was built on the principle that the public is better served when responsibility and power are shared

³⁹ Ann-Marie Hendra and Kit Toogood QC "Strikes and Lockouts" in New Zealand Law Society *Employment Law Conference* (Butterworths, Wellington, 2000) 55, 61.

⁴⁰ *Ibid.*

⁴¹ The Code was added by s 36 of the Employment Relations Amendment Act (No 2) 2004.

⁴² Employment Relations Act 2000, s 100D(4).

⁴³ Anna Fitzgibbon "Individual Employment Agreements, Code of Good Faith for Public Health Section Institutions" in New Zealand Law Society *Employment Law Conference* (New Zealand Law Society, Wellington, 2004) 23, 26.

between government, DHBs and health unions, than when they are wielded against one and other. The Code was developed in the context of a move towards a tripartism which is reflected in three main objectives:⁴⁴

1. To promote productive employment relationships in the public health sector;
2. To require the parties to make or continue a commitment to develop to maintain and provide high quality public health services, to ensure the safety of patients and to re-engage constructively and to ensure participate fully and effectively in all aspects of their employment relationships; and
3. To recognise the importance of collective arrangements and the role of unions in the public health sector.⁴⁵

2 *Coverage*

The Code is widely applicable and under schedule 1B(1) it applies to DHBs, employees of DHBs, unions whose members are employed by DHBs and any other employers to the extent that they provide services to DHBs or the New Zealand Blood Service.

3 *Patient safety provisions*

It was considered that a code of employment practice was a more effective way to balance the needs of health sector employees with public health and safety during industrial action as it allowed for a consensus approach to managing staffing levels during strikes. The Code contains an obligation for employers to provide for patient safety during industrial action by ensuring that life preserving services (LPS) are available to prevent serious threat to life or permanent disability. Crisis intervention regarding therapeutic services, without which life would be jeopardised, and urgent diagnostic procedures that are required to obtain information on potentially life threatening conditions, must also be provided for. The Code sets out specific requirements to ensure patient safety under sections 11-13 of Schedule 1B. As enacted, it recognises that it is the employer who is responsible for patient safety during a strike. The purpose of giving 14 days notice of industrial action under section 90(3) is to ensure that the employer understands the nature of the notified action, has time to consider what risks it poses and to prepare appropriate contingency plans.

⁴⁴ Employment Relations Act 2000, Schedule 1B(3).

⁴⁵ Employment Relations Act 2000, Schedule 1B(2).

Under the Code employers are obliged to develop contingency plans and there are mechanisms to require union members to stay at work to assist in maintaining LPS. A failure by the employer to make adequate provisions for safety does not shift the responsibility to the union or to the medical professionals engaged in industrial action.⁴⁶ If an employer believes that it cannot arrange to deliver LPS without the assistance of members of the union, a request may be made to the union seeking assistance.⁴⁷ The request must include:⁴⁸

- a. Specific details concerning the LPS the employer seeks assistance to maintain;
- b. The employer's contingency plan; and
- c. What support is required from union members.

The obligation of good faith requires that the parties must meet and make every effort to agree on:⁴⁹

- a. The extent of the LPS necessary to provide for patient safety;
- b. The number of staff necessary to enable the employer to provide that LPS; and
- c. A protocol for the management of emergencies which require additional LPS.

In order to fulfil its obligation under the Code, the employer's plan must minimise the demand for LPS and must also minimise or ideally eliminate any reliance on health sector workers who are covered by the strike notice.⁵⁰

4 *The Main objections to the code*

Under the ECA (prior to the Code being inserted into the ERA), the requirement to provide life saving services was not statutorily enforceable. This posed a serious risk to patient safety. Commenting on a national resident doctors' strike scheduled to

⁴⁶ Geoff Annals "Health Sector Code of Good Faith developed: a Health Sector Code of Good Faith, designed to assist relationships between workers and employers, has been developed over the last two years. It sets out rights and responsibilities, most notably when health workers take industrial action" (October 2004) 10(9) Kai Tiaki Nursing New Zealand 29.

⁴⁷ Schedule 1B 12(2)

⁴⁸ Schedule 1B(3)

⁴⁹ Schedule 1B(5)

⁵⁰ Annals, above n 46, 29.

take place in November 2004, Ian Powell, Executive Director of the Association of Salaried Medical Specialists said:⁵¹

There is no way that safe emergency care can be provided for such a long period of time... This planned strike is something that a public health system has not experienced before and is not resourced to handle without seriously compromising patient safety.

The major risk to patients in the event of a strike arises from a failure to properly assess risk or failure to plan to manage those risks. Often, these failures occur because employers and unions have not been clear who is responsible for safety during a strike.⁵² Any risk to patients also poses serious risk to the effectiveness of industrial action. The fear of harm to patients is one of the most significant factors that stop health professionals from taking strike action. It is in the interests of both patients and effective industrial action that the critical issue of patient safety is managed via the Code.

While the Code provides significant extra protection for unions and their members, it is questionable how much protection it affords to patients and out-patients of hospitals and health services. The minimum number of personnel needed to guarantee services is perhaps one of the most difficult issues in health sector bargaining.⁵³ Often DHBs may try to broaden the definition of "essential medical services" while the negotiating union may try to minimise the number of employees required to work during the strike. It is also possible that the need to secure agreement over the processes to manage industrial action will be used by some employers as a means of preventing otherwise legitimate strike action from occurring. This would, however, be an employment relationship problem and as such attract the use of mediation.⁵⁴

⁵¹ Association of Salaried Medical Specialists "Six Day National Resident Doctors Strike a Catastrophe" (18 October 2004) Press Release.

⁵² Annals, above n 46, 29.

⁵³ International Council of Nurses, above n 26, 9.

⁵⁴ Briefing Paper from the Department of Labour to the Minister of Labour "Review of Employment Relations Act – Refinement of Proposals for Legislative Fine Tuning (April 2003) (Obtained under Official Information Act 1982 Request to the Department of Labour).

In light of a seven day medical laboratory workers' strike which helped to expose this legislative flaw, Health Minister Peter Hodgson has acknowledged that Government shares the concern that patients' lives and health have been put at risk by strikes within the health sector. Patient safety provisions under schedule 1B were amended to include provision of LPS to prevent serious threat to life or "permanent disability". While such explicit clarification in the proposed amended schedule to the ERA would "go a long way to better protect the right to strike in the health sector" and "help to allay some of the understandable but misplaced criticism of the health sector strikes", it does not completely eliminate the vagueness in this grey area.⁵⁵

The issue remains and has now been extended to, how far does "serious threat to life" and "permanent disability" extend? Although many illnesses manifest themselves in forms including severe pain, if a patient is not seriously at risk of permanent disability or death they may be turned away due to lack of resources during a strike. Past strikes indicate that it does not extend to the provision of all long term or ongoing treatment such as radiotherapy or chemotherapy. Thus, many cancer patients have the commencement or continuation of their treatment put on hold if considered to be less serious form of cancer. It is disruption to and the lack of coverage under patient safety provisions in relation to cancer patients that has caused much public and political outcry.

It may be argued that the real threat to patient safety over the past decade has been under-funding. This has resulted, for example, in the crisis situation in Christchurch Hospital in the mid-1990s and downward pressure on salaries which has caused the serious staff shortages that only union bargaining settlements in the past couple of years has started to address. Yet the finger tends to be pointed at the striking health workers when they resort to industrial action. In fact this is the only option the law provides when a settlement cannot be reached with their employers. Calls for a ban on strike action unfairly imply that the breakdown of negotiations is always the fault of health workers rather than the employer.⁵⁶ Moreover, it is ironic that on one occasion during negotiations under Schedule 1B, when staffing levels could not be agreed on

⁵⁵ Association of Salaried Medical Specialists "Patient Safety Change Applauded" (18 December 2006) Press Release.

⁵⁶ Ross Wilson (19 February 2007) *The Dominion Post* Wellington www.union.org.nz (accessed 20 August 2007).

during a mental health workers strike, an independent adjudicator appointed more night staff than the DHB employer had agreed to as normal staffing.⁵⁷ Not only does this indicate that staffing levels generally are a risk to patient safety but also suggests that there is a serious issue employment issue justifying industrial action.

E General Rules Relating to Replacement Labour

Section 97 sits alongside the Code and provides for the employment of replacement workers during strikes in certain situations. The Labour Relations Act 1987 and the ECA both permitted the employment of replacement workers in all circumstances. Conversely, the ERA limits the employer's ability to employ replacement workers, which in turn increases the bargaining power of the striking union. An employer may only employ another person to perform the work of striking employees if the person is already employed by the employer at the time the strike commences, is not principally employed for the purpose of performing the work of striking employee(s) and if they agree to perform the work.⁵⁸ An employer may also engage another person to perform work if there are reasonable grounds for believing it is necessary for the work to be performed for reasons of health or safety.⁵⁹

F Conclusion

The key concern of the legislative scheme covering strikes in the health sector is the degree to which the provisions are able to limit such action and/or allow for their management in a way that prevents endangerment to life or limb.⁶⁰ Effective industrial action is legislatively compatible with being a health professional so long as essential services are provided.⁶¹ Total abandonment of ill patients is inconsistent with the purpose and philosophy of health professionals as reflected in almost all medical codes of ethics. Thus, the right to strike needs to be balanced with the vital concern of patient safety; that is the preservation of life and prevention of permanent disability. I

The right to strike is not unlimited. Industrial action is not permitted for the first 40 days after bargaining is initiated and strike action in the health sector requires that

⁵⁷ Ibid.

⁵⁸ Employment Relations Act 2000, s 97(2)(a)-(c).

⁵⁹ Employment Relations Act 2000, s 97(4)(a).

⁶⁰ Department of Labour "Review of Employment Relations Act", above n 54.

⁶¹ International Council of Nurses, above n 26, 5.

notice be given to the employer and to the Department of Labour, who must then provide mediation in an attempt to avoid the industrial action. In light of this, strikes are truly a last resort. The above restrictions and requirements help to maintain a balance in a modern health system within a modern employment relations regime.⁶² Moreover, National- and Labour-led governments have, for more than 15 years, provided the right to strike as the final means of resolving bargaining. Striking under the ECA was legal. The key difference now is that unions and employers must agree as to how LPS will be provided. The ERA establishes a strong protective legislative base with regard to strikes in the health sector. However, while the current legislation has been effective, has greatly advanced previous law and provided significant limitations on the right to strike in the health sector, calls for legislative change continue.

IV LEGISLATIVE ALTERNATIVES: IS THERE A VIABLE SOLUTION?

A Introduction

The significant impact of industrial action and the increasing public animosity towards striking health sector workers has led to comment and debate, both political and moral, as to the appropriate governing legislative scheme. The question must be asked whether the ERA achieves an appropriate balance between the rights of workers, employers and affected third parties or whether New Zealand requires a legislative change.

B Compulsory Arbitration

Whether the health sector should be viewed as any other emergency service and therefore subject to alternative routes of resolving disputes such as compulsory arbitration is topical in light of the recent health sector strikes. A possible solution may focus on the health sector being deemed an essential service, like the police, for whom strike action is illegal under the Police Act 1958.⁶³ Under the Police Act final offer arbitration (FOA) replaces the right to strike.

FOA involves an arbitrator being present with the union's final claim and the employer's final offer. The arbitrator must choose one or other of the two positions

⁶² Hon Ruth Dyson (15 November 2006) 635 NZPD 6499.

⁶³ Police Act 1958, s 80.

presented, in its entirety and cannot select certain aspects of each offer.⁶⁴ FOA attempts to eliminate strikes and to encourage settlement reached by collective-bargaining. Under a restrictive model, theoretically the parties are forced to be reasonable with regard to every aspect of their claims and offers because the result is all or nothing. The value judgment behind it is that the settlements reached by collective bargaining are healthier for the industrial relations system than arbitrated decisions.⁶⁵

The FOA system is not without flaws. As the British Advisory Conciliation and Arbitration Service commented, FOA "may not necessarily stand the test of fairness or improve relations in the long term."⁶⁶ Damage caused by an unworkable or unacceptable imposition of a final offer far outweighs the theoretical benefit of encouraging the parties to settle on their own account. FOA does not allow for a compromise to be reached. The more the parties differ in their assessment of the arbitrator's likely decision, the wider apart the final offers will be. Therefore, where negotiation fails, the arbitrator's award will be more extreme. If the system produces awards which are considered unjust, extreme or unworkable, parties may lose faith and behave in a manner that undermines the system. Moreover, the outcome of FOA will depend on the arbitrator's perception of what is reasonable, which tends to heavily favour employers and is likely to be met with union and employee hostility.

Other forms of FOA are more flexible and may overcome the inadequate and unsatisfactory results produced by more restrictive FOA. In some jurisdictions a tripartite panel makes decisions instead of a single arbitrator. Another form of FOA is "issue-by-issue" FOA where the arbitrator is able to select a number of items from the union's final claim and the rest from the employer's final offer. While this introduces an element of compromise, arbitrators are likely to be swayed by DHB arguments that the union's demands are too costly in light of inadequate government funding. By imposing FOA, the right to strike is completely removed. Given that it is a model that has already been employed in New Zealand, the focus on FOA is not unreasonable. However, it is arguable that while workable, such drastic legislation should be reserved

⁶⁴ Karen Roper "An Offer They Can't Refuse: The Imposition of Final Offer Arbitration in the New Zealand State Sector" (1988) 13 NZJIR 79, 76.

⁶⁵ Ibid, 83.

⁶⁶ Ibid.

for situations where industrial action would result in lawlessness and create a guaranteed national emergency.

C Solutions within the Current Act?

Another possible solution can be found within the ERA itself. In 2004 the Act was amended and section 50A was added with the purpose of facilitating collective bargaining. Section 50A provides a process enabling parties to seek assistance of the Employment Relations Authority in resolving serious difficulties in concluding a collective agreement. Section 50B enables one or more matters relating to bargaining for a collective agreement to be referred to the Authority for facilitation. While facilitation is not defined in the ERA, it is clearly intended to be distinguished from mediation.⁶⁷ The Authority may make non-binding recommendations about the process or substantive outcome of bargaining for a collective agreement and has discretion to give public notice of such a recommendation.⁶⁸ The publication of a recommendation is likely to have a considerable impact on public opinion, whether for or against the union's cause.

These legislative provisions may provide an appropriate and balanced solution to some of the issues raised in this paper. A facilitation process eliminates the arbitrariness associated with FOA. While the recommendations made are not binding, as a neutral-third party, the Authority may act as a "circuit breaker" and draw the parties' attention back to the central issues of the dispute.⁶⁹ However, facilitation is not compulsory under the ERA and it is up to a party to the dispute to make a reference to the Authority. If facilitation was made a compulsory step in the collective bargaining process when bargaining reaches an impasse, it would potentially provide further protection against the possibility of strikes in the health sector. If section 50C(1)(c) and (d), the grounds on which the Authority may accept reference, are modified to require that reference must be made when a strike appears imminent, further protection may be provided against the negative effects of strikes.

While compulsory facilitation may provide extra protection against the possibility of strikes, such provisions do not completely eliminate the possibility of

⁶⁷ Gordon Anderson *Employment Law Guide* (7 ed, LexisNexis, Wellington, 2005) 326.

⁶⁸ *Ibid*, 333.

⁶⁹ *Ibid*, 334.

industrial action. However, this added bargaining process may achieve a workable balance by providing appropriate Authority input that is aimed at avoiding industrial action.

V *INTERNATIONAL COMPARISON*

Guidance on viable legislative changes may be taken from consideration of other jurisdictions' legislative schemes. Strikes in the health sector are not unique to New Zealand. In the past 20 years there have been strikes by medical professionals and other health sector workers in over 20 countries.⁷⁰ Some countries have chosen to severely limit the right to strike generally while others have focused on direct legislation pertaining to the health sector. The question remains, what legislative scheme and who internationally has struck the right balance between the rights of workers and the rights and interests of patients and the public at large? Australian federal legislation provides a useful comparison when considering whether the ERA provides a fair and correct balance.

A *Australian Work Choices: Suppression of Strikes Australia-wide*

The "right to strike" in Australia is a legislated right first granted by the Federal Parliament in 1993 and replicated under the Workplace Relations Act 1996. It was considered at the time that unless there was legal immunity given to employees to withhold their labour when negotiating workplace agreements, the bargaining system could not operate effectively.⁷¹ However, although the Government claimed that "we won't remove the right to strike" under the Work Relations (Work Choices) Amendment Act 2005 the legal right to strike is practically fictitious.⁷² Work Choices is a prescriptive, command and control penal model designed to legally curtail "unlawful" industrial action.⁷³

1 *The legislative scheme*

Work Choices gave significant new rights to halt "protected action" to any third party affected by industrial action; that is, not the employer and employees in dispute.

⁷⁰ These include Australia, Belgium, Canada, Chile, Finland, France, Germany, China, India, Ireland, Israel, Italy, Korea, Malta, Peru, Serbia, Spain, Sri Lanka, Romania, USA, UK, Zambia and Zimbabwe: Frizzelle, above n 2.

⁷¹ "The Right to Strike" (July 2002) No 89 Australian Chamber of Commerce and Industry Review 1

⁷² Ibid, 66.

⁷³ Ibid, 68.

Under section 111 of the Act, the Australian Industrial Relations Commission (AIRC) must stop all strikes that are not “protected action”.⁷⁴ As in New Zealand, industrial action is still legal during a recognised bargaining period for a new collective agreement. However, the bargaining period can be suspended or terminated by government decree, by the AIRC or through legal action by an affected third party. Executive power is given to the minister to declare a bargaining period terminated, resulting in industrial action being halted.⁷⁵ The minister may form an opinion on what is likely to cause “significant damage to an important part of the Australian economy” which is not limited to the essential services of the army, police and senior public servants but can extend to cover the health sector. To restrain or prevent strike action the minister must be sure that industrial action is being taken, is threatened, impending or is probable;⁷⁶ and if satisfied of that, the minister must present a written declaration that the strike is hurting a business or its employees,⁷⁷ threatens the life or health of the population⁷⁸ or could damage the Australian economy.⁷⁹

When there is significant harm to any third person, or action adversely affects the employer, AIRC must suspend the bargaining period.⁸⁰ Therefore, industrial action is at risk where third parties are considered “particularly vulnerable” or industrial action “threatens to damage the viability of business”, “disrupts the supply of goods or services to a business”, “reduces the person’s capacity to fulfil a contractual obligation” or “causes other economic loss”.⁸¹ In relation to strikes within the health sector that constitute protected action, it is difficult to imagine that such action will not result in some economic damage to third parties as patients and any person affected by public sector bargaining, can apply to have the bargaining period suspended.

⁷⁴ Workplace Relations Amendment (Work Choices) Act 2005 (Cth), s 108. Action by a person is *protected action* if: (a) the action is protected action under subsection (2) or (3); and (b) no provision of Subdivision B excludes the action from being protected action; and (c) subsection 107K(3) does not exclude the action from being protected action.

⁷⁵ Workplace Relations Amendment (Work Choices) Act 2005 (Cth), s 112.

⁷⁶ Workplace Relations Amendment (Work Choices) Act 2005 (Cth), s 112(1)(a)

⁷⁷ Workplace Relations Amendment (Work Choices) Act 2005 (Cth), s 112(1)(b)

⁷⁸ Workplace Relations Amendment (Work Choices) Act 2005 (Cth), s 112(1)(c)(i)

⁷⁹ Workplace Relations Amendment (Work Choices) Act 2005 (Cth), s 112(1)(c)(ii)

⁸⁰ Workplace Relations Amendment (Work Choices) Act 2005 (Cth), s 107J

⁸¹ Workplace Relations Amendment (Work Choices) Act 2005 (Cth), s 107J (2)(a-d)

With high penalties to curtail prospective strike action, Work Choices moved away from “repressive tolerance” towards the legal suppression of strikes in Australia.⁸² While this legislation is not health sector-specific, it shows a significant shift to greater corporate power and state intervention against unionised industrial action. It appears to do little more than implement an ideological agenda in which workers and their trade unions are the primary victims.⁸³ No balance is struck between the right to strike and the safety of patients. While Work Choices may prevent any inconvenience, delay in treatment and other associated problems with strikes, it takes away the legitimate right of workers to withdraw their labour. As Victorian Industrial Relations Minister Rob Hull said, Work Choices “kicks workers in the guts twice.”⁸⁴ If similar legislation was enacted in New Zealand, the ability to negotiate better pay and conditions, which is invariably associated with the ability to engage in industrial action, would be prevented. The outcry of the public would simply be replaced with the protests of unions and employees prevented from striking. Such a legislative scheme would unfairly favour DHBs. A legislative model that creates an almost fictitious right to strike and that tips the balance so strongly in favour of employers would not be acceptable in New Zealand.

B Comparative International Position of Health Sector Workers: Does the ERA Strike the Right Balance?

Unionisation is not straightforward for health sector workers as there is a clear fiduciary relationship with their patients. The fiduciary relationship does not sit well with unionisation as the full potential of a unionised workforce is often manifested in strike action.⁸⁵ In America, some bargaining groups such as Physicians for Responsible Negotiation – the labour arm of the American Medical Association – voluntarily reject strike action.⁸⁶ The absence of the threat or possible employment of industrial action significantly reduces the bargaining power of the negotiation body. In light of the fact that health sector workers are currently permitted to strike coupled with their

⁸² White, above n 25, 77.

⁸³ Craig Thomson, National Secretary Health Services Union “Submission to Senate Employment, Workplace Relation and Education Legislation Committee, Inquiry into the Workplaces Relations Amendment (Work Choices) Bill 2005”.

⁸⁴ Ian Haberfield and Lincoln Wright “New Laws to bust Strikes: Minister Gets Broad Powers” (18 December 2005) *Sunday Herald Sun* Melbourne.

⁸⁵ Roderick Mulgan *Why Has Labour Law Failed Resident Doctors?* (LLB(Hons) Research Paper, Victoria University, 2006) 9

⁸⁶ *Ibid.*, 9.

willingness to take industrial action, it is tempting to conclude that success in New Zealand, be it limited success, is a result of a more liberal legislative approach guaranteeing the fundamental right to strike, compared to that taken in Australia. Internationally, New Zealand cannot compete economically in terms of wages, therefore it is important that health sector workers are able to engage in industrial action in order to secure the best possible conditions and prevent the emigration of health professionals.

VI CONCLUSION

The right to strike should not be removed without serious, careful consideration and balancing of the interests of the effected parties, the employer and the employees. Although not contained in the New Zealand Bill of Rights Act 1990, the right to strike is an internationally recognised human right. If legislation deprives a workforce of the right, those workers must be afforded appropriate guarantees to compensate for this restriction.⁸⁷ A prohibition in such circumstances should at least be accompanied by adequate, impartial and speedy conciliation and arbitration proceedings in which both the employer and employees or their union take part. While compulsory arbitration is generally regarded as unacceptable by the ILO, it may be regarded as acceptable as an alternative to strikes in essential services where interruption to those services would endanger the life, personal safety or health of the whole or part of the population.⁸⁸ Thus, by international standards, the removal of the right to strike in the health sector would be acceptable.

While the health sector would certainly fall within the ILO's "essential service" definition, legislation in New Zealand has dealt with "endangerment of life, personal safety or health" by imposing restrictions on the right to strike, rather than removing it altogether. The Code's requirement of provision of LPS adequately deals with safety issues that may arise during industrial action. Effective contingency planning on behalf of the employer ensures that if a patient requires LPS he/she will receive it. The ERA provides a real right to strike compared to Australian legislation where severe legislative limitations mean the right is practically fictitious. Such a legislative scheme is unacceptable. The fact that New Zealand cannot compete economically with other

⁸⁷ International Labour Organization *Freedom of Association: Digest of Decisions and Principles of the Freedom of Association Committee of the Governing Body of the ILO* (4 ed, International Labour Organization, Geneva, 1996) para 546.

⁸⁸ *Ibid*, para 515.

jurisdictions means that it is important that health sector workers are able to engage in industrial action in order to secure the best working conditions possible. If not New Zealand's medical brain-drain will continue. If the right to strike can be preserved without endangerment of life or health, legislation must preserve this right.

The motivation behind industrial action is that it causes disruption and delay to the employers' business in order to force the parties back to the table. It is the delay in treatment that has sparked the majority of public and political anger and debate. However, hospitals are already understaffed and in many cases, long waits are customary for operations, treatment programmes and emergency department services. While strike action adds to this delay, it is also industrial action that seeks to change working conditions and increase staffing levels which will in turn provide better care and treatment for patients.

To remove the right to strike is to eliminate all union bargaining power and unfairly advantage DHBs. In light of the legislative limitations and safety provisions, the removal of this right is not really necessary. However, several viable legislative changes may enable enhanced protection for patients and against the possibility of industrial action in future disputes. One solution may focus on limiting the period of time for which strikes in the health sector may extend. This may prevent some of the treatment delay caused by industrial action. Another possibility is an extension of the Code's patient safety provisions to include the provision of long-term, ongoing treatment. This would enable cancer patients, who appear greatly affected by health sector strikes, the necessary treatment to ensure the best possible outcomes. Compulsory facilitation may also provide greater protection against strikes, without removing the right altogether. If legislative change is considered necessary by the Government, it is important that the right to strike is not removed simply because of public pressure. From a principled employment law perspective, a complete removal of the right to strike would create an uneven balance between the interests of the public, employees and health sector workers.

BIBLIOGRAPHY

I ACTS

Employment Contract Act 1991.

Employment Relations Act 2000.

Police Act 1958.

Workplace Relations Amendment (Work Choices) Act 2005 (Cth).

II BILLS

Employment Relations Law Reform Bill 2004, no 24- 2.

III CASES

Air NZ Ltd v NZ Air Line Pilots Assn [1987] NZILR 742

IV CONFERENCE PAPERS

Fitzgibbon, Anna "Individual Employment Agreements, Code of Good Faith for Public Health Section Institutions" in New Zealand Law Society *Employment Law Conference* (New Zealand Law Society, Wellington, 2004) 23-33.

Hendra, Ann-Marie and Kit Toogood QC "Strikes and Lockouts" in New Zealand Law Society *Employment Law Conference* (Butterworths, Wellington, 2000) 55-66.

V JOURNALS

Belich, Angela "Being Outcome Focused Over Membership Empowerment: Putting the Second 'C' Into the MECA" (2004) 61 *The Specialist*.

Dzendrowskyj, Peter, Geoff Shaw and Lucy Johnston "Effects of Nursing Industrial Action on relatives of Intensive Care Patients: A 16-month Follow-up" (2004) 117(1205) *New Zealand Medical Journal*.

Frizelle, Frank "Is it Ethical for Doctors to Strike?" (2006) 119(1236) *New Zealand Medical Journal*.

Powell, Ian "Downing Scalpels and Stethoscopes: The 2003 South Canterbury Senior Doctor's Strike and the Challenges facing their Union" (2005) 30 *NZJER* 77-85.

Powell, Ian "Empowerment and the Employment Relationship" (2004) 117(1204) *New Zealand Medical Journal*.

Rietveld, John "Strike Action by Senior Staff in Timaru – How did this Come About?" (2003) 116(1170) *New Zealand Medical Journal*.

Roper, Karen "An Offer They Can't Refuse: The Imposition of Final Offer Arbitration in the New Zealand State Sector" (1988) 13 NZJIR 79.

Roper, Karen "Final Offer Arbitration and the State Sector Act" (1988) 13 NZJIR 87.

Sachdev, PS "Doctors' Strike – an Ethical Justification" 99 (1986) New Zealand Medical Journal 412-4.

"The Right to Strike" (July 2002) No 89 Australian Chamber of Commerce and Industry Review 1.

White, Chris "Workchoices: Removing the Choice to Strike" (2005) 56 Journal of Australian Political Economy 66.

VI NEWSPAPERS

Haberfield, Ian and Lincoln Wright "New Laws to Bust Strikes: Minister Gets Broad Powers" (18 December 2005) *Sunday Herald Sun* Melbourne 6.

Hayman, Kamala "Mother Deborah" (17 June 2006) *The Press* Christchurch A9.

Hayman, Kamala "Unions Angry at PM after Criticism" (5 December 2006) *The Press* Christchurch 5.

Hayman, Kamala "Longer Wait Blamed on Unions" (16 January 2007) *The Press* Christchurch 2.

Hayman, Kamala "Government Action Called For" (18 January 2007) *The Press* Christchurch 4.

Hayman, Kamala "Relief Doctors Costing Millions" (14 June 2007) *The Press* Christchurch www.stuff.co.nz (accessed 20 August 2007).

Houlahan, Mike "Junior Doctors out of Patience" (23 October 2004) *The Press* Christchurch A21.

Johnston, Martin "Calls Grow to Outlaw Strikes by Health Staff" (4 December 2006) *The New Zealand Herald* Auckland www.nzherald.co.nz (accessed 20 August 2007).

Kelly, Andrew "Festering Sores the Doctors Can't Heal" (26 September 2006) *The Dominion Post* Wellington A9.

Kiong, Errol "Health Strikes Reveal Risk to Patient in Legal Flaw" (19 December 2006) *New Zealand Herald* Auckland www.nzherald.co.nz (accessed 20 August 2007).

Martin, Yvonne "Medical Manoeuvres; Doctors Lured by 'Silly Money'" (26 August 2000) *The Press* Christchurch 1.

McFadden, Suzanne "Young Doctors Back to the Wards" (2 September 1996) *New Zealand Herald* Auckland A13.

Mickelborough, Peter and Tanya Gyles "New Strike Law is Fair" (21 April 2004) *Herald Sun* Melbourne 4

Spearing, Ruth "Vital Tuition or Overwork?" (15 June 2006) *The Press* Christchurch A9.

Wilson, Ross (19 February 2007) *The Dominion Post* Wellington www.union.org.nz (accessed 20 August 2007).

VII PARLIAMENTARY MATERIALS

(4 March 2004) 615 NZPD 11592.

(4 August 2004) 619 NZPD 14606.

(12 September 2006) 634 NZPD 5335.

(8 November 2006) 635 NZPD 6294.

(14 November 2006) 635 NZPD 6409.

(15 November 2006) 635 NZPD 6499.

(23 November 2006) 635 NZPD 6782.

(5 December 2006) 636 NZPD 6841.

(2 May 2007) 638 NZPD 8831.

VIII PRESS RELEASES

Association of Salaried Medical Specialists "Employment Relations Law Reform Bill: A Real Advance for the Health Sector" (21 September 2004) Press Release.

Association of Salaried Medical Specialists "Six Day National Resident Doctors Strike a Catastrophe" (18 October 2004) Press Release.

Association of Salaried Medical Specialists "Patient Safety Change Applauded" (18 December 2006) Press Release.

Counsel of Trade Unions "District Health Boards Exploiting Low Paid Health Workers" (13 December 2006) Press Release.

Counsel of Trade Unions "Ryall's Proposal Recipe for Complete Chaos in Health Sector" (16 April 2007) Press Release.

Mapp, Wayne, New Zealand National Party "Time for Minister to Act on Health Strikes" (15 November 2006) Press Release.

IX REQUESTS MADE UNDER THE OFFICIAL INFORMATION ACT

Briefing Paper from the Department of Labour to the Minister of Labour "Review of Employment Relations Act – Refinement of Proposals for Legislative Fine Tuning (April 2003) (Obtained under Official Information Act 1982 Request to the Department of Labour).

Briefing Paper from the Department of Labour to the Minister of Labour "Health Sector Code of Good Faith" (19 August 2004) (Obtained under Official Information Act 1982 Request to the Department of Labour).

Briefing Paper from the State Services Commission to the Minister of State Services "Health Sector Code of Good Faith" (19 August 2004) (Obtained under Official Information Act 1982 Request to the Department of Labour).

Cabinet Policy Committee Paper, Employment Relations Law Reform Bill- Codes of Employment Practice for the Health Sector" (December 2003) (Obtained under Official Information Act 1982 Request to the Department of Labour).

Cabinet Business Committee Paper "Employment Relations Law Reform Bill- Refinement Options" (2 July 2004) CBC (04) 99 (Obtained under Official Information Act 1982 Request to the Department of Labour).

Cabinet Policy Committee Paper "Employment Relations Law Reform Bill- Report Back on Outstanding Issues" (July 2004) (Obtained under Official Information Act 1982 Request to the Department of Labour).

Cabinet Paper "Employment Relations Law Reform Bill – Negotiated Bargaining Fee Clauses and thresholds for Breaches of Good Faith in Collective Bargaining" (September 2004) (Obtained under Official Information Act 1982 Request to the Department of Labour).

Cabinet Paper "Employment Relations Law Reform Bill – Code of Good Faith" (19 August 2004) CAB (04) 330 (Obtained under Official Information Act 1982 Request to the Department of Labour).

Cabinet Paper "Code of Good Faith for the Health Sector" (December 2006) CAB (06) 573 (Obtained under Official Information Act 1982 Request to the Department of Labour).

Health Report "Tripartite Code of Good Faith Committee" (September 2003) (Obtained under Official Information Act 1982 Request to the Ministry of Health).

Health Report "Briefing for Tim Barnett Regarding Patient Safety and Industrial Action in the Health Sector" (March 2004) (Obtained under Official Information Act 1982 Request to the Ministry of Health).

Health Report "Employment Relations Law Reform Bill: Clause 100D and Patient Safety" (April 2004) (Obtained under Official Information Act 1982 Request to the Ministry of Health).

Health Report "Employment Relations Law Reform Bill: Clause 100D and Patient Safety" (May 2004) (Obtained under Official Information Act 1982 Request to the Ministry of Health).

Letter from Ministry of Health to Department of Labour "Draft Employment Relations Law Reform Bill Amendments in Relation to Schedule 1AA- Health Sector Code of Good Faith" (July 2004) (Obtained under Official Information Act 1982 Request to the Ministry of Health).

Memorandum from Cabinet "Review of the Employment Relations Act- Refinement of Proposals for Legislative Fine Tuning" (April 2003) (Obtained under Official Information Act 1982 Request to the Department of Labour).

Paper from the Department of Labour to the Minister of Labour "Employment Relations Law Reform Bill: Report to the Transport and Industrial Relations Committee - 9 September 2004" (7 September 2004) (Obtained under Official Information Act 1982 Request to the Department of Labour).

Policy Document "Excerpts taken from Draft Employment Relations Act Review Papers Sent to the Ministry of Health from the Department of Labour" (2004) (Obtained under Official Information Act 1982 Request to the Department of Labour).

X TEXTS

Anderson, Gordon *Employment Law Guide* (7 ed, LexisNexis, Wellington, 2005) 326.

Gernigon, Bernard, Alberto Odero and Horacio Guido *ILO Principles Concerning The Right To Strike* (International Labour Organisation, Switzerland, 1998).

Wilson, Hon Margaret "The Employment Relations Act: A framework for a fairer way" in Erling Rasmussen (ed) *Employment Relationships: New Zealand's Employment Relations Act* (Auckland University Press, Auckland, 2004).

XI UNPUBLISHED RESEARCH PAPERS

Mulgan, Roderick *Why Has Labour Law Failed Resident Doctors?* (LLB(Hons) Research Paper, Victoria University, 2006).

XII WEBSITES

"Cancer Patients Get More Bad News" (8 June 2006) *One News Auckland* www.tvnz.co.nz (accessed 20 August 2007).

"Church Wants to End Radiation Row" (10 January 2007) *Newstalk ZB Auckland* www.tvnz.co.nz (accessed 21 August 2007).

"Health Sector Disruptions Escalate" (26 April 2007) *Newstalk ZB Auckland* www.tvnz.co.nz (accessed 20 August 2007).

Statistics New Zealand www.statistics.govt.nz (accessed 20 August 2007).

XIII OTHER SOURCES

Annals, Geoff "Health Sector Code of Good Faith developed: a Health Sector Code of Good Faith, designed to assist relationships between workers and employers, has been developed over the last two years. It sets out rights and responsibilities, most notably when health workers take industrial action" (October 2004) 10(9) Kai Tiaki Nursing New Zealand 29.

Department of Labour "Report to the Employment and Accident Insurance Legislation Committee on the Employment Relations Bill 2000" (June 2004).

The New Zealand Medical Association *Code of Ethics* (2002).

NZPA "Ban on Strike by Health Workers Only Way Forward" (29 November 2006) *Financial Times Information*.

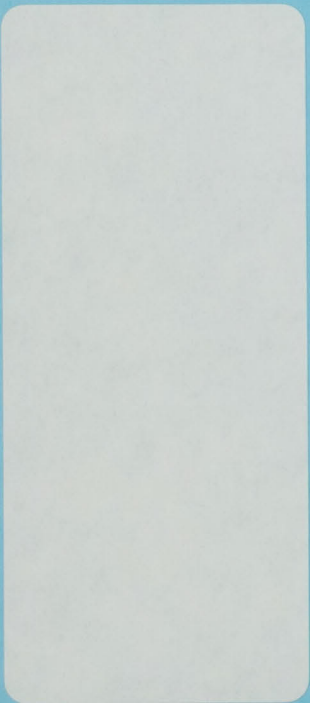
International Council of Nurses *Guidelines on Essential Services During Labour Conflict* (International Council of Nurses, Geneva, 2004) 5.

International Labour Organization Freedom of Association: Digest of Decisions and Principles of the Freedom of Association Committee of the Governing Body of the ILO (4 ed, International Labour Organization, Geneva, 1996) para 546.

Johnson, P "Rural Peoples' Experience of Critical Illness Involving Inter-hospital Transportation: a Qualitative Study" (1999) 12(1) *Australian Critical Care* 12-16.

New Zealand Nurses Organisation "Submission to the Transport and Industrial Relations Select Committee on the Employment Relations Amendment Bill 2004".





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