

Report of the Industrial Inquiry Commission

into the

British Columbia Ambulance Service

January 15, 2010

Submitted by: Chris Trumpy
Submitted to: The Honourable Murray Coell, Minister of Labour

Transmittal letter

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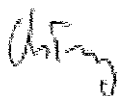
Dear Minister Coell,

On November 19, 2009, I was appointed Industrial Inquiry Commissioner into matters relating to the British Columbia Ambulance Service as set out in Appendix I. I am pleased to submit my report. In the absence of participation by CUPE Local 873, there were some issues I was asked consider in my terms of reference that I have been unable to address. I do not believe that taking additional time for further consideration of these issues without the union's participation would be productive. I am pleased to advise that I received cooperation from several other health care unions, fire chiefs, BCAS management and labour practitioners. I received insightful comments from a number of individual paramedics who care deeply about the work they perform on behalf of the citizens of British Columbia. I also benefitted from expert labour relations advice from well respected lawyers who typically represent both employers and unions/employees.

I was asked to identify options for the delivery of ambulance services in British Columbia and for effective labour relations for this sector. The time provided did not permit a detailed review, however, I do not feel that there are other possible options beyond those presented in this report based on discussions I have had, and reviews of other jurisdictions. This information is presented in sections A and B of this report. I have also attempted to set out the implications of each option including an initial review of possible legislation required for implementation. My terms of reference also included staff recruitment, training and retention; staff workload; occupational health and safety issues; deployment strategies in comparison with other Canadian ambulance service delivery models; and models and rates of total compensation for ambulance paramedics and dispatchers. Data and information on these issues was collected and reviewed with input from BCAS managers. However, a comprehensive analysis and development of options for these matters was not possible. Rather than options, I have included observations that might be areas for further inquiry.

As government considers the options related to effective labour relations and the structure of the ambulance service, I believe it needs to find a way to engage CUPE Local 873 and its membership in discussions. As noted earlier, I received a number of submissions from individual paramedics who care passionately about what they do and who believe that change is required in some form. They are committed to providing professional care throughout British Columbia and would love to get involved in moving the ambulance service forward.

Yours sincerely,

A handwritten signature in black ink, appearing to read "Chris Trumpy". The signature is written in a cursive, flowing style.

Chris Trumpy

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Executive Summary

1. Five broad options for the delivery of ambulance service in British Columbia are presented (Part A):

- status quo;
- closer integration with health care;
- closer integration with first responders;
- community driven service delivery; and,
- private sector delivery.

There are implications associated with every option, and it is possible to blend some of the options presented. Ambulance delivery models vary across Canada and are described in Appendix 2.

2. Two arbitration options and the associated implications are presented for resolving labour disputes involving essential services (Part B):
 - interest based; and,
 - final offer selection.
3. Two negotiation structure options and associated implications are presented (Part B):
 - stand alone bargaining unit (which is currently the case); and,
 - multi employer which would result in paramedics negotiating as part of a larger group.
4. A discussion of legal implications of implementing various options is presented (Appendix 3).
5. An interprovincial comparison of compensation is provided in Appendix 5 that shows how British Columbia paramedics are paid at the top end of paramedics across Canada.
6. An interprovincial comparison of training is provided which shows training requirements are higher in some other provinces (Part C) and that professional development approaches are different in different provinces.
7. Recruitment processes and challenges are outlined in Part C. Rural recruitment is a common challenge amongst jurisdictions with different recruitment and deployment solutions.
8. British Columbia's deployment approach is described in some detail in Part C. British Columbia's station based model is fairly common but other approaches are used in some metropolitan areas.
9. Lack of cooperation from some parties did not allow sufficient information to be gathered to form fulsome views on staff workload and occupational health or safety issues.

A. Ambulance Service Delivery Options

The Ambulance Service in British Columbia is unique in Canada because it is a province-wide, government operated system. A summary of ambulance service systems in other provinces is found in Appendix 2. Many have a number of service providers ranging from funeral homes to fire departments, hospitals and the private sector, although government establishes standards for paramedic qualifications in all cases.

The terms of reference for this report require consideration of three delivery options: the status quo, closer integration with the health system and closer integration with the emergency response system. This report will also look at a community-based option and private sector delivery.

Under any of the options that contemplate change, except private sector delivery, certain functions required for consistent service and seamless deployment would continue to be done provincially. The Ambulance Service would continue to provide air ambulance services, set standards for paramedic qualifications and service, and operate dispatch (even under the private sector model it is proposed that standards and qualifications would be set by the Province and air and dispatch services would be provided on a provincial basis).

Status Quo

History

Until the mid 1970s, emergency medical services in the province were provided by a wide range of commercial and municipal operators, including funeral homes and volunteer fire departments. Some services were partially subsidized by municipalities and others were paid for by user fees. Given the diversity in service providers, there were significant inconsistencies in terms of response times, quality of service, and quality of ambulances and equipment. In 1970, the *Health Security for British Columbians* report, prepared by Dr. R. G. Foulkes to identify and address many of the health care issues at the time, recommended that the Government assume responsibility for all privately and municipally operated ambulance services in the province and create an amalgamated service. In 1974, legislation was passed mandating the establishment of a service to provide high quality and consistent levels of pre-hospital emergency medical services across the province.¹

Governance - Emergency Health Services Commission

The British Columbia Ambulance Service (BCAS) operates under the authority of the Emergency and Health Services Commission (EHSC) as established by the *Emergency and Health Services Act*. The EHSC is mandated to provide emergency response health services, delivered through the BCAS.

¹ <http://www.bcas.ca/EN/main/about/history.html>

EHSC is also responsible for non-emergency health and tele-health services, provided through HealthLink BC².

The EHSC has a reporting relationship to the Ministry of Health Services and receives direction from a board of directors that includes representation from the Fraser, Interior and Northern Health Authorities and the Ministry of Health Services executive.

BC Ambulance Service

The BCAS employs 3,983 individuals ranging from front line staff such as paramedics and dispatchers (CUPE employees), to support staff providing communications, finance and administration, human resources, technology and other support (includes BCGEU employees). BCAS' budget for 2008/09 was \$268 million.

Total Personnel (March 31, 2009)

Total Paramedics / Dispatchers (CUPE Local 873)	3,614
Full-Time	1,485
Part-Time	2,129
Total Management Staff (includes shared services staff)	148
Total Support Staff (includes shared services staff)	221
Total Staff	3,983

(Source: 2008/09 BCAS Annual Report)

BCAS operates 187 stations, 480 ambulances and 47 support vehicles. It also has nine dedicated ambulance aircraft available to be dispatched on a 24/7 basis. Staffing of ambulance stations throughout the province depends on the call volumes. Stations in remote and rural areas tend to rely heavily on part time and on-call paramedics while busier stations use full time employees. In addition to the 187 ambulance stations, BCAS facilities include:

² Under section 5 of the *Emergency and Health Services Act*, the commission also has the authority to:

- (b) establish, equip and operate in areas of British Columbia that the commission considers advisable,
 - (i) emergency health centres and stations, and
 - (ii) centres from which health services may be provided
- (c) assist hospitals and other health institutions and agencies, municipalities and other organizations, and persons, to
 - (i) provide emergency health services and health services, and
 - (ii) train personnel to provide emergency health services and health services;
- (d) enter into agreements or arrangements for the purposes set out in paragraph (c);
- (f) make available the services of trained persons on a continuous, continual or temporary basis to those residents of British Columbia who are not, in the opinion of the commission, adequately served by existing emergency health services and health services;

- Provincial Headquarters located in Victoria;
- three regional Dispatch/Communications Centres located in Victoria, Vancouver and Kamloops;
- one Provincial Air Ambulance Coordination Centre, located in Victoria;
- four Regional Offices located in Victoria, Vancouver, Kamloops and Prince George;
- 10 local offices for Superintendents located in Campbell River, Castlegar, Chilliwack, Cranbrook, Dawson Creek, Kelowna, Parksville, Smithers, Kelowna airport and Vancouver airport³.

BCAS also coordinates and undertakes inter-facility patient transfers, accounting for 28% of all transports. BCAS has a small number of ambulances dedicated to inter-facility transfers (Transfer Fleet), but also uses Basic Life Support ambulances to transfer patients between health care facilities. Health Authorities also contract with private patient transfer operators to provide non-medical patient transfers for stable patients who do not require the skills of a paramedic during transport.⁴

The three Dispatch/Communications Centres are responsible for the deployment of ground-based ambulances throughout the province:

- The Lower Mainland Dispatch/Communication Centre, located in Vancouver, dispatches ambulances to over 30 communities as far east as Lytton and Boston Bar, and north to Pemberton and Lillooet. It includes the Sunshine Coast and Bowen Island. On an average day the Centre responds to 900 calls and 250 inter-facility transfers, with as many as 1,400 calls on a busy day.⁵
- The Interior/Northern Dispatch/Communications Centre, located in Kamloops, provides service to all communities outside of the Lower Mainland and the Vancouver Island Region. The Centre is responsible for dispatching ambulances to 98 communities throughout British Columbia and processes an average of 500 to 600 calls per day.⁶
- The Vancouver Island Dispatch/Communications Centre dispatches ambulances to all of Vancouver Island, Powell River and the Gulf Islands. It handles an average of 250 to 300 calls per day.⁷

BCAS also operates the Air Ambulance program with flight centres located in Vancouver, Kelowna and Prince George employing six dedicated fixed wing aircraft, three dedicated helicopters and 40

³ BC Ambulance Service 2008/09 Annual Report, http://www.bcas.ca/assets/About/PDFs/NOV_Annual%20Report.pdf

⁴ BC Ambulance Service 2008/09 Annual Report, http://www.bcas.ca/assets/About/PDFs/NOV_Annual%20Report.pdf; and Information provided by BCAS

⁵ <http://www.bcas.ca/EN/main/services.html>

⁶ <http://www.bcas.ca/EN/main/services.html>

⁷ <http://www.bcas.ca/EN/main/services.html>

charter carriers. Air ambulances are staffed by specially trained emergency medical personnel including Advanced Care Paramedics specializing in Adult Critical Care and Child and Maternal Critical Care. All requests for Air Ambulance, including neonatal, maternal and paediatric services are processed through the Provincial Air Ambulance Coordination Centre.⁸ The Air Ambulance Service is the second busiest provider of air ambulance transport in North America. In 2008/09 it handled 8,356 calls for service.⁹

The Provincial Programs department is responsible for provincial programs including management of the air ambulance service, fleet, scheduling and emergency management programs.¹⁰ The BC Ambulance Services Medical Programs Division provides medical oversight to paramedics in the provision of quality patient care and undertakes four major functions: physician oversight of programs and standards, clinical performance management (quality assurance), clinical education, and research.

The provincial government funds the BCAS. Fees for service are charged, but are heavily subsidized for individuals covered by the BC Medical Services Plan.

BCAS works with hospitals and first responders (fire departments) in performing its functions. Paramedics provide pre-hospital care and transport services between health care facilities for patients. Fire departments are often first on the scene of an emergency and provide some limited health care services before paramedics arrive. In both relationships, the responsibilities of the parties are limited to certain activities.

Observations:

- There is a consistent service approach throughout Province – standardization of service provision across similar communities (i.e., all rural communities treated the same, all urban communities treated the same)
- There are province-wide standards for paramedic qualifications, provincial dispatch and provincial air services
- Staffing, wages and terms of employment are standardized
- The province-wide system allows for efficient deployment of resources through dispatch centers
- BCAS is a distinct organization in the health care system
- The one size fits all approach may not be appropriate
- There are challenges finding qualified rural residents to work as paramedics in their communities

⁸ <http://www.bcas.ca/EN/main/services/air-ambulance.html>

⁹ BC Ambulance Service 2008/09 Annual Report, http://www.bcas.ca/assets/About/PDFs/NOV_Annual%20Report.pdf

¹⁰ Information provided by BCAS

- The single employer relationship with principle bargaining unit should allow focus on specific problems but the relationship between the employer and the bargaining unit are strained

Health Care Integration

Currently, ambulance services are offered through a distinct corporate entity (the EHSC) that operates under the Ministry of Health. Although the current board of EHSC is made up primarily of Health Authority CEOs, this has been the case only recently. Operating as essentially a separate entity under the EHSC, BCAS has created its own distinct identity and there is great pride in working in this part of the health care system. However, it is also true that the Ambulance Service is distinct from the rest of the health care system and while many practitioners align themselves closely with health care providers, some align themselves with emergency responders (fire and police).

Greater integration with the health care system would be based on the premise that emergency medical and paramedical service is a first line of response in a health services continuum and not a distinct function. The benefits of greater integration of the ambulance service into the health service continuum would be more seamless delivery of services, potential for increased scope of practice for paramedics to work to their potential and improved education for paramedics, all leading to better service and care to the patient. The risk is a degradation of the relationship with first responders.

There are several possible ways to enhance the linkages with the health care system ranging from structure and governance changes to service and operational changes.

Governance and structural options include moving the governing body for the BCAS under the umbrella of the Provincial Health Services Authority (the PHSA is responsible for provincial health services and agencies such as the BC Cancer Agency and the BC Centre for Disease Control) or, in the extreme, moving responsibility for ambulance service out to the five regional health authorities¹¹.

Moving the BCAS to either the PHSA or the Health Authorities would ensure stronger linkages and clearer alignment of the BCAS with the health sector. In the case of moving the service under the authority of the Health Authorities, it would ensure that the service was under the direct control of, and accountable to, the health authorities. The key difference between the two governance and structural approaches is that if the ambulance service becomes another subsidiary of PHSA, then there is still a single employer and a province-wide model, while transferring to individual health authorities would result in five different employers and over time the way service is delivered could evolve. Devolving the function to individual health authorities would require that “boundary issues,” particularly in the lower mainland that is served by two separate health authorities, be

¹¹ As is done in Alberta (although there is only one health authority district for the entire province) and Ontario.

addressed (i.e., through mutual aid agreements; shared response and emergency management protocols).

Greater integration with no changes to structure or governance could also be achieved by:

- strengthening the relationship between the BCAS and the health system by building stronger ties between EHSC, the Ministry of Health Services and Health Authorities;
- working with the ministry and Health Authorities to create partnerships and relationships that integrate health and emergency services to better meet clients needs and serve communities. That could include the creation of joint or multi disciplinary teams (such as the proposed pilots in the Chicoutin and Lytton areas, and the program in Midway where paramedics provide home support at night for assisted living tenants in a particular facility);
- establishing an enhanced system of medical oversight for paramedics, including linkages to health facilities with a strong regional presence;
- establishing an enhanced program of ongoing monitoring and improvement of standards and continuing education and training requirements to ensure paramedic practice is consistent with best emergency medical practices;
- strengthening the capacity of paramedics to extend their skills beyond their current role (i.e., to allow them to assist and provide transitional services in an emergency room environment under appropriate supervision – as in the agreement to provide seasonal support of paramedics in the Kelowna General Hospital Emergency Department to help improve patient flow and mitigate impact of ambulance delays or the physician’s license approach in Manitoba and Nova Scotia or Ontario’s base hospital program.

Implications:

- A change in governance and structure would clearly establish the ambulance service as a health care service, but would require legislation
- Any structural change has transition costs including capital costs if stations are relocated to health facilities; resource implications are unclear over the longer term
- Moving the ambulance service to Health Authorities would result in closer integration of ambulance services with the health service facilities receiving the patients
- Closer integration with the health care continuum could allow paramedics to work to their full potential as part of health care system
- Health care integration should improve education opportunities for all paramedics
- With closer health care system integration, there would be greater opportunities for collaboration and coordination, including integration of services in small communities, thereby ensuring provision of both certain basic health services on an ongoing basis and emergency response when needed

- Enhancing skills and capacity of paramedics would likely require changes to regulations under the *Emergency and Health Services Act*
- A move to Health Authorities could require changes to the collective agreement and related documents since paramedics would fall under the Health Employer Association of BC bargaining umbrella
- Closer integration with health services could distance ambulance service from emergency responders.

Emergency Responder Integration

In many cases, fire departments funded by local governments are the first responder to a call for medical assistance. Because firefighters do not spend a lot of time responding to structural fires they have the capacity and the desire to respond to emergency calls. Since there are far more fire stations in the province than ambulance stations, in many cases the firehall is closer to the scene of an emergency than an ambulance (there are approximately 350 fire stations across the province, with about 200 of them providing first responder medical services to their communities).¹² While individual firefighters generally do not have the training or expertise of a paramedic, they play a valuable role. They perform initial assessments and some treatment, and in the event of a motor vehicle accident or other physical emergency stabilize the accident scene for the paramedics.

The relationship between fire departments and paramedics appears to be generally good although there is a level of suspicion that exists. Some fire departments, particularly in metro areas, would like to take over responsibility for ambulance services and be seen as emergency responders for the full range of health and safety issues in a community. Other fire departments are not interested, but want clarity on roles and feel that they could do more to relieve the pressures they see on the paramedics. Many like the status quo, and, in rural areas dependent on volunteer fire departments, this is understandable.

From the paramedics side, some feel that undertrained firefighters are encroaching on their profession and that there would be risks to patient safety if the firefighters took on additional work. They are also frustrated at what they perceive to be a relatively rich, well funded system compared to the ambulance service.

The goal of achieving closer integration of the ambulance service with fire fighters would be the efficient and seamless delivery of emergency response service to those in need. Closer integration would serve to leverage existing resources, promote greater coordination thereby reducing duplication of services, and increase the overall responsiveness of the first responder system.

¹²: In 2008 there were approximately 373,000 medical responses across BC (BCAS data); of these 149,000 were 1st responder (medical) calls. In 2009, from January to November there were approximately 323,000 medical responses across BC (BCAS) and of these 145,000 were 1st responder (medical) calls. At this rate it is estimated that there will be approximately 174,000 1st responder calls out of approximately 387,600 BCAS calls (Source: Fire Chiefs Association of BC).

Like the health integration model, emergency responder integration could take several forms:

- transferring governance and oversight for the existing system to the provincial Ministry of Public Safety and Solicitor General (MPSSG) that has responsibility for police, fire and emergency response, but retaining the provincial service delivery model;
- transferring governance and oversight to MPSSG and responsibility for the ambulance service directly to individual fire departments and their local governments either on a wholesale basis or only for certain identified metro areas;
- working with MPSSG and first responders to promote greater integration and coordination of the ambulance service and fire departments as first responders, through overall agreements that support their shared mission, and specific service delivery agreements and arrangements.

Arrangements at the regional and local levels could see joint or mutually beneficial service delivery models developed, but on an optional basis. An example of such an arrangement is in Kitimat where the EHSC has an agreement with the City of Kitimat to allow employees of the Kitimat Fire and Rescue Services, who are firefighters, to be trained and certified as paramedics for the purpose of providing emergency health service (the EHSC also provides two ambulances and all necessary medical supplies). This is a historical remnant of the system prior to the establishment of the BCAS in 1974 when most emergency services of fire departments were transferred to the Ambulance Service and the remaining services were phased out throughout the early 1990s. An out of province example of agreements between first responders is that the Saskatoon MD Ambulance Care Limited has partnerships with many first responder groups in the rural areas that it serves.

If responsibility for ambulance services were transferred to fire departments and local governments, there would be issues to negotiate between the province and local governments because fire services are funded by local taxpayers. There would also be collective agreement and labour relations issues to address.¹³

It would also be possible to improve the integration with first responders without governance or structural changes through initiatives like:

- adding a first responder representative to the EHSC;
- providing more transparency about how the dispatch system works;

¹³ The Winnipeg Fire and Paramedic service has two divisions under an umbrella management structure. The Winnipeg Emergency Management Service is the traditional ambulance service provider utilizing ACP and PCP personnel who provide inter-facility and emergency patient transports. The Winnipeg Fire Department also provides emergency medical First Response utilizing licensed Fire Fighter PCP's belonging to a different Union with different wage and collective agreement components. Both Divisions are dispatched from one combined Communications Centre employing cross-trained Dispatch personnel. Two separate unions represent the Dispatchers and once again do so with differing collective agreements. These arrangements were made possible following the creation of "work share" agreements several years ago providing Winnipeg with the opportunity to send the right resource to the right call in the right amount of time.

- examining the scope of practice for medically trained first responders, and establishing protocols for first responders to deal with certain emergency situations;
- establishing some form of medical oversight for fire departments who wish to “grow their role.”

Implications:

- Transferring authority to MPSSG, and/or service delivery to individual fire departments and local governments would clearly align the ambulance service as an emergency response service.
- Transferring governance authority and/or service delivery would require legislative change to move the ambulance service from under the responsibility of EHSC.
- Moving the responsibility of the ambulance service to fire departments and local governments would likely have cost implications since firefighters are paid more than paramedics. Salary increases may be offset if there is improved staff utilization.
- Transferring governance or service delivery could lessen ties to health services.
- There could be opportunities to increase responsiveness and coverage because of the number and location of fire stations.
- If responsibility moved to fire departments,, it would require changes to the collective agreement and related documents (see Appendix 3) and it is possible that CUPE Local 873 would no longer represent paramedics.
- This approach would require the commitment of local government and fire departments, which does not currently exist throughout the province.
- Cost sharing agreements or service contracts would be required between the province and local governments if delivery responsibility were transferred.
- Agreements would be required to ensure the system remains seamless.

Community Based System

With 187 stations located around the province, the BCAS attempts to operate a system that offers the same level of care throughout all regions. The reality is this is not possible. The current model flows from the creation of the system in the 1970s as a patchwork of service providers throughout the province was replaced with a single professional ambulance service. Distances in rural areas combined with difficulties attracting appropriately qualified staff means that the service is not as consistent or high quality in rural and remote areas as it is in urban areas.

It is also the case that, as with any skill, if it is not regularly exercised it can be lost. Paramedics practicing in remote and rural areas do not get to hone their skills the way a crew in Metro Vancouver does because they do not see the same volume of patients or range of cases. Since the road to full time employment as a paramedic starts with on-call or part time work it is also the case that many rural communities are served by paramedics who do not live in the community.

The urban areas have their own issues with crews often challenged with very high work loads.

BCAS has taken steps to address the consistency of service issue. The deployment model anticipates different levels of service based on the type of the community - Metropolitan, Urban, Rural and Remote (discussed in more detail later in the section on deployment). It has implemented an Emergency Medical Responder (EMR) position and has developed a *Part-time Recruitment and Retention Strategy* that is aimed at working with targeted communities to develop strategies and actions to attract, recruit and retain staff to deliver ambulance services in remote and rural communities (discussed in more detail later in the section on Staffing, Recruitment and Retention). This work has been done in the context of continuing with a provincial system.

An alternative to the top down approach to addressing the need for ambulance services outside the urban areas would be to build service provision from the “bottom up.” Regions that have call volumes that support full-time, fully engaged paramedics could continue to be operated provincially or as in the case of parts of the Lower Mainland be delivered through first responders. Service areas not requiring full time paramedics would establish community specific solutions in consultation with the BCAS. Community based solutions could range from a fire department taking on responsibility (i.e., Kitimat), to a combined fire and paramedic service, to an ambulance service closely integrated with a health facility. Whatever the approach chosen in a community, the arrangement would be documented and secured through a contractual arrangement. If no community-based solution could be achieved the fall-back would be the status quo delivery model.

This would build on the work already underway by the BCAS to engage communities to gain their commitment and partnership in the delivery of ambulance services, but the options under consideration would be broader and not predicated on the traditional model of provision solely by BCAS employees.

Standards need not be compromised. In fact, under either of these options even better service could result. Feedback received from individual paramedics who are practicing or have practiced in rural and remote areas suggests that there are alternatives to the “one size fits all” model.

Implications:

- A change in the service model and a move to community-based solutions would likely require changes to the collective agreement because it has specific contractual language on deployment.
- A move to a new formal Urban / Community based service model would require time to transition and make changes.
- The result would be more complex to manage if multiple models evolve.
- The approach would be responsive to community needs and circumstance.
- Success would be dependent on willingness of communities to take on responsibilities.
- The provincial service could provide backstop to a community based system.

- A new approach to staff succession may be required given the potential impact on part time positions.
- The cost implications are uncertain.
- Depending on the approach, CUPE Local 873 representation of members may be affected.

Private Sector Model

The BCAS is a province-wide, government-operated system. The previous options – closer integration with health services, closer integration with emergency services and the community-based model – consider alternative service delivery within the public sector domain. An additional option would be to move to private sector delivery.

Under a private sector delivery model, the benefits of the current province-wide system, and provincial programs such as central and seamless dispatch, could be maintained, but delivered outside of government. The government could maintain oversight by retaining responsibility for professional standards for paramedics and establishing and monitoring performance standards.

Private sector delivery could entail transferring the entire system to a single private sector operator, or there could be several operators in the province similar to highway maintenance contractors. It is not proposed that the private sector model include a combination of public sector and private sector delivery models – i.e., in one community, the service is delivered by the local government through the fire department and in another it is delivered by a commercial operator.

The provinces of Nova Scotia, New Brunswick and Prince Edward Island have transferred responsibility for the delivery of their ambulance services to a private company. The Provinces maintain oversight, governance and regulation of the service, but have entered into a performance-based contract with a company, Emergency Medical Care, Inc., to deliver the service on a provincial basis as part of their health care systems. The contract outlines performance expected in three main areas: clinical care, response time reliability (based on three defined service areas – urban, suburban and other – and financial efficiency. As well, there are performance standards for fleet/equipment maintenance as well as ensuring timely reporting and accountability to the Department of Health.

Under a private sector delivery model, closer integration with the health sector and other first responders could still be achieved, but would be a function of contract terms, the approach of the private operator and the receptiveness of first responders and health authorities.

Even if full-scale transfer to a private sector operator is not pursued, consideration could be given to privatizing or contracting out inter-facility transfers. As noted above, some Health Authorities already contract with private operators for non-medical patient transfers. The BCAS maintains a separate transfer fleet and inter-facility transfers account for 28 percent of all calls. Although inter-

facility transfers do not take priority over emergency calls this is a workload issue for the fleet. This was an option suggested by several paramedics responding to the review.

Implications:

- Legislation would be required to move the BCAS to a private sector operator.
- The successor employer(s) would inherit the existing collective agreement, which might not fit with delivery models they would propose.
- Cost implications of transferring service to a private operator are not known and could be higher or lower. Further work would be required to establish the financial implications.
- Increased provincial monitoring of paramedics by medical practitioners would likely be required.
- Specific performance standards for contract would need to be developed.
- Moving ambulance service out of public sector may increase difficulties of establishing links to first responders and health authorities.
- Service contracts would need to address liability issues for private operator(s).
- Although the system would continue to be publicly funded such a change may be perceived as a privatization of health care.

B. Effective Labour Relations

Effective labour relations in the context of collective bargaining occur when the parties are able to reach an agreement without any third party intervention. For this to occur there must be a willingness to compromise on the part of both parties and compromise is usually driven by the potential consequences of a labour disruption - whether caused by a strike or a lock out. Labour disruptions generally damage both employees through lost wages and the employer due to service disruptions and, in the case of the private sector, temporary or permanent loss of revenues or market share. In the case of public sector disputes, public inconvenience or the risk of health and safety impacts put pressure on elected officials to get involved to settle a dispute.

Labour relations for paramedics in British Columbia has not been effective in recent rounds of bargaining. Since 1986, there have been eight agreements and over three quarters have required some form of third party intervention. Even the 2004 settlement, which was reached without a labour disruption, became controversial soon after signing as provisions of a Memorandum of Agreement that was part of the settlement were disputed.

One of the reasons for the failure to reach agreements is that labour disruptions have a minimal effect on service delivery. While the paramedics have a theoretical right to strike, practically speaking the right to strike does not exist due to the essential nature of the service they deliver to the citizens of the province.

Under the British Columbia Labour Relations Code paramedics are subject to an essential services designation that has the effect of mandating the continuation of services necessary to prevent “immediate and serious danger to the health, safety or welfare of the residents of British Columbia” (s. 72(2)). This means that some workers will be prohibited from striking even when they are in a legal position to strike. During the recent paramedics strike, over 95% of paramedics were deemed to be essential services workers by an order issued by the Labour Relations Board. Very little service impact was felt by the public, which meant there was limited pressure on management to settle. From the union’s perspective, since the vast majority of their members continued to work with no impact on income there was also limited pressure to settle for less than they were demanding. With limited service impact, public pressure was not high on the government to intervene until they decided there would potentially be risks associated with the H1N1 pandemic impacting the acute care system and risks to the upcoming Olympic Games. The government introduced back to work legislation as the paramedics were voting on a proposed settlement.

There are two possible structures for labour negotiations between the paramedics and their employer. There is also a fundamental process issue that affects possible structures – use of binding interest arbitration. In considering the options for the Ambulance service, an appropriate, effective and efficient operational structure focused on patient service should be the primary consideration with the arbitration issue considered second and then the labour relations structure.

Any change in bargaining structure or process that affects entrenched rights runs the risk of being challenged legally. This means that if any change to the status quo is made government will need to satisfy itself that legal risks including adequate consultation have been addressed. Any decision by CUPE Local 873 not to participate in a consultation process increases this risk.

Arbitration

Police and fire workers perform public safety functions in the same way as paramedics and other health care workers do. Because police and fire workers are in the municipal public sector and outside provincial public sector bargaining their labour relations are governed by a different legislative model that has built into it the ability of either party to seek binding interest arbitration if agreement cannot be reached at the bargaining table. The theory is that they “exchanged” the right to strike/lockout for the ability to have an independent third party determine a settlement without service interruption to the public. This does not eliminate bargaining, but rather creates a “backstop” to failed negotiations. For police and fire services that are bargained throughout the province by local governments, in a given round of bargaining typically there are several negotiated or arbitrated settlements and then the remaining negotiations or arbitrations usually follow the pattern established by the preceding agreements. The legislative framework provides criteria to be established for an arbitrator, including the ability of the Minister of Labour to add additional terms of reference.

Arbitration for the resolution of labour disputes can take two basic forms: conventional interest arbitration or “final offer selection” interest (FOS) arbitration. Both forms may involve mediation in advance of, or as a part of the arbitration process.

Under conventional forms of interest arbitration, the parties make submissions on outstanding issues and the arbitrator then makes a binding award based on the arbitrator’s view of what the parties would likely have bargained on their own. The arbitrator is free to accept some, all or none of each party’s submissions in fashioning an award subject to the terms of reference agreed to by the parties and, in the case of police and firefighters, any provisions set out by the Minister of Labour.

Under FOS, the arbitrator or “selector” has jurisdiction only to select one or the other party’s final offer. FOS may refer to the parties’ final offers in bargaining or final offers fashioned for the FOS process itself, although the latter is more typical. FOS may also be structured to require selection of one party’s position on all remaining issues (sometimes called “package” FOS), or to permit the arbitrator to select one party’s position on an issue-by-issue basis.

Employers and funders typically prefer FOS to conventional interest arbitration for several reasons. First, FOS creates a “higher risk” arbitration setting for both parties so will, in theory, encourage the parties to put more effort into negotiating their own agreement. The parties will engage in bargaining rather than a prolonged preparation for inevitable arbitration. Secondly, traditional interest arbitrated decisions are typically more costly because the arbitrator will find middle-ground even where the employer or funder may have thought that none existed. FOS does not permit the arbitrator to create middle ground. Finally, although FOS ultimately results in selection of only one side’s proposal, the settlement is generated from the positions of the parties themselves and not entirely by a third party.

While FOS is generally expected to push the parties to ensure that they put forward “reasonable” final offers, it is also generally believed to be most effective in disputes that boil down to few and relatively simple issues. For example, while FOS may be an effective “back stop” for a dispute about wage levels, it may be less effective for the resolution of disputes about complex work rules or pension arrangements. Notwithstanding the relative merits of FOS, any form of arbitration affects collective bargaining if the parties expect that arbitration is inevitable. Positions can harden up if arbitration is viewed as inevitable.

Arbitrators in either form of interest arbitration may also play the role of mediator and assist in bringing the parties together in advance of rendering an award.

Arbitration as a tool to settle disputes is typically used where it applies to all members of a bargaining unit. While it would be possible to have arbitration for a subset of a bargaining unit this would likely prove to be very disruptive to negotiations.

Despite resulting in the end of a collective bargaining dispute (or even the avoidance of one altogether), interest arbitration results in key financial decisions being made by a third party. This loss of control over the outcome is an important consideration for any employer.

Implications of Arbitration:

- Provides certainty of settlement and limits risk of labour disruption.
- Interest arbitration backstop means that bargaining may not be in earnest.
- Allows for criteria on terms of reference for arbitrator.
- Evidence seems to suggest that conventional interest arbitration results in higher costs.
- Settlement costs are generally known within limits.
- FOS results in a proposal put forward by one of the parties being implemented and may incent parties to settle without intervention.
- Would require legislation.
- Under conventional interest arbitration settlement can be different than what either party proposes.
- FOS may not be appropriate for all types of disputes.
- Third party may potentially impose costs on the employer.
- The inability to reach agreements through negotiation may lead to lasting relationship issues between employers and unions.

Labour Relations Models

Option 1 – Stand Alone Bargaining Unit

A stand alone bargaining unit exists when a single collective agreement bargained by one union covers employees of a single or multiple employers. This is the current situation where the Emergency Health Services Commission, as the employer, negotiates with CUPE 873 to reach an agreement. EHCS receives its mandate through the Ministry of Health Services from the Public Sector Employers' Council, which establishes labour negotiation mandates for the entire public sector in British Columbia. If the parties are unable to reach an agreement and a labour disruption is possible then, typically, the employer will apply to the Labour Relations Board for an essential services designation to ensure that the health, safety and welfare of British Columbians are not affected. As noted previously, this results in the vast majority of paramedic services being continued in the event of a strike or lock-out.

While the EHSC is the current employer, it is not the only possible employer of a stand alone bargaining unit that would preserve single employer status. Under the delivery options section of this report, the Provincial Health Services Authority could be the employer or, if paramedic services were devolved to fire departments, individual local governments could become single employers as

well. A multiple employer structure with one bargaining unit is also possible (for example registered nurses in the health sector).

The current legislative framework in the Labour Relations Code provides rules and processes to resolve impasses, including mediation, and there is no requirement for interest arbitration. Governments also have the power to legislate settlements. In the last round of bargaining between the EHSC and CUPE 873 the union called for binding arbitration, but the employer did not agree and an agreement was legislated.

Implications:

- This process is used in the vast majority of labour negotiations to successfully reach agreements.
- The legal framework in the Labour Relations Code is well established.
- Service to the public of this vital function is not affected.
- Labour disruption does not result in lost income for vast majority of paramedics.
- No legislated intervention is required but may be imposed.
- CUPE Local 873 continues to represent employees.
- Because service levels and income are not affected due to high essential services designation there is no incentive to settle.
- Lack of settlement leads to ill will between management and paramedics which affects workplace.
- There is a risk of illegal escalations in job action due to the perceived ineffectiveness of strikes.
- The right to strike does not practically exist for paramedics.

Option 2 – Multi-Union Bargaining Structure

As mentioned above, one of the challenges to effective labour negotiations in the current structure is that in the event of an impasse there is no real incentive for either management or union to reach an agreement since neither service nor wages are impacted. In situations where there are both service and income impacts there would be increased pressure on both parties to reach an agreement. The Community Social Services Sector represents approximately 15,000 workers, approximately half of whom are considered essential since they provide essential services including support for group homes. In the last decade they have had only one set of negotiations that has lead to a strike.

In British Columbia the vast majority of health sector workers negotiate as one of five health care sector bargaining units that negotiate with the Health Employers Association of BC (HEABC) which represents health sector employers. Each bargaining unit includes employees of multiple employers who are represented by one or more unions that form an association of unions for each bargaining unit. If paramedics were integrated in to one or more of the existing bargaining units in

the health sector, then the dynamics of bargaining could change significantly. As part of a multi-union bargaining group paramedics would work with other unions to present a united front in negotiations. As part of a larger group not made up almost exclusively of essential service workers pressure on the employer from a work stoppage could be significantly higher.

Implications:

- Service and income impacts with a larger group would increase pressure to settle without intervention.
- Would allow effective collective bargaining to proceed.
- Depending on configuration CUPE Local 873 may continue to represent paramedics.
- Would require legislation to move to HEABC bargaining structure and reconcile collective agreements.
- Would change nature of CUPE Local 873's representation as it would be required to join one or more associations of unions.
- May be difficult for union bargaining team to be cohesive.
- If paramedics ended up in different bargaining units this would create additional work for CUPE Local 873 to represent its members.

C. Other Matters

The Terms of Reference also included: staff recruitment, retention and training; staff workload; deployment; occupational, health and safety; and total compensation. Given the broad scope and complex nature of these matters, lack of clarity of the issues, lack of participation by the union and the time constraints of the review, a comprehensive and rigorous analysis of the issues was not possible. Accordingly, the following sections provide some background on these matters and some general observations on the issues identified based on available data and information and relatively brief consultations with other jurisdictions.

The first section provides an overview of the service and staffing model for the BCAS as context to the following sections.

Overview of Service and Staffing Model

The majority of paramedics working across British Columbia are “Primary Care Paramedics”(PCPs) who provide Basic Life Support (BLS). They respond to and provide care for medical emergencies or traumatic injuries. PCPs work in both-full and part time positions in large and small communities throughout the province.

Where a higher level of training is required to respond to an emergency, a BLS paramedic crew may be assisted by an Advanced Life Support (ALS) paramedic crew. ALS staffed ambulances also have supplemental equipment to deal with more medical emergencies. ALS ambulances are staffed by at least one, and usually two Advanced Care Paramedics (ACPs). ACPs advanced training enables them to perform more advanced emergency care procedures including cardiac monitoring, advanced airway maintenance, and drug administration. Full-time ALS crews are employed in Victoria, Nanaimo, Vancouver, Abbotsford, Chilliwack, New Westminster, Surrey, North Vancouver, Richmond, Kelowna, Kamloops, and Prince George.

There are also certain specialty paramedic positions: Critical Care Transport Team paramedics who provide highly specialized care and long distance transport between health facilities for critically ill or injured patients; and Infant Transport Team paramedics who provide services to paediatric, neonatal and high risk obstetrics patients.

The BCAS also employs Emergency Medical Responders (EMR)s. An EMR is an entry-level, community focused position and is generally staffed by individuals who live and work in a rural or remote area. EMRs are employed on an on-call, part-time basis.

As well, there are BCAS employees who drive ambulances, but do not attend patients (they also help lift patients and carry equipment), called Driver Onlys, and who are not required to be licensed

paramedics. Driver Onlys are employed only where there are limited licensed staff available, typically in remote stations¹⁴.

Approximately 100 dispatchers¹⁵ staff the three Dispatch/Communications Centres in Victoria, Vancouver and Kamloops.

There are two types of full-time employees: full time regularly scheduled employees who work full time hours, have an assigned station and shift pattern, and full time “irregularly” scheduled employees who work the equivalent of full time hours, but do not have an established shift pattern or assigned station¹⁶. The majority of BCAS employees are part time. Part-time employees submit their availability for work on a monthly basis and are scheduled and assigned to work. Rural and remote stations are largely staffed by part-time employees. Rules on shift patterns and scheduling are set out in the collective agreement.

The following table provides a list of all CUPE BCAS full time and part time staff broken down by total number of staff, by FTE count and median age:

	Full Time	Part-Time	Total
<i>Total # of Staff</i>	1485	2129	3614
<i>FTE Count</i>	1547 (FT FTEs)	1076 (PT FTEs)	2623
<i>Median Age</i>	46	39	

(information provided to IIC by BCAS)

¹⁴ Information provided by BCAS

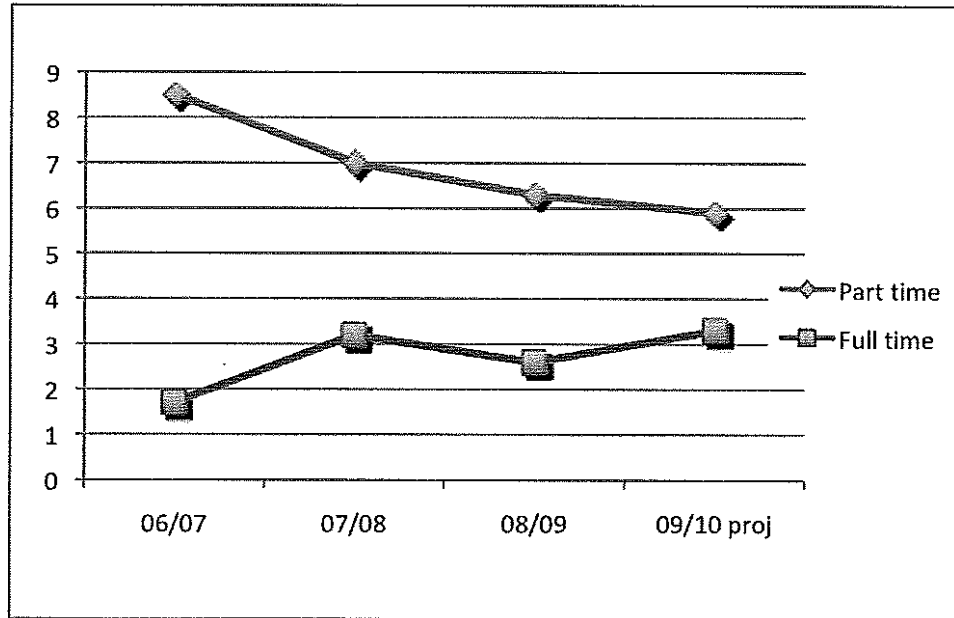
¹⁵ total number of staff; not FTEs

¹⁶ Irregularly scheduled employees are generally assigned to a post based on the historic need for shift coverage. Where irregularly scheduled employees are required to be scheduled, predictable work (e.g., annual vacations, training) will be assigned to irregularly scheduled employees on an equitable basis and the balance of the irregularly scheduled employees 100% availability will be scheduled for unpredictable vacancies. Unpredictable work will be assigned in order of service seniority.

Staff Recruitment, Retention and Training

Recruitment and Retention

Overall attrition of both full time and part time staff in the BCAS is relatively low, and is within the range of other employees in the provincial health care sector¹⁷.



However, the recruitment and retention of employees to staff rural and remote stations is an ongoing and growing challenge. In a number of communities ambulance services are provided by paramedics who live elsewhere. A significant number of paramedics spend some time working in communities other than where they live¹⁸. This is a function of changing demographics, an aging workforce and a shifting economy as well as the way the collective agreement works.

Consultations with select jurisdictions and ambulance services across Canada indicate that staffing of rural and remote stations is an historic and ongoing struggle for all jurisdictions as well (with some in non-compliance with provincial standards for qualified paramedics). Some jurisdictions have implemented requirements for lesser qualified positions such as the EMR or equivalencies to staff rural areas whereas others are exploring innovative service delivery options (discussed further in the deployment section).

Further, overall recruitment, retention and promotion will become a more general concern for BCAS in the next five to 10 years. The median age of full time employees is 46 and for part time

¹⁷ 2008 attrition rate for: Care Aides: full time – 3.6% and part time – 5.3%; LPNs: full time – 5.1% and part time – 5.5%; Nurse (RNs): full time – 4.6% and part time – 4.4%. Note these are professional specifications not bargaining unit specifications (Source HEABC).

¹⁸ A rough analysis, excluding paramedics working in the Lower Mainland, indicates that about one out of every six paramedics may work in a community that they do not reside in.

employees is 39. Data indicates that 11.5% of BCAS staff are in the age range of 55 to 64 and 29.2% are in the 45 to 54.

In response to its recruitment challenges, the BCAS has introduced the EMR position in certain targeted regions; as an incentive, EMR training is offered locally and paid for by the BCAS. It has developed a *“Part time Recruitment and Retention Strategy”* aimed at recruiting part time employees to staff community based ambulance stations in rural and remote settings.

The *Strategy* recognizes the need to address provisions in the collective agreement respecting scheduling, benefits and training to make part time work with BCAS more attractive. These have been identified for discussion with the union. In order to meet its future human resource needs in a changing environment, the BCAS may need to develop a broader succession plan and strategy, as well as considering alternative ways to meet service needs and attract, retain and grow staff.

Observations

- There is an ongoing challenge in staffing rural and remote stations with qualified paramedics.
- Similar to many public sector employers, the BCAS has an aging workforce and recruitment and retention of staff will become a general issue as a significant number of employees reach retirement age in the next five to 10 years.
- There are a number of recruitment and retention challenges including:
 - Deployment and seniority based system has the effect of requiring many paramedics to work outside the community in which they live.
 - Some of the paramedics who responded to the review indicated that various collective agreement provisions and service delivery approaches combine to increase the length of time to achieve full time status and act as an impediment to making the service a career. Anecdotal evidence indicated that it can take four to six years to become a full time paramedic.

Training

EMRs are employed on an on-call, part-time basis and receive four to six weeks of training. Twelve weeks training (provided by the Justice Institute and other providers), plus a preceptorship period is required to become a PCP. PCPs are required to maintain their license through patient contacts and/or continuing education courses. As part of PCP training, a PCP is trained in the initiation of intravenous IVs; in order to maintain this endorsement PCPs must perform a certain number of IV initiations each year. PCPs may also obtain endorsement for additional practices such as intubation. To obtain an ACP designation, a paramedic must have successfully completed the ACP course that takes approximately one year, inclusive of preceptorship and an additional six to nine month mentorship program.

Dispatchers are generally trained paramedics who receive additional training and meet the qualifications of a dispatcher as determined by the Commission. The provision and payment for

paramedics training and continuing education are long-standing matters. All jurisdictions surveyed require paramedics to pay for their own pre-hiring education but there are differences in how ongoing education is funded and delivered. The following table outlines the initial training qualifications and continuing education requirements for PCPs and ACPs in select jurisdictions.

Jurisdiction	Training Requirements		
	EMR	PCP	ACP
BC	4 to 6 weeks, (paid for by BCAS in "targeted" areas)	12 weeks (provided by Justice Institute and other providers), plus preceptorship Maintain their license through patient contacts and/or a range of continuing education courses offered by BCAS In order to maintain endorsement for initiation of IVs (gained as part of PCP training), PCPs must perform a number of IV initiations each year	PCP, plus ACP training course that takes approximately one year, inclusive of preceptorship, and then an additional 6 to 9 month mentorship Maintain their license through a range of continuing education courses offered by BCAS
Alberta	4 to 6 weeks, basic program Must meet requirements of Continuing Competency Program - an electronic based, self reported continuing education program - each year required to complete some education with an overall goal of completing education in all mandatory competencies over a 4 year cycle	EMR plus didactic followed by hospital and ambulance practicums. (the length of training, program content and skills are comparable to the BC program and meet the requirements for Canadian Labour Mobility at that level) Must meet requirements of Continuing Competency Program	A 2 year training process which includes didactic, hospital and multiple ambulance practicums (similar to BC program; and exceeds the current scope requirements in BC in a few area) Must meet requirements of Continuing Competency Program
Saskatchewan	n/a – no such position	28 weeks Continuing education requirements include: 16 hours of credits, plus three hours of mandatory skills checks per year	59 weeks: Year One – 43 weeks; Year Two – 16 weeks Continuing education requirements include: five hours of credits per year, plus 24 hours mandatory courses and 10 hours mandatory skills checks over two years

Jurisdiction		Training Requirements	
		EMR	PCP
City of Winnipeg	N/a – no such position		<p>City established training program (developed and implemented by Medical Director); training courses must be consistent with the guidelines, as established by the Canadian Medical Association Standards for Pre-Hospital Emergency Care and as amended from time to time by the Canadian Medical Association (employees have three chances to pass training program and then may be reclassified or obtain alternate employment with city)</p> <p>Medical Director may exempt certain employees or group of employees</p>
Ontario	N/a – no such position	<p>Two (2) year Community College Diploma</p> <p>[A-EMCA Certificate issued by the Ontario Ministry of Health and Long Term Care] Ongoing: Two (2) days of Continuing Education per year, on-duty. Twelve (12) hours of this is mandatory (base hospital) for maintenance of certification.</p> <p>Certification from a Base Hospital to perform prescribed additional medical procedures</p>	<p>One (1) year Community College Diploma (in addition to PCP diploma)</p> <p>[ACP Certificate issued by the Ontario Ministry of Health and Long Term Care] Ongoing: Three (3) days of Continuing Education per year. Twenty-four (24) hours of this is for maintenance of certification: twelve (12) mandatory (on duty) and twelve (12) self-directed (compensated with 12 hours lieu time).</p> <p>Certification from a Base Hospital to perform prescribed additional medical procedures</p>
Nova Scotia	N/a – no such position	<p>10 month program – five months didactic (course work and classroom instruction); 120 clinical hours; and 500 ambulance hours</p> <p>Required to re-register every two years; must have continuing education credits and required number of patient contacts</p>	<p>One year didactic (course work and classroom instruction); 192 clinical hours and 504 ambulance hours</p> <p>Required to re-register every two years; must have continuing education credits and required number of patient contacts</p>

Observations

- The BC and Alberta programs are relatively similar in content and length. The PCP training programs in other jurisdictions appear to be substantially longer.
- Paramedics in BC are required to have less pre-employment training than other health professionals in the province (Health Care Aid - 12 to 14 weeks training; Licensed Practical Nurse - 12 months training; Registered Nurse - 3 to 4 year University degree).
- Some jurisdictions have comprehensive and rigorous professional development and continuing education requirements. In some jurisdictions compliance with meeting these requirement is monitored and audited.
- In some other jurisdictions, hospitals play a role in monitoring and ongoing training of paramedics.

Deployment Strategies

Under the September 11, 2004 Memorandum of Agreement between the EHSC and the Ambulance Paramedics of British Columbia, CUPE Local 873, a new Service Model was agreed to, based on the concept of Community Response Designations for different posts. A post is a community that may have several ambulance stations. The goal of the memorandum was “a responsive and flexible model to meet the diverse needs of per-hospital care and transfers of patients in different areas of the province” and recognized that given the call volumes it did not make sense to staff remote and rural stations with full time paramedics.

The parties agreed to the post designations of “remote, rural, urban and metropolitan” communities and to the use of these designations as the basis for the deployment strategy applied in each community:

- **Remote deployment** – PCP is the minimum qualification for ambulance paramedics in remote posts, but in order to provide and / or maintain services in remote posts the Ambulance Service may employ paramedics with lesser qualifications. On-call assignments are the method of shift coverage in remote designated communities. All part time primary operator employees covering on-call shifts will receive on call shift coverage pay (\$2 an hour); where they respond to a callout call they will be paid at the appropriate paramedic rate.
- **Rural deployment** – PCP is the minimum qualification for ambulance paramedics in rural posts, but in order to provide and / or maintain services in rural posts the Ambulance Service may employ paramedics with lesser qualifications. The memorandum established a new category of shift – a standby shift (in station) that is done by primary operator employees. Primary operator employees may be assigned to standby shifts in the station while others may be assigned to on call work (by pager). Except for regularly scheduled full time shifts, the first line duty car will be staffed as a standby shift in each station. Primary operator employees assigned to a standby shift are paid \$11.12 an hour; where they respond to a call-out call they will be paid at the appropriate paramedic rate for the

duration of the call or work request during the assigned shift with a three hour minimum for the call.

- **Urban deployment** – PCP is the minimum qualification for ambulance paramedics in urban posts, with the exception of transfer cars that have a minimum qualification of EMA 1, but the ambulance service may employ paramedics with lesser qualifications as necessary to maintain services in the absence or unavailability of a paramedic with PCP qualifications. Primary operator staff will be part-time paramedics attached to an operator or post to access work assignments, and full-time paramedics attached to an operator or post to access on-call or standby work assignments that are separate from their normal full-time work assignment. Primary operator staff may be assigned to standby shifts within an urban post to augment, but not displace or replace full time positions.
- **Metropolitan deployment** – PCP is the minimum qualification for ambulance paramedics in urban posts, with the exception of transfer cars that have a minimum qualification of EMA 1, but the ambulance service may employ paramedics with lesser qualifications as necessary to maintain services in the absence or unavailability of a paramedic with PCP qualifications. There are no standby shifts in Metropolitan posts and call out shifts were to be phased out within two years of signing the Memorandum.

BC ambulance stations by type of community designation:

Type of Ambulance Station:	Number in 2008/09
Metro	36
Urban	35
Rural	50
Remote	66
Total	187

Within these broad community designations, a variety and combination of shift patterns and types of employees are then used to schedule employees and staff posts and stations to meet expected service demand. A Metro station is staffed on a full time basis 24 hours a day, seven days a week using a combination of shifts staffed by full time paramedics; an urban station has the flexibility to structure its deployment using a combination of shift patterns and full time paramedics and standby and on call staff; rural communities can have a variety of full time, standby and on-call staff; and an on-call shift pattern is generally the standard for all remote stations.

Pre-Hospital Events and Responses by Community Designations

Community Designation	# Events by Community	# Pre-Hospital Responses by Station	# Transfers by Station
Metro	218,164	301,074	68,737
Urban	103,382	130,068	50,390
Rural	28,631	42,771	21,861
Remote	7,675	9,371	3,455
Remote-no-Station	13,700	-	-
Total	371,552	483,284	144,443

(Source BCAS – Note “Event” is a call to a Dispatch Centre; response is number of ambulances sent)

Shift patterns for full time employees are established in the Collective Agreement and include:

- *Alpha* – Cars are staffed 24 hours a day. Staff on these cars work a four-on, four-off shift pattern: two day shifts and two night shifts followed by four days off. Shifts are usually 12 hours, some are 10 hour days and 14 hour nights. Shift change is usually around 0600 and 1800 hours. Paramedics on Alpha shift work an average of 42 hours per week.
- *Bravo* – Cars are staffed 11 hours a day, every day. The actual times vary from station to station. Some cars operate from 0900 to 2000 hours, but most work from 0730 to 1830 daily. Staff on Bravo cars work a four-on, four-off pattern. Paramedics on Bravo and Charlie shifts work an average of 38.5 hours per week.
- *Bravo/Charlie* – Cars are staffed 11 hours a day, every day. The hours of operation are 1300 to 2400. These cars are found only at stations where there is also a Bravo car. Staff work two Bravo and two Charlie shifts and then have four days off.
- *Delta* – Shift pattern is a day shift. Normal hours of work are 1000 to 1700 Monday to Friday. These cars are not manned on statutory holidays. Paramedics on Delta shift work 35 hours per week.
- *Echo* – Shift pattern is a straight day shift. The days and actual time of operation vary with the station. Rotation is four, 10-hour days on, three days off. Paramedics on Echo shift work 40 hours per week. The Echo call sign is also used with extra cars put on for backfilling.

Fox cars are community “standby” crews that are staffed 24/7, nights only, or a combination of days and nights (usually where Echo shifts exist). These are staffed by both part-time and full time employees and staff are expected to be available in quarters although it is understood that there is some flexibility around this requirement (unlike Kilo – see below – where staff can be up to 10 minutes away from the station). Fox cars are required to return to their community as soon as possible after clearing the hospital.

Kilo refers to the “call-out” cars that are usually staffed by “on-call” part-time employees, and sometimes, off duty full-time employees. These cars do not have a normal shift pattern.

As noted earlier under the section on recruitment and retention, despite the implementation of this service delivery and deployment model, staffing rural and remote stations continues to be a

challenge. Some jurisdictions and services across Canada have employed different service delivery approaches to address these same challenges. For example, in Saskatchewan there is no typical rural service with small rural operators using paramedics on call via rover vehicles or using dedicated community volunteers with a minimal level of training and supported by paramedics¹⁹. Nova Scotia has chosen to not adopt the alternative of implementing less qualified staff – BC EMR – but rather uses alternative service models to ensure coverage including, supporting a paramedic in a remote island community by coordinating with the Ministry of Health and having the paramedic provide certain health services, not only maintaining their skills, but also ensuring that emergency medical service is available when needed²⁰.

Nova Scotia employs a mobile province-wide deployment model to serve a range of urban, suburban to rural/remote areas. In concept, an ambulance can be deployed anywhere in the province; shifts are mobile and in suburban / rural areas an ambulance may be centred between two communities.

The Ottawa Paramedic Service covers an area of 2,796 sq. km and responds to over 100,000 calls per year. The Ottawa Paramedic Service has divided the city into two deployment areas: High Density areas defined by the volume of calls and accounting for over 90 per cent of the calls received each year but comprising only 14 % of the geographical area of Ottawa and; Low Density areas also defined by the volume of calls received each year, accounting for 10 % of the calls received but comprising 86 % of the geographical area of this city. Paramedic teams are placed (deployed) using a model based on expected calls and dispatched from a central depot. Ottawa does not have BC-like ambulance stations. Historic analysis of call locations at specific time of the day determine high probability areas for call occurrences. For the most part, all paramedics work a scheduled rotation of 12 hours. Start times for shifts are staggered to maximize paramedic deployment throughout the day.

Toronto EMS, the largest municipal land ambulance service in Canada, serves an area over 620 sq. km., and an urban population of 2.6 million. Toronto EMS uses a fluid rather than station-based deployment model - deployment is dependent on historic call demand versus geographic station location. Toronto EMS staff a minimum of 90 transport ambulances at peak times of activity on weekdays and 65 transport ambulances at peak on weekends. Tiered response protocols are in place and overseen by a committee composed of Police, Fire and EMS. To ensure responsiveness across regions, mutual aid agreements are in effect with surrounding GTA EMS services. .

With its move to a health integration model, Alberta is experimenting with different service models including specialized services to meet the needs of specific communities. The Calgary City Team

¹⁹ Saskatchewan Emergency Medical Services (EMS) Review: Final Report, October 2009, <http://www.health.gov.sk.ca/ems-review>

²⁰ Emergency Health Services, Nova Scotia Department of Health. It is understood that Nova Scotia is considering and moving to a community health model.

(CCT) operates 24 hours a day, seven days a week, 365 days per year, focusing on the Calgary downtown core to provide early intervention services to mitigate the need for more acute care in the future. The CCT has the authority to direct patients to non-hospital resources and is responsible for navigating the “fine line between social, mental and health issues” to ensure that patients get the right resources at the right time.²¹

Observations:

- British Columbia uses a station based deployment model based on formal community post designations. Other jurisdictions use a variety of deployment models including mobile, response volume-based and community specific needs driven models.
- Staffing rural and remote stations is a problem in all jurisdictions.
- Urban areas that generally have the broadest range of health services available also have the most highly trained paramedics.

Staff Workload

Staff workload is a shared issue between the employer and the union. There is a joint Provincial Staffing and Workload Committee in place with a mandate to “investigate, share information, summarize the data and potential make recommendations to the PJLMC [Provincial Joint Labour Management Committee] – either collectively or individually – regarding workload, response times, and work distribution”.

The work of this Committee is based on analysis of the current environment - the existing, status quo service model – and the paradigm of continuing to do business in the same way. Responses from individual paramedics, and input from other parties, suggests that consideration of the way the service “does business”, including the current service structure and how the service responds to calls (such as, two ALS per ambulance and an ALS ambulance being assigned, in addition to a BLS, in certain situations and whether it should even respond to certain calls), should be undertaken to address a number of issues including staff workload and response times.

Observations:

- Without considering changes to the way the BCAS does business or the current service model, the only way to address staff workload issues is through increased resources.

Occupational Health and Safety Issues

Similar to staff workload, Occupational Health and Safety is a shared matter and interest between the union and employer. In fact, responsibility for Occupational Health and Safety is shared between the individual employees, their supervisors and managers, and the employer.

²¹ Alberta Health Services, Emergency Medical Services, “On the Move – Toward Integration with Health”, October/November 09.

As of January 1, 2010, the way that EHSC is insured through WorksafeBC (WSBC) was changed from a *Direct Deposit Account* (self-insured) system to a *Rateable Classification Scheme*-essentially an insurance-like premium based scheme. This transition has the potential for considerable financial benefits to EHSC dependent on EHSC's claim experience.

BCAS management has indicated that this change has provided momentum to BCAS Occupational Health and Safety programs – prevention and intervention – and integrated disability management – rehabilitation and return to work.

Observations:

- Enhanced programming in the areas of occupational health and safety and claim and case management should have a beneficial impact on short term and long term disability rates and management and should improve the handling of human rights and duty to accommodate issues.

Total Compensation

BCAS staff receive a base rate of pay arising from on their position classification. In addition to their base pay, employees receive experience and service pay lifts. Full time employees receive experience lifts in each of the first three years of employment and service lifts when they reach 10, 15, 20 and 25 years of service. Part-time employees receive only service lifts starting at 5 years service and then when they reach 10, 15, 20 and 25 years service. Employees do not receive premiums for nights or weekend shifts. Certain employees acting in a supervisory capacity – Dispatch Officer, Charge Dispatcher, Unit Chief and District Supervisor - receive supervisory pay lifts.

The BCAS has a comprehensive benefits package for full time employees. Part-time employees do not receive benefits unless they have completed 1000 hours or more paid work in previous year or until they have achieved six years service as a part time employee and worked 96 shifts of on call coverage. Up to that point, they receive 17% wage in lieu of benefits including vacation pay. The benefits scheme for part time employees has been identified by paramedics and the BCAS as an impediment to recruitment and retention.

An historic issue relating to base pay is that although the full time shift patterns range in the total number of hours of worked from 1820 to 2184 hours, the total pay by position classification was the same regardless of hours worked (see Appendix 4, "Hours of Work by Shift Pattern for Full-time Employees")²².

²² Several years ago the Alpha shift, although having the most total hours, was highly desirable given that it was possible to rest during the night shifts. However, as service demands increased during the night shifts, full time staff working the Alpha shift found themselves working more hours for less pay than other full time staff working other shift patterns.

In recent years, efforts were made to correct this anomaly and move to a universal hourly base wage rate per position classification. In 2000, funding was provided to equalize this wage disparity. Hourly rate adjustments were made four times between April 1, 2001 and March 31, 2005 in order to move to the same hourly rate – there was a general lift to each classification’s base pay rate and then a shift adjustment based on the shift pattern (and the shift adjustment was higher for those shifts making less per hour). Funding was not sufficient to completely move “adds to pay” rates (overtime, additional shifts, call-out pay) to the same universal hourly rate, but this is still a goal for the system.

In comparison to other jurisdictions, and on the basis of an analysis of total compensation (combination of pay and benefits) undertaken by the Public Sector Employers’ Council and validated with select other jurisdictions, the PCPs in the BCAS rank amongst the highest in Canada in terms of total compensation. (Appendix 5 contains an explanation of the PSEC total compensation model and graph showing the total compensation picture for PCPs across Canada.)

In terms of wages only, information supplied by the BCAS based on an internal survey and contracted survey of other jurisdictions indicates that British Columbia’s 2009 wage rate for PCPs is below the Ontario median, but is slightly above other jurisdictions including Alberta. For ACPs, British Columbia is above the Ontario median, below the municipalities in the Greater Toronto Area, but above other Canadian jurisdictions (see Appendix 5).

Observations:

- The various shift patterns, with different total hours worked, results in a discrepancy between total pay and hours worked.
- In terms of comparing total compensation and wages with other jurisdictions, such comparisons are complicated by the fact that some jurisdictions have a number of employers, and the differences in staffing models, addition of shift premiums and benefit schemes.
- Based on total compensation BC paramedics are paid slightly less than Ontario, but generally more than other provinces.

Appendix 1 – Terms of Reference

1. On or before January 15, 2010, the Industrial Inquiry Commission will prepare a non-binding report for the Minister of Labour that provides options to the Province for an appropriate collective bargaining structure that support the efficient and effective delivery of ambulance services through different service delivery and operational models. The collective bargaining structure must support the means for effective resolution of collective bargaining impasses. Possible service delivery and operational models that the Industrial Inquiry Commission should consider and evaluate in relation to collective bargaining structure include the following:
 - The delivery of ambulance services by way of an independent commission under the Emergency and Health Services Act (status quo);
 - The transfer of ambulance services to the Health Sector as either an independent commission or integrated into an existing service delivery structure in accordance with the Health Authorities Act;
 - Service redesign to facilitate greater alignment with Municipal fire services.
2. The Industrial Inquiry Commission will also investigate and prepare options regarding the following issues:
 - Staff recruitment, training, and retention;
 - Staff workload and occupational health and safety issues;
 - Deployment strategies in comparison with other Canadian ambulance service delivery models;
 - The models and rates of total compensation for ambulance paramedics and dispatchers applied by other jurisdictions in Canada based on: (a) wages; (b) premiums for hours worked and hours on-call in rural and remote areas; (c) benefits, including health and welfare benefits and pension plan; and
 - Any other related matter referred to the Industrial Inquiry Commission by mutual agreement of the parties.

Appendix 2 - Overview – Governance, Structure and Service Delivery Models in Other Jurisdictions

*Alberta*²³

On May 29, 2008, the Minister of Health and Wellness announced a shift in the way that ground ambulance services would be governed, delivered and funded in the Alberta. Historically, emergency medical services was a municipal responsibility, but under the change would be transitioned to become an essential component of the healthcare system. This shift was made to standardize processes, ensure paramedics work to their full potential, improve utilization of the ambulance fleet, and enhance educational opportunities for all emergency medical service staff regardless of where they live and work. The governance transition occurred effective April 1, 2009. Over the next few years, following this governance transition, work on a long term plan to achieve the health system benefits of a seamless emergency medical services system that is fully integrated into the health will be undertaken.

Under the transformed system, the Alberta government is responsible for overall system standards and performance measures and monitoring, and the provincial health authority, Alberta Health Services (AHS), will be responsible for ensuring that ambulance service is provided. In public materials, the Alberta government clarified that this was not a “provincial” service such as that in BC, but “rather it is a province-wide approach to delivering services that helps ensure access and the quality that Albertans have come to expect and value in ambulance services”. The distinction is not clear.

Under the new model, AHS will make decisions around the most appropriate way to deliver coordinated ambulance services whether through third party contracts with one or more providers (such as a municipality or integrated service) or by direct delivery. Initially, contracts would be for up to two years, or subject to an appropriate business plan, could be negotiated for longer-term periods. All contracts would be in the form of a standard agreement to ensure a province-wide approach and consistency across the sector, but would include specific schedules applicable to each service provider to provide a degree of flexibility to meet local conditions. In addition to the standardization of contracts, as part of the transition to the new model, all Alberta EMS service providers are to be integrated under a common employer, within a paramedics unit under the Health Services Association of Alberta (HSAA).

²³ <http://www.albertahealthservices.ca/209.asp>;
<http://www.albertahealthservices.ca/files/nls-otm-2009-11.pdf>
<http://www.albertahealthservices.ca/files/nls-otm-2008-08.pdf>

As well, by the Spring of 2010, the goal is to reduce the more than 30 emergency medical dispatch centres to three to provide integrated and coordinated dispatch of resources throughout the province.

Prior to transitioning to the new model, municipalities were responsible for funding one-third of the cost of emergency medical services. Under the new model, municipalities will no longer be required to provide funding; the province will cover 90% of the costs of the system with user fees covering the remaining 10%. Provision of air ambulances service will continue to be a government responsibility. Alberta Health and Wellness contracts with fixed wing flight service providers to ensure that dedicated air ambulance services are available 24 hours a day, seven days a week, every day of the year, throughout the province. The Ministry, through Alberta Health Services, also contracts with STARS to provide dedicated rotary air ambulance service from bases in both Calgary and Edmonton.

*Saskatchewan*²⁴

In Saskatchewan, governance of ambulance services is the responsibility of Saskatchewan Health (Ministry of Health), and the provision of ground ambulance services is the responsibility of health regions. Some of the ambulance service operations are health region-owned and operated, while other services are provided through contracts with fire departments. The health regions provide funding to contracted operators to cover a portion of their service costs, with the remainder being funded through client charges.

The dispatch of ambulances is performed by one of the five wide-area ambulance dispatch centres located in Moose Jaw, Prince Albert, Regina, Saskatoon, and Yorkton. The dispatch of ambulance service is paid for by the regional health authorities.

Saskatchewan Air Ambulance is a provincial program. LIFEGUARD, is the oldest non-military air medical transport program in the world. The service is administered by Saskatchewan Health and is based at the Saskatoon airport. The service is available 24 hours a day and can be dispatched to an emergency within 30 minutes. Individuals are responsible for the full cost of the air ambulance service and the ground ambulance costs to and from the airport, however, residents with low incomes are subsidized.

Saskatchewan has recently completed a review of its emergency medical services; an air medical services review was conducted at the same time to ensure coordination between the air and ground ambulance system. The reports of the review were publicly released by the Minister of Health on November 26, 2009. The purpose of the review was to create a strategic vision for the emergency medical service in the province and provide prioritized recommendations for a five-year plan to achieve the strategic vision. The review and recommendations focused on changes to the

²⁴ <http://www.health.gov.sk.ca/ems-review>
<http://www.health.gov.sk.ca/emergency-services>

system designed to ensure timely service, consistent quality, acceptable and reasonable cost and a sustainable system over the longer-term. The report recommended that roles and responsibilities in the current system be clarified to facilitate the development of a collaborative, mobile health services system in Saskatchewan. This includes a clarity of roles with the Minister of Health providing system leadership and the health regions providing operational leadership.

*Manitoba*²⁵

Up to 1999, Manitoba's emergency medical services system was delivered by a number of independent and municipally operated services. At present, Manitoba's emergency medical services system operates within the broader provincial healthcare delivery system. It is a core health service of the regional health authorities and the Ministry of Health, Manitoba Health and Healthy Living. The key services in the emergency medical services system include: emergency medical dispatch; emergency medical response and medical care; emergency medical transport; and inter-facility medical transportation.

The Manitoba Health Emergency Medical Services Branch provides provincial leadership and monitoring of the emergency medical services system. Regional Health Authorities are responsible for the delivery of emergency medical services; some Authorities undertake the service directly whereas others contract with service providers (e.g., municipalities, First Nations communities).

Dispatch of ambulance services is undertaken by local dispatch coordination centres. Dispatch of all rural and northern medical services, including inter-facility transfers is undertaken by the Medical Transportation Centre in Brandon.

Manitoba Health and Healthy Living provides funding to Regional Health Authorities to support the operation of the system. There are also user fees.

The Manitoba Health Emergency Medical Services Branch also coordinates the operation of the LifeFlight Air Ambulance program. LifeFlight provides the primary means of air transport on a 24 hour a day, seven days a week basis for all seriously ill or injured Manitobans from areas outside the 80-mile radius of Winnipeg in rural and northern Manitoba to urban referral centers in Winnipeg.

In 2009, the Manitoba Health & Healthy Living and the regional health authorities developed a planning framework designed to enhance emergency medical services delivery in the province. This includes looking at how individual parts of the system can better work together and determining what improvements need to be made including strengthening quality of emergency medical services through improved quality assurance, standards and monitoring; enhanced training and

²⁵ <http://www.gov.mb.ca/health/ems/index.html>
<http://www.gov.mb.ca/health/ems/lifhtflight.html>
<http://www.gov.mb.ca/health/ems/planning.html>

education for paramedics; better coordination of services between health authorities; and improved integration of emergency medical services with other sectors in the health system.

*Ontario*²⁶

Up to the late 1960s, ambulance services in Ontario were provided by over 400 private operators. There was no public funding and payment was on a full fee for service basis. In smaller communities, ambulance services were often a sideline for funeral homes, or even taxi and towing companies. In larger communities, a number of commercial ambulance services were generally available. There was no central dispatch and no standard of training.

A comprehensive review of ambulance services undertaken in the late 1960s was charged with developing "a balanced and integrated system of ambulance services" out of this "hodgepodge". The result was a move to a "public consolidation" model based on control assumed by hospitals where stable funding, training and quality assurance could be maintained. The cost of this initiative was, however, greatly underestimated and the 1970s and 1980s saw a move back into private management of ambulance services. An eclectic mix of private operators (about 40%), hospital based services, municipal services and directly operated government services, (all publicly funded) survived until 1998 when, under the Local Services Realignment Initiative, responsibility for ambulance services was transferred to municipalities and designated delivery agents (regions, counties, selected cities and designated Service Delivery Boards in Northern Ontario). This transfer was complete by January 1, 2001.

The provision of ambulance service across Ontario is now a joint responsibility of approximately 50 Upper Tier Municipalities, designated agents and the Ministry of Health. The Ministry is responsible for overall governance of the system including setting and monitoring compliance with standards. Municipalities and designated agents are responsible for the delivery of land ambulance services either directly or through contracts with service providers. Each municipality is required to maintain an ambulance service that is "accessible, integrated, seamless, accountable and responsive".

Dispatch of ambulance services is provided through 21 Central Ambulance Communication Centres (CACCs).²⁷ Under the *Ambulance Act*, the Ministry, alone or in conjunction with others is responsible for providing "seamless access" to ambulance services by the public. CACCs coordinate, direct and deploy the movement of ambulances and emergency response vehicles within and across large geographic areas to ensure that the closest available and most appropriate ambulance is assigned.

²⁶ http://www.health.gov.on.ca/english/providers/program/ambul/ehs_mn.html
<http://www.emsontario.ca/about/ems.htm>
<http://www.emsontario.ca/about/history.htm>
http://www.health.gov.on.ca/english/public/program/ehs/air/air_mn.html

²⁷ Information from Ministry of Health

Ornge, a non profit body accountable to the Ontario government through a performance agreement, is responsible for the provincial air ambulance program, including: contracting with flight service providers; medical oversight of paramedics; air dispatch; and authorizing air and land ambulance transfers.

All land or air ambulance service delivery operators must be certified to operate an air or land ambulance service – new operators must pass a certification process and current operators must be recertified every three years²⁸. The Ministry conducts regular quality assurance reviews of air and land ambulance services, base hospitals and CACCs.

Monitoring and ensuring the quality of patient care and service delivery is undertaken through a medical quality control program provided by doctors in designated base hospital programs. The medical director of each base hospital program is responsible for certifying and delegating to each paramedic the authority to perform certain controlled medical acts and then monitoring the quality of care provided by paramedics. They are also available to provide advice and direction to paramedics.

The Ministry fully funds the provincial air ambulance, dispatch and base hospital programs and provides financial assistance to municipalities and designated agents based on a cost-sharing grant to cover 50% of the approved cost of the land ambulance service²⁹.

*Nova Scotia*³⁰

Prior to 1995, over 50 private and public ambulance operators provided emergency transport services in Nova Scotia. The system had inconsistencies in terms of medical care, levels of staff qualifications and the type and condition of ambulances. The type of care patients received was often times dependent on where they resided in the province.

A move to modernize the system was begun in 1994, when the government determined that the province's ambulance system was not merely an emergency transportation system, but rather a pre-hospital medical system. Initiatives to improve the system included: development of a fleet of ambulances; requirements for trained and registered paramedics to staff the ambulances; establishment of an air ambulance program; creation of a centralized EHS Medical Communications centre to handle calls and dispatch for the entire system; and provision of educational resources and programs to provide ongoing training for paramedics.

²⁸ The three decades old licensing system was replaced in 2000 with a periodic quality based certification scheme.

²⁹ It is understood that many municipalities exceed the 50% cost sharing in order to provide quality services and meet standards.

³⁰ <http://www.gov.ns.ca/health/ehs/>
<http://www.gov.ns.ca/health/ehs/comm/groundAmbulance.asp>
<http://www.gov.ns.ca/health/ehs/comm/lifeFlight.asp>

At present, the emergency health services ground ambulance system is regulated by the Nova Scotia Department of Health and managed by a private company, Emergency Medical Care, Inc. (NS EMC) (since 1997)³¹. The province has entered into a performance-based contract with EMC that includes standards for consistent quality and cost of service throughout the province. The contract identifies the performance expected in three main areas: clinical care, response time reliability and financial efficiencies. As well, there are performance standards for fleet/equipment maintenance as well as ensuring timely reporting and accountability to EHS.

Dispatch of ambulance services throughout the province is undertaken by one centralized dispatch coordination centre.

The air ambulance service is provided by EHS LifeFlight. Similar to the ground ambulance service, EHS LifeFlight is regulated by the Nova Scotia Department of Health and managed by EMC through a performance-based contract.

NS EMC is funded through operating subsidies and can be subject to financial penalties for not achieving its performance targets.

*New Brunswick*³²

In June 2007, the New Brunswick Minister for Health announced that all ambulance services in the province – land, air and dispatch would be consolidated within a six-month period and delivered by a new public sector company, Ambulance New Brunswick (ANB). Up to this time, land ambulance service in New Brunswick was delivered under more than 50 contracts with over three dozen different contractors including for-profit operators, regional health authorities, municipalities, non-profit organizations and First Nations. The air ambulance service had also been contracted to a private sector company. The main advantages of the consolidation and creation of ANB are standardized training for paramedics, standardized response times, round the clock coverage throughout the province, standardized consistency of care, and recruitment of more paramedics.

ANB's, paramedics are public sector employees and ANB reports to the Health Emergency Management Services of the Department of Health, however, it is managed by a private company, New Brunswick Emergency Medical Services Inc. (NB EMS)³³. The New Brunswick government and ANB have negotiated a 10-year performance-based contract with NB EMS to manage the day-to-day operations.

Dispatch of ambulance services throughout the province is undertaken by one centralized dispatch coordination centre.

³¹ NS EMC is a subsidiary of Medavie EMS that in turn is a wholly owned subsidiary of Medavie Blue Cross.

³² <http://www.gnb.ca/cnb/news/he/2007e0751he.htm>

³³ NB EMS is a subsidiary of Medavie EMS and holding company Medavie Blue Cross.

NB EMS is paid a management fee by government and the ANB and any savings realized through efficiencies are shared equally between ANB and NB EMS. If NB EMS does not meet its service targets, such as standardized response times, it can be penalized financially.

Prince Edward Island³⁴

The Department of Health regulates the emergency medical system in the province and ensures the provision of emergency and non-emergency ground ambulance services on a 24-hour, seven day per week basis through a negotiated, performance-based agreement with a private ambulance operator, Island EMS³⁵. The Department of Health has established requirements and standards to be met by Island EMS in the provision of quality emergency medical services. Air ambulance service is contracted and purchased from New Brunswick and Nova Scotia. This service is monitored by the Department of Health based on standards and performance criteria established in Memoranda of Agreement with New Brunswick and Nova Scotia.

Dispatch of ambulance services throughout the province is undertaken by one centralized dispatch coordination centre.

Island EMS is funded through operating subsidies provided by the Department of Health. Island EMS is also responsible for collecting user fees.

Newfoundland and Labrador³⁶

Ambulance services in Newfoundland and Labrador are delivered by a range of public and private operators including funeral homes, volunteer fire departments, and non profit organizations, and larger commercial operators. The Newfoundland and Labrador Ambulance Operators Association is a voluntary organization representing ambulance operators. Services are provided on a fee for service basis.

³⁴ <http://www.gov.pe.ca/health/index.php3?number=1020955&lang=E>

³⁵ Island EMS is a subsidiary of Medavie EMS and holding company Medavie Blue Cross

³⁶ <http://www.nlcaa.com>

Summary Overview – Governance and Service Delivery Models

Jurisdiction	Recent Reform to System	Current Form of System:				Funding
		Land		Air		
		Governance	Service Delivery	Governance	Service Delivery	
BC	No	Provincial -EHSC	Provincial – BCAS Three dispatch centres	Provincial -EHSC	Air Ambulance Program	Government funded; user fees apply (subsidized for MSP members)
Alberta	Yes – move from municipal delivery to delivery by the Alberta Health Services (integral part of health system)	Provincial – Ministry - Alberta Health and Wellness	Alberta Health Services – direct delivery or on contract with service providers Three dispatch centres	Provincial – Ministry - Alberta Health and Wellness	Fixed wing – contract with various providers to provide dedicated air ambulance services Rotary – Contract with STARS	Province covers 90% of cost; user fees cover remaining 10%
Saskatchewan	Comprehensive review of system complete Nov 2009	Provincial – Ministry – Saskatchewan Health	Health Regions – direct or through contracts with emergency service providers Five dispatch centres	Provincial - Saskatchewan Health	LIFEGUARD Air Ambulance Program (dedicated contract service)	Government funded; user fees apply
Manitoba	2009 developed a Provincial Emergency Medical Services Framework intended to be a guide to enhanced service delivery	Provincial – Ministry – Manitoba Health and Healthy Living, Manitoba Health Emergency Medical Services Branch	Regional Health Authorities – direct delivery or through contract with service providers Local dispatch centres; one medical transportation centre for rural and northern medical services	Provincial - Manitoba Health Emergency Medical Services Branch	LifeFlight Air Ambulance Program (dedicated contract service)	Government funded; user fees apply
Ontario	Yes – 1998 moved from disparate system of private commercial and municipally run operations to a system of joint	Ministry of Health – sets and monitors compliance with standards	Tier One Municipalities and designated agents either directly or through contract service providers 21 dispatch centres – Central Ambulance Communication Centres	Provincial – Ministry of Health	Ornge, non profit agency in performance contract with Ontario government	Government fully funds dispatch, base hospital program and air; 50% funding for municipalities for ground

Jurisdiction	Recent Reform to System	Current Form of System:				Funding
		Land		Air		
		Governance	Service Delivery	Governance	Service Delivery	
	responsibility between Ministry of Health and Municipalities/ designated agents		operated by the Ministry, hospitals and municipalities			ambulance services
Nova Scotia	Starting in 1995 comprehensive quality reforms to system; in 1997 entered into performance-based contract with NS EMC to deliver ambulance services	Nova Scotia Department of Health	NS EMC (private company, subsidiary of Medavie Blue Cross) One centralized dispatch centre	Nova Scotia Department of Health	NS EMC manages EHS LifeFlight through a performance based contract	Government operating subsidies; user fees apply
New Brunswick	2007 announced consolidation of service under Ambulance New Brunswick and entered into a performance based management contract with NB EMS	Department of Health, Health Emergency Management Services	Ambulance New Brunswick – managed under contact by NB EMS One centralized dispatch centre	Department of Health, Health Emergency Management Services	Ambulance New Brunswick – managed under contact by NB EMS	Management Fee; user fees apply
PEI	No information found	Department of Health	Island EMS One centralized dispatch centre	Department of Health	Contracted and purchased from NS and NB	Government operating subsidies; user fees apply
Newfoundland and Labrador	No	Ministry of Health and Community Services	Various private and public operators (Newfoundland and Labrador Ambulance Operators Association) Local dispatch	Provincial - Department of Works, Services and Transportation	Provincial - Department of Works, Services and Transportation	Fee for service

Appendix 3 – Legislative Implementation Implications of Various Models

Legislative amendment that entrenches on established collective agreement rights, particularly without advance consultation or negotiation, may violate the union members' Charter s. 2(d) rights to free association in the form of collective bargaining. There is also a risk that any legislative amendment to the collective bargaining structure would attract a similar complaint and government will need to consider this in contemplating options especially given CUPE 873's decision not to participate in the review.

Interest Arbitration

The model of collective bargaining established by the BC *Labour Relations Code* does not contemplate any form of interest arbitration other than in the context of first collective agreement negotiations.

The *Fire and Police Services Collective Bargaining Act* provides a model for arbitration in BC. Arbitration legislation exists in a number of other provinces as well. For Fire and Police, interest arbitration may be directed by the minister upon application of either party after collective bargaining has taken place (see section 3). Section 3(2) requires that the minister receive a report from the associate chair of the mediation division of the Labour Relations Board in advance of any interest arbitration direction. That report must address, among other things, whether "the dispute or some elements of the dispute should be resolved by applying the dispute resolution method known as final offer selection" (pph. 3(2)(b)(iii)). Section 4 sets out further requirements of the arbitration process including criteria that the arbitrator must consider (section 4(6)).

There are many varieties of interest arbitration that could be contemplated or directed but some legislative amendment would be required to add some form of mandatory interest arbitration to the collective bargaining regime in place for EHSC. This legislation could take the form of an amendment or addition to the *Fire and Police Services Collective Bargaining Act*, the *Emergency and Health Services Act* or as a separate piece of legislation applicable only to EHSC.

Mandatory or Ministerially-directed interest arbitration may be added to the other options reviewed below, but is likely only appropriately considered for those options that maintain the EHSC or some other separate entity bargaining with CUPE Local 873 on its own. While it is technically "possible" to legislate interest arbitration for paramedics and dispatchers even after they join a larger group of employees for collective bargaining purposes (e.g. within the health sector or public service), it would be highly irregular and likely destabilizing to do so for only one group of employees involved in a single set of negotiations. Moreover,

there would arguably be no need for interest arbitration if the risk of labour disputes is moderated by adding the paramedics to a larger bargaining unit.

Status Quo

The status quo requires no legislative amendment unless the government wishes to explore the option of some form of mandatory or Ministerially-directed interest arbitration or wishes to put EHSC under HEABC. The implications of putting the EHSC under HEABC is covered below in the section on health sector integration.

Health Care Integration

The *Health Authorities Act* (Part 3) creates five province-wide, multi-employer bargaining units for the “health sector”, a term defined to include all unionized members of HEABC and their unionized employees. The key to EHSC inclusion in this structure is HEABC membership. HEABC membership is, in turn, governed by the *Public Sector Employers Act* and the *Health Care Employer Regulation*. The *Public Sector Employers Act* requires those employers listed in the *Regulation* to become and remain members of HEABC. EHSC and its employees could, therefore, be added to HEABC membership and the health sector by an OIC designating EHSC under the *Regulation*.

Section 19.5 of the *Health Authorities Act* permits the Minister of Labour (the “minister charged with administration of the Code”) to “after the investigation considered necessary or advisable” direct the Labour Relations Board to add another bargaining unit as an appropriate bargaining unit. It is possible, therefore, for the Minister to rely upon section 19.5 to add current EHSC employees to the health sector in some form but within a separate bargaining unit. If that occurred, employees would not be split into different existing units and the new bargaining unit would not be multi-employer and multi-union as are the existing units that EHSC employees would otherwise join. This was contemplated in the 2004 Memorandum of Agreement between the EHSC and CUPE Local 873 but never acted upon.

Government could also consider legislation to address the transition of EHSC’s collective agreement etc. to the health sector and/or to specify which of the five bargaining units EHSC employees would join. The paramedical professional health sector bargaining unit would certainly include some paramedics but the criteria for inclusion in this group set by the Labour Relations Board may result in some paramedic classifications being included in either the community or facilities subsector health services and support bargaining units. Examination of this issue would require further investigation. CUPE, Local 873 could continue to represent EHSC employees, but would be required to join one or more of the associations of unions that bargains the collective agreements with HEABC. CUPE Local 873 would be obligated to generally operate in accordance with established Articles of Association for whichever association(s) it is obligated to join. It is unlikely that other unions would dispute Local 873’s right to continue to represent the employees as they

would not be actively intermingled with employees of an existing employer if they remain employees of EHSC or some other dedicated employer.

If EHSC continues as a separate entity, the organization and its unionized employees can be legally added to the “health sector” collective bargaining structure created by the *Health Authorities Act* whether or not the EHSC is added to the PHSA group of “branch societies”. Similarly, EHSC can be legally added to the PHSA structure with or without the further addition of EHSC and its employees to the health sector collective bargaining structure (similar to the BC Mental Health and Addiction Services Society that is a branch society of PHSA with unionized employees treated as part of the public service).

Adding EHSC to the PHSA structure:

Unlike the regional health authorities, the PHSA is not created by statute. It is, instead, a society incorporated under the *Society Act* as are its branch societies. Part 7 of PHSA’s Bylaws specifically addresses the creation of branch operations and, among other things, requires that branch society bylaws and boards mirror those of PHSA. As a result, adding EHSC to the existing PHSA structure would require legislative amendment to the *Emergency and Health Services Act* as EHSC would cease to be an independent commission/agent of government and would, instead, become a society formed and governed in a manner consistent with PHSA’s by-laws. This change alone would not affect the EHSC’s collective bargaining structure.

Ambulance services delivered directly through Health Authorities:

This option would require amendment to the *Emergency and Health Services Act* to eliminate or modify the EHSC. It would not likely be necessary to amend the *Health Authorities Act* to specifically add this function to regional health authority responsibilities as section 5 already establishes very broad purposes for regional health boards. As noted above, Government could consider legislation to address transition issues and bargaining unit placement of employees within the health sector. With this option other unions already certified to represent employees in the health sector at the health authority locations at and from which paramedics would work may assert jurisdiction to represent former EHSC CUPE Local 873 members.

First Responder Integration

EHSC moves to Ministry of Public Safety and Solicitor General:

As long as the EHSC remains the employer then there is no impact on the relationships or roles. If the EHSC were abolished and EHSC employees became direct employees of Government and members of the public service then they would become members of the BCGEU. That arrangement would require legislative amendment to the *Emergency and Health Services Act* and possibly transitional provisions. CUPE 873 would cease to represent its current members who would become BCGEU members.

Ambulance services delivered through Fire Departments:

This option would also require amendments to the *Emergency and Health Services Act* to eliminate it all together or to merge it in some way with existing fire departments. There would likely need to be long transitional periods to accommodate the transition.

Depending on the level of integration with firefighters, paramedics could be absorbed into the firefighters union in which case CUPE 873 would cease to represent paramedics.

Under this option paramedics would become local government employees. It is also important to note that local government labour relations are not overseen by PSEC. There may be additional legislative requirements if not all local governments are interested in assuming this responsibility.

Community Based Model

At a minimum, this option would require amendment to the *Emergency and Health Services Act* to allow for a wider range of delivery options. In addition, transitional provisions may be required for the employees that would transfer to health authorities or first responders. Legislation would be clearer once this model(s) is further developed.

Private Delivery

The current collective agreement between the EHSC and CUPE, Local 873 includes the following contracting out restriction:

7.01 Contracting Out

The Employer agrees not to contract-out any work presently performed by employees covered by this Agreement which would result in the laying off or the reduction in classification of such employees.

Accordingly, a contracting out option that resulted in employee lay-offs or classification reductions would require legislative intervention failing agreement with the Union in the current bargaining between EHSC and CUPE Local 873.

Such a legislative amendment that entrenches on established collective agreement rights, particularly without advance consultation or negotiation, may violate the union members' Charter s. 2(d) rights to free association in the form of collective bargaining. There is, of course, also a risk that any legislative amendment to the collective bargaining structure would attract a similar complaint.

This option may also require amendment to s. 5(1)(d) of the *Emergency and Health Services Act* to allow the EHSC to enter into agreements or arrangements for purposes beyond those set out in paragraph 5(1)(c) if necessary.

Appendix 4 - Hours of Work by Shift Pattern for Full Time Employees

Shift Type	Shift Pattern	Bi-Weekly Hours	Annual Hours
Alpha Shift (shift code A)	12, 12, 12, 12 OR 10, 10, 14, 14 = 4 and 4	In 56 days, an employee will work 28 shifts averaging 12 hours per shift – $28 \times 12 = 336$ hours 336 hours divided by 8 weeks = 42 hours per week x 2 = <u>84 hours biweekly</u>	2184 hours per year (42 hour week x 52 weeks)
Bravo (Charlie) Shift (shift code B)	11, 11, 11, 11 = 4 and 4	In 56 days, an employee will work 28 shifts of 11 hours each – $28 \times 11 = 308$ hours 308 hours divided by 8 weeks = 38.50 hours per week x 2 = <u>77 hours biweekly</u>	2002 hours per year (38.5 hour week x 52 weeks)
Delta Shift (shift code D)	7 hour day = 5 and 2	In 56 days, an employee will work 40 shifts of 7 hours each – $40 \times 7 = 280$ hours 280 hours divided by 8 weeks = 35 hours per week x 2 = <u>70 hours biweekly</u>	1820 hours per week (35 hour week x 52 weeks)
Echo Shift (shift code E)	10, 10, 10, 10 = 4 and 3	In 56 days, an employee will work 32 shifts of 10 hours each – $32 \times 10 = 320$ hours 320 hours divided by 8 weeks = 40 hours per week x 2 = <u>80 hours biweekly</u>	2080 hours per week (40 hour week x 52 weeks)
Dispatch Shifts (shift code D)	7 hour day = 5 and 2	In 70 days, an EMD will work 50 shifts of 7 hours each – $50 \times 7 = 350$ hours 350 hours divided by 10 weeks = 35 hours per week x 2 = <u>70 hours biweekly</u>	1820 hours per week (35 hour week x 52 weeks)
	12.5, 12.5, 12.5, 12.5 = 4 and 6	In 70 days, an EMD will work 28 shifts of 12.5 hours each – $28 \times 12.5 = 350$ hours 350 hours divided by 10 weeks = 35 hours per week x 2 = <u>70 hours biweekly</u>	
	10, 10, 10, 10 = 4 and 4	In 70 days, an EMD will work 35 shifts of 10 hours each – $35 \times 10 = 350$ hours 350 hours divided by 10 weeks = 35 hours per week x 2 = <u>70 hours biweekly</u>	
	10, 10, 10, 10, 10, 10, 10 = 3 on, 4 off; 4 on, 3 off	In 70 days, an EMD will work 35 shifts of 10 hours each – $35 \times 10 = 350$ hours 350 hours divided by 10 weeks = 35 hours per week x 2 = <u>70 hours biweekly</u>	

(source: BCAS Expenditure and Payroll Processing Manual, Chapter 3, 3.3.3 Hours of Work)

Appendix 5 – Interprovincial Compensation Comparisons

Total Compensation – PCPs Across Canada

The Public Sector Employers' Council has developed a total compensation model for public sector employers to support compensation comparisons with other jurisdictions. It is a model that compares wages/salaries and benefits across jurisdictions for selected benchmark positions and provides an indication of a total compensation ranking. Position matching for selected benchmark positions is critical in order to ensure an “apples” to “apples” comparison. Total compensation costs for employers includes wages/salaries, health and welfare benefits, group insurance, sick leave and pensions.

The comparative information included in the model is obtained from collective agreements, employer and union websites, direct surveying of other jurisdictions and BC employer wage and benefit comparisons

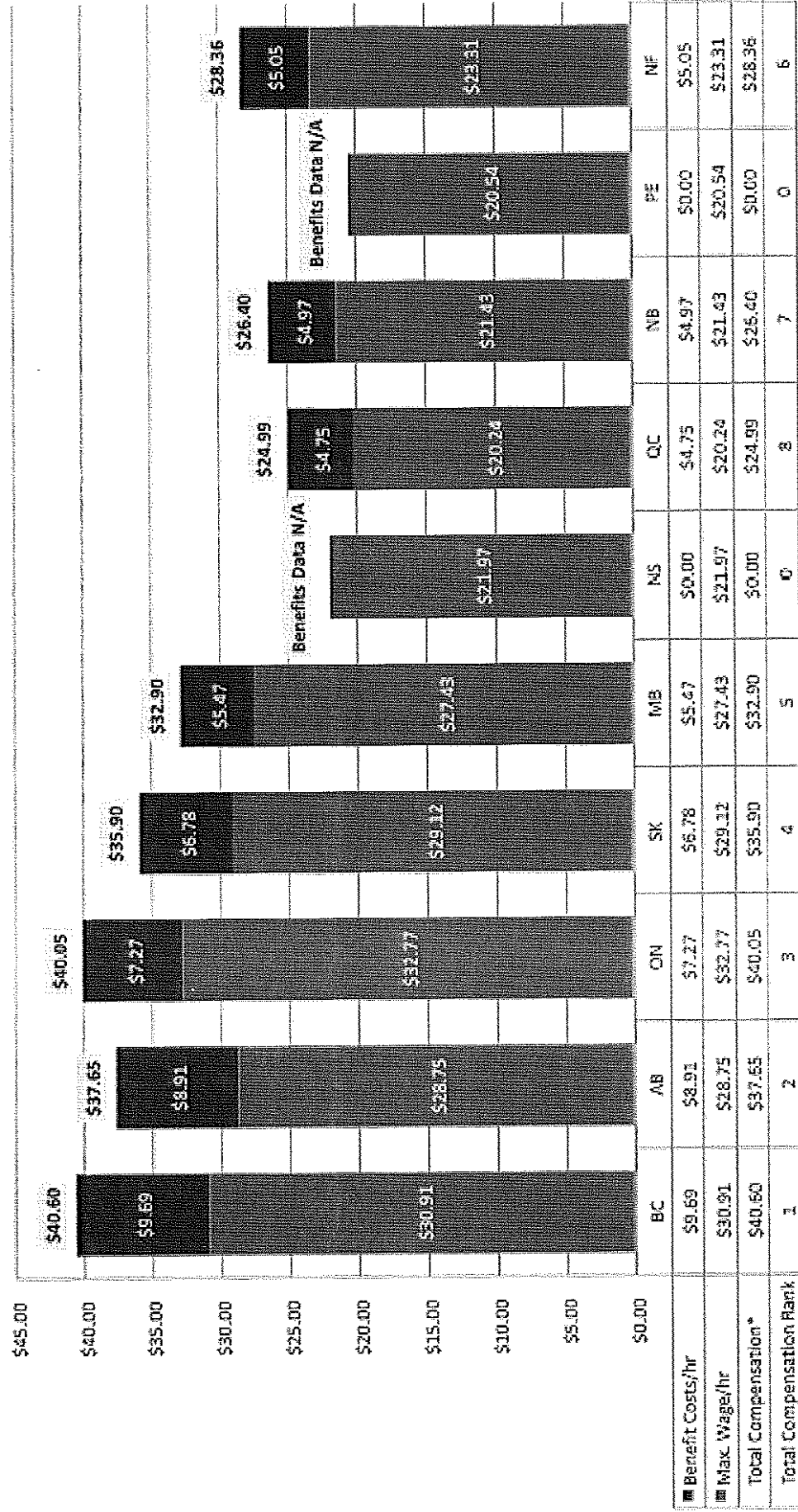
The model makes assumptions for aspects of total compensation where precise data is not available, for example, benefits costs in other jurisdictions and wage increases where collective agreements have expired. Additionally, the model “does not provide an accurate depiction of how much of an increase would be required to address labour market challenges. There are a number of other HR metrics that require consideration before determining this, such as turnover, recruitment challenges, internal and external candidate pool/quality, etc. Employers who administer human resource management, payroll and labour relations are relied upon to provide more precise proposals in this regard”³⁷.

With respect to benefits, the cost of providing benefits in other provinces is based upon modeling. In practice, the cost of benefits depends on many variables, including availability and levels of coverage, number of employees covered, local competitiveness of insurers, etc. This information, as well as the actual costs of providing benefits in other jurisdictions, is proprietary in nature. In the model it is assumed that if one province has a similar benefit to BC, then the cost of providing that benefit would also be the same. If a benefit in another province is greater than in BC, it is assumed that it costs more. The benefit figures are based on comparisons of employer premiums for specific benefits and the levels of coverage for each benefit. The benefits compared include: dental, extended health, sick leave, long-term disability, group life, accidental death & dismemberment, vacations, provincial medical plans and pensions. The wage comparison does not include overtime rates or shift premiums.

The following graph is PSEC's 2009/10 Total Compensation Comparison for Ambulance Primary Care Paramedics.

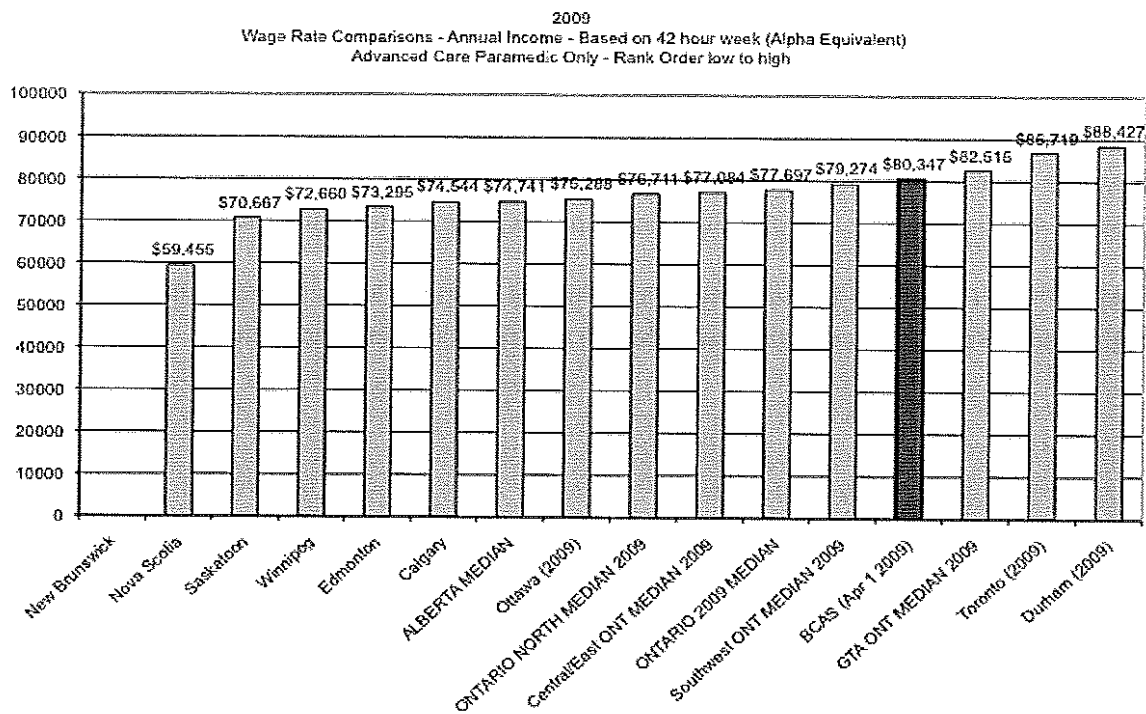
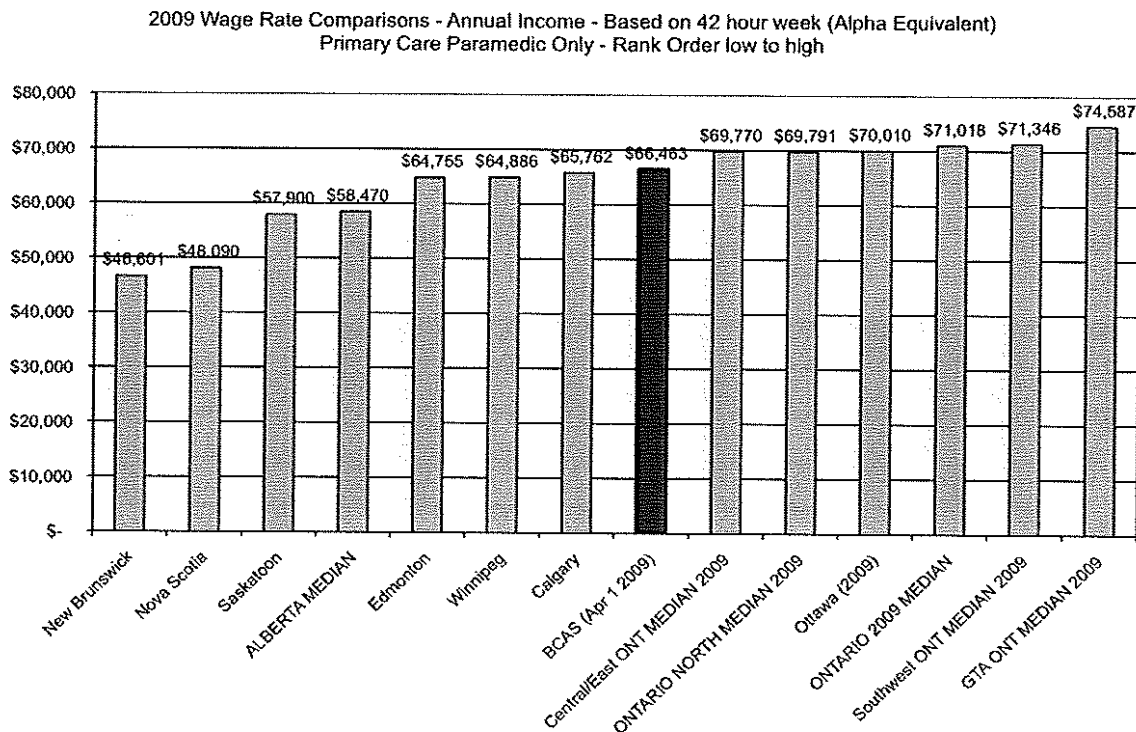
³⁷ PSEC presentation, Public Sector Cross Jurisdictional Total Compensation Comparisons

2009/10 Ambulance Primary Care Paramedic Total Compensation Comparison

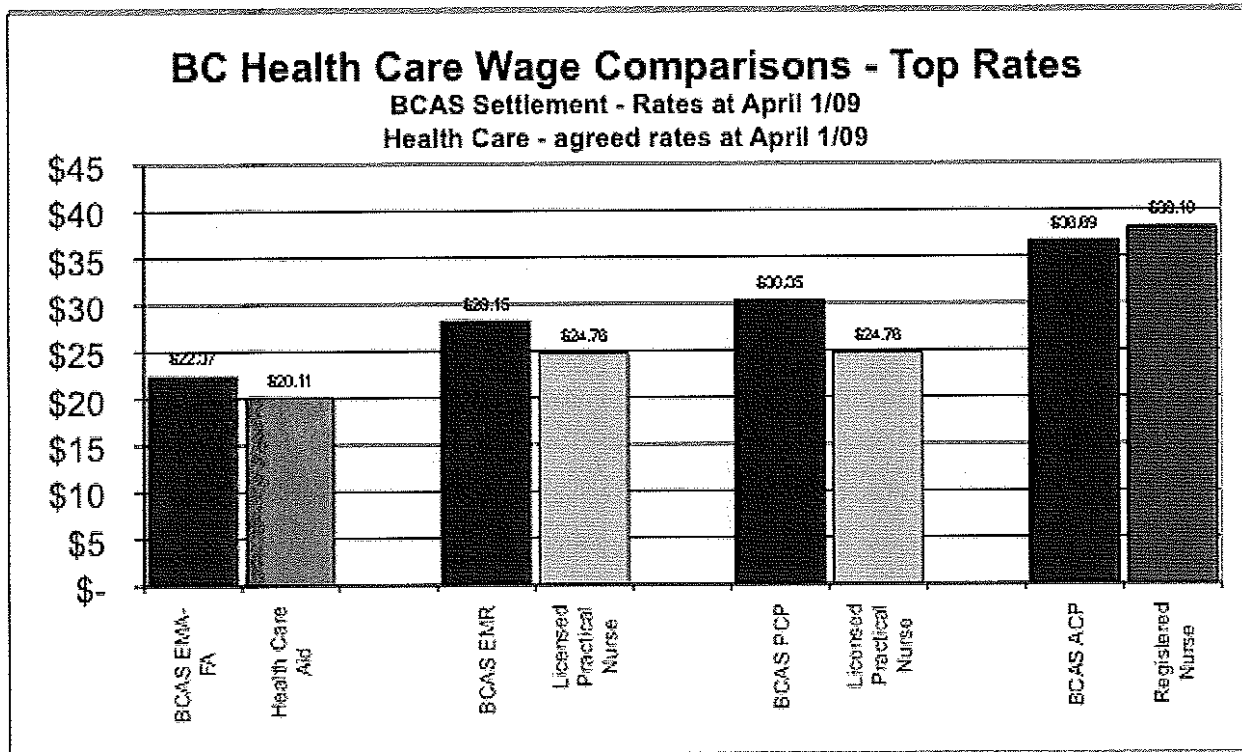


Wage Comparisons for PCPs and ACPs

2009 wage comparisons for PCPs and ACPs - select Canadian jurisdictions; BC and select Alberta services; and BC and select Ontario services:



Wage Comparisons – BCAS Paramedics versus Other BC Health Care Professionals



Type of Position and Description of Qualifications:

BCAS EMA – FA – three weeks of OFA training; minimal licensing requirements

Health Care Aid - 12 to 14 weeks training, graduation diploma, no licensure

BCAS EMR - 4 to 6 weeks training, minimal licensing requirements

BCAS PCP - 4 to 6 months training, diploma program, licensing requirements

Licensed Practical Nurse - 12 months training, diploma program, licensure requirements

BCAS ACP – PCP, plus 9 to 12 months training, diploma program, licensing requirements

Registered Nurse - 3 to 4 year University, degree program, licensing requirement

Appendix 6 – Parties Consulted in Preparation of Report

BC Ambulance Service

Advanced Life Support Paramedics of British Columbia Society

Public Sector Employers' Council (PSEC)

Emergency and Health Services Commission (EHSC)

British Columbia Nurses' Union (BCNU)

B.C. Government and Service Employees' Union (BCGEU)

Health Sciences Association (HAS)

Community Social Services Employers' Association (CCSEA)

Fire Chiefs Association of BC

Several individual Fire Chiefs

Individual paramedics

City of West Vancouver

Alberta Health Services

MD Ambulance Care Ltd, Saskatoon, Saskatchewan

Winnipeg Fire and Paramedic Service

Ontario Ministry of Health

Toronto, EMS

Emergency and Transportation Services, Frontenac County, Ontario

Emergency Health Services, Nova Scotia Department of Health

Nova Scotia EMCI

Allan Black of Black Gropper Labour and Employment Lawyers

Delayne Sartison of Roper Greyell Employment and Labour Lawyers

Ministry of Labour

Ministry of Health Services

Ministry of Public Safety and Solicitor General

