Article

"Impact of Nursing Unionism in the Hospital Industry: The Saskatchewan Experience"

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Impact of Nursing Unionism in the Hospital Industry

The Saskatchewan Experience

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This paper reports results of a survey which assesses both management and union perceptions of the impact of a professional nurses' union upon hospitals in Saskatchewan's centralized health-care bargaining system. It evaluates union impact on four dimensions: economic outcomes, employee attitudes and behavior, management policy and control and quality of patient care.

During the 1970's, there was renewed scholarly interest in the impact of unionization and collective bargaining upon employer organizations. Researchers have sought to broaden their assessments of «union impact» by examining a wider variety of bargaining outcomes and by investigating more fully the effects of bargaining relationships upon individuals and organizations. Economic-based researchers, for example, have moved from a primary focus on wage effects to one which includes fringe benefits, work rules, internal and external labour market mobility, and economic performance[1]. Institutionalists have developed contract indices to bring greater objectivity and comparability across organizations to their assessments of

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1 Richard B. FREEMAN and James L. MEDOFF, «The Impact of Collective Bargaining: Illusion or Reality?», *U.S. Industrial Relations 1950-1980: A Critical Assessment*, Madison, WI, Industrial Relations Research Association, 1981, pp. 47-98.

union impact[2]. Behaviouralists have increasingly sought to bring concepts and methods developed in organizational behaviour to the study of union-management relations[3].

The intent in a number of these studies is to look beyond the formal «outputs» of collective bargaining — the «web of rules» — to the more general implications of unionization and bargaining for individuals and organizations. Kochan, for example, has cited the need for a comprehensive program of research which includes assessment of the effects of union-management relationships upon «...the personnel/human resource concerns valued by employers...» as well as the «...economic and behavioural outcomes valued by employees»[4]. Specifically, he sets forth a three stage model of union effects which includes: (a) primary effects — the «web» of negotiated contract rules, (b) secondary effects — including managerial adjustments such as through technological change or modified human resource practices, and (c) third-order effects — or the consequencies of (a) or (b) for the goal attainment of the parties[5].

These calls by industrial relations scholars for a broader and deeper understanding of union impact are paralleled by those put forth by organizational behaviour researchers, who have expressed specific interest in the implications of union-management relationships for organizational effectiveness. As Goodman and Sandberg have noted, while there is extensive research literature on both labour relations and organizational effectiveness, «...there is little literature linking the two to define and measure organization effectiveness in a labour relations context»[6].

Beyond their general scholarly appeal, these arguments to assess more fully the effects of unionization and collective bargaining on the employer are particularly compelling in human service industries. For example, in health care — the locus of the present study — organizational effectiveness and performance must ultimately be understood primarily in terms of the

2 Myron J. ROOMKIN and Hervey A. JURIS, «A Critical Appraisal of Research on Unions and Collective Bargaining,» *Industrial Relations Research in the 1970's: Review and Appraisal*, Madison, WI, Industrial Relations Research Association, 1982, pp. 311-354.

3 Jeanne M. BRETT and Tove Helland HAMMER, «Organizational Behavior and Industrial Relations», *«Industrial Relations Research in the 1970's: Review and Appraisal*, Madison, WI, Industrial Relations Research Association, 1982, pp. 221-2822.

4 Thomas A. KOCHAN, «Assessing the Effects of Labor-Management Relations on Individual and Organizational Goals», paper presented at the *Annual Meeting of the Academy of Management*, August, 1980, Detroit, Michigan.

5 Thomas A. KOCHAN, *Collective Bargaining and Industrial Relations*, Homewood, Ill., Richard D. Irwin Inc., 1981, p. 331.

6 J. P. GOODMAN and William R. SANDBERG, «A Contingency Approach to Labor Relations Strategies», *Academy of Management Review*, 6,1, January 1981, p. 146.

employer's ability to provide vital human services. Understanding the scope and depth of union effects which may impact this ability directly or indirectly remains a timely and salient research objective.

In seeking to have the design of the present study informed by these trends in research, the authors were confronted with some significant conceptual and methodological difficulties. One is the lack, within the organizational literature, of any generally accepted definition of organizational effectiveness. Cunningham's review, for example, identified no less than seven distinct conceptual formulations[7]. Goodman and Pennings described the situation this way:

> The literature in the OE (organizational effectiveness) area is in a preliminary state. The construct... has never been well specified. Many different definitions abound, and few attempts to reconcile the differences exist... The empirical literature reflects the character of the theoretical literature — it is in disarray and noncumulative in nature.[8]

However, some guidelines have emerged: (a) the use of multiple measures to reflect the multiplicity of goals extent in employer organizations, (b) the need for both general measures that can be used for interorganizational and interindustry comparisons and specific measures tailored to the organization under study, and (c) the need for measures meaningful to both scholars and to those who are members (workers and managers) of the organization under study. The specific variable adopted to operationalize these guidelines in the present study are discussed below.

Furthermore, disagreement persists among both industrial relations and organizational researchers as to the most appropriate approach to specifying the operationalizing relevant outcome variables. Economists generally rely primarily on «objective» measures; institutionalists combine objective measures (e.g. contract indices) with participant perceptions; behaviouralists appear to rely on measures of attitude, perception and behaviour.

These approaches should be viewed as being complementary rather than competitive, with each contributing to the cumulative understanding of union impact. The «hard data» approach provides insights into the quantifiable effects of unionization and bargaining. However, perceptual measures are better for assessing how the parties themselves understand and evaluate their situation. As such, these measures provide a firm basis for

7 J. Barton CUNNINGHAM, «Approaches to the Evaluation of Organizational Effectiveness», *Academy of Management Review*, 2,3, July 1977, p. 471.

8 Paul S. GOODMAN and Johannes M. PENNINGS, «Critical Issues in Assessing Organizational Effectiveness», in Edward E. Lawler III et al., (eds.), *Organizational Assessment*, New York, John Wiley and Sons, 1980, pp. 186-7.

predicting the parties future actions. In their analysis of industrial disputes Stagner and Rosen made the following observation:

> The kind of image a worker has of his boss, and the image the boss has of himself and his workers, will determine what each does in a given industrial situation. The image may be erroneous (i.e. does not agree with what an impartial observer would report), but the person behaving is guided by his image; to him it is reality. Such images often provide the key to understanding an industrial dispute.[9]

Their argument is no less salient in assessing union impact. Knowing how the parties view the organizational effects of unionization and bargaining should enhance the researcher's understanding of why the parties take the positions and actions they do, and why individual bargaining systems attain, or fail to attain, maturity and stability. For these reasons, perceptual measures were employed in the present study; they are described fully below.

THE INSTRUMENT

Both union and management perceptions of the impact of unionization and collective bargaining were assessed. The instrument contained 41 items, representing a subset of a similar list of 79 questions field tested in an earlier study of U.S. hospital industry-labor relations conducted by Juris and his colleagues at Northwestern University[10]. In this earlier study, factor analysis of survey results generated twelve reliable multi-item scales measuring various dimensions of union impact. For the present study, factor analysis of the 41 items from the «short-form» instrument yielded eight scales which closely resemble the U.S. study scales (see Table 1)[11]. These scales were created to measure the effects of unionization and collective bargaining on the performance and effectiveness of the employer organizations.

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9 Ross STAGNER and Hjalmar ROSEN, *Psychology of Union-Management Relations*, Belmont, Ca., Wadsworth Publishing Co., 1965, p. 7.

10 Hervey A. JURIS and Charles MAXEY, «The Impact of Hospital Unionism», U.S. Department of Health and Human Services Research. U.S. Department of Health and Human Services, Grant Number HS 01557, July 1981, p. 263.

11 The term «short form» refers to the reduction of the number of impact questionnaire items employed in the original Juris-Maxey study from 79 to 41. Part of the reduction reflects the fact that funding in Canadian hospitals comes largely from government. Impact items which related to the establishment of internal administrative policy and interhospital relations areas to which the union would have limited access, were also excluded from the questionnaire. Scale reliabilities were computed and found acceptable for both the original U.S. data and the Canadian data. Reliabilities for the scales employed in the present study are included in Table 1. Minor wording changes were made to questions in the Canadian version to reflect organizational and institution differences.

TABLE 1

UNION IMPACT SCALES

ECONOMIC IMPACT

Factor 1: Replacement Effects (.81)[a]
- Reduction in the size of the hospital's workforce
- Contracting out work formerly done by hospital employees
- Substitution of automated equipment for employees
- Substitution of one type of employee for another in specific work

Factor 2: Staffing (.80):
- Success of the hospital in attracting adequate numbers of new employees
- Quality of new employees
- Ability of the hospital to retain employees

Factor 3: Compensation (.81):
- Level of wages paid to union employees
- Fringe benefits provided by the hospital

EMPLOYEE ATTITUDES AND BEHAVIOR

Factor 4: Employee Attitudes and Behavior (.78):
- Employee absenteeism
- Employee morale
- Willingness of employees to perform at minimally acceptable levels
- Willingness of employees to exceed minimum performance expectations and take on added duties
- Commitment of employees to the mission of the hospital
- Quality of interpersonal relations among employees and supervisors
- Worker willingness to cooperate with others in achieving the performance goals of the hospital

MANAGEMENT POLICY AND CONTROL

Factor 5: Impact on Supervision and Management (.73):
- Time management must spend attending to disciplinary matters
- Amount of authority or flexibility supervisors have in decision making related to their duties
- Overall difficulty of the supervisor's job
- The general ability of management to run the hospital
- Incidence of conflict between managers at various levels over policy or operational decisions

Factor 6: Formalization of Personnel Policies (.67):
- Extent to which personnel policies exist in written form
- Extent to which personnel policies are consistent across departments
- Extent to which personnel policies are determined by top administrators rather than by supervisors or department heads

Factor 7: Overall Quality of Management:
- Overall quality of management

QUALITY OF CARE

Factor 8: Quality of Patient Care (.88):
- Number of incidents that occur to patients
- Incidence of medication errors
- Patient accidents
- Attitudes of hospital employees toward patients
- Overall quality of care provided by employees with direct patient contact
- Quality of medical record keeping
- Maintenance of the patient environment
- Replenishment of supplies or delivery of needed equipment
- Worker commitment to patient care
- Overall quality of patient care provided by the hospital

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a Reliability coefficient (alpha)

For all survey items, management and union participants were requested to indicate the degree and direction of the union impact. Responses were recorded on a scale ranging from «+4» (strong, positive impact) to «–4» (strong, negative impact), with a value of «0» representing no perceived impact. Scale values were constructed by summing the response values for each item within the factor-derived scale and dividing that sum by the number of items in the specific scale.

Economic Impact

The parties' perceptions of the economic impact of unionism and collective bargaining was measured using three scales focusing specifically on labor market effects.

The first economic scale, «replacement effects» (Factor 1), focuses on the respondents' perceptions of the union impact on the size and internal allocation of the workforce within the hospital. The four items comprising this scale reflect the respondents' views of the union's impact on the ability of the hospital to reduce the size of the workforce, to subcontract, to engage in capital-labor substitution, and to reassign or substitute workers.

The second scale, «staffing» (Factor 2), consists of three items measuring management and union views concerning the relationship between unionism and the hospital's ability to attract adequate numbers of new employees, the quality of new employees, and the retention of employees.

The third scale, «compensation» (Factor 3), includes two items pertaining to the respondents' perceptions of the impact of unionization on wage and fringe benefit levels.

Employee Attitudes and Behavior

Previous research suggests that the presence of a union can have significant effects on employee attitudes and behavior. In the health-care industry, the potential of such an impact is particularly important because of the possible implications for the quality of the basic services provided by the employer organization (i.e. health care).

The «employee attitudes and behavior» scale (Factor 4) consists of seven items measuring perceived effects on absenteeism, general morale, employee commitment to the mission of the hospital, employee willingness to perform at or above minimum performance standards, the quality of interpersonal relations among employees and supervisors, and employee willingness to cooperate with others in meeting patient-care objectives.

Management Policy and Control

The literature suggests that management perceives collective bargaining as an adversarial process, frequently associated with an erosion of management's ability to develop and implement effective work and human resource management policies. Three scales were developed to address this issue.

The «supervision and management» scale (Factor 5) focuses on the union impact on the roles of first-line supervisors and management. The five items address the overall difficulty of the supervisor's job, supervisory flexibility and autonomy in decision making, time directed to disciplinary matters, management's ability to run the hospital, and the extent of intramanagement conflict. The scale «formalization of personnel policies» (Factor 6) assesses union impact on human resource policy development within the individual hospitals. Three items capture respondent perceptions of the degree to which policies exist in formal written form, are consistent across departments and operating units, and are promulgated centrally rather than at the department or unit level. The third scale, «management quality» (Factor 7), assesses changes in the overall quality of hospital management.

Quality of Care

Public statements by many health-care industry representatives in recent years have reflected a concern that unionization and collective bargaining adversely affect the quality of health care. Thus, items were developed to assess respondent perceptions of union impact on patient care. The «patient care» scale (Factor 8) uses ten items to evaluate changes in the quality of care. Specifically, the items refer to: overall quality of care provided; worker commitment to patient care; incidents of patient abuse; medication errors; attitudes towards patients; patient accidents; problems associated with patient supervision; maintenance of the patient-care environment; supplies and equipment; and the quality of medical record keeping.

SAMPLE AND METHOD

Data were collected from a population of 117 unionized hospitals in Saskatchewan. Management questionnaires were submitted to chief executive officers (CEO's) and directors of nursing (DON's) in all hospitals and to support service department heads in larger institutions. Usable responses were received from 196 managers (71.6%) representing 101 hospitals (86.2%).

A professional nurses' union, Saskatchewan Union of Nurses (SUN) represents registered nurses in 107 hospitals. SUN is a periodically[12] militant organization with a demonstrated willingness to exercise the strike weapon. It also maintains a keen interest in professional issues. The union negotiates on a centralized multiemployer basis[13]. Some local bargaining occurs, primarily in a few larger hospitals in urban areas. In effect, essentially uniform contractural terms are established for all hospitals which negotiate with the nurses' union. Questionnaires sent to the chief local union officer at each hospital yielded 72 usable responses (67.3%).

For the current analysis, the sample group was reduced to 105 respondents, representing matched triads of union (SUN) and two management representatives (CEO's and DON's) from within 35 hospitals. This matched within-hospital triad design was used to minimize biases between union and management responses which could be attributable to uncontrolled differences in local environments and to provide a stronger basis from which to compare union and management perceptions of the impact of unionism.

The respondent triads were divided into two further groups, those from hospitals with fewer than 85 beds (small hospitals; n = 63, or 21 triads) and those from hospitals with 85 or more beds (large hospitals; n = 42, or 14 triads). The rationale for this was that most 85-plus-bed hospitals are regional or base hospitals while the less-than-85-bed hospitals are local community hospitals[14]. The large hospitals have local bargaining and/or union-management committees while the small hospitals have neither.

There are a number of distinguishing features associated with hospital size in a multiemployer bargaining structure none of which provides sufficient conceptual cohesion to permit the generation of hypotheses. For instance, it is evident that large hospital parties exercise effective control over bargaining[15]. What that means for small hospital parties in terms of union

12 Militancy is used to mean a readiness to engage in confrontation with the employer to achieve an objective. The SUN-SHA relationship has been typified by hard bargaining. Two work stoppages have occured, including a ten-day strike affecting 80 hospitals.

13 Kurt WETZEL and Daniel G. GALLAGHER, «The Saskatchewan Government's Internal Arrangements to Accomodate Collective Bargaining», *Relations Industrielles*, vol. 34, no 3, 1979, pp. 452-470.

14 The community hospitals are small, rural facilities of 10-30 beds and provide basic medical services. The regional hospitals (91-312 beds) offer consulting services and more complex medical services. Base hospitals (300-500+ beds) serve as referral facilities, housing specialized equipment and personnel.

15 Kurt WETZEl, Charles MAXEY and Daniel G. GALLAGHER, «Management and Union Assessments of Multi-employer Bargaining in Healthcare: A Canadian Example», *Journal of Health and Human Resources Management*, in press.

impact is not obvious. Large hospitals had local collective bargaining before the smaller hospitals were unionized. Moreover, there is less likely to be as much day-to-day union activity and presence at small hospitals. The multifaceted character of issues such as staffing and formalization of policies together with nature of the parties' experience with those issues in particular institutional contexts would necessitate the positing of multiple hypotheses. Hence, size was treated as a potentially important but highly complex exploratory variable.

The perceived impact of unionization was simultaneously examined from both inter- and intraorganizational viewpoints. The analysis compared management and union perceptions of the impact on the hospitals of unionization and collective bargaining by professional nurses. The perceived impact of unionization was assessed from two management perspectives, that of individuals responsible for the overall administration of the hospitals (CEO) and that of the functional managers directly responsible for the administration of nursing services (DON). An intramanagement comparison of CEO and DON perceptions of nurses union impact explored the possibility that the impact of unionism is differentially perceived depending on the managerial vantage point. In all these comparisons, the influence of hospital size was also considered.

It is anticipated that union representatives will be more positive in their evaluations of the union impact than management representatives since collective bargaining is an institution which nurses have used to negotiate changes in the terms and conditions of employment which are more favorable to them. Within the management groups, it is hypothesized that DON's will be more critical of the union impact than will the CEO's. This latter expectation is based largely on the belief the DON's may be more directly and immediately affected by unionism and collective bargaining outcomes than the more organizationally distant CEO's.

RESULTS

Two-way analysis of variance (ANOVA) was utilized to examine collectively the effects of respondent position (CEO, DON, SUN) and hospital size (less than 85 beds, 85 beds or more) upon the respondents' perceptions of union impact. The use of the two-way design makes it methodologically possible to ascertain, by way of the reported interaction term, if the main effect of respondent position varies significantly by the category of hospital size and vice versa.

Due to the fact that the respondents' positions are classified into three (3) groups, an *a posteriori* comparison of all possible pairs of position responses was conducted in order to pinpoint the location of possible differences between position groupings. Table 2 presents the results, giving scale score means for the two management levels and union by hospital size. The reported F-statistics pertain to the main effects of position and hospital size, as well as the interaction term. Where a significant overall position effect was found to exist, the identification of significant difference among the three (3) groups is noted.

The results reveal that, contrary to expactations, *both* union and management respondents have generally positive perceptions of the organizational impact of unionism. Also contrary to expectations, the views of the two management groups were similar. Both indicated the union's impact has been slightly negative in only two areas, replacement effects (economic) and employee attitudes and behavior. Union respondents felt that the union has had a modestly negative impact in one area, replacement effects. The size of the hospital in which the respondents were employed appeared to have little effect on the reported perceptions of union impact.

There were significant union-management differences in other areas, though these were differences in the magnitude and not necessarily in the direction of the impact. These will be detailed below as the results are discussed for the four dimensions of organizational effectiveness: economic; employee attitudes and behavior; management policy and control; and quality of patient care.

Economic Impact

As expected, both parties believe that the nurses' union has had a positive impact upon wages and benefits (Factor 3). Union members see this impact as being stronger than managers do. The analysis further reveals that the overall effect which is associated with respondent position is primarily attributable to perceptual differences between CEO's and union representatives (SUN). This may suggest that top managers credit factors such as the political or market environments as well as the union for the gains made by nurses while the nurses are more likely to credit their union.

It is also noteworthy that small hospital nurses and managers do not perceive a stronger economic impact from collective bargaining than do those of their urban counterparts. It might have been expected that small hospital nurses would perceive that they had made substantial gains because they were able to capitalize on the militancy and bargaining power of the large hospital nurses.

TABLE 2

Analysis of Variance Results
Perceptions of Union Impact by Position and by Hospital Size[a]

Position	*Hospital Size*			*Significance[b]*		
	Small (N=21)	*Large (N=14)*	*Total*	*Position*	*Hosp. Size*	*Pos. XSize*
Economic Impact						
Factor 1: Replacement Effects						
CEO[c]	-.38 [d]	-.66	-.50	.71	.06	1.46
	(1.37)	(1.71)	(1.51)	NS	NS	NS
DON	.02	-.48	-.20			
	(1.02)	(1.79)	(1.48)			
SUN	-.37	.33	-.08			
	(.86)	(1.52)	(1.19)			
TOTAL	-.25	-.32				
	(1.12)	(1.69)				
Factor 2: Staffing						
CEO	.83	1.26	1.00	.68	4.51	.06
	(1.28)	(1.27)	(1.28)	NS	.04	NS
DON	.61	1.24	.88			
	(1.65)	(1.42)	(1.56)			
SUN	.98	1.62	1.26			
	(1.01)	(1.05)	(1.06)			
TOTAL	.81	1.37				
	(1.33)	(1.24)				
Factor 3: Compensation						
CEO	1.71	1.46	1.61	3.33	.02	.31
	(2.16)	(2.70)	(2.36)	.04	NS	NS
DON	2.10	1.80	1.98	CEO-SUN		
	(1.78)	(2.71)	(2.16)			
SUN	2.67	3.07	2.84			
	(1.08)	(1.03)	(1.06)			
TOTAL	2.14	2.12				
	(1.77)	(2.33)				
Employee Attitudes and Behavior						
Factor 4: Employee Attitudes and Behavior						
CEO	-.60	-.86	-.70	11.21	.59	1 .81
	(1.46)	(1.85)	(1.61)	.001	NS	NS
DON	.11	-.51	-.14	CEO-SUN		
	(1.24)	(1.73)	(1.46)	DON-SUN		
SUN	.83	1.13	.96			
	(.92)	(1.16)	(1.02)			
TOTAL	.07	-.14				
	(1.35)	(1.80)				
Management Policy and Control						
Factor 5: Impact on Supervision and Management						
CEO	.26	-.35	.00	4.69	.32	1.29
	(1.57)	(1.88)	(1.72)	.01	NS	NS
DON	.17	-.24	-.00	CEO-SUN		
	(1.57)	(2.16)	(1.82)	DON-SUN		
SUN	.79	1.38	1.05			
	(.87)	(.86)	(.91)			
TOTAL	.37	.22				
	(1.41)	(1.87)				

Factor 6: Formalization of Personnel Policies						
CEO	1.50	1.15	1.36	.18	.62	.98
	(1.53)	(1.46)	(1.49)	NS	NS	NS
DON	1.05	1.57	1.26			
	(1.13)	(1.95)	(1.52)			
SUN	1.21	1.86	1.51			
	(1.64)	(1.56)	(1.61)			
TOTAL	1.26	1.52				
	(1.42)	(1.66)				
Factor 7: Overall Quality of Management						
CEO	1.86	1.50	1.71	1.16	.13	.64
	(1.71)	(2.24)	(1.91)	NS	NS	NS
DON	1.29	.86	1.11			
	(1.53)	(2.03)	(1.72)			
SUN	1.00	1.50	1.21			
	(1.54)	(1.51)	(1.52)			
TOTAL	1.37	1.28				
	(1.59)	(1.93)				
Quality of Care						
Factor 8: Quality of Patient Care						
CEO	.02	.07	.04	7.26	.01	2.33
	(.78)	(1.67)	(1.16)	.001	NS	NS
DON	.51	-.18	.26	CEO-SUN		
	(.97)	(1.56)	(1.24)	DON-SUN		
SUN	.85	1.43	1.09			
	(.84)	(1.32)	(1.08)			
TOTAL	.45	.47				
	(.92)	(1.64)				

a. Response code: Negative: -4 strong; -3 major; -2 modest; -1 slight;
No impact: 0
Positive: 1 slight; 2 modest; 3 major; 4 strong.

b. Overall F-score and p value; under *Position*, the significant (.05) paired comparisons are listed.

c. CEO = Chief Executive Office; DON = Director of Nursing; SUN = Saskatchewan Union of Nurses representative.

d. Mean (standard deviation)

All position groups felt that unionism has had a slight to modest positive impact on the staffing function (Factor 2), the ability of the hospital to attract and retain adequate numbers of good employees. The one significant difference in this entire analysis based on hospital size occurs within this factor. Respondents from large hospitals indicated a more positive evaluation of the impact of unionism on staffing than did respondents from small hospitals. This result is somewhat surprising in that one might have expected that small hospital parties would have experienced, due to provincewide standardization of compensation, a greater impact on their ability to attract and retain good employees.

Each position group indicated that, from its perspective, the impact of unionism with regard to replacement effects (Factor 1 — reducing the workforce, contracting out, automation) was slightly negative. This can be interpreted to mean that union members are inclined to believe that as a result of the role played by the union, employers have developed a proclivity

to replace bargaining unit members where possible. The negative management response suggests that the union's presence has made replacement of bargaining unit labour slightly more difficult to accomplish.

Employee Attitudes and Behavior

Union and management perceptions of the effect of the union upon employee attitudes and behavior (Factor 4) differed significantly. Management perceived a negative impact while union representatives felt that the union has had a positive impact upon employees' attitudes and behavior. Paired comparisons of position-based responses indicate no significant differences between the management groups' perceptions (CEO and DON), but a significant perceptual difference does exist between union representatives and both of the management groups (see Table 2).

Management Policy and Control

Management respondents indicated that unionism's impact upon day-to-day supervisory and management functions (Factor 5) has been negligible, while union respondents reported a positive impact, i.e. the job of managing a hospital is not made more complex and demanding by a union. Once again, the responses of both CEO's and DON's differed significantly from those of union representatives.

Respondents from all three position groups indicated that the impact of unionism upon formalization of personnel policies (Factor 6) and the overall quality of management (Factor 7) has been positive. With the exception of the compensation area, Factors 6 and 7 revealed the most substantial organizational impact associated with unionism of all impact areas examined in the survey.

Quality of Care

Union respondents perceive unionism as having had a modest positive impact on patient care. Management felt it has had a nonexistent or very slight positive impact. Both management groups were similar in their perceptions of the impact which unionism had upon the quality of patient care, and such perceptions significantly differed from the more positive view of SUN representatives.

CONCLUSION

No claim can be made that the perceptual measurements used in this study are substitutes or surrogates for objective indices of union impact. The measures do, however, provide valuable insight into the views of those directly involved in the bargaining system. How management and union representatives evaluate the impact of their relationship on the organization may be of equal or greater importance for the participants than objective measurements.

The substantive findings suggest that, in this industrial relations system, collective bargaining is associated with few perceived negative consequences for the organizations. Unionists are, as expected, generally more positive in their assessments of the organizational consequences of bargaining. Perhaps more surprisingly, managers also perceive positive outcomes for their organizations, suggesting that the adaptations to union-management relations are internally regarded as successful. As noted, management perceptions did not differ significantly on the basis of closeness to the day-to-day functioning of nursing-related activities (i.e. CEO's versus DON's). Nor are there substantial differences in either union or management perceptions on the basis of hospital size. Certainly, there is no basis for concluding that the Saskatchewan Union of Nurses has had a negative impact upon these hospitals' perceived ability to perform effectively.

From a public policy perspective, the parties' perceptions of the impact of their bargaining relationships upon the operation of hospitals provide a dimension for assessing unionism which extends beyond the more publicly visible issues of funding and industrial conflict. The results support the conclusion that collective bargaining within the Saskatchewan hospital industry has not yielded dysfunctional results. Moreover since this is not an anomalous perception derived from one management level or one type of institution, it would seem to justify an approach to labour policy which acknowledges that organizations can and do derive benefit from engaging in collective bargaining[16].

By implication, the findings reflect positively upon the centralized multiemployer bargaining arrangement. It is evident that neither party at small hospitals has had imposed upon it agreements which have proven unsuitable to the requirements of those institutions.

16 It should be noted that in 1983, the year following the collection of the data, the government of Saskatchewan enacted legislation designed to weaken unions in their dealings with individual members and employers.

The general absence of either strong negative management perceptions or extremely positive union perceptions of the impact of unionism on hospital effectiveness and human resource management functions may raise some questions concerning the strenght of the union examined and the extent to which the findings can be applied to other settings. In response to the first concern, it should again be noted that SUN is not a weak union.

While the results of this study are directly applicable to this industrial relations system, they are fairly consistent with the results derived using a more extensive form of this survey instrument with a sample of U.S. hospital administrators[17]. An exception does exist in the fact that although Saskatchewan hospital managers tend to demonstrate a similar order of impact areas to their U.S. counterparts, they are more favorable in their perceptions of the magnitude of the impact of unionism. Such a finding may reflect the fact that within Canada, and more specifically Saskatchewan, the health care industry has a longer history of unionism than is found in the U.S. The findings of this study are also supported by the research of Miller et al. which has found that bargaining has placed few negative restrictions on the management of hospital manpower[18]. Furthermore, the suggestion of Becker et al. that union pressure has forced administrators to improve personnel policies and practices also appears to be consistent with the positive impact which management representatives in this study associated with unionism[19].

In broader terms, the findings of this study also appear consistent with Freeman and Medoff's more comprehensive analysis of the effects of unionism on the behavior of workers and management. More specifically, their summary research suggests that popular perceptions of unionism tend to overlook the positive individual, organizational and societal consequences[20]. From the organizational perspective, the findings of Freeman and Medoff tend to parallel the results of this study in several areas, most notably: the positive impact of unionism on the formalization of rules; the ability of the organization to attract and retain high-quality employees; and productivity. The principle rationale supporting the findings of Freeman and Medoff is similar to that initially noted by Slichter et al. and Kochan — management reacts to accommodate and adjust to the changes wrought by

17 JURIS and MAXEY, *op. cit.*

18 Richard U. MILLER, Brian E. BECKER, and Edward B. KRINSKY, *The Impact of Collective Bargaining on Hospitals*, New York, Praeger, 1979.

19 Brian E. BECKER et al., «The Union Impact on Hospitals — A National Study», National Center for Health Services Research, U.S. Department of Health and Human Services, unpublished, 1981.

20 Richard B. FREEMAN and James L. MEDOFF, *What Do Unions Do?*, New York, Basic Books, Inc., 1984.

collective bargaining. As noted, unionism and centralized collective bargaining have existed in the Saskatchewan health-care system for over a decade. The longevity of this bargaining relationship may have provided hospitals with sufficient opportunity to evaluate and respond to union impact on organizational practices related to workforce management. In effect, the general absence of negative organizational impact which hospital managements associate with unionism may reflect the hospitals' gradual adjustment to unionism. This accommodation is now perceived favorably by both management and union. The credibility of these findings is enhanced by the fact that this perception is shared by two levels of management, those with overall organizational responsibility and those with responsibility for the nursing function.

L'influence du syndicalisme infirmier dans les hôpitaux l'exemple de la Saskatchewan

Cet article traite des perceptions que direction et syndicat se font de l'influence d'une association professionnelle d'infirmiers et d'infirmières au plan local dans les hôpitaux de la Saskatchewan où il existe un mécanisme de négociation collective centralisée en matières de soins hospitaliers. Contrairement à la plupart des études sur l'influence du syndicalisme qui portent sur les enjeux immédiats et objectifs de la négociation collective, celle-ci a été conçue de façon d'abord à s'enquérir auprès des parties, au plan local, de ses conséquences sur le fonctionnement et la performance de l'organisation. Le plan de l'étude comportait la mise au point et l'utilisation d'un instrument d'enquête apte à fournir des données multidimensionnelles sur l'influence des syndicats dans les institutions hospitalières telles que la percevaient les représentants de la direction et du syndicat au niveau local. L'instrument d'enquête consistait en huit échelles à questions multiples de façon à apprécier l'influence du syndicalisme dans les hôpitaux touchant quatre sujets généraux: l'aspect financier, le comportement et les attitudes des employés, la politique et le contrôle administratifs et la qualité des soins aux malades.

Les données furent recueillies à partir d'un échantillon d'hôpitaux syndiqués en Saskatchewan. Les questionnaires furent postés à des personnes appartenant à deux niveaux de direction: les hauts dirigeants administratifs et les directeurs des soins aux malades. L'instrument d'enquête fut aussi distribué aux principaux dirigeants locaux des syndicats d'infirmiers et d'infirmières de la province. Cet échantillon trilobé permettait à l'analyse de refléter ce que l'on percevait de l'influence du syndicalisme des points de vue des administrateurs de haut niveau, des dirigeants sur le terrain directement responsables de l'administration des soins ainsi que des représentants syndicaux.

Pour chacun des aspects de l'appréciation, on a demandé aux participants, tant du côté de la direction que du syndicat, d'évaluer à la fois du jugement (positif ou négatif) et de l'ampleur de l'effet que pouvait avoir le syndicalisme au niveau de l'hôpital local. L'échantillon fut ramené à 105 répondants représentant les triades associées des trois groupes au sein de ces 35 hôpitaux. Les réponses furent divisées en

deux catégories correspondant aux dimensions des hôpitaux. Les grands hôpitaux régionaux et les hôpitaux mixtes formaient un groupe et les petits hôpitaux ruraux complétaient l'ensemble. L'analyse des données de l'enquête étudiaient l'opinion des répondants relative à l'influence du syndicalisme au niveau de chaque hôpital du point de vue de l'ensemble des institutions et à l'intérieur de chacune d'entre elles.

Les résultats révèlent que, contrairement à ce que l'on s'attendait, les répondants, tant du côté de la direction que de celui des syndicats ont une perception positive de l'influence du syndicalisme au sein des institutions. Comme on le prévoyait, les représentants syndicaux ont une perception passablement plus positive que celle des représentants patronaux dans quatre des huit échelles d'appréciation. Plus précisément, les représentants syndicaux se montrent plus favorables dans leur perception que les représentants patronaux de l'influence du syndicalisme en ce qui a trait aux traitements, aux attitudes et au comportement des employés, à la direction et à la supervision ainsi qu'à la qualité des soins aux patients. On ne décèle aucune différence appréciable touchant les comparaisons sur l'influence des syndicats de la part des deux niveaux de la direction. Leur perception de la signification et de l'ampleur de cette influence est fondamentalement la même et, en conséquence, elle n'a aucun effet significatif.

Les résultats de l'enquête indiquent que, tant de la part des représentants syndicaux que patronaux, l'influence du syndicalisme au sein du personnel en soins hospitaliers est généralement positif en ce qui a trait au fonctionnement et à l'efficacité des institutions. Ces constatations sont confirmées par le fait qu'elles reflètent l'opinion et la perception des deux niveaux de direction d'hôpitaux de dimensions différentes. Elles démontrent aussi que les parties savent tirer des avantages réciproques de la négociation collective.