IN THE MATTER OF AN INTEREST ARBITRATION

BETWEEN:

The Participating Hospitals

and

CUPE/OCHU & SEIU

(Bill 124 Reopener)

Before: William Kaplan, Chair
Brett Christen, OHA Nominee
Joe Herbert, Union Nominee

Appearances

For the OHA: Craig Rix
Hicks Morley
Barristers & Solicitors

For the Unions: Steven Barrett
Goldblatt Partners
Barristers & Solicitors

Jonah Gindin & Doug Allan
CUPE/OCHU

Matthew Cathmoir
SEIU

The matters in dispute proceeded to a hearing in Toronto by Zoom on May 10, 2023. The Board met in Executive Session on May 25, 2023.

Introduction

As is well known, on November 24, 2022, the *Protecting a Sustainable Public Sector for Future Generations Act*, generally known as Bill 124, was ruled unconstitutional. The November 3, 2022, award between these parties contained a normative reopener provision. With their agreement, an attempt was made on March 23 and 24, 2023, to mediate the reopener, but when it was unsuccessful, CUPE and the SEIU (the unions) and the Participating Hospitals filed detailed briefs and the reopener proceeded to a hearing held by Zoom on May 10, 2023. The Board met in Executive Session on May 25**,** 2023.

The unions have different collective agreement terms: CUPE, September 29, 2021, to September 28, 2023, and SEIU, January 1, 2022, to December 31, 2023. For all intents and purposes, however, the reopener years are 2022 and 2023 and will be referred to as such (although the precise terms will be used for the economic awards).

Statutory Criteria

T*he Hospitals Labour Dispute Arbitration Act* (*HLDAA*) governs these proceedings and sets out the specific criteria to be considered:

Criteria

9 (1.1) In making a decision or award, the board of arbitration shall take into consideration all factors it considers relevant, including the following criteria:

1. The employer's ability to pay in light of its fiscal situation.
2. The extent to which services may have to be reduced, in light of the decision or award, if current funding and taxation levels are not increased.
3. The economic situation in Ontario and in the municipality where the hospital is located.
4. A comparison, as between the employees and other comparable employees in the public and private sectors, of the terms and conditions of employment and the nature of the work performed.

5. The employer's ability to attract and retain qualified employees.

Issues in Dispute

There are six issues in dispute:

1. General Wage Increase
2. RPN Adjustment
3. Call Back Premium
4. Shift and Weekend Premiums
5. Vacation Entitlement
6. Health and Welfare Benefits

Union Submissions

Summary

The position of the unions can be readily summarized. During the period of the reopener, or stated somewhat differently, for 2022 and 2023, Ontario's hospitals were and are in the throes of an unprecedented staffing crisis; a crisis that affects all employee classifications. Recruitment and retention – one of the *HLDAA* criteria – had to be immediately addressed and one way of doing so was by substantially increasing wages, premiums, benefits and vacations, with additional attention paid to RPN rates. Further justifying, indeed demanding, a significant wage increase was inflation. It had, over the two years of the term, seriously eroded buying power and the award had to take this into account and provide an adjustment so real wages did not continue to fall behind. In addition, the unions were of the view that this reopener provided an overdue opportunity to acknowledge and appropriately recognize the extraordinary contribution of union

members who helped keep Ontario's hospitals open during the most challenging days of the pandemic.

Recruitment and Retention

The staffing crisis, the unions argued, was real and the pandemic had made this persistent problem even worse. Ontario had fewer healthcare staff per capita than the other Canadian provinces. Resignations were substantially up. Turnover was substantially up. Vacancies were also substantially up. Working conditions were deteriorating daily. Hospital hallway healthcare was real. Emergency room closures were now chronic and continuing. In 2022, for example, the Financial Accountability Office (FAO), a government appointed body that provides independent analysis of the province's finances, trends in the provincial economy, and related matters, reported 145 emergency room closures. This had happened once before: a single unplanned closure in 2006. Emergency room shutdowns have continued in 2023. Lack of healthcare workers – the unions' members – was the reason. They could not be recruited and retained.

Surgical procedures have been cancelled across the system and there were 93,812 fewer surgeries in 2022, a 14% reduction from 2019. Wait times were 49% longer in 2022 than in 2019 (with the FAO reporting that more than 100,000 patients were waiting longer than the maximum clinical guidelines for their surgeries, an all-time high). The FAO had observed that "without additional measures" Ontario would not achieve its goal of reducing the surgery waitlist to pre-pandemic levels. A big part of the explanation for this, like the emergency room closures, was the human resources deficit. The FAO reported that hospital staffing shortages would go from

bad to worse – especially among the regulated professionals: RNs and RPNs, and also PSWs – from 24,000 currently to 33,000 by 2027.

Even these numbers, in the unions' view, vastly understated the demand for healthcare workers – given predicted population growth, not to mention an aging citizenry and the anticipated collateral increase of high acuity hospital patient admissions that would inevitably accompany it. So called prophylactic measures, such as, for instance, the expansion of private healthcare, would not solve any of these problems, the unions argued: they would make an intolerable situation even more untenable by draining personnel from the Participating Hospitals to private clinics with better hours and compensation. This was not, the unions argued, a controversial view: it was the view of the President of the Ontario Hospital Association (OHA), who, in announcing his organization's concerns about the expansion of private healthcare, observed, "We certainly aren't interested in seeing members of the hospital teams being poached by other employers."

Admittedly, the unions acknowledged, there was no single answer to solving Ontario's healthcare human resources crisis, but real improvements in terms and conditions of employment were an important part of the solution. In fact, the unions argued that the OHA had said just that in its *Practical Solutions to Maximize Health Human Resources*, February 2022 (*Practical Solutions*):

> The Ontario Hospital Association (OHA) has repeatedly heard from members and other stakeholders that health human resources and staffing concerns have become the most urgent and pressing issue emerging from COVID. This document discusses the concerns and practical solutions raised to enhance health human resources now and into the future.
>
> …

In our discussions with members and system stakeholders, it has become clear that workforce issues are at a tipping point – solutions are needed immediately.

…

Challenges and Concerns about Future Health Care Workforce Supply

HHR Issues Exacerbated by COVID-19

Hospital staffing models prior to the pandemic were finely tuned and calibrated to be efficient and safe to respond to patient demands amid the funding realities of the time. As of 2020, Ontario had 609 registered nurses per 100,000 population employed in direct care (CIHI) – the lowest in the country when compared to other provinces.

COVID-19 has disrupted this balance both by its impact on existing health care workers and on the need to hire net new positions across hospitals. Hospitals have seen an increase in turnover, largely driven by health care worker resignations. During the pandemic, there have been significant investments and opportunities for hospitals to hire additional staff to respond to COVID-19 through creating net new positions. Both factors have resulted in an overall increase in the number of vacancies that have to be filled in hospitals in a competitive labour market.

System Wide Capacity Challenges

HHR challenges are being felt across the entire system impacting the care continuum and patient flow. Difficulties accessing primary care during the pandemic negatively impacted emergency departments (ED) which saw a rise in the acuity level of patients seeking care. In addition, HHR challenges and decades of fiscal constraints within long-term care (LTC) and home care also negatively impacted hospitals' ability to discharge patients to more appropriate settings.

As of mid-January 2022, there are approximately 5,800 patients waiting in hospital beds for alternate levels of care (ALC). While there was an influx of beds in 2020 by government (approximately 3,100), some targeted to addressing the ALC issues, the capacity challenges continue. The focus remains on improving the flow of patients across the continuum of care, away from acute care/bedded capacity. Mitigating the ALC challenge and facilitating patient flow can only be successful if we take a system view to HHR solutions.

Bill 124 and Compensation Restraint

Under the already challenging circumstances, Bill 124 (which restricts health care worker and other public sector employee compensation to a maximum increase of 1 per cent annually for a term of three years) has been raised as potentially one of several factors leading to health care worker recruitment and retention challenges.

The OHA and its member hospitals were not supportive of Bill 124 when it was introduced and sought an exemption from this legislation prior to it being passed. At the time, the OHA expressed concerns that temporary wage restraint would have unintended consequences that could negatively impact hospital employees and create financial and operational disruption that would overshadow the impact of any short-term cost avoidance on compensation increases. In particular, the OHA raised that wage restraint legislation would create uncertainty, risk and anxiety amongst front-line employees and health care employers during a period of health care transformation. The OHA also objected to government intervention on free collective bargaining on a principled basis and further questioned the necessity of these measures given that hospitals have a history of responsible compensation outcomes.

HHR Issues at a Critical Point

Our members have suggested that exhaustion and ongoing workloads have led to burnout of experienced, late career nurses who have decided to leave frontline clinical practice or the profession entirely. There is anecdotal evidence to suggest that some nurses are leaving hospitals to work for agencies and/or other health care facilities (e.g., public health, surgical centres, independent health facilities) or leaving the industry entirely for a more balanced

lifestyle. Members felt that these issues affecting nursing care are a risk to the delivery of the most critical services in EDs, operating rooms, and intensive care units. Some hospitals and other health providers have no alternative but to fill vacancies by relying more on agency staff than in the past, often spending significant dollars doing so.

In northern hospitals, utilization of agency nurses combined with a heavy reliance on locum physicians is significantly impacting patient care – concerns were raised that some of these professionals do not have the necessary cultural and/or Indigenous training needed to work within these regions. With limited HHR supply in these environments, aggressive recruitment efforts by staffing agencies and increasing top-ups are driving up hospital costs. Many hospitals report that they are spending inordinate amounts of time, energy and dollars trying to recruit permanent or semi-permanent staff.

HHR Issues Are Impacting the Delivery of Care

Many hospitals are dealing with an abundance of one-two sick day calls and an increased number of staff, including physicians, taking extended sick leaves. Members reported that the increased amount of sick time leave is impacting the ability of hospitals to deliver care in specific programs. For example, we have heard about shuttering of neonatal intensive care units, birthing units and surgical wards.

There are also growing concerns that HHR issues are impacting the operations of EDs. Most recently, several hospitals within rural and northern communities have considered potential closures to their EDs because of a lack of nurses in the region. Others have had to scale down or close other programs to staff their EDs or other critical areas of care.

A review of the ED metrics (November 2021) shows increases in ambulance offload times, time to physician assessment of patients and wait times for patients being admitted to an inpatient bed. These increases are being observed all while ED volumes remain relatively low, when compared to previous years. Hospitals and ED physicians have indicated that these increases are due, in part, to HHR challenges, as well as the increasing complexity of care which is in turn straining hospital resources.

Profound Challenges to Operating Essential Services in Rural and Northern Communities

For hospitals in small, rural, and remote communities, the challenges to safely operate and provide essential programs and services are now insurmountable given their long-standing HHR concerns. Currently there are more than 300 physician vacancies within rural and northern communities. Hospitals are doing their best to maintain services and keep hospitals open, however significant gaps in nurse and physician coverage are putting hospitals at risk for poor outcomes and creating disincentives to recruitment efforts. To avert a crisis, there is an immediate need for practical solutions to maximize capacity in the short, medium and long-term.

Practical Solutions proposed, among other things, a series of measures to address the staffing shortages including the creation of "robust retention strategies," "immediate funding to bolster staffing models," and filling vacancies "in real time to ensure that there are no service delivery gaps," and by doing so, "create more manageable workloads for staff, help increase retention rates…." *Practical Solutions* was clear: "Our members have suggested that exhaustion and ongoing workloads have led to burnout of experienced, late career nurses who decided to leave frontline clinical practice or the profession entirely." The government's announced creation of

3,100 new hospital beds was a start but given that Ontario had the lowest nurse per capita rate in the country, there was a need to hire at least 10,000 RNs and 3,500 RPNs over the next five years to meet anticipated needs. There was also a need to redress the consequences of Bill 124: "it has been raised as a significant concern impacting healthcare worker morale and potentially one of several factors leading to health care worker recruitment and retention challenges." The unions translated: working conditions and low, suppressed wages drove employees from the hospitals and made it difficult to recruit replacements.

Unfortunately, the unions observed, instead of instituting system-wide "robust retention strategies" and the other measures that *Practical Solutions* proposed – solutions which the unions endorsed and were seeking to achieve in these proceedings – many of the Participating Hospitals were taking matters in their own hands by, for example, and completely outside and offside of the provisions of the central collective agreement, offering employees double overtime including on call back to incentivize the unions members to work even harder. Other incentives include referral, recruitment and retention bonuses and tuition reimbursement. The excessive use of agency nurses – being paid a multiple of the rates received by Participating Hospitals nurses – demonstrated, as if more evidence was required, a healthcare system in freefall, one that had failed to adequately and systematically address the recruitment and retention issues that everyone agreed – and as *Practical Solutions* made clear – demanded urgent attention.

The fact of the matter was that the wage rates of union members had fallen seriously behind because of state intervention; Bill 124 unconstitutionally suppressed union member wages, and the reopener had to address that. At the same time, the economic picture had changed, and that

meant taking into account inflation – the overall economic context which was another one of the *HLDAA* criteria – in determining the appropriate wage outcome.

The Economic Context

Not only were substantial compensation improvements necessary to address the recruitment and retention crisis, but also essential were increases that ameliorated the corrosive and continuing effect of several years of high inflation. Even if inflation has begun to abate – a somewhat dubious proposition and one that in any event remains to be seen – several years of high past inflation was now baked into prices leading to a significant increase in the consumer price index and concomitant decline in the value of wages and living standards (consumer inflation was 3.5% in 2021 and 6.8% in 2022 with at least 3.6% forecast for 2023). Substantial compensation improvements were justified on this basis and providing them was demanded by the proper application of *HLDAA* criteria.

Government revenues were up, job growth was up, a recovery not a recession was underway, reflected in a dramatic improvement in the government's fiscal situation, all as detailed in the unions' submissions. These factors and others have led, the unions observed, to a series of awards and settlements beginning in mid-2022 providing higher than usual wage outcomes in all sectors but including healthcare, in some cases substantially so. These compensation outcomes were carefully reviewed in the unions' brief and at the hearing, but with a qualifier: Of all the awards that were reviewed, the unions made clear their position that the ONA reopener awards were not dispositive or in any way governing for failing as they did to give both recruitment and retention and the impact of inflation adequate, if any, real consideration. There are two ONA

reopener awards: (*ONA & Participating Hospitals*, unreported award of Stout dated April 1, 2023 (Stout Reopener 2021 Award) and *ONA & Participating Hospitals*, unreported award of Gedalof dated April 25, 2023 (Gedalof Reopener 2022 Award).

At one time, indeed for a long time, settlements in the Participating Hospitals followed or resembled each other, but that could no longer be the case. The employees the unions represented, including substantially lower paid service and clerical workers, could not be bound by ONA's asks in its two reopener processes, or the substandard results that were obtained. A further distinguishing feature which the unions urged this Board to consider was that the ONA post-Bill 124 adjudication for a new collective agreement was underway in marked contrast to the unions with their yet-to-expire current collective agreements. In any event, a separate bargaining unit representing a single different classification and advancing different priorities should not be permitted to set the pattern for these service and clerical units. The unions made it clear that they would not voluntarily be bound by the ONA outcomes, which they argued were completely inadequate to address the demonstrated need that they had established: Demonstrated need to address recruitment and retention and demonstrated need to ameliorate against the corrosive continuing impact of inflation.

Across-the-Board Wage Increases and Other Adjustments

In the result, the unions submitted that the following wage increases should be awarded in this reopener: 8.5% in 2022 and 11.8% in 2023. Together with wages, the union sought premium, benefit and vacation improvements. Furthermore, the unions advanced their case for a special RPN adjustment.

RPN Adjustment

The unions represented approximately 12,000 RPNs, about 25% of the CUPE members, and 30% of the SEIU members. RPNs and RNs had a unified scope of practice. Like RNs, RPNs were regulated health professionals – regulated by the very same college. However, RPN wage rates had not kept up and were, in fact, lagging far behind their peers elsewhere in Canada. Exacerbating the compensation situation was an unfortunate and unjustifiable compression with PSW rates, far from the historic spread: in some hospitals the rates were now separated by less than one or two dollars (in part the result of a recent permanent PSW wage enhancement). The low wages and decreased delta unfavourably compared on the one hand with PSW rates and, on the other, and also unfavourably, with RN rates. Specifically, the wage gap between RPNs and PSWs shrunk from an average of $6.72 in 2021 to $4.78 in 2022, or in other words by nearly 30%. At the same time, the wage gap between RPNs and RNs grew from $17.16 to $19.19, or an increase of 12%. This was largely the result of the Participating Hospitals refusing over successive terms to bargain RPN rates centrally. For the first time, in this bargaining round, the Participating Hospitals agreed to making RPN rates a central issue providing an unprecedented opportunity to redress a longstanding historical wrong by awarding a classification adjustment; one that was completely justified by any objective examination of the unions' established claim of demonstrated need.

There was a benefit to low RPN wages, the unions observed, to the Participating Hospitals: it served their interests to increasingly rely on RPNs to deliver hospital nursing healthcare, but at rates much lower than those paid to RNs. This was hardly a surprising result given the current 90% overlap in RPN-RN competencies. The Participating Hospitals were saving money by using

RPNs but, at the same time, refusing to pay them proper rates. This was demonstrated in the data: a 41% increase in hospital RPNs since 2015 from 17,737 to 25,028 (while hospital RN numbers had remained largely stable).

The trend was clear: RPNs were increasingly providing more and more direct hospital care. RPNs were working in most, if not all, areas including those providing acute care. As *Practical Solutions* established, there were recruitment and retention issues across the system, but recruitment and Retention of hospital RPNs stood out. An RPN hospital vacancy rate of 6.75% in 2017 grew to 10.24% in March 2022 and11.89% by October 2022 (the overall hospital vacancy rate was 8.84%). As of October 1, 2022, there were 2,355 hospital RPN vacancies, a situation that has only worsened. Participating Hospitals were addressing the issue with various *ad hoc* measures (earlier described). They were clearly doing this out of extreme necessity because of the dire staffing shortage. There was evidence, canvassed in the brief, of extremely high RPN turnover, a symptom to be sure of the extraordinary recruitment and retention challenges – a specific *HLDAA* criteria the unions again pointed out.

A classification adjustment for RPNs, the unions argued, should not be a contentious matter: the Participating Hospitals readily acknowledged the "evolving and increasingly overlapping scope of practice of Registered Nurses (RNs) and Registered Practical Nurses (RPNs)." Indeed, the Ontario government had gone so far as to introduce legislation providing for compensation enhancements to encourage recruitment and retention. One government measure, for example, was the Community Commitment Program for Nurses (CCPN). Its features include providing a $25,000 grant in exchange for a two-year commitment to an eligible employer. Other hospitals

were providing market adjustments to incentivize RPNs to come to work. During the pandemic, the government provided a $4 per hour increase – albeit temporary – to RPN rates reflecting its appreciation of the actual value of the work given the unprecedented demands for hospital RPNs.

Union Proposal RPNs Adjustment

The unions proposed, given the recruitment and retention challenges, not to mention the PSW compression and the eroded relationship with RN rates that was completely unjustifiable on any principled grounds given the shared scope, that as of the first day of each applicable term, the Participating Hospitals, prior to any awarded general wage increase, adjust the maximum rate for RPNs to $35.17 and adjust all other steps on the grid to maintain the existing differential. This would reflect a $4 per hour increase to the lowest current RPN job rate.

Participating Hospitals Submissions

Summary

In its brief, the Participating Hospitals agreed that there should be a wage increase, over and above the 1% previously awarded: an additional .75% in each of the two years as "reasonable and appropriate in the circumstances…[and]…that no additional non-wage monetary increases are warranted in the circumstances." At the hearing, however, the Participating Hospitals presented a somewhat revised economic submission; again the .75% in each year, but some very modest premium and other changes as well. In the submission of the Participating Hospitals, the wage settlement should be governed by historical bargaining patterns, patterns in which the unions normally received less than ONA. Notwithstanding this dispositive bargaining history,

there was no basis for the unions – over the course of the term – to receive more than what was awarded in the Stout and Gedalof 2021 and 2022 Reopener awards.

Reopener Wage Increases

The question to be asked, and answered, is what would have been awarded but for Bill 124? Neither party, the Participating Hospitals submitted, should be put in a better or worse position due to the passage of time or events that arose after issue of the initial award. Replication demanded that an identifiable, relevant and clear pattern be followed where there was a long-established practice of these parties doing just that; namely, following ONA but generally not doing as well. Both the Stout and Gedalof 2021 and 2022 Reopener awards were wrongly decided according to the Participating Hospitals: they went much further than appropriate in making economic improvements; but even so, they established the pattern. Another part of the overall context had to be assessed as well: When Bill 124 was in effect, the Participating Hospitals were effectively prescribed from pursuing any of their non-monetary bargaining objectives, a situation that continued under the reopener because it was limited to compensation. Moreover, there was a correlation between government funding and wage increases – not between inflation and wage increases – and data was referred to in support of this submission (and the point was also made that many increases in government funding were targeted and unavailable to support general wage increases). There was no reason to believe that if the unions' proposals were awarded, government funding would follow.

The ONA Re-Opener Awards and the Proper Economic Outcome

The Stout Reopener 2021 Award – which the Participating Hospitals argued was the comparator for the first year of this reopener – granted an additional 1%, for a total of 2%. To the extent that the Stout Reopener 2021 Award took inflation into account, it nevertheless awarded an increase substantially below prevailing rates. This was in full accord with the authorities, the Participating Hospitals pointed, out referring to the decision of Arbitrator Hayes in *Homewood Health Centre & UFCW* (unreported award dated June 1, 2022) and its observation that "the harsh reality is that no-one can expect to be fully immunized from the negative impacts of extraordinary inflation. This award does not come close," (at para. 31, a finding that has been adopted with approval in other cases cited by the Participating Hospitals). Inflation, the Participating Hospitals argued, may be a factor in determining the appropriateness of a wage outcome, but there is no reason to conclude that wage increases must match or exceed the rate of inflation. That was clearly the conclusion reached in the Gedalof Reopener 2022 Award, which the Participating Hospitals argued was the comparator for the second year of this reopener, and which awarded an additional 2%, for a total of 3%. (The Gedalof Reopener Award also eliminated the 25-Year Step and made significant compressions to the grid to the overall economic advantage of RNs.)

The Gedalof Reopener Award, the Participating Hospitals pointed out, categorically took into account changes in circumstances since that Board's initial award was issued:

> … where comparator bargaining patterns have previously been well established, there is little or no reason to depart from those patterns. But where there have been significant intervening events (in this case a global pandemic, a staffing crisis in nursing, soaring inflation, and freely bargained and awarded outcomes that depart from the asserted pattern) arbitrators exercising their jurisdiction under *HLDAA* will have regard to those considerations (at para. 36).

Having taken these diverse circumstances into account, including specifically, "soaring inflation," the Gedalof Reopener 2022 Award and its additional 2% compensation was the best

comparator for replication purposes. It was not an exaggeration to say that the Stout and Gedalof 2021 and 2022 Reopener Awards were by the parties own longstanding bargaining patterns effectively governing. Accordingly, these two reopener awards set the upper limit of what could be achieved in this case; namely an additional 1% in the first year, and an additional 2% in the second. This conclusion – that any wage increases had to be no greater that what was awarded in these reopeners – was the only outcome that would give effect to long-established bargaining patterns and the replication principle.

In addition, as noted, Arbitrator Hayes (followed by others) was on record that there can be no expectation that awards fully ameliorate against inflation. Such an approach, as adopted in these two reopener awards reflected the funding reality of Ontario hospitals: their funding was not indexed to inflation, imposing structural constraints on how much inflation can be considered, which was almost not at all. And this conclusion was further reinforced by careful consideration of the recruitment and retention situation, so heavily relied upon by the unions in their submissions in support of large across-the-board increases. To be sure, there was no basis to take into account settlements outside of healthcare, and the Participating Hospitals argued they were irrelevant and inapplicable, especially because there were established bargaining patterns to follow.

Recruitment and Retention

The Participating Hospitals acknowledged that recruitment and retention were among the *HLDAA* factors to be considered. There was no dispute but that there were health human resources challenges in Ontario hospitals and across the healthcare sector more generally. But

this was the result of a dramatic increase in capacity: more beds meant a need for more employees. Normally, growth in hospital capacity would be accompanied by increases in staffing, but the exigencies of the pandemic did not allow this to occur (even though cumulative numbers – the headcount – have increased).

The OHA had assessed recruitment and retention across the Participating Hospitals, looking at resignations and retirements, turnover and vacancies. There was, as detailed in its written submissions, growth in turnover/vacancies. Part of that was due to employees moving from hospital to hospital, and most of that was due to the increase in capacity. In fact, retirements were stable. The Participating Hospitals were not unique in facing staffing challenges; it was part and parcel of a country-wide labour market shortage. It was correct that some hospitals had hired agency nurses and initiated temporary incentives to deal with urgent, usually seasonal, staffing challenges. However, this did not establish demonstrated need to justify the unions' demands, which, on a wage and total compensation basis, were virtually unprecedented in any sector.

In these circumstances, there was no reason to believe that an increase in compensation would generate new employees. *Practical Solutions* did not say that, and there was no evidence that it was true. In any event, unlike the private sector, publicly funded institutions like the Participating Hospitals could not increase the cost of their services to offset increases in wages. The Participating Hospitals had to live within their means and that meant within the funding provided by the provincial government. This funding was not sufficient to meet ongoing operational needs, much less to pay for inflationary increases.

A solution to the staffing issues was required, but that solution was province-wide initiatives involving all the stakeholders as outlined, among other places, in *Practical Solutions* including:

- Establish a government-led provincial, multi-stakeholder strategy to advice, plan and implement system-wide solutions to address health human resources in the near and longer term.
- Develop a centralized strategy and evidence-based capacity plan that includes health human resources.
- Increase supply through expansion of the Extern program.
- Support inclusive and comprehensive tuition strategies.
- Strategically design and locate clinical placements in high vacancy areas.
- Engage health system providers and colleges and universities in efforts to create innovative education and training opportunities.
- Regulate nursing agency fees.

Other proposed initiatives included providing equitable opportunities to access internationally educated nurses and other nursing support. These and like measures would address the workforce issues, not compensation increases, either across the board, or premiums, benefits and improved vacation, and certainly not, an unnecessary, unjustified RPN adjustment. One thing was certain – and the Participating Hospitals emphasized this – was that *Practical Solutions* may have catalogued staffing concerns, but it never ever suggested nor agreed that major compensation increases, such as those sought by the unions here – were a solution much less a panacea for complicated human resource issues that required a sophisticated multi-party approach. Such major compensation increases were unfunded, unaffordable, extreme, and would do very little, if anything, to address the underlying issues.

The Proposed RPN adjustment

This was, the Participating Hospitals observed, the first time that RPN adjustments have been negotiated centrally; but it was not the first time the unions sought RPN increases; additional compensation had been sought in local issues bargaining over successive rounds. In previous local rounds these requests were rejected, as they should be this time too. A centralized RPN rate was not sustainable or appropriate given the realities of the *Pay Equity Act* and the continuing obligations – and challenges – of local parties to maintain pay equity locally. PSW compression was not in issue as the government subsidy of PSW rates was not to be incorporated into the PSW grid. For all these reasons, and others, the Participating Hospitals argued against any RPN adjustment.

Discussion

As earlier indicated, this Board of Interest Arbitration is subject to *HLDAA*, which sets out the criteria we are to consider in determining the proper outcome. Some specific criteria are listed, and as elaborated below, have been carefully considered. Also relevant is the fact that the legislation makes it crystal clear that the Board is to take into account "all factors it considers relevant," not just the enumerated ones. Likewise, it is generally accepted that *HLDAA* does not ascribe a particular weight to any single factor; all relevant factors, including the listed criteria, must be considered in overall context. In general, that context is one in which compulsory interest arbitration is imposed because a public policy decision has been made to substitute adjudication rather than strikes and lockouts as the means to reach a collective agreement. The overriding objective is to replicate what the parties would have agreed to do in free collective

bargaining where there is the right to strike or lockout. Neither party is to be advantaged or disadvantaged by the substitution of an interest arbitration regime.

In the normal course of adjudicating interest disputes, one looks to the comparator settlements and awards that occurred for the term in question and one then fashions an award that takes those outcomes into account together with any other relevant considerations. Usually, that means looking at the applicable and prevailing comparator bargaining trends at the time of bargaining/hearing because those are the results that are memorialized in agreements and awards for those same or similar terms. In this case, the initial award was circumscribed by legislation later found to be unconstitutional and our task, under the reopener, is to determine the appropriate compensation for 2022 and 2023. (There is no basis to conclude that since one of the terms begins three months before the end of 2021, while the other begins on January 1, 2022, that 2021 is the first year of the term.) For the reasons given in *OPG & The Society* (unreported award dated May 8, 2023), it is our view that all relevant information – especially information about the economy and awards and settlements since the issuing of the award – which, after all, was not that long ago – must be considered in best replicating free collective bargaining. It now goes almost without saying that there is no basis to fetter this or any other similar adjudication by looking only at information about settlements, awards and the economy at the time of the initial hearing, or before.

Notwithstanding their primary position that compensation increases should be limited to .75 in each year, the Participating Hospitals nevertheless argued that the Stout and Gedalof 2021 and 2022 Reopener Awards were the beginning and, effectively, the end of the analysis. They took

this position for the reasons outlined above: over successive bargaining rounds the unions have followed ONA outcomes, and regularly fell short. There was no basis to depart from long-standing consensual bargaining patterns. We agree that there is a historical pattern but disagree about its continuing relevance.

The Stout Re-Opener 2021 Award is not even applicable, applying as it does to 2021, and the first year of this term by any fair analysis is 2022. (ONA asked for an additional 1% in that award and was granted what it requested and there were some other improvements as well.) The Gedalof Re-Opener 2022 Award is arguably relevant, and in normal times, given historical bargaining patterns, might have been followed. In that case, ONA asked for an additional 2% and was granted what it requested (along with some costly changes to the grid to the benefit of a majority of RNs with an approximate value of 1.75%). It is impossible for us to say what underlay these modest asks, but they would normally be consequential for these parties, given historical patterns.

What can be said is that in response to the ONA asks, the Stout and Gedlaof Reopener 2021 and 2022 Awards fall far short of adequately addressing either inflation or recruitment and retention (albeit both awards are fully responsive to the proposals put before them). Neither award – and time constraints were in issue as both arbitrators were asked to issue decisions on an expedited basis – engage with the corrosive impact of inflation on wages, not to mention a true RN recruitment and retention crisis in Ontario's hospitals.

There are other reasons not to follow these two ONA reopener awards.

It is correct that over a long period of time the unions prioritized non-monetary collective agreement provisions, mainly job security, and regularly received less than ONA. Given the current, continuing and real recruitment and retention crisis, job security has, at best, moved to the back burner. This makes sense: job security is not threatened – the recruitment and retention challenges make that self-evident – and wage gains are, in the current economic context, imperative. The unions cannot be held in perpetuity to an earlier, albeit longstanding, bargaining approach when that approach is clearly now of historic interest only. In addition, the unions have presented evidence, primarily about recruitment and retention and the effect of inflation on wages, that establishes demonstrated need for increases beyond what was awarded in either of the ONA reopeners. It would be perverse to follow those reopener awards; awards that did not fully and comprehensively engage with the hospital healthcare staffing crisis and which imposed economic outcomes – albeit requested ones – well below inflation in either year in supposed fealty to a bargaining relationship and approach that manifestly no longer applies. For whatever this observation is worth, the day in which it was readily accepted that lower paid workers receive lower across-the-board increases than higher paid workers – at least in hospital healthcare – are almost certainly over.

Application of the Criteria

Under *HLDAA*, a Board of Interest Arbitration is to consider the employer's ability to attract and retain employees. The evidence presented establishes that there is truly a recruitment and retention crisis in Ontario's hospitals: *Practical Solutions* – an OHA report – is unequivocal about this. That is why it recommended "robust retention strategies," and "immediate funding to bolster staffing models." *Practical Solutions* repeated the unions' refrain: their members were

leaving their jobs because vacancies were not being filled, creating unmanageable workloads leading to burnout and exhaustion driving employees from the workforce. The evidence referred to in this award unambiguously establishes that there are historic numbers of vacancies which generally take very long to fill, and the suggestion that this can be explained by employees moving intra-hospitals is not supported in the evidence. Increased capacity with staffing not yet catching up may be a small part of the answer. As the Participating Hospitals' data establishes, the resignation rate for employees represented by the unions has grown significantly since pre-pandemic (even if it may recently have begun to plateau). However, there is no reason to believe that any of the proactive steps raised in *Practical Solutions* would, even if fully and immediately implemented, address the recruitment and retention problem in the short or medium term. It is unlikely that the economic proposals of the Participating Hospitals, an additional 1% in the first year and 2% in second, together with an increase in shift premiums by .02¢ and weekend premiums by .09¢, would assist in attracting and retaining staff. These increases would not be considered responsive by the unions to the impact of inflation on pay, nor to the recruitment and retention crises, and we cannot disagree.

Hospitals are using agency nurses because they are compelled to do so. Hospitals are offering inducements, offside and outside the collective agreement, because that is the only way in which they can meet their staffing needs: that is also the only explanation for hiring agency nurses at double or triple the collective agreement rates; because compensation is a, if not the, key driver in attracting employees. The province is offering a buffet of policies and programs – almost all financial in nature – to incentivize employees to careers in healthcare because of its axiomatic conclusion that this approach will work; at least that is the underlying premise. The Participating

Hospitals suggest that compensation increases will not solve these problems, but this submission fails in a context when many of their members are using financial incentives to attract and retain staff, and the government is adopting and backstopping this same approach. Wage increases can reasonably be expected to keep people in the workforce, attract people who have left to return, and incentivize future employees. There is no reason we can think of, why members of the unions – who are generally speaking, the lowest paid in hospital healthcare – should receive wage increases that do not even come close to restoring lost earning power.

The Economic Situation in Ontario and the Employer's Ability to Pay

The Participating Hospitals argued that there was no guarantee that any awarded increases will be funded and urged us to keep that in mind in fashioning our award. We decline this invitation in that allowing the Province to determine the results of our award through its funding allocations would fetter the independence of this process, which is to replicate free collective bargaining and arrive at an award that achieves this result. The economic situation in Ontario is another matter. The FAO in its May 31, 2023 *Ontario Health Sector: 2023 Budget Planning Review* estimates that the province has allocated a total of $4.4 billion more than what is necessary to fund existing programs and announced commitments from 2022-23 to 2025-28. There is, however, a sobering flip side: the FAO also projected that if all hospital employees were awarded retroactive compensation, hospital spending could increase by an additional $2.7 billion over this period. On the other hand, recent Federal Government GDP updates establish reasons for optimism about the overall economic situation, and high employment augers well for recovery, not recession.

The Unique Economic Circumstances of this Reopener

Taking the current state of the economy into account is fully in line with what the OHA argued in an earlier proceeding with another one of its central partners, OPSEU.

In June 2009, the Participating Hospitals and OPSEU (on behalf of paramedical employees) proceeded to an interest arbitration hearing to resolve their collective agreement with a term of April 1, 2009, to March 31, 2011. The Board's unanimous award was issued on November 4, 2009 (*Participating Hospitals & OPSEU,* unreported award of Gray, hereafter Gray Board). The award noted that a global economic crisis had begun in the fall of 2008, some months before the parties began their bargaining. Uncertainty about the length and duration of the downturn, when recovery would begin, and how long it would take, not to mention its longer-term effects, were among the factors the Gray Board identified as leading to a bargaining impasse and the referral of the matters in dispute to interest arbitration. It was obvious that the effects of this downturn on the Ontario economy and public spending were profound.

Some further context is in order. In 2008, ONA and the Participating Hospitals signed a three-year deal with the following increases: 3.25% (2008), 3% (2009) and 3% (2010). Before the Gray Board, OPSEU sought the 3% increases negotiated by ONA for 2009 and 2010 (like ONA they had received 3.25% for 2008). The Participating Hospitals disagreed. Any pre-existing pattern did not matter; what governed were the changed economic circumstances: "The hospitals argued that whatever comparative value the last two years of their central agreement with ONA might otherwise have had was diminished by the fact that that settlement was made before the downturn began" (at para. 19).

The Participating Hospitals insisted that the Gray Board take subsequent economic events into account and not follow the pattern. Put another way, the Participating Hospitals argued that because of a real change in economic circumstances, the Gray Board should not follow the pattern and award lower increases reflecting the dismal economic situation. OPSEU rejected this approach, arguing that the pattern should be followed. In effect, these contrary views mirror the contemporary context except that the union and employer positions were reversed.

In that same way, the Participating Hospitals also insisted that the Gray Board cast a wide net and take into account settlements outside of healthcare. In particular, the Participating Hospitals asked the Gray Board to "reopen our hearing to receive further evidence about quite recent settlements…" (at para. 26).

> The hospitals argued that whatever comparative value the last two years of their central agreement with ONA might otherwise have had was diminished by the fact that that settlement was made before the downturn began … the hospitals … referred to the more modest post-downturn settlements in the public service federally and provincially, as well as even more modest post-downturn settlements in portions of the private sector, some of which included no wage increases (para. 19)

Over OPSEU's objections, the Board concluded that it would hear representations from either party "about *any* event(s) that may have occurred since our hearings in June that the party considers pertinent…" (at para. 27, emphasis ours). In response to the Gray Board's ruling, both parties referred to settlements in sectors beyond healthcare including the Ontario and federal governments, teachers, municipal police, the OPP, fire fighters, LCBO, municipalities, and energy, to just name some of the bargaining outcomes canvassed by the Gray Board in its award. To repeat, this is another mirror of the situation – also with positions reversed –where the unions rely on settlements from many sectors and the Participating Hospitals say they should be disregarded.

Ultimately, the Gray Board concluded that the lens to examine and adjudicate the economic proposals was as proposed by the Participating Hospitals – that meant contemporary evidence about the economic lay of the land and evidence about how the larger collective bargaining landscape was affected by the changed economic circumstances:

> The recession that began in the fall of 2008 has clearly had an impact on collective bargaining outcomes (para. 58).
>
> …
>
> … the recession cannot be ignored. One of the reasons for wages increases is to offset inflation. The wage increases needed to counter the effects of inflation over the course of an agreement for the period April 2009 to March 2011 would certainly be more modest that might have been thought in February 2008, when the hospitals agreed with ONA to increases of 3% for each of those years … This consideration weighs in favour of an outcome in which wage increases are more modest than they might have been if the period in question had been the subject of agreement between these parties in February 2008… (at para. 59).

In the result, the Gray Board deviated from the pattern and awarded a lower increase than would have otherwise been the case.

In the submission of the Participating Hospitals, the changed economic circumstances relied on by the Gray Board, and its decision not to follow the existing pattern and to award reduced compensation, did not apply to these reopener proceedings because the economic circumstances have not changed since issue of the Stout and Gedalof Reopener 2021 and 2022 Awards. Inflation has not changed since those cases were issued mere weeks ago and a consideration of inflation obviously informed both these outcomes, as did recruitment and retention, clearly matters of concern to ONA and RNs. The Gray Award was distinguishable because of a much longer time lag between the time when the comparator settlement was entered into and the hearing and that Board's deliberations, which was another important factor to consider.

With respect, we disagree. In our view, the Gray Board – as requested by the Participating Hospitals – quite properly looked at the changed economic circumstances – like inflation today, because the recession in that case represented a sea change from when the ONA deal was initially entered into (and which would otherwise have certainly been followed). It would have been wilful blindness for the Gray Board to refuse to consider the dramatically changed economic context and settlements and awards from all sectors that reflected what was actually occurring especially the freely bargained outcomes. It is factually and legally significant that in fashioning its award, the Gray Board looked at absolutely everything: it examined, as set out above, settlements in sectors beyond health care including the Ontario and federal governments, teachers, municipal police, the OPP, fire fighters, LCBO, municipalities, and energy. We agree with this approach given the equally dramatic and profound changes to the economic landscape before us.

In these circumstances, the Stout and Gedalof Reopener 2021 and 2022 Awards are not determinative or, indeed, persuasive. Before the Stout and Gedalof Boards, ONA resurrected earlier asks that had been formulated at a time when inflation had not yet taken root. However, in the meantime, annual inflation hit 3.5% in 2021 and 6.8% in 2022. The fact that ONA did not change its proposals to reflect intervening events does not make this change in circumstances any less material. The fact that ONA relied on its earlier asks cannot mean that the unions are somehow bound to follow reopener awards that failed to address relevant interest arbitration criteria such as the state of the economy and recruitment and retention. Following either of these reopeners would not be replication since the overall settlement trend is completely contrary to either of these outcomes. Cleary, this settlement trend is being reached without taking either of

these reopeners into account given their unique distinguishable circumstances. But to the extent that either of these awards takes inflation and recruitment and retention into account, they fail to do so in any meaningful fashion and we cannot, therefore, be constrained in any manner by either of these outcomes. (We have already concluded for the reasons given that the unions are not locked into previous bargaining patterns where the interests underlying them no longer apply.)

Obviously, there is no opportunity in this reopener for the Participating Hospitals to pursue any of their legitimate non-monetary interests as the focus on the reservation of jurisdiction is compensation. However, it is also the case, experience indicates, that there would be challenges in this reopener to the Participating Hospitals extracting or trading for concessions given the economic circumstances and the recruitment and retention situation. Earnings have fallen because of inflation with increases in the cost of living embedded in prices. Notably, the unions have categorically rejected the ONA reopeners awards as in any way governing; and there is no basis to conclude that they would ever agree to either of these outcomes that would put their members even further behind, all in the hope of catching up at some point in the future. Such an outcome would not replicate free collective bargaining.

Much was made by the Participating Hospitals of an *obiter* observation in a long-term care award of Arbitrator Hayes. All we can say about that is that these *obiter* observations are not governing – even if picked up in other long-term care awards – and they cannot direct the outcome of these proceedings. Long-term care has never been a comparator for central hospital negotiations, although in line with our general approach we have considered settlements from

this sector. These observations are also inconsistent with bargaining patterns of the unions and the Participating Hospitals that are generally the opposite when it comes, over time, to the relationship between inflation and general wage increases. There is absolutely no evidence of collective bargaining settlements of these parties of wage settlements less than half the level of inflation. And this is, of course, another reason for declining to follow either the Stout or Gedalof Reopener 2021 and 2022 Awards. The Stout and Gedalof Reopener 2021 and 2022 Awards, as noted, are not dispositive but having considered them and their context, we find them *sui generis*.

Settlements outside of healthcare have not generally been considered in determining central hospital outcomes. On the one hand, the unions assert given the dramatically changed economic landscape that they must be reviewed, and on the other, they are rejected as comparators by the Participating Hospitals as either relevant or useful. They were however, as just discussed, in the unique circumstances of a recession considered by the Gray Board. They were also previously considered and applied to central hospital parties the last time inflation was high and persistent.

In *Participating Hospitals & CUPE* (unreported award of Weiler dated June 1, 1981), the arbitrator reached a number of conclusions that we follow (because the Board in that case, like the Gray Board and the Board in this one, had to address extraordinary economic circumstances). In summary, the Weiler Board held that the appropriate standard for decisions in this sphere should be drawn from external collective bargaining between sophisticated union and management negotiators whose bargains are shaped by real economic forces: “The parameters of change in the Hospital system as a whole must be drawn from and be compatible with the external world of collective bargaining in the Province” (at 6).

Adopting this exact approach, we agree with both the Gray Board – acting at the behest of the Participating Hospitals and with Arbitrator Weiler and many others – that in extraordinary circumstances it is entirely appropriate to look at settlements from sectors not normally considered. Having done so, we find that the best evidence of free collective bargaining is the OPG and PWU settlement – authorized by Ontario's Treasury Board – and the recent settlements between the Government of Canada and PSAC covering 155,000 core public servants and employees of the Canada Revenue Agency. For whatever reason, including possibly happenstance, in terms of the numbers, these settlements – again freely negotiated in strike/lockout regimes – are identical.

In OPG and PWU, wage increases of 4.75% and 3.5% were agreed upon for 2022 and 2023, along with signing bonuses of $2,500 in each year, along with a number of other significant compensation improvements. In the federal government PSAC settlement, the parties agreed on the exact same percentage general wage increases for 2022 and 2023, along with a $2,500 signing bonus, and some other (more modest) compensation improvements. These two settlements are extremely instructive and have informed our view of how to best replicate free collective bargaining in this reopener. These settlements are among the best evidence available of free collective bargaining in a high and sustained inflation environment. They fall far short of what the unions have requested – and they do not fully immunize against inflation – but our job is to replicate what the parties would have done in free collective bargaining because we follow free collective bargaining. The last time significant inflation so dramatically affected spending power, arbitrators, like Professor Weiler in the case earlier cited, awarded double-digit increases.

But in doing so the Weiler Board was following free collective bargaining outcomes, not leading them.

It is our view that freely bargained outcomes are the touchstone – and in the federal sphere were achieved after relatively lengthy strikes. We conclude that these voluntarily negotiated outcomes covering so many employees in the public and quasi-public sector are the best comparator for setting compensation in the current circumstances. Our job, as noted above, is to replicate free collective bargaining, and to ensure that the parties end up no better and no worse than if their right to strike and lockout had not been curtailed. It is impossible for us to conclude that the unions would have surpassed these outcomes, even taking the dire recruitment and retention situation into account (not a real factor in either of these settlements). While we are not awarding any lump sums, we are making adjustments to the RPN rate and premiums and benefits beyond the general wage increase in response to the recruitment and retention challenges, among other reasons in application of the statutory and normative criteria.

For all these reasons, we have awarded an across-the board-increase in 2022 of 4.75% (or 3.75% of new money) and 3.5% in in 2023 (or 2.50% of new money). While the Participating Hospitals have not – in this reopener – had the opportunity to pursue their non-monetary bargaining objectives, we are not reducing either of these general wage increases because of our findings of demonstrated need based on recruitment and retention.

We are fully satisfied that a case has also been met for an RPN adjustment. The small spread between PSWs and RPNs is not justifiable (and we categorically reject any notion that the

provincially funded PSW wage increase is separate and apart from the wage grid). There is no rational job classification system that would ever arrive at this result given education, scope and responsibility. We are not tying the RPN rate to some percentage of the RN rate, but we express the general proposition that RN rates are the ones to look to in determining compensation for RPNs.

On premiums, we are increasing compensation which also reflects the *ad hoc* measures that a number of the Participating Hospitals have already put in place on their own initiative to meet the staffing shortage. It does not make sense to us that members of the unions should be treated any differently when it comes to call-back after completing a shift as the inconvenience to them – and the provision mostly applies to RPNs – is exactly the same as that experienced by ONA members. The same reasoning justifies an increase in the shift and weekend premiums while making it clear in the CUPE agreement, as it is with SEIU, that the shift and weekend premiums are distinct and both are to be paid for relevant hours (maintaining and memorializing the preponderant Participating Hospitals practice). On massage and vision, there is simply no justification for the discrepancies between the unions and ONA (and the $7 cap per visit in the CUPE agreement renders the massage benefit entitlement meaningless and we, therefore direct its elimination). Massage and vision cost the same no matter what union an employee belongs to.

To the extent that this is still actually an issue, it is our view that the funding arrangements for the PSW adjustment are categorical and the additional hourly amount must be included in the PSW wage grid and that any across-the-board wage increases are to be applied thereafter. There is no practical barrier to applying the differing amounts where a Participating Hospital operates a

long-term care facility within the hospital bargaining unit. Different rates apply and the different rates - $2 vs. $3 – are to be included, as appropriate, in the wage grid.

All of these adjustments are made effective date of award and are subject to superior conditions.

Award

Wages (New Money)

CUPE

September 29, 2021: 3.75%

September 29, 2022: 2.5%

Full retroactivity within 90 days to current and former employees.

SEIU

January 1, 2022: 3.75%

January 1, 2023: 2.5%

In accordance with Article 29.03 of the Collective Agreement.

RPN Adjustment

CUPE & SEIU

Effective date of award add $2 to the preponderant maximum RPN rate in effect on the expiry of the prior agreement - $31.18 – and adjust other rates accordingly.

For further clarity, the first year maximum RPN rate at any Hospital, will not be less than $33.18 prior to the general wage increases for the two years of this agreement. Establishing a "floor" maximum RPN rate in this way, is in line with previous Local Issues awards between these parties, which have raised the "floor" for a Hospital's RPN rates when those fall below the "floor," as we do here. Hospitals providing maximum RPN rates above the "floor" will continue those RPN salary grids, modified of course by the general wage increases for the period of this agreement.

This RPN adjustment is effective the date of this award.

Call Back

CUPE & SEIU

Effective date of award increased to double time.

Shift and Weekend Premiums

CUPE & SEIU

Effective date of award increase by $1 for shift premium, and $1.50 for weekend.

Parties to amend CUPE central agreement to ensure that both premiums paid if both shift and weekend are worked. Any superior conditions maintained.

Benefits (Massage & Vision)

Union proposals awarded effective date of award. Per visit massage cap is replaced by "reasonable and customary" limitation.

Conclusion

At the request of the parties, we remain seized with respect to the implementation of our award including, if necessary, to address any issues that may arise should the government's Bill 124 appeal prove successful.

DATED at Toronto this 13th day of June 2023.

"William Kaplan"

William Kaplan, Chair

I dissent. Dissent attached.

Brett Christen, OHA Nominee

I dissent. Dissent attached.

Joe Herbert, Unions Nominee

Dissent

I respectfully dissent from the Award of the Chair dated June 13, 2023 (the "Award") and the reasons therein.

The Award is a supplemental award to an award dated November 3, 2022 (the "Initial Award") and addresses compensation issues not addressed in the Initial Award which was issued when the *Protecting Sustainable Public Sector for Future Generations Act*, 2019 ("Bill 124") was in effect. The Initial Award contained a typical reopener clause which allowed for monetary issues to be re-visited in the event that Bill 124 was determined to be unconstitutional. After the Initial Award was issued, the Ontario Superior Court declared Bill 124 to be unconstitutional and of no force or effect.

The Award addresses the additional compensation to be awarded under the reopener provision. Like other situations involving reopeners, there was no opportunity for the hospitals to negotiate any trade offs against the monetary gains sought by the Unions.

The two collective agreements under consideration have slightly different terms and the Chair determined that the years covered by the reopener award were best described as 2022 and 2023 for the purpose of considering appropriate comparators (at p.19). As noted by the Chair at pp. 9-10, there have been two recent reopener awards between ONA and the Participating Hospitals: the Stout Reopener 2021 Award and the Gedalof Reopener 2022 Award. The latter award determined the additional compensation to be awarded to ONA for the last year of ONA's moderation period under Bill 124 and predominantly relates to 2022. That is, the Gedalof Reopener 2022 Award addresses the same period as the first year of the Award.

In addition to some non-wage benefit amendments, Arbitrator Gedalof awarded a total ATB wage increase of 3% and a change to the ONA wage grid to the immediate benefit of bargaining unit members with 8 or greater years of service. Whatever one may think of the Gedalof Reopener 2022 Award, upon its issuance it became a highly relevant comparator for the reopeners involving the Participating Hospitals for 2022. ONA has long been a significant direct comparator for OPSEU in the hospital sector and a relevant comparator considered in CUPE and SEIU negotiations. This established relationship between settlements involving the major bargaining agents in the hospital sector has provided predictability in the sector and has served the parties well by discouraging resort to interest arbitration to settle bargaining disputes.

The Award declines to follow the Gedalof Reopener 2022 Award and awards a total ATB wage increase of 4.75% for 2022.

ONA has been the traditional leader in the hospital sector and it proceeded to litigate its two reopeners first. The other hospital unions had full knowledge that ONA was proceeding first and of the traditional implications of an ONA award upon their settlements. In these circumstances, I would have preferred that the Chair awarded no more than the wage increase in the Gedalof Reopener 2022 Award for 2022 to maintain the traditional relationships in central bargaining in

the hospital sector. This is particularly the case where there was no opportunity for the hospital to obtain non-monetary trade -offs in exchange.

When relevant central comparators in the hospital sector are not followed the risk of inappropriate leapfrogging/whipsawing greatly increases. For example, here the Chair awarded an increase to the call back premium to maintain parity with an increase to call back ONA received in its initial interest arbitration under Bill 124's compensation restraint which was wholly unjustified.

In advancing their case before the Board, the Unions very heavily relied upon the recruitment and retention problems facing hospitals. Staffing issues in hospitals, however, are significantly exacerbated by provisions in both collective agreements that restrict the hospitals' ability to efficiently schedule and assign employees to address staff shortages within the hospital. These are exactly the provisions that the hospitals would have sought to amend in exchange for the significant monetary increases obtained by the Unions in this proceeding had they not been precluded from doing so in the reopener process. Amendments to these provisions will presumably be carefully considered in future negotiations and interest arbitration awards to ensure that interest arbitration works fairly for both of the parties involved in the process.

The Award also grants significant amendments sought by the Unions to several benefits. In light of the wages awarded for 2022 and 2023, and having regard to the interest arbitration principles of incrementalism and total compensation, I would have awarded more modest benefit changes or deferred any benefit increases to the next round of bargaining.

Finally, I would note my strong disagreement with the interpretation of *Practical Solutions* asserted by the Unions to the effect that that document proposes increased wages as a solution to staffing shortages.

Dated June 13, 2023

"Brett Christen"

Brett Christen
Nominee of the Participating Hospitals

DISSENT

In a unique time of high inflation, significant real economic growth, and of acute staffing problems in Ontario's hospitals, an award which prevents hospital workers' wages from even keeping pace with inflation surely falls short.

Three factors have traditionally governed wage determination in pattern-setting awards such as this one. These are 1) inflation; 2) the presence, or absence, of 'real' (as opposed to nominal) economic growth, and; 3) settlements. In addition, and exacerbating the need for a substantial wage increase in this particular case, there are present somewhat unprecedented difficulties in recruitment and retention in Ontario hospitals.

The best analysis of the interaction of these factors is to be found in Professor Weiler's seminal 1981, *Participating Hospitals and CUPE* decision. Adoption of the same approach here, ought to have resulted in higher wage increases in each of the two years, where, instead of trailing inflation real wage growth ought to have occurred. Here's how these factors, properly considered, ought to have shaped this award differently.

Inflation

According to the O*ntario Budget, 2023*, headline inflation for 2022 was about **6.8%**. The most recent (April 2023, released in May) 2023 CPI indicator shows an uptick to inflation, annualized at another **4.4%**. Significantly, the Index in this period has been driven by increases to key consumer items, food and fuel prices, and more recently, housing prices. These are of course, essential needs, and the reduction of employee purchasing power against these basic needs signals a decline in employee wealth. That is particularly so for employees such as these who are not advantaged by higher incomes.

Professor Weiler's analysis tracks the relationship of wage increases against inflation. Although he would measure inflation differently, his general premise is the obvious one – that wage increases that fail to keep pace with inflation leave workers with a decline in purchasing power. The one economic factor that could justify such a result, a loss of employee purchasing power, is a real decline in economic growth. He wrote:

> The ideal towards which interest arbitration aims is to replicate the results which would be reached in a freshly-negotiated settlement. The negotiators at the bargaining table typically work towards a figure which will protect the worker against unanticipated inflation and provide real income gains to the extent these are permitted by rising productivity in the economy. It is important to emphasize that the rise in the cost of living — whether measured by the Consumer Price Index or otherwise — is not the be-all and end-all of rational wage determination. *If there is real per capita growth in the economy, wage gains can and do exceed the rate of price inflation.* (emphasis added)

The conclusion, an easily reached one, that wage growth should exceed the rate of inflation in times of real economic growth, is echoed in later Central awards. In the 1985-1987 award, another of the major influences on modern day interest arbitration, arbitrator Kevin Burkett, awarded these employees wage increases of 5% and 4.5%, when inflation was at or slightly above 4%, thus providing enhanced real purchasing power to employee wages in a period of economic growth. In the following round, arbitrator Stanley did the same while noting:

> General economic indicators taken into consideration by arbitrators, include the rate of inflation and the rate of economic growth. Clearly employees in the public sector are entitled to share in the prosperity of the province as evidenced by real growth.

Arbitrators Burkett and Stanley awarded wage increases greater than those awarded here, in times of economic growth when CPI was increasing at a lesser rate than it is now. But more telling, each awarded increases that provided some real growth to employee earnings, i.e. *above* the rate of inflation, when inflation less than its present rate was matched with real economic growth. Never before the present award, to my knowledge, during the entire period of application of the *Hospital Labour Disputes Arbitration Act*, has there been an occasion where an arbitrator has awarded real wage diminution to these classifications of employees, totaling as it does here about 3% during the period of a single collective agreement, when there

has been concurrent real economic growth. This award, for these employees at least, provides an unappealing first in that regard.

Economic Growth and Settlements

The Ontario Budget, 2023, notes real GDP growth for 2022 of **3.7%**. That is real growth in the economy measured in constant dollars, not a mirage created either by inflation or currency fluctuation. For 2023, the Budget was more conservative, predicting actual real growth but only at the level of .2%. However, the May 31, 2023 federal government update shows that the economy is instead growing in 2023 at an annualized rate of **3.1**%. The economic downturn in 2020 was entirely, or almost entirely, made up for by real growth in 2021. The economic growth in 2022 and 2023, the years covered this award, is both real and substantial.

The arbitrator has paid particular attention to recent major public sector settlements, and following Professor Weiler's admonishment against a singular "incestuous" focus within the same sector, on the settlements at Ontario Power Generation, and virtually identical settlements at the federal government's Treasury Board bargaining tables, as well as the federal Canada Revenue Agency. The latter two settlements, at federal Treasury Board and Canada Revenue Agency, cover approximately 155,00 people. I make two observations.

First, and of lesser importance, these settlements included other significant wage-related payments beyond the 4.75% and 3.5% across-the-board increases – not the least of which were additional lump sum payments of $2,500 made twice in the OPG settlement, and once in the federal Treasury Board and CRA settlements.

Second, and of more importance, ours is a pattern-setting award for RPN's, service, clerical and maintenance employees across Ontario hospitals. While other settlements are important to consider, they do not necessarily have the same weight in my view, in a pattern-setting award such as this one, as they would in one that is instead following a pattern. That is particularly the

case when one examines the evidence put before us in respect of recruitment and retention – problems which have arisen to a different extent in Ontario's hospital sector than they have elsewhere.

Recruitment and Retention

In the entire period of operation of the *Hospital Labour Disputes Arbitration Act*, save perhaps for the RN recruitment and retention crisis of the 1980's/1990's, there has never been a period rivalling the present one for hospital-sector staffing shortages. Closings of emergency rooms across the province and record lineups for surgeries are now rooted not in pandemic causes, but instead in the chronic and systemic inability of hospitals to adequately staff for normal hospital services.

In our case, the unions were able to demonstrate numerous financial incentives – several pages of them in fact – where hospitals involved in this case have instituted payments to employees over and above those contained in the collective agreement, and in many cases in violation of the terms of the collective agreements - recruitment payments, retentions bonuses, enhanced pay, enhanced overtime premiums, enhanced shift premiums.

Recruitment and retention difficulties are not necessary to prove in order for unions to gain a real wage increase for their members during a period of economic growth. However, difficulties of the current degree, augment an already substantial case that these employees ought to have received wage increases somewhat greater than the rate of inflation.

In the 1987-1989 central round of hospital bargaining, arbitrator Stanley awarded CUPE increases of 6% and 5% during a time when there was, like the present, real economic growth and when the rate of inflation was somewhat lower than it is now. In my view, a proper balancing of the above normative factors – the increases to CPI in the context of underlying real economic growth - would have resulted in real wage gains for these employees, that is,

increases somewhat greater than the rate of inflation in each of the two years under consideration.

The case put forward by the Hospitals did not, in my respectful view, successfully rebut those normative factors which called for a higher wage increase. The Hospital's case was premised largely upon giving inflation little or no weight, while claiming that the award in *Participating Hospitals and ONA*, April 25, 2023 (Gedalof), hereafter the 'Gedalof award', established the upper barrier to what could be awarded here. According to the Hospitals, a 'new consensus' has emerged among arbitrators, or at least among arbitrators Gedalof and Hayes, that wage increases during periods of elevated inflation are to necessarily trail the rate of inflation. Gone apparently, are traditional considerations of whether there is actual real per capita economic growth. Instead, it is to be taken as a 'given' that even when the economy and productivity are expanding and creating new wealth, such new wealth should not find its way into wage outcomes, and instead elevated inflation will eat into the real earnings of workers. Indeed, inflation is given such little weight in arbitral outcomes it was suggested, that the time has come for it to be excluded as a factor altogether.

In my view, the Gedalof award can only be properly understood within its context. By the time of the Stout and Gedalof wage re-openers, the ONA was well advanced in its bargaining for the subsequent renewal collective agreement beginning in 2023. In fact, by the time of the ONA Bill 124 're-opener hearings', those parties were at the arbitration stage for the renewal 2023 collective agreement and had already been bargaining the Association's economic proposals for the renewal agreement. Accordingly, the two interest boards that had adjudicated the collective agreements covering the Bill 124 period, those chaired by arbitrators Stout and Gedalof, were asked to quickly issue re-opener awards for the Bill 124 period within a few weeks of each other, to be issued in advance of the May 2023 arbitration hearing for the collective agreement that would begin in April 2023.

And it is in that 2023 collective agreement, currently subject to adjudication, that the ONA had already been bargaining to make the sorts of gains necessary to address the changed economic circumstances of recent inflation, and to further address issues of recruitment and retention. For the purposes of the 're-opener awards', including the Gedalof award, ONA was content to proceed with its original proposals formulated before the current economic climate and high inflation took hold. Thus, in front of arbitrator Gedalof, ONA pursued only the 3% wage increase for 2022 it had sought when it began its bargaining for that collective agreement years before, with the 'main event' set to occur in May 2023 at the hearing for the renewal collective agreement. And in that re-opener, arbitrator Gedalof fully awarded the across-the-board increase sought.

Those circumstances are significantly different from the ones here. These employees do not have another collective agreement, and another arbitration hearing, lined up at which they can deal with the economic world which emerged in 2022. Here, for the employees covered by this award, the terms and conditions of employment are being determined in 'real time' for the 2022 and 2023 period. There is no 'other' bargaining that has been under way for a later agreement, there is no other collective agreement in which the current economic realities can be addressed. It would be unreasonable to assume that these unions would permit another bargaining agent's bargaining strategy, adopted in the different context described above, to eliminate their own ability to address the present economic circumstances in their present collective agreement.

And if I am wrong in that, if as the Hospitals argue the Gedalof award stands for the proposition that hospital workers should lose almost 4% of their purchasing ability (the difference between 6.8% CPI and a 3% salary increase) in a single year, despite a growing economy and the creation of new wealth that has been normatively been shared, then such an award constitutes a radical departure from well-established interest arbitration principles in this sector, without any rational justification given for such an extreme outcome. If the Gedalof award were to be understood as the Hospitals argue, then it would simply be one that does not warrant being

followed on its merits. I do not think however, that the Hospitals' approach to the award is the correct one.

Conclusion

Present economic circumstances support the need for a higher wage award, in both of the years covered by this award, than has occurred. A 'real' (i.e. above the rate of inflation) increase to incomes was warranted on the basis of traditional economic factors, and further supported by demonstrated problems in recruitment and retention. Instead, employees have been awarded increases that will not keep place with inflation, inflation occurring in particularly sensitive consumer items, resulting in an easily observed loss of purchasing power – one generally unprecedented for these employees, and certainly unprecedented during a period of significant underlying real per capita growth.

I should note that my criticism of the wage outcome is not intended to suggest that the Chair has not approached this matter in a manner of utmost fairness. Simply reading his award makes it clear that he has.

I do note that the other areas of the award – the RPN adjustment, the increase to call-back and shift/weekend premium increases in particular – will hopefully assist with staffing problems that have resulted in hospitals providing compensation over and above that set out in the collective agreements in these areas. I also obviously agree with the modest improvements made to health benefits of massage and vision.

Dated this 13th day of June, 2023.

Joe Herbert, Nominee of CUPE/OCHU, and of the SEIU