IN THE MATTER OF A COMPENSATION REOPENER

BETWEEN:

The Participating Hospitals

(Represented by the Ontario Hospital Association)

and

OPSEU

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

Appearances

For the OHA:	Craig Rix Hicks Morley Barristers & Solicitors
For OPSEU:	Steven Barrett Colleen Bauman Goldblatt Partners Barristers & Solicitors

The matters in dispute proceeded to a mediation in Toronto on February 18 & 19, 2023 and to a hearing held by Zoom on May 29, 2023. The Board met in Executive Session on June 1, 2023.

Introduction

On July 7, 2022, the Board issued its award settling the terms of a collective agreement between the parties with a term of April 1, 2022, to March 31, 2025. The jurisdiction of the Board was constrained by the *Protecting a Sustainable Public Service for Future Generations Act, 2019* (Bill 124*).* Accordingly, and as was normative in cases of this kind, the Board included in its award a reopener provision.

Reopener

We remain seized with respect to a reopener on monetary proposals in the event that OPSEU is granted an exemption, or Bill 124 is declared unconstitutional by a court of competent jurisdiction, or the Bill is otherwise amended or repealed.

After Bill 124 was declared unconstitutional on November 29, 2023, the reopener provision was invoked and issues arising out of it proceeded to a mediation in Toronto on February 18 & 19, 2023, and then to a hearing held by Zoom on May 29, 2023. The Board met in Executive Session on June 1, 2023.

Statutory Criteria

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

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.

General Background and Union and Participating Hospitals Reopener Proposals

OPSEU (union) represents more than 12,000 paramedical employees at 49 Participating Hospitals working in more than 200 different classifications. The most populous group – representing just over 40% of the bargaining unit – are the Registered Technologists (RTs) – who are integral to almost all hospital health care. For example, approximately 85% of all diagnoses are dependent on a laboratory result, one provided by an RT. RTs and others are subject to applicable college regulation.

The union proposed the following adjustments:

1. General wage increases of an additional 6% in each year of the collective agreement.
2. A one-time adjustment of 7.9% to the top rate for all job classifications. Or, in the alternative, all RTs moved from RT Wage Grid to RT Plus Grid.
3. Effective April 1, 2022, a one-time lump sum payment of $8400 pro-rated for part-time employees ($3400 pandemic pay and $5000 retention bonus).
4. Amendment to call back provision to provide two times hourly rate for call backs.
5. Increases to evening, night and weekend shift premiums.
6. Increase vacation to five weeks after eleven years and seven weeks after twenty-five (with corresponding changes to part-time).
7. Increase vision care and add option to use coverage for laser surgery.
8. Increase Health Care Spending Account.

The Participating Hospitals proposed the following adjustments:

1. Effective April 1, 2022, an additional .75%.
2. Effective April 1, 2023, an additional 2%.
3. Effective April 1, 2024, an additional 2%.

Union Submissions

Overview

In the union's view, its general wage increase request squarely aligned with economic, social and political realities and was needed to address three main *HLDAA* criteria: recruitment and retention, the economy; namely, the unprecedented and continuing erosion of wages brought about by persistent high inflation, and comparability between RTs and RNs. Meaningful adjustments were necessary to restore the historic relationship between the two and that meant parity at the top of the wage grid. The growing and unjustified wage gap between union members and RNs represented by ONA required immediate attention; on wages to be sure, but also premiums and other benefits.

In brief, it was the union's submission that the application of the three identified statutory criteria, together with the normative ones – above all replication of free collective bargaining – justified each of the union's proposals. Moreover, the union observed, this reopener provided an opportunity to recognize the extraordinary efforts of union members who worked tirelessly throughout the pandemic to ensure that vital health care services were provided to the people of the province. Recognition of the union members' service and sacrifice was made even more critical because during the pandemic – even though they attended at their hospitals throughout

and made themselves available as required – they were deprived not only of the pandemic pay provided to other hospital workers, but also the retention pay provided to nurses. One of the union's proposals was directed at redressing this, something the union described as a manifest injustice.

In the union's view, the wage offer of the Participating Hospitals did not even come close to addressing key *HLDAA* and other criteria. Recent public sector settlements – PSAC and the federal government/CRA and OPG and the PWU (approved by Ontario's Treasury Board) – made this crystal clear. These freely bargained settlements providing for 4.75% in 2022 and 3.5% in 2023 (plus signing bonuses and in the case of the PWU other significant compensation improvements) established the baseline for replicating free collective bargaining (as did the negotiated outcome between Ontario's school boards and CUPE in November 2022, as did emerging bargaining trends in the broader public sector, as did negotiated private sector settlements, as did health care settlements in other provinces).

In the union's submission, replicating free collective bargaining meant adopting these outcomes: along with other sought after economic adjustments. The reason for this was obvious: When rampant inflation, the recruitment and retention situation, and the long overdue correction of the comparability disparity were added to the mix, the case for substantial general wage and other compensation increases beyond these bargained outcomes, together with other enhancements, became even more compelling. The Participating Hospitals' proposal – even including the 1% in each year already awarded – amounted to a huge decline in real wages. And it was a result that

would never be agreed to and, thus, it could not be the outcome of an arbitrated interest award which must replicate free collective bargaining.

Numerous other reasons supported the union asks: no application of any of the criteria, statutory or otherwise, could rationally lead to the numbers proposed by the Participating Hospitals because the evidence established that since the 1990s – albeit with some variation – union wage increases had by and large tracked or exceeded CPI. Paradoxically, when inflation tracked at 2% or less, the Participating Hospitals argued that wages should keep pace with inflation, not exceed it. Now that that argument no longer served its interests with the union asking for a general wage increase that mitigated against inflation, the Participating Hospitals were adopting the opposite argument; that inflation should not be considered or applied, a convenient but inconsistent approach with one predictable result: it would leave union members even further behind.

Why ONA was no longer an Appropriate Comparator for General Wage Increases

There was no doubt about it, the union submitted, that the longstanding key comparator for general wage increases for the union and its members in central hospital bargaining has been ONA. Since 1991, general wage increases, almost without exception, have moved lockstep with those obtained by ONA. However, the current situation was complicated by the two ONA reopener awards, along with what only could be described as a major change in circumstances.

There first of these was *ONA & Participating Hospitals*, (unreported award of Stout dated April 1, 2023) – the Stout Reopener – and the second was *ONA & Participating Hospitals*, (unreported award of Gedalof dated April 25, 2023) – the Gedalof Reopener. It was impossible, the union

argued, to conclude that the Stout Reopener for 2021 considered the impact of inflation by holding ONA to its earlier bargaining proposal and arriving at only a total 2% increase (1% added to the 1% initially awarded) when inflation in Ontario in 2021 was 3.5%. The Gedalof Reopener for 2022-2023 (which covers the first year of this reopener) awarded an additional 2% general wage increase for a total of 3% and collapsed the grid adding an additional 1.75% for nurses between 8 and 25 years. From a costing perspective, this worked out to an approximately 0.9% increase for the bargaining unit as a whole, leading to the conclusion that the total compensation value of the Gedalof Reopener was 3.9%. However, the union argued that notwithstanding historical comparability, the Gedalof Reopener (like the Stout Reopener), should not be followed.

The reason for this submission was that in the Gedalof Reopener ONA only requested a 3% general wage increase (together with other improvements). But circumstances had materially changed, and there was no basis, therefore, to follow this ONA outcome even though doing so would have been previously anticipated by the parties. The awarded 3% did not come close to addressing inflation or recruitment and retention and fell far short of rectifying the parity gap that had arisen between RN and RT wages. As well, the Gedalof Reopener was decided without the benefit of access to relevant free collective bargaining outcomes: namely, the one agreed to by OPG and the PWU with the sanctioned approval of Ontario's Treasury Board and the PSAC settlements covering 155,000 core federal government employees and those employed by the CRA (in both cases reached following relatively lengthy strikes).

The authorities established, the union submitted, the absolute necessity of taking these freely bargained settlements into account, and the key cases on point were discussed in the union's brief and at the hearing and the point made that it would indeed be an astonishing result if employees working at home during the darkest days of the pandemic received freely bargained wage increases far in excess of union members who regularly attended at their hospital workplaces to ensure that vital health care services were delivered to the people of Ontario. Accordingly, while ONA has been a key comparator for general wage increases in the past, there was a strong legal and factual basis to depart from that relationship given the inadequacy of the ONA reopener outcomes and the manifest change in circumstances including the persistence of inflation and ongoing recruitment and retention challenges (discussed below).

Specific Application of the Criteria

The Economy

The economic situation in Ontario was one of the *HLDAA* criteria, and the application of this criterion, in the union's view, led to the inescapable conclusion that its compensation proposals should be granted. The Ontario economy was on a very strong footing with both revenue growth and budget surpluses. Transfer payments from Ottawa – earmarked for health care – were up. Notably, the Financial Accountability Office (FAO), an Ontario government-appointed body that provides independent analysis of the province's finances, trends in the provincial economy, and related matters, concluded in its *Winter 2023 Economic & Budget Outlook* that "Ontario's economy rebounded rapidly from the pandemic...." Similar upbeat predictions were reflected in the Ontario government's March 2023 budget. Other positive economic indicators included record strong job growth and decreasing unemployment. On the other hand, inflation was

unrelenting and had led to real hardship to union members whose wages had been substantially eroded with inflationary increases now thoroughly baked in even if, for the sake of argument, it was accepted that the inflation rate had begun to modestly decelerate.

Indeed, the union argued, the impact of inflation was dramatic: the pandemic and post-pandemic period had been marked by high and persistent inflation beginning in the spring-summer of 2021, continuing until today and projected to continue well into the future. In 2021, inflation in Ontario averaged 3.5%; the next year it reached 6.8%. In 2023, inflation may have begun to slightly abate, but was still sitting above 3% with no one credibly forecasting a return to historic numbers in the near or medium term. If all went well, inflation might return to earlier norms in 2024, but it was impossible to predict with any accuracy for obvious reasons. In the meantime, the cost of living had become unaffordable; real wages had taken a huge hit. The economy was a *HLDAA* criterion and, properly applied, meant that above-inflation general wage increase were required to offset the erosion in spending power – a conclusion that was reinforced by an examination – reviewed in the union's brief and at the hearing – of the arbitral authorities where leading arbitrators had done just that when inflation last reached historic proportions.

Hospital Funding and Level of Services

Funding for hospital health care, the union noted, was increasing; the March 2023 Ontario budget was categorical in projecting an increase in spending from $74.9 billion in 2022-23 to $87.6 billion in 2025-26. Part of this growth was earmarked to "support health human resources to optimize the existing workforce and recruit and retain health care providers." Many hundreds of millions of dollars – enumerated in the union brief – had been allocated specifically for the

Participating Hospitals. Consistent with government policy – as set out in the budget – there was money to recruit and retain. In an era of emergency room closures, surgical waiting lists and hospital hallway health care, it was inconceivable that services, already stretched to the limit, could be further reduced.

The fact of the matter was that increased compensation to recruit and retain indispensable health care workers was required to prevent further reductions in services; it was definitely not something that could lead to fewer services in a world where hospitals were crying out for more employees. Various examples were provided illustrating this point. Critical health care services like emergency rooms and surgeries were being curtailed because of a lack of staff, not money to pay salaries. Positions were posted; the problem was that no one was applying to fill them. In any event, however, it was long established, and well established, that public sector employees do not subsidize the public with substandard wages and, as importantly, that government funding decisions cannot determine independent interest arbitration where a statutory regime has been instituted in substitution of the right to strike (or lockout).

Recruitment and Retention

Overall, the union observed, hospital health care was facing a most serious and severe recruitment and retention crisis: there were not enough RTs to provide required levels of service. According to the FAO, "other health care worker" vacancies, meaning mainly employees represented by the union, had more than doubled between 2018 and 2021 to 4770. Recruitment and retention problems were considerable and serious across the broad swath of health care, but the situation faced by the RTs was emblematic and especially problematic.

The RT classification included the Medical Laboratory Technicians (MLTs) – the largest group – followed by the Medical Radiation Technologists (MRTs) and then the Respiratory Technologists and the Biomedical Technologists. The MLTs – there were approximately 6100 of them – performed the laboratory tests that diagnose disease, and during the pandemic their workload considerably expanded with multiple millions of PCR tests completed. Yet, at the same time, survey results indicated that instead of increasing in numbers, MLT ranks were on the decline with further reductions expected as the cohort aged and became eligible for retirement, and this did not include voluntary departures for other reasons such as burnout brought about by the pandemic's excessive and onerous workload.

Notably, the number of MLTs registered with their College was declining at the same time as demand was increasing, especially in rural areas and at remote laboratories. Simply stated: demand far exceeded supply, a chronic situation that was expected to continue. Unfortunately, seven MLT programs were permanently closed in the 1990s under the completely misguided and ultimately erroneous assumption that technology and instrumentation upgrades would reduce the need for MLTs. Currently, there were not enough MLTs to train students during clinical placements, a vicious circle to be sure, leading for example, in March 2022, to a backlog of many millions of diagnostic tests. Members of the Participating Hospitals were doing what they could to fill vacancies; for example, in December 2022, Kingston Health Sciences Centre began offering a $3000 referral bonus for RNs, RPNs and MLTs (together with other inducements). At the other end of the province, the Lady Dunne Health Centre in Wawa introduced a $20,000 retention incentive for full-time MLTs. Private clinics were regularly headhunting hospital

MLTs. (The union set out a long list of other Participating Hospitals offering various inducements to recruit staff.)

Only a handful of the Participating Hospitals responded to the Board's production order, but when the data was examined from those that did, the picture of a true recruitment and retention crisis was glaring, and chilling. Between 2019-2020 and 2021-2022, MLT vacancies increased by nearly 25%. The situation with the MRTs was even worse. Between 2019-2020 and 2021-2022, MRT vacancies increased by nearly 48%. There was the burnout leading to voluntary departures, but there was also a current lack of supply, anticipated to deteriorate further.

Here too, members of the Participating Hospitals were again taking matters into their own hands; London Health Sciences Centre (LHSC), for example, had begun paying employees to attend school to become MRTs: they receive their wages and all their education-related expenses while in class and on clinical placement. (LHSC offered similar inducements to encourage employees to become certified as Anesthesia Assistants and Cardiovascular Perfusionists.)

The situation with MLTs and MRTs was acute, but it was a problem that presented in virtually all the paramedical classifications represented by the union. Overall turnover had increased from 6.11% in 2017 to 8.95% in 2023. The overall vacancy rate had doubled from 3.69% in 2017 to 7.69% in 2023. Likewise, the resignation rate went from 3.53% in 2017 to 6.37% in 2023. As a result, jobs were not being filled. A representative sampling – compiled by the union – of recent job vacancies at LHSC, St. Joseph's Healthcare Hamilton and Joseph Brant Hospital illustrated the extent of the problem. As of January 2023, for example, LHSC had 90 vacant positions that

fell within the union's bargaining unit, and the average length of a job posting was 115 days. Some positions – Certified EEG Technician, MRT, MLT, Pharmacy Technician and Registered Respiratory Therapist – cannot be consistently filled. St. Joseph's Healthcare had 136 vacancies in union bargaining unit positions with postings taking an average of 141 days to fill. The same story could be told about Joseph Brant Hospital including one particular posting that remained unfilled for years.

These shortages had tangible implications for the delivery of health care. Without staff to perform procedures, surgical backlogs, for example, increased. In January 2023, the Ontario government introduced its plan to address this situation and it included allowing private clinics to conduct MRI and CT scanning. However, there was a rub: to operate, these clinics would require hiring regulated professionals working in the Participating Hospitals and when recruited the ensuing vacancies would make the delivery of health care in those very same hospitals even more challenging. The inevitable outcome would be a drain on the talent pool from the public system. The union's concern was shared by the President of the OHA: "We certainly aren't interested in seeing members of the hospital teams being poached by other employers." The union referred to evidence indicating the enhanced pay being offered to its members in targeted classifications to switch to (non-hospital) employers; and it was not confined to higher pay as scheduling flexibility was also on offer. Wage increases, the union argued, were necessary not just to recruit but also to retain.

At the end of the day, the union argued that the evidence was unassailable that the lack of real wage growth has compounded recruitment and retention issues. Only meaningful compensation

increases would stop the exodus of employees leaving for various reasons including excessive and unmanageable workloads, exhaustion, burnout and better employment opportunities in private laboratories.

The Union Proposals in More Detail

General Wage Increases and Re-establishment of RT/RN Parity

In addition to the 1% previously awarded in each of the three years of the collective agreement, the union sought a further 6% of new money in each year. These additional amounts – 18% over and above the 3% initially awarded – were necessary to address the historic and continuing erosion of wages due to inflation, the recruitment and retention crisis and re-establishment of RT/RN parity.

In addition to a general wage increase that mitigated against inflation, re-establishing RT/RN wage parity was also on the top of the list of union priorities. This parity was lost in 1991 and further eroded since. Accordingly, a one-time adjustment of 7.9% was required for all classifications. As a result of the Gedalof Reopener, the disparity in wages at the top of the grids had grown to 13.86%. The parties agreed that ONA was the comparator for rates, and in the result, the time was long overdue for this unjustified disparity to be addressed (even though the requested 7.9% adjustment would not fully accomplish this task). In the alternative, the union proposed that all RTs be moved from the RT wage grid to the RT plus wage grid, which provides a higher wage rate at the 8th year for specified health care professionals (a proposal which would reduce the ONA comparability gap and one with meaningful antecedents in the Gedalof Reopener and its collapse of the 25-year rate with the self-evident objective of encouraging

retention of the most senior employees). Notably, the regulated health care professionals were the ones with the most alarming recruitment and retention challenges.

Pandemic Pay and Retention Bonus

Unlike nurses and other health care professionals, the vast majority of union members who attended faithfully to their jobs in the Participating Hospitals throughout the pandemic were ineligible for pandemic pay as well as the $5000 retention bonus offered to nurses. Awarding appropriate compensation was one means of recognizing the efforts of union members during the dark days of the pandemic. This reopener was also the opportunity to rectify this inequity caused by Ontario government's exclusion of its members though awarding one-time payments of $3400 (pandemic pay) and $5000 (retention bonus), with part-time employees receiving pro-rated amounts.

Remarkably, the union observed, the Participating Hospitals agreed that an unfairness had occurred. In its 2022 brief – leading to the initial award – the OHA stated: "regrettably most of the employees covered by the OPSEU central agreement were excluded by the government from their pandemic pay initiative." Exclusion from the $5000 retention bonus paid to hospital nurses was equally unfair. Simply put, the benchmark classifications populated by very many of the union's members were – just like the RNs – integral to delivering hospital health care during the pandemic and they should receive both pandemic and retention pay. Union members worked countless hours of overtime: the MLTs, for example, ensured that 23 million COVID-19 tests were completed. Other classifications, such as the Occupational Therapists, worked side by side with the RNs providing direct patient care but, inexplicably, were excluded from eligibility for

pandemic pay. Ontario was one of the few provinces that did not include therapeutic, diagnostic and rehabilitative workers in their pandemic pay programs. This wrong, the union argued, had to be set right.

Other Union Proposals

Other union proposals included increasing call-back to double time regular pay – something that was awarded in the case of ONA and CUPE/SEIU. There was no principled reason, in the union's submission, why its members, called back in the middle of the night to perform vital life-saving procedures, should be treated any differently than any other similarly situated health care professionals. The union's argument was straightforward: no matter what task was being performed during the call-back, an employee has been called back to work at irregular hours at significant disruption to their personal life. All employees – regardless of bargaining unit – should be compensated in exactly the same way.

The union also sought increases to shift and weekend premiums – again to restore historic parity with ONA, but only to the rates in effect as of April 1, 2022. The argument here was exactly the same as that with call-back: the disruption to the employee was the same and there was no principled basis to apply differing compensation depending on whether the employee was an RN or a RT. The union further sought increases to vacation after eleven, twenty and twenty-five years, It was appropriate, the union argued, given recent trends, to award these enhancements which would reward the longest-serving employees of the Participating Hospitals and add a further recruitment and retention incentive. The same could be and was said about the requested improvement to vision care and the proposed increase to the Health Care Spending Account.

Submissions of the Participating Hospitals

Overview

In the submission of the Participating Hospitals, appropriate application of the statutory and normative criteria was critical and properly applied supported its offered economic increases; namely, an additional .75% in the first year and 2% in both the second and third year. Inflation, while relevant, could not and should not be determinative especially in these circumstances where there was no compelling history of general wage increases always matching/exceeding existing inflation rates. The overall total compensation cost of the increases sought by the union were unfunded and unaffordable. The union's economic demands far exceeded any negotiated settlement or award in any comparable sector. To be sure there were some staffing issues, but it was on a much smaller scale in this bargaining unit than, for example, ONA, and also had to be seen in a much broader context of human resource challenges in all sectors across the country. Furthermore, attention needed to be paid to the fact that the reopener jurisdiction was limited and effectively precluded the Participating Hospitals from advancing amendments it urgently required to modernize the collective agreement so that it could make best use of employee complement in responding to operational needs with the objective of serving the public.

The Economic Context

The Participating Hospitals cited with approval Arbitrator's Hayes observations in *Homewood Health Centre & UFCW* (unreported award dated June 1, 2022) and its conclusion 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, an approach that has been adopted, also with approval, in other cases cited by the Participating Hospitals). While this award

was not governing, the Participating Hospitals urged that it be closely followed. Inflation may be a factor in determining the appropriateness of a wage outcome, but there was no reason to conclude that wage increases must match or exceed the rate of inflation and no demonstrable history of them ever having done so. In fact, when virtually all recent settlements and awards were carefully considered, it was obvious that Arbitrator Hayes' admonition had been followed with increases not reflective of current or past inflation.

There was another important factor that needed to be borne in mind: the Participating Hospitals relied on the government to provide funding. Unfortunately, as the province emerged from the pandemic it faced an uncertain economic future. At best, there would be slow economic growth; at worst, a recession could take place during the collective agreement term. Various economic indicators such as bond yield curves, real GDP growth, and net debt to GDP ratio, – referred to in the Participating Hospitals' brief, and discussed at the hearing – were canvassed to illustrate these points. Indeed, just weeks before the hearing, two major American banks collapsed; an ill wind with future repercussions that remained to be seen.

Potentially making matters even worse was the state of the province's finances. Both the existing provincial debt, and the rising interest rates that came with it, and deficit spending, again more debt and more interest, were reaching new highs seriously impacting the ability of the funder – the government – to provide the money needed to maintain existing operations much less afford the increases being sought by the union. There was no reason to believe that hospital funding would follow any award. To be sure, funding had been announced for various hospital health care initiatives – but, by and large, these were investments directed at increasing capacity and

providing services, not to pay for unjustified and unaffordable increases arising out of Bill 124 reopeners.

Recruitment and Retention

The Participating Hospitals did not dispute that there was currently a health human resources challenge in Ontario. It was also generally agreed that there was a significant increase in the number of vacancies across all hospital employee groups. According to OHA data, paramedical vacancies rose from 3.69% on March 31, 2017 to 7.69% on March 1, 2023 – a much lower vacancy rate than any other hospital bargaining unit, by a substantial degree: 3.51% lower than the overall hospital rate, and 7.77% lower than the RN rate. Turnover and retirements were decreasing – the paramedical group had the lowest rate by far – suggesting that vacancy numbers were most likely attributable to the growth in capacity – as outlined in the Participating Hospitals' brief and discussed at the hearing. Voluntary separations, however, had grown from 3.53% in 2016/2017 to 6.37% in 2022/2023 (and 3.41% lower than the total hospital rate and 3.56% lower than the RN rate). At the same time, the number of positions across the system was increasing: headcount was 10,655 in 2016 and 12,536 in 2022. Unlike the situation with RNs, there was virtually no agency use and minimal use of temporary incentives (and when offered were seasonal or otherwise time limited). Some of the Participating Hospitals were undoubtedly responding to local labour market conditions, but the evidence here, it was pointed out, was limited and anecdotal.

Nevertheless, the Participating Hospitals and Ministry of Health were aware that across-the-board province-wide human resource initiatives were necessary to bolster the number of

paramedical employees. Both the *Rehabilitation Incentive Grant Program* and the *Learn and Stay Grant* – both of which were described in the brief, were the kinds of programs that were currently under way to ensure a steady supply of RTs for the short, medium and long term. *Practical Solution* outlined the need for a multi-faceted multi-stakeholder approach to tackle ongoing RT (and other health professionals) needs. Specific proposals under current consideration included exploration of alternate and expedited approaches to entry for physiotherapists, innovative education and training opportunities and institution of an exemption under the *Controlled Acts Regulation* to allow respiratory therapists to perform diagnostic ultrasounds without a medical directive. Overall, it was anticipated that the implementation of well-crafted strategic initiatives would begin to address the recruitment and retention issues (which in any event paled in comparison to other hospital classifications, most particularly the RNs). To be sure, there was no reason to believe that the massive increases to compensation proposed by the union would successfully address the limited human resource issues.

Participating Hospitals Proposals

In the outlined circumstances – where inflation did not direct wages – and where the recruitment and retention issues were not of the same significance and magnitude of other classifications, and where solutions to them were currently underway, the Participating Hospitals argued that its proposed general wage increases of an additional .75% in year one, and 2% more in each of year two and three, were the appropriate outcome. The union's requested general wage increase numbers were unprecedented; even more so, when those numbers were added to all the other asks and considered from a total compensation perspective. They were unaffordable and unfunded.

Obviously, neither the Stout nor Gedalof Reopeners addressed inflation in the manner sought by the union, but the Participating Hospitals emphasized and again endorsed Arbitrator's Haye's observations and findings that the "harsh reality is that no one can expect to be fully immunized from the negative impacts of extraordinary inflation." This conclusion was made even more clear when a year-over-year comparison was made of the general wage increases and inflation rates. The bottom line was that general wage increases – the ATBs – have never necessarily mirrored inflation and any assertion to the contrary was without persuasive evidentiary foundation. In addition, hospital funding was not tied to inflation, and that meant the Participating Hospitals had to live within their means, and those means precluded paying for inflation-driven wage results. A much better comparison, the Participating Hospitals argued, was between funding and ATBs.

It was also legally and factually significant, the Participating Hospital's observed, that the union could not point to any settlement or award of 23.707% in the first year, and 5.808% in the second which is what the union was seeking. The Stout and Gedalof Reopeners, the Participating Hospitals argued, set the maximum that could be achieved by the union case and both reopener awards, one way or the other (i.e., either directly or indirectly) took inflation into account. Consideration of health care awards more generally – for example in long term care – reinforced this conclusion, making clear that the range of settlement was around 3%. There was, in any event, a historic bargaining pattern of this union following ONA outcomes (and there was no persuasive reason to break that decades-long relationship). On the other hand, while there was once parity between RTs and RNs, that ceased to be true decades ago, and so there was no basis, and certainly no demonstrated need, to re-establish it now. It was material that interest arbitrators have, ever since the parity relationship was broken in the early 1990s, repeatedly declined union

invitations to restore it. There was no basis to conclude that replicating free collective bargaining could – in the historical context – lead to the granting of this union request.

Finally, the Participating Hospitals took issue with all the other union demands. They were not justified on a demonstrated need basis, on an application of the statutory or normative criteria basis, or on a funded basis. They were actually unaffordable. The same was true about the union request for pandemic pay and a retention bonus. Both these programs were established by the government on its own initiative. The government determined how much and who was eligible. The government provided the additional monies. The Participating Hospitals had no money to extend either program to non-eligible employees and they were actually prohibited from doing so under program terms. The Participating Hospitals had no money to pay for either of these programs which, in any event, had to be considered in a total compensation framework.

Discussion

It is now well established that reopener awards must consider all relevant information including negotiated and awarded outcomes from all sectors, not just traditional comparators: the very best evidence, in other words. It is also now generally agreed that there are no cut-off dates following which relevant evidence is to be ignored. We have followed this approach. In the result, we have paid careful attention to the settlement between OPG and PWU – one very recently reached with Treasury Board approval – and the virtually identical also recently reached settlement between PSAC and the Government of Canada/CRA. Replicating free collective bargaining – what these parties would have likely done had they been able to strike or lockout – is the most important of the normative interest arbitration criteria. Notably, both PSAC settlements were agreed upon

following lengthy strikes. Also carefully considered were the *HLDAA* criteria, which are not prioritized, leaving it open to a Board of Interest Arbitration to determine which ones, and to what extent, are the most applicable in any proceeding. In this case, the impact of inflation on real wages and recruitment and retention have figured prominently in our analysis.

Obviously, there is a historic relationship between ONA general wage increases and the ones awarded to the union. For years this was dispositive (except in one case where an interest arbitration board was persuaded that the union should get less because of changed economic circumstances). We cannot, however, conclude that this is an appropriate case to follow the ONA reopener for 2022. We decline to follow this award because it does not in our opinion adequately address inflation, past or present, when inflation has seriously eroded spending power.

Inflation was 6.8% in 2022 and no one is seriously suggesting it will dip below 3% in 2023. If all goes well – and some of the economic projections turn out to be correct – it may begin to reach historical numbers by 2024, or it may not. We need to address this in our award. Inflation – before and during the term of this agreement – has been persistent and its results are now entrenched. While there is some evidence that inflation has begun to decelerate, not even the most optimistic economists are predicting a return to historic norms any time soon, and certainly not during the term of this collective agreement. Even if inflation begins to fall, the increases to the cost of living – and therefore the real erosion of spending power – will not change: they are now baked into prices. No one suggests that de-inflation is on the horizon.

A year-over-year comparison of ATBs with inflation indicates that in many years, the ATB was higher, in some it was lower. But in no year were the reported inflation results approaching the scale of at least the first two years of this reopener. That is worth bearing in mind. Also attracting attention is the fact that the wage increases proposed by the Participating Hospitals would do nothing more than embed into wages previous, current and future real wage cuts resulting from inflation. That would not be the proper application of any of the *HLDDA* criteria and cannot be the outcome of this award (and it is unlikely to be the outcome of free collective bargaining). The point must also be made that the Gedalof Reopener – the only one that is really applicable to this proceeding – was issued before the arbitrator had the advantage of broader information about free collective bargaining settlements.

In arriving at appropriate compensation, we have also borne in mind the limited scope of a Bill 124 reopener, one in which the Participating Hospitals were not able to advance any of their non-monetary proposals. This would normally result in some adjustment to otherwise persuasive free collective bargaining comparators. However, we have not reduced any amounts because there are recruitment and retention issues – that is established in the evidence – albeit not on the scale of those affecting other hospital workers most particularly RNs and RPNs.

Recruitment and retention issues are complicated, requiring a comprehensive and sophisticated approach, but there is no question that compensation is a key driver in attracting and retaining health care employees, a conclusion that is reflected in individual hospital initiatives (discussed above) and government programs. As *Practical Solutions* makes clear, insufficient staffing is one of the reasons explaining the turnover and resignation rates, and consequentially impacting the

delivery of key hospital services reflected in emergency room closures, long surgical waitlists and hallway health care. Unless recruitment and retention is addressed, services will be reduced not because there is no additional money to pay for posted positions but because of an absence of health care workers to perform key functions. Hundreds of unfilled postings – discussed above – proves this point.

We are not persuaded to award a RT-RN parity relationship, and we note that previous arbitrators have declined to do so on the repeated occasions when this issue has been raised. There is, however, a basis to increase the maximum RT and above rates (and doing so is fully in accord with the approach taken in the Gedalof Reopener). And providing the adjustment to those grids at the RT and above levels is also in keeping with and adopts the approach of the August 29, 2003 award of Arbitrator Bendel between these Parties.

The government made a public policy decision to offer pandemic pay to most unionized hospital workers and retention bonuses to nurses, but neither to the members of the union. The RN retention bonus was clearly initiated in response to more than 9000 vacancies system wide. However, on a comparability basis – one of the *HLDAA* criteria – it is impossible to understand the basis for excluding union members from the time-limited modest pandemic pay. The background facts are straightforward.

On April 25, 2020, the Ontario government announced a program of support for the "Heroes" of the pandemic. Between April 24 and August 13, 2020, eligible employees received pandemic pay. In our view, a pandemic payment is justified on a comparability basis. We note that this

payment was received for the period April to August 2020 and it is now the summer of 2023. Accordingly, we have attempted to create an equitable payment model which ensures that there are no implementation difficulties for individual hospitals.

We have also increased shift and weekend premiums, as requested by the union, bringing them closer to current ONA entitlements.

One final observation is in order. In the recent *ONA and Participating Hospitals* award, under the heading **Overall Approach**, the principle of replication relied upon at interest arbitrations was given effect. It requires consideration of the trade-offs that are made in free collective bargaining to reach a settlement; to achieve an outcome that is balanced and fair to both parties. Nothing in this award, which deals with a reopener process which by the reservation of jurisdiction is limited to compensation (as did the recent *OCHU/SEIU & Participating Hospitals* award), should be taken as in any way diminishing the **Overall Approach** taken in the *ONA and Participating Hospitals* award.

Award

Grid

Effective September 1, 2023, increase maximum rate on RT and above grids by 1.75%.

General Wage Increase

After hearing the submissions of the parties, we direct that the collective agreement be amended to provide for the following increases in addition to the 1% initially awarded:

April 1, 2022: 3.75%

April 1, 2023: 2.5%

April 1, 2024: 2.0%

Pandemic Pay

A one-time lump sum payment to all full-time, part-time and casual employees in the bargaining unit as of August 13, 2020, and who did not receive pandemic pay under the government program, as follows: $1,750 full-time, $1,250 part-time, and $750 casual. Payments to be made within sixty days less deductions required by law.

Call-Back

Effective date of award, union proposal awarded.

Shift and Weekend Premium

Effective date of award, union proposal awarded ($2.25 evening, $2.88 night, and $3.04 weekend)

Vision

Union proposal awarded effective April 1, 2024.

Health Care Spending Account

Union proposal awarded effective April 1, 2024.

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 3rd day of August 2023.

"William Kaplan"

William Kaplan, Chair

I dissent. Dissent attached.

Brett Christen, OHA Nominee

I dissent. Dissent attached.

Joe Herbert, OPSEU Nominee

DISSENT OF OHA NOMINEE

I respectfully dissent from the Award of the Chair dated August 3, 2023 (the "Award") and the reasoning and analysis that led to the items awarded therein.

The Award is a supplemental award to an award dated July 7, 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. It must be emphasized that, 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 Award covers the period April 1, 2022 to March 31, 2025. That is, for purposes of analyzing comparable settlements and awards, the Award covers three years: 2022, 2023, and 2024. The prior collective agreement was for three years (2019, 2020, and 2021) and was the result of a voluntary settlement between the parties. That voluntary settlement provided for general wage increases of 1.75% in each year of the agreement. No other changes to wages or benefits were agreed.

In my respectful view, the Chair's Award is excessive and does not follow recognized principles of interest arbitration or the *HLDAA* criteria, exceeds the Chair's jurisdiction, and the reasoning

giving rise to the items awarded is contradictory, deeply flawed, and wholly unpersuasive. The Award does not represent a considered application of replication and other principles of interest arbitration as they have traditionally been applied in the hospital sector.

The Union's Arguments

The various arguments of the Union in support of its many requests for increased entitlements are summarized by the Chair in the Award (at pp. 4 – 16; the long list of Union proposals advanced at arbitration are at p.3).

It was the Union's position that Registered Technologists (RTs) in the Union's bargaining unit should have wage parity with Registered Nurses (RNs) in the ONA bargaining unit. The Union also argued that ONA was an appropriate comparator for call back pay, and shift and weekend premiums. It was also the Union's position that its members should receive the same retention bonus provided to nurses and the same pandemic pay received by nurses (and other hospital employees) under government programs. The Union also relied upon a 1.75% increase to the ONA Central Grid's 8 year rate awarded in the recent ONA Central reopener arbitration to argue for increased RT wage rates. Despite these positions, it was also the Union's position that ONA was not an appropriate comparator for the general wage increases it sought. I found the Union's argument to be inconsistent and unpersuasive.

In asserting that ONA was not the appropriate comparator for general wage increases, the Union argued that the first central reopener award for ONA covering and 2020 and 2021 by Arbitrator Stout (the "Stout Reopener") and the second central reopener for ONA covering 2022 by Arbitrator Gedlof (the "Gedalof Reopener") should not be followed.

The Stout Reopener dealt with two years, neither of which were years covered by the Award. The purported relevance of the Stout Reopener to the issues under consideration is therefore somewhat difficult to understand. In any event, in the second year of his award (2021), Arbitrator Stout awarded ONA a 2% ATB increase. 2022 was the third year of OPSEU's voluntary settlement. As noted, in that settlement OPSEU agreed to a 1.75% general wage increase for 2022. It now criticizes Arbitrator Stout's award of 2% to ONA for 2022 as inadequate.

The Union's argument is that Arbitrator Stout: (i) failed to properly consider the rate of inflation in 2022 and (ii) that he was unable to award more than 2% since that was ONA's proposed wage increase for that year. The first argument ignores the fact that the Stout Reopener awarded non-wage compensation that the Union, in my view, should not have been awarded (as described in my dissent to that award) and also fails to address the fact that the total general wage increase over the two-year period covered by the award amounted to 3.75% which wasn't that different from inflation over that same period.

The Union's second argument is equally perplexing. In addition to ONA's proposed general wage increase, ONA pressed for increases across the RN wage grid, which Arbitrator Stout declined to award. It would have been a simple matter (however unjustified) to award increased compensation in the form of grid adjustments had Arbitrator Stout in fact felt constrained by the wage increase proposed. However, Arbitrator Stout rejected all of the grid adjustments sought by ONA.

The Union's argument with respect to the Gedalof Reopener, which does actually address a year covered by this award (2022), is that it shouldn't be given weight because Arbitrator Gedalof was constrained by ONA's request for a 3% general wage increase for 2022 and due to the fact that additional bargained wage settlements made after the release of his April 25, 2023 award, weren't

available to be considered by him. In the Gedalof Reopener, as was the case in the Stout Reopener, ONA sought wholesale changes to the RN wage grid in addition to its proposed general wage increase. Arbitrator Gedalof was fully aware that the rate of inflation for 2022 was 6.8% and that nurse staffing was the most severe recruitment and retention issue faced by hospitals. Arbitrator Gedalof awarded a 1.75% increase to the 8 year step of the grid (which impacted approximately half of the bargaining unit) to address the anomalous 25 year rate as well as recruitment and retention, in addition to a 3% general wage increase and other items.

The Union's arguments in respect of the Gedalof Reopener amount to nothing more than conjecture and should have been given no weight. This is particularly the case since Arbitrator Gedalof expressly addressed the question of whether it was appropriate to award greater compensation increases to the Union and expressly determined that the recognized interest arbitration principle of total compensation principle did not allow him to do so (at para. 59):

> 59. In our view, with these changes, we have exhausted the total compensation available in this single year. Any further compression of the grid, changes to the complex landscape of highly differential NP grids across the different hospitals, introduction of other forms of retention bonus or benefit improvements must be addressed by the parties in future rounds of bargaining.

The Union also argued strongly that government funding decisions relating to health care (which the Participating Hospitals had argued were a better predictor than was inflation of general wage increases awarded at interest arbitration) were not relevant to the determination of a general wage increase at interest arbitration (p.10). The Union simultaneously noted that health care transfer payments from the federal government were increasing (p.9), that provincial funding of hospitals including for recruitment and retention was also projected to increase (pp.9-10), and that the

government had a budget surplus (p. 8). I found the Union's argument to be inconsistent and unpersuasive.

The Union also argued that the recruitment and retention data supplied by it and the OHA fully supported the Union's position including the cost of its proposed increases, totaling a 23.707% increase to total compensation in year 1. In fact, the data, while showing some recruitment and retention issues in this bargaining unit, did not come anywhere close to the recruitment and retention issues established by ONA in its recent central interest arbitration awards. Further, the Union's reliance on examples of staffing shortages impacting the hospitals' ability to provide services related largely to staffing shortages in other bargaining units.

The Award

The items awarded by the Chair in this reopener process are found at pages 27-28 and must be read in conjunction with the Initial Award (which awarded wages and non-wage compensation of 1% in each of the three years being determined by this reopener award). The general wage increase awarded for 2022, 2023, and 2024 are, respectively, 4.75%, 3.5%, and 3.0%. Pandemic pay is also awarded and, in 2023, the maximum rate on RT and above grids is increased by 1.75%. In addition to these increases, call back pay, shift and weekend premiums, vision, and the heath care spending account are increased. The awarded items are excessive. In particular, pandemic pay and the adjustment to the maximum rate of the RT and above grids are, in my view, unjustified and inexplicable on the basis of recognized principles of interest arbitration.

The Chair's analysis in support of the Award is found at pages 22 to 26. I will deal with the numerous flaws in the Chair's reasoning and analysis that led to the profligate award in summary form.

Relevant hospital Comparators

I disagree with the Chair's statement that it is now "well established" (p.22) that reopener awards must consider negotiated and awarded outcomes from all sectors. Although this is this Chair's view, the proposition is stated too broadly and it remains to be seen whether it will be embraced by other Arbitrators in future and/or in different circumstances. If the statement is intended to imply that settlements and awards from other sectors should be given precedence over traditional hospital sector comparisons, then this view represents a fundamental departure from the long-standing accepted approach in this sector and is an approach that will lead to unpredictability of outcome, increased litigation costs, even fewer voluntary settlements, and the imposition of "whipsawing" awards on the hospitals.

Inflation

I also strongly disagree with the Chair's comments regarding inflation at pages 22 – 23. The rapid rise in the rate of inflation in Canada in 2021 and 2022 was the result of many unprecedented factors including the unexpected onset of a world-wide pandemic, the infusion of massive stimulus payments into the economy by the federal government in response, the collapse of the supply chain and the corresponding rapid outstripping of supply by demand, and the invasion of Ukraine. In the three years preceding the award (2019, 2020, 2021) inflation was 1.9%, 0.7%, and 3.4%. In the first year of the award (2022) inflation was 6.8%. In the second year of the award (2023), the rate of inflation has fallen from 5.9% in January to 2.8% in June. While there was undeniably a spike in inflation in the months immediately following the onset of the pandemic, there is considerable room for debate about whether inflation over the years preceding and covered by the Award has been, or will be, persistent or how it will compare to historical norms.

The events giving rise to the inflation spike are very different from those giving rise to previous periods of excess inflation and have been met with aggressive responses from centrals banks including through the introduction of rapid and unprecedented interest rate increases. In all of these circumstances, it is exceedingly difficult to anticipate future inflation or how much past inflation is "baked into" prices. For example, price increases resulting from commodity inflation are generally not permanent, as evidenced by the decline in oil/gas and food prices from 2022 highs. Immediately prior to the onset of the pandemic, inflation in Canada was low, several industrialized countries were in a deflationary environment and some of these had introduced negative interest rates. Given all of this, and with respect, I find the Chair's comments on inflation to be somewhat unbalanced.

Gedalof Reopener

I also, for the reasons set above, strongly disagree with the Chair's attempt to distinguish the Gedalof Reopener as a means of minimizing the general wage increase for 2022 awarded to ONA, the traditional comparator for OPSEU.

Increase to maximum rate of RT Grid and above

The award of a 1.75% increase to the maximum rate of the RT grid and above grids is not warranted by the evidence and is not supported by either the Gedlof Reopener or the 2003 Bendel Award referenced by the Chair. The 1.75% increase to the 8 year rate in the Gedalof Reopener was stated to be a response to the failure of the 25 year rate (imposed upon the parties at interest arbitration years earlier) to address recruitment and retention issues. Although there was no evidence supporting the need for this particular change before the Gedalof panel, there was detailed evidence before Arbitrator Gedalof regarding significant recruitment and retention issues in the ONA

bargaining unit generally, which is not present here. In short, the Union's evidence of retention and recruitment issues was not in any way comparable to that advanced in other central arbitrations. Notably, there was no compelling evidence of a particular issue with the retention of employees on the RT Grid or above grids at or above the maximum grid rate. The Bendel Award was based upon evidence of recruitment and retention issues in existence in 2003 and is not of any relevance to the issues before this board.

Pandemic Pay

As noted by the Chair, the Ontario Government's decision to provide pandemic pay in 2020 to certain hospital employee groups but not others was an exercise of public policy. It is not the function of this Board to second guess and effectively override public policy decisions and the Board is, in my view, without jurisdiction to do so.

I would also note that some members of the bargaining unit, such as Respiratory Therapists, and many employees who were reassigned to other roles, did receive pandemic pay under the government's program.

The pandemic pay program was not awarded at interest arbitration nor freely negotiated and is not therefore supported by the replication principle. The Chair's reliance on the *HLDAA* criterion of comparability is unconvincing since that criterion is in respect of "terms and conditions of employment". The pandemic pay program was a government entitlement for qualifying employees that was fully funded by the government (and not from hospital funding allocations). It was not a hospital initiative and did not form part of the terms and conditions of employment of bargaining unit employees. It is also of note that interest arbitrators have not factored in pandemic pay or

retention bonuses received by other employee groups in determining the awarded compensation for years in which those payments were received.

Although I strongly disagree with the award of pandemic pay, I agree with the method of payment that the Chair has determined is appropriate, which avoids numerous issues with implementation at this time.

The Reopener Process

In the award the Chair makes some final observations about the overall approach taken in the *ONA and Participating Hospitals* award. That award – not a reopener – attempted to achieve a balance by taking into account proposals from both the Participating Hospitals and ONA. That is the way interest arbitration is supposed to work: historically, interest arbitration has been completely unbalanced with meritorious management proposals being given, at best, short shrift. This needs to change.

Dated August 3, 2023

"Brett Christen"

Brett Christen
Nominee of the Participating Hospitals

DISSENT OF UNION NOMINEE

In a Dissent to *Participating Hospitals and CUPE/OCHU and SEIU*, I commented on the history of arbitration awards that have protected employees from the losses in real income occasioned by inflation. I won't repeat those comments other than to acknowledge that they are just as applicable here.

There are issues unique to this relationship that will require serious attention in bargaining. In particular, I am concerned that wage increases that have been awarded will be insufficient to deal with certain recruitment and retention issues. Just as importantly, there are also issues of internal equity which need to be addressed.

One expects unionized workforces to enjoy compensation greater than the bare market minimum necessary to attract new employees and retain current ones. Yet for some of the occupations covered by this collective agreement that is not necessarily the case. That points to a systemic failure.

A good example of the convergence of recruitment and retention problems, and issues of internal equity in the hospital sector, is provided by the Perfusionist classification. These specialists operate sophisticated equipment during heart surgeries to maintain heart functions. One qualifies by taking a two-year M. Sc. Programme at Michener, for which the prerequisites are stern – physics, chemistry, maths and anatomy. Alternative admission however is available to Registered Nurses with a degree, and to Respiratory Therapists with a Diploma.

OPSEU officials have pointed to the loss of Perfusionists to hospitals not covered by this agreement paying much greater salaries. Heart surgeries are cancelled as a result. https://www.thespec.com/news/hamilton-region/hamilton-health-sciences-loses-more-than-a-quarter-of-key-cardiac-surgery-staff/article_17dcef46-7cec-553e-9cc6-f8307da1e88c.html?

It goes without saying that in order to attract RN's, who are much more numerous than Respiratory Therapists, to undertake a two-year Masters program to become a Perfusionist, there must be some significant income differential. The recent necessary increases to RN salaries resulting from the ONA award, issued after the hearing in this matter, have instead reduced the gap between Perfusionists and RN's. While I agree with the Chair's decision here to provide an adjustment to RT and above classifications, the 1.75% awarded will in many cases not be enough to deal with recruitment issues, and will certainly not deal with internal equity issues.

Dated July 29, 2023.
Joe Herbert
Nominee of Ontario Public Service Employees' Union