IN THE MATTER OF AN ARBITRATION

BETWEEN

THE PARTICIPATING HOSPITALS

("the Hospitals" / "the Participating Hospitals" / "the Employer")

- AND -

ONTARIO NURSES' ASSOCIATION

("the Union" / "ONA")

CONCERNING AN INTEREST ARBITRATION UNDER THE *HOSPITAL LABOUR DISPUTES ARBITRATION ACT*, RSO 1990, c H-14 (HLDAA)

ONA File # 201600047

BOARD OF ARBITRATION

Christopher Albertyn – Chair

Brian O'Byrne – Employer Nominee

Elizabeth McIntyre – Union Nominee

APPEARANCES

For the Union:

Stephen Flaherty, Presenter

Sue McCulloch, Presenter

Dan Anderson, Bargaining Spokesperson

Bev Mathers, Bargaining Spokesperson

Cathryn Hoy, Region 2 Full-Time Representative, Chair

Linda Haslam-Stroud, President

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For the Hospitals:

Sunil Kapur, Presenter, Counsel, McCarthy Tétrault

Participating Hospitals Bargaining Committee:

Elizabeth Buller (Chair), St. Joseph's Health Centre, Toronto
Colleen Armstrong, Peterborough Regional Health Centre
David Coward, Royal Victoria Regional Health Centre
Margaret Czaus, Humber River Hospital
Rebecca Officer, The Ottawa Hospital
Rob Jones, Bruyère Continuing Care
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Hearing held in TORONTO on March 21 and 22, 2016.
Executive Meetings held on March 29, May 9, 24, 27 and 30, June 14, and July 20 and 26, and August 17, 2016.
Award issued on September 7, 2016.

AWARD

1. This is an interest arbitration under the *Hospital Labour Disputes Arbitration Act*, RSO 1990, c H-14 ("HLDAA" or "the Act").

Term of the agreement

2. The term of the renewal collective agreement covered by this award is from April 1, 2016 for an agreed period of 2 years until March 31, 2018.

Agreed upon items

3. The renewal agreement will consist of the unchanged items from the collective agreement which expired on March 31, 2016, the items agreed by the parties themselves (Union's Exhibit 2), which are incorporated into this award, and the items we describe below on which the parties made submissions to us.

General considerations

4. We have carefully reviewed and considered all of the submissions, and we have taken account of all of the relevant statutory and jurisprudential factors recommended to us by the parties, particularly comparability, replication, total compensation and demonstrated need.

5. The Hospitals particularly emphasize the dire financial circumstances of the provincial government, which funds the Hospitals, and that we ought to be particularly cognizant of the cost implications of what we award. The Hospitals provide substantial information to support the needs for restraint so as not to add to the provincial government's debt burden.

6. In response, the Union points out that the federal government's health care transfer payment is projected to grow at the rate of 5.94% and that the recent Ontario budget has increased the overall funding for hospitals for 2016-2017 by 2.1%.

7. The Union particularly emphasizes what it sees as a significant and growing threat to the job security of its members by the replacement of RNs with RPNs within hospitals. ONA sees this cost-saving drive by the Hospitals as a threat to the job security and professional work of its members, at times with insufficient regard for the health care needs of patients.

8. In response, the Hospitals explain that Ontario health policy, which is focused on quality, efficiency and access, includes expanding the scope of practice for a number of regulated health professionals. The Hospitals point out that the overall number of RN's in hospitals has not declined.

Issues in Dispute

9. All of the Union and Employer proposals not specifically addressed below are dismissed. The wage increases awarded are, where applicable, retroactive to the dates specified. Unless a specific date is set for an item awarded, it will be effective from the date of the award.

10. We address each of the issues on which an award is made in the order in which they appear in the collective agreement.

Article 6.05
Occupational Health & Safety

11. The Union proposes broadening the definition of "workplace violence", which appears in Article 6.04(e)(xi)B)4). The Union wishes also to amend Article 6.05(b). The Union presents information of the troubling extent of violence to RNs in some hospitals, by patients particularly, and of the need to ensure proper protections for nurses' safety at work. We recognize that this is an important issue for the Union and one of great concern to its members.

12. The Hospitals acknowledge the need to provide a safe workplace for nurses. They submit, however, that no amendments to the current provisions in the collective agreement are necessary to do so. Also, the Hospitals say that this Board of Arbitration does not have the jurisdiction to address the issue in the manner the Union wants because the local parties – ONA locally and each hospital – determine what is to be done regarding violence in the workplace.

13. Given that the central agreement defines "workplace violence" and that Article 6.05 deals with Occupational Health & Safety, we find that this Board of Arbitration has the jurisdiction and the authority to make amendments to the provisions regarding workplace violence within the central agreement. We amend the first bullet point under Article 6.05(b), which is to read as follows:

> - Violence in the Workplace (includes Verbal Abuse).
> In particular, the local parties will consider appropriate measures to address violence in the workplace, which may include, among other remedies:
>
> i) Electronic and visual flagging;
>
> ii) Properly trained security who can de-escalate, immobilize and detain / restrain;
>
> iii) Appropriate personal alarms;
>
> iv) Organizational wide risk assessments assessing environment, risk from patient population, acuity, communication, and work flow and individual client assessments;
>
> v) Training in de-escalation, "break-free" and safe immobilization / detainment / restraint.

Article 10.08
Layoff – Definition and Notice

14. The Hospitals advanced a proposal that would allow them to offer transfers to vacant positions approved by the Union as a means of avoiding layoffs. The Union opposes this proposal on several grounds, including that it

would encourage hospitals to hold back on posting vacancies in anticipation of layoffs. We recognize that this is an important issue for the hospitals. We are of the view that this matter should be the subject of further bargaining between the parties during the next round.

15. Article 10.09(b)(iii)(A) will be amended to read as follows (the bolded portion is what has been added):

> Any agreement between the Hospital and The Union concerning the method of implementation of a layoff shall take precedence over the terms of this article. **While an individual nurse is entitled to Union representation**, the unavailability of a representative of the Union shall not delay any meeting regarding layoffs.

Article 10.12
Work of the Bargaining Unit / Agency Nurses

16. As mentioned, this is the issue most emphasized by the Union. The Union is deeply concerned by what it sees as the erosion of the work of its bargaining unit through the replacement of RNs by RPNs in the hospitals' mandate to save money. The Union worries that hospitals are compromising patient care to meet their financial imperatives. The Union provides evidence of both the elimination of RN positions and the issuance of layoff notices to its members at a number of the hospitals. The union also relies on information from the OHA which shows that the proportion of RNs to RPNs employed in hospitals has decreased from 4.5 RNs to 1 RPNs in 2007/08 to 3.9 in 2014/15 and ONA projects it will to decrease to 3.4 by 2021/22. The union asserts that its bargaining unit is under threat and

that its current collective agreement does not offer adequate protection from this threat. ONA compares the protection of bargaining unit work in its collective agreement with the provisions of the collective agreements that apply to RPNs in hospitals, and it claims that its agreement is less protective of the work of its RNs than are those agreements of the work of RPNs. As a result, ONA claims, its bargaining unit is more easily denuded by transferring the work of RNs to RPNs than would be the case if work were taken from RPNs. ONA points out that its collective agreements in the long term care sector contain language to protect the work of the bargaining unit that is missing from its hospital agreements. ONA also relies on the provisions negotiated by nurses' unions in Alberta and British Columbia where nurses have the right to strike. Those unions have achieved provisions that do not allow the reduction in RNs' hours and/or numbers during the term of the collective agreement applying to a single nurses' bargaining unit.

17. The Union is faced with an historical circumstance that is not to its advantage. Following the Report of the Johnson Hospital Inquiry Commission in 1974, the current structure of hospital bargaining units was established. At that time the role of nursing assistants was very different from the role now played by RPNs within the health care system. The scope of practice of RPNs has expanded significantly over the years since the 1970s and they now have considerable community of interest with RNs. The problem, though, is that they are in separate bargaining units from the RNs. This reality appears to be creating labour relations problems for some hospitals, for ONA, and for the unions representing RPNs. There is no easy solution, so the Union has understandably reacted to it by seeking greater enforcement of the protections it has to its bargaining unit work,

and by seeking to extend and improve those protections.

18. To address the situation the Union is facing, ONA proposes a number of changes to the provisions of the collective agreement. It proposes to extend the restriction on any person performing bargaining unit work, not just to those in supervisory positions, as currently exists. The Union also proposes that there be no overall reduction in the total hours worked by RNs at each hospital, with an exception in the event of the permanent closure of an entire unit. In that event, ONA proposes the maintenance of the ratio of RNs' to RPNs' hours in the hospital concerned.

19. The Union raised the issue of bargaining unit job protection before the Thorne board of arbitration for the 1993 round of bargaining. As here, the Union proposed protection of the work of ONA's bargaining unit from the assignment of work to persons outside the bargaining unit. The proposal was not accepted by the Thorne board of arbitration, which was not prepared "to restrict what public policy encourages in the assignment of work to the various health disciplines".

20. Like the Thorne board, we see the proper staff mix to be fundamentally a patient care determination, rather than a labour relations determination. However, to the extent that changes on staff mix impact on the job security and professional interests of ONA members, the Union has a legitimate interest. Having carefully considered what additional protections are needed at this time, in the context of trying to replicate the kind of agreement the parties would themselves have come to, we have concluded that the question of greater bargaining unit job security for

RNs in relation to RPNs is a matter to be left to future bargaining between the parties, once fuller information becomes available under the provision awarded below.

21. While acknowledging that the increasing scope of practice of RPNs has led to hospitals examining the skills mix between RNs and RPN, the hospitals dispute that this and the layoffs which have been announced have led to a reduction in RN numbers.

22. However, the evidence shows that the proportion of RPNs to RNs is increasing, albeit at a fairly slow rate. Also the LHINs are mandating hospitals to balance their budgets. Hospitals are being required by the LHINs to consider "optimizing operational efficiencies, including a review of staffing patterns and mix to ensure staff are working at maximum scope".

23. At present there is insufficient information to properly assess the extent and detail of the skills mix changes that are occurring between RNs and RPNs. There ought to be better information provided by hospitals to the OHA and to ONA so that both sides have the same data on the ratio, and on changes to the existing ratio. To this end we find that there ought to be provision in the collective agreement to enable the parties to more accurately monitor the ratio of RNs to RPNs. To address this, we award the following provision.

24. Effective October 1, 2016, a new Article 10.12(a)(iii) will read:

> In order for the Union to be able to monitor the extent of work assignment between RNs and RPNs in the Hospital, the Hospital will provide the Union's Labour Relations Officer and Bargaining Unit President with semi-annual reports (by March 31 and September 30 each year), by bargaining unit, site and by nursing unit, of the following:
>
> (A) the number of part-time and full-time RN bargaining unit hours worked;
>
> (B) the number of part-time and full-time RPN bargaining unit hours worked.

25. As part of its effort to maintain job security for its members, the Union has proposed the elimination of the use of agency nurses. We have been provided with details of the extent of use of agency nurses by participating hospitals. There is a substantial variation. A number of hospitals make no use of agency nurses. A few use agency nurses extensively. The Union asks for a complete prohibition against the use of agency nurses. In our view greater effort should be made by hospitals to avoid the use of agency nurses by bolstering the pool of part-time and casual nurses in the bargaining unit.

26. To this end, we make two amendments to Article 10.12(c). Effective January 1, 2017, "2%" will change to "1.5%", and the payment in the last sentence will change from "38 cents" to "62 cents".

Article 12
Sick Leave and LTD

27. Article 12.05 is amended to read:

> Any dispute which may arise concerning a nurse's entitlement to short-term or long-term benefits under HOODIP or an equivalent plan may be subject to grievance and arbitration under the provisions of this agreement. However, the nurse is required to use the carrier's medical appeals process, if available to the nurse, to attempt to resolve disputes. The Union may file a grievance on the nurse's behalf, but the arbitration hearing of the grievance will not occur until the determination of the nurse's appeal, or within 90 days of the filing of the appeal, whichever is the sooner. Any delay occasioned by the appeal will not count against the timeliness of the grievance, nor against any time limit in section 49 of the *Labour Relations Act, 1995*. For this reason the time limit for referring such a grievance to arbitration will be extended until the result of any appeal is known to the Union.

28. The bracketed entry above Article 12.12 will read:

> (Articles 12.12, 12.13, 12.14 and 12.15 apply to both full-time and part-time nurses).

29. A new Article 12.15 will read:

> Attendance Management
> Days of absence arising out of a medically-established serious chronic condition, an ongoing course of treatment, a catastrophic event, absence for which WSIB benefits are payable, medically necessary surgical interventions, or days where the employee is asymptomatic and is under a doctor's care from the commencement of symptoms for a confirmed communicable disease (and has provided medical substantiation of such symptoms) but is required to be absent under the Hospital or public health authority protocol, will not be counted for the purposes of being placed on, or progressing through, the steps of an attendance

management program. Leaves covered under the *Employment Standards Act, 2000* and leaves under Article 11 will not be counted for the purposes of being placed on, or progressing through, the steps of an attendance management program.

Article 14
Premiums

30. The standby premiums in Article 14.07 will increase from $3.30 to $3.45 and from $4.90 to $5.05.

31. The shift, evening and weekend premiums in Articles 14.10 and 14.15 will increase by 5 cents effective the date of the award. A further increase of 10c will be effective from April 1, 2017.

Article 17
Health & Welfare Benefits

32. The hearing aid maximum in Article 17.01(c) is increased from $500 to $600 effective the date of the award, and to $700 effective April 1, 2017.

33. The vision care maximum in Article 17.01(c) is increased from $400 to $450 effective April 1, 2017.

34. "(Crowns, bridgework and repairs to same)" in Article 17.01(f) is amended to "(Crowns, bridgework, implants and repairs to same)".

Article 19
Compensation

35. Article 19.01(a), the RN salary grid is amended as follows:

a. An increase of 1.4% effective April 1, 2016;
b. An increase of 1.4% effective April 1, 2017.

36. We are persuaded by the Union that there ought to be a salary grid for the Classification - Nurse Practitioner (NP). From the info provided by the parties in their briefs it is apparent that there is a wide discrepancy both in the number of steps of NPs' salaries, and in the salaries paid to them.

37. We award the following increases to existing NP wage grids.

a. For each hospitals with an existing start rate for NPs at or above $47.15:
    i. Effective April 1, 2016 a 1.4% increase across the grid;
    ii. Effective April 1, 2017 a 1.4% increase across the grid.

b. For each hospital with an existing start rate for NP below $47.15 the NP grids will be adjusted as follows:
    i. Effective April 1, 2016:
        1. the start rate will be $47.80;

2. the maximum rate will be the existing rate plus 1.4%;
3. the rates for the other steps on the grid will be agreed between the parties to maintain proportional ratios. We remain seized if they are unable to agree.

ii. Effective April 1, 2017, a 1.4% increase across the grid.

c. In the application of the above, every NP currently employed by a hospital will get a minimum wage increase of 1.4% on April 1, 2016 and a further 1.4% increase on April 1, 2017, in addition to any movement on the grid to which they are entitled.

38. A committee is to be struck between the Hospitals and the Union to make recommendations to the parties on an integrated Classification Grid for NPs that will form part of the central agreement, having regard to the range of rates applicable across the participating hospitals, for use in future bargaining. The parties are directed to agree to a letter giving effect to this Committee. If they cannot agree to the letter, we remain seized.

39. The responsibility allowance in Article 19.04(b) is increased by 10c.

40. The team leader allowance in Article 19.04(d) is increased by 35c.

41. Effective April 1, 2017, Article 19.09 is amended by the addition of the following:

> Notwithstanding the foregoing, educational allowances for possessing a baccalaureate degree in nursing (BScN) will not be payable to nurses hired on or after April 1, 2017.

42. To somewhat address the loss of the education allowance, the start rate for RNs, from April 1, 2017 will increase by 32c, after applying the 1.4% increase referred to above.

Seized

43. Pursuant to s.9(2) of the Act, we remain seized of the implementation of this award until a collective agreement is in effect between the parties.

DATED at TORONTO on September 7, 2016.

Christopher J. Albertyn
Chair: Board of Arbitration

PARTIAL DISSENT OF THE UNION NOMINEE

Having reviewed the award of the Chair, I would like to dissent on several issues.

General Wage Increase:

The general wage increases awarded are inadequate for a number of reasons.

First, to maintain the value of the nurses wages when compared against increases in the cost-of-living, higher increases are required. The inflation rate predicted for the third and fourth quarters of 2016 are 1.6% and 1.7%. Predictions are that the inflation rate in 2017 will be closer to 2%. Accordingly, in awarding wage increases of 1.4%, the Chair is failing to maintain the value of the current wage grid.

Secondly, the awarded increases are less than those received by nurses in a number of other provinces for the same time period. This is unacceptable given the historical relationship between Ontario's nurses and their counterparts across the country.

Thirdly, the Board was presented with evidence of recent increases received by fire and police in Ontario. These groups are comparable to nurses in that they provide essential round the clock services to the public; they are also subject to interest arbitration because interruption in their services is unacceptable to the public. These male dominated groups were historically paid less than nurses, a

female dominated group. However, since 2004 this relationship has been reversed with the male dominated group now making more than nurses. This is unacceptable.

In my view the basis for a greater increase, particularly in the second year, was established and should have been awarded.

Educational Allowances:

I disagree with the removal of the educational allowance as awarded by the Chair. Currently, approximately seventy of the Hospital collective agreements contain an education allowance for nurses who possess a baccalaureate degree; these allowances have been preserved as superior conditions for decades. Accordingly, the elimination of the education allowances constitutes a major change in these collective agreements and for those employers, it is a very significant cost savings. These savings will potentially multiply in future years as the proportion of nurses disentitled to the education allowance increases. Accordingly, in free collective bargaining, the Union would not have agreed to the elimination of this benefit without corresponding and significant improvements.

The Chair has awarded an additional $0.32 per hour increase in the start rate in the second year to coincide with the elimination of the education allowance for new hires. This is a woefully inadequate tradeoff and much less than the Union would have achieved in free collective bargaining. In my view it would have been more appropriate to have eliminated the first step of the grid in the second year of

the contract and the corresponding $.0.47 per hour differential between the start rate and step 1. This would have come closer to the adjustment necessary to fully compensate new hires for the loss of the educational allowance.

The adjustment, albeit inadequate, made to the start rate by the Chair, is in recognition that it is new nurses, at the start rate, who will be most impacted by the loss of the educational allowance. It is to be assumed that the parties will make appropriate adjustments to the other steps on the grid on a go-forward basis to compensate nurses for the loss of the educational allowance as they move through the grid.

More problematic is the fact that adjustments to the start rate do not recognize that nurses, newly hired at grid levels above the start rate, will not be compensated for the loss of the education allowance to which they otherwise would have been entitled. This too can be addressed by the parties as they adjust other steps on the grid to compensate for the loss of the educational allowance.

With the award of this Board, the start rate for nurses in Ontario for April 1, 2017 will be $32.21. The evidence provided to the Board shows that this start rate will be below that of a number of other provinces in both the west and the east of the country. In Alberta, for example, the start rate was $35.78 effective April 1, 2015 and $36.86 effective April 1, 2016. In Saskatchewan, the start rate was $34.94 effective April 1, 2013. In Manitoba, the start rate was $34.62 effective April 1, 2015 and $35.32 effective April 1, 2016 and will be $35.67 in October 2016. In New Brunswick, the start rate is scheduled to increase to $32.38 on January 1,

2018. In Nova Scotia, the start rate was $32.84 in November of 2013. The small adjustment made to the start rate for the second year of this collective agreement does not go far enough in addressing this intra-provincial disparity.

Finally, it is unfortunate that educational allowances are being eliminated for a group of female employees at a time when they are facing increasing professional demands from an aging population with increasingly acute conditions. It is to be assumed that the bonus for a nurse with a BScN was historically agreed to in recognition of the increased value of a degree. The fact that all new nurses must attain this educational level in no way depreciates this value. Fortunately, the overall increase in educational credentials for the profession should be recognized in the pay equity maintenance review which the parties are currently conducting.

Nurse Practitioners:

I concur with the award of the Chair in setting up a process for the parties to work toward establishing a common grid for Nurse Practitioners that will apply across the province. I also concur with the award of the Chair in setting a minimum start rate. The minimum start rate awarded reflects the average start rate paid by hospitals. Where I disagree with the award is in setting the end rate to be 1.4% above the existing end rate. In my view, it would have been more appropriate to maintain the existing differentials between steps on the grid and/or to have awarded an end rate that reflected the average already paid.

Work of the Bargaining Unit:

As indicated by the Chair, the number one priority of the Union in this round of bargaining was the job security of its members. The Union's concerns stem from changes being made to the staffing model in hospitals which it alleges is resulting in the erosion of the work of RNs. The union is particularly concerned with the replacement of RNs with RPNs as well as the ongoing use of agency nurses by some hospitals. To demonstrate the need for change to the collective agreement the Union provided detailed evidence of numerous lay-off notices and elimination of RN positions in hospitals across the province.

The Union's assertions on demonstrated need are buttressed by an extensive, well researched report by the Registered Nurses' Association of Ontario called *Mind the Safety Gap in Health System Transformation: Reclaiming the Role of the RN*. That report, which examines changes being made to Ontario's health system and the transformation of service delivery, focuses, in part, on health human resources. With respect to nursing, the report concludes as follows:

> "Recent organizational nursing skill mix changes have focused on replacing RNs with RPNs, and replacing RNs and/or RPNs with UCPs. These changes are based on budgetary decisions and not on patient care needs or evidence." (p. 13, 14)

The report provides a detailed analysis of nursing human resource trends, from 2005 to 2014, based on data published by the College of Nurses of Ontario. One of the resulting conclusions is as follows,

> "Overall, RN employment growth has done little more than keep pace with population group, at times falling below it…NP and RPN employment have markedly exceeded that of RN growth, meaning that the RN share of employment has been dropping steadily."
> (p. 17)

With respect to the hospital sector in particular, in comparing 2005 to 2014, the report concludes that:

> "There was modest growth in RN employment in the sector: about a 1.2 per cent annual increase in counts…RPN counts grew over three times faster than RN counts (about 4.2 per cent per annum). As a consequence, the RN share of hospital employment dropped from 83.3 per cent to 78.7 per cent, while the RPN share rose from 16.5 per cent to 20.1 per cent. That is striking considering rising patient acuity in hospital." (p. 23)

Based on its analysis of the needs of the health care system the report adopts, as one of its recommendations, the following:

> "The MOHLTC legislate an all-RN nursing workforce in acute care effective within two years for tertiary, quaternary and cancer centres and within five years for large community hospitals." (p. 4)

In response to the Unions submissions, the Hospitals rely on assertions that, in spite of layoffs and elimination of RN positions, there has been no resulting overall reduction in RN positions in the hospital system generally. Although the

Board received information from some of the participating hospitals regarding actual number of RN and RPN hours and changes in these numbers from 2015/2015 to 2015/2016, the information was incomplete. Accordingly, the award of this Board requiring detailed and ongoing disclosure of numbers will be helpful to the parties to assess the impact of changes to the skill mix that is taking place in hospitals.

In my view, however, the award did not go far enough in addressing the issues identified by ONA and reinforced by the report of the RNAO. Clearly, in the context of the current transformation of the health care system, the Union has demonstrated a need to address skill mix through collective bargaining. The changes that are occurring impact not only the job security of ONA's members, but also their professional practice. The skill mix of the team with which each nurse works impacts not only, on her/his workload, but also on the quality of patient care in the workplace. Nursing professionals clearly have an interest in both of these issues and collective bargaining is an appropriate forum in which to address their concerns. It is hoped that the parties can do so in a meaningful way in future rounds of bargaining.

September 3, 2016

"Elizabeth McIntyre"

Elizabeth J. McIntyre

Union Nominee

PARTIAL DISSENT OF HOSPITALS' NOMINEE

I am partially dissenting from the Chair's award.

While I agree with the Chair's disposition of certain issues (including some 15 proposals of ONA that were rejected, including ONA's extensive proposals dealing with work of the bargaining unit), I disagree with his disposition of various other issues. I do not intend, in this Partial Dissent, to comment on all the issues where I disagree with the Chair, but instead will confine my comments to the ones with which I disagree the most.

1. Economic Package – Year One

In my view, the economic package awarded by the Chair in year one is too rich. The monies used to pay the wages and benefits for the nurses covered by this award come, almost entirely, from the public purse.

The Information placed before us at the hearing indicated that the state of Ontario's economy is not good. In particular:

(i) Ontario has become the world's most indebted sub-sovereign state. Its debt

load is more than double that of the biggest U.S. state (California), even though Ontario's population is about one-third the size. Ontario's estimated total debt for the 2016-2017 fiscal year is $334.8 billion dollars – more than double what it was 9 years ago.

(ii) Ontario is paying around $12 billion dollars per year on interest payments on its debt.

(iii) Former Ontario Finance Minister Dwight Duncan, in his first column for the Queens Park Briefing earlier this year, described Ontario's mounting debt in the following terms:

> "A Province that is dangerously ill equipped to face the next, and inevitable, economic downturn.
>
> A Province that does not have the means to address its pressing infrastructure and social needs in a timely fashion.
>
> Finally, and ominously, an unprecedented interest rate risk, completely out of government's hands, that threatens the sustainability of the very public services and infrastructure for which the borrowing was undertaken in the first place.
>
> The Wynne government is the first Ontario government that is truly hampered by the province's debt load. In a very real way, the size and cost of Ontario's debt is now constraining, and indeed, molding Ontario's public policy choices."

(iv) Ontario's Net Debt-to-GDP ratio is approximately 39.6% today. In 1990, it

was only 13.4%.

The growth of debt needs to stop and allow the growth in GDP to bring this ratio down to manageable levels.

a. Wage Increase

The foregoing has obviously been taken into account by broader public sector employers and a number of the unions that represent the employees of these employers as can be seen from the following information:

(i) Public Sector (non-municipal) wage increases for unionized employees in 2015, as reported by the Ministry of Labour, were 0.7%. The same percentage increase applied to settlements arrived at in early 2016.

(ii) CUPE's and SEIU's centrally bargained wage settlements for the public hospital employees that they represent were 0.7% in 2016.

Regrettably, the Chair has not seen fit to follow these settlement patterns. In my view, the wage increase in Year 1 should have been 0.7%.

b. Premiums/Allowances

There is no proper justification whatsoever, in my view, for the Chair increasing the shift and weekend premiums by 5 cents; the standby premium by 15 cents; the

responsibility allowance by 10 cents and the team leader allowance by 35 cents.

ONA was already enjoying, before any increases, the highest such premiums/allowances of all of the unions in the public hospital sector in Ontario.

Just because ONA tables proposals to increase the dollar value in nearly every provision in the collective agreement having a monetary cost, does not mean you have to address these items. The proper response, in my view, would have been to say no to all of these proposals.

2. Hospitals' Proposals

The Hospitals had a limited number of proposals in issue at this arbitration, in addition to their counter-proposal on wages. ONA, on the other hand, had 30 proposals. Two of the Hospitals' proposals were dealt with in the award – elimination of the BScN allowance and utilization of the insurance carrier's medical appeals process prior to utilizing the grievance and arbitration provisions in disputes involving entitlement to LTD benefits. In my view, other proposals of the Hospitals (and in particular, those related to temporary staffing and re-deployment of nurses) were sensible, fair and reasonable and a clear demonstrated need was shown for them. However, the Chair did not award anything with respect to either of them.

At present, temporary vacancies not arising from specific leaves of absence, are limited to 60 days' duration. That is a very short time frame and way out line with

how temporary vacancies are typically defined in most collective agreements. The Hospitals proposed that vacancies of greater than 60 days and lasting up to 12 months be posted and filled in accordance with the selection process article of the collective agreement. They also proposed that upon completion of the temporary vacancy, the nurse who was awarded the temporary vacancy would be reinstated to her former position. In my view that is a far more sensible approach to dealing with temporary vacancies than the process which currently exists. At present, a vacancy of over 60 days which did not arise from a specific leave of absence has to be posted as a permanent vacancy even when everyone knows that the job would only last, for example, for six months. At the end of the six-month period, the person who got the job would have to be laid off which would then trigger the extensive layoff provisions of the collective agreement including the real possibility of having to pay a severance package. This, in my view, is a ridiculous situation. The Hospitals were right to come to the Board to seek to change it and the Chair was wrong, in my view, in deciding not to deal with this issue.

Another compelling Hospitals' proposal that was not dealt with involved the layoff process. The Hospitals wanted to review with ONA, prior to issuing any notices of layoff, a list of re-deployment opportunities *i.e.* vacancies which had not yet been posted. The idea was that, hopefully, the parties could agree that some or all of these re-deployment opportunities would not have to be posted and instead, an employee who was otherwise subject to layoff, could be offered the opportunity to transfer into one of these re-deployment opportunities for which she was qualified, and thereby avoid a layoff and the attendant disruption that ensues. The proposal made absolute sense and the Hospitals showed a clear demonstrated need for it.

Nevertheless, the Chair did not see fit to award it. The current collective agreement language dealing with the whole process of layoffs is very problematic for Hospitals. It is costly and inefficient and is in dire need of significant change.

Dated at TORONTO on this 7th day of September, 2016.

"Brian O'Byrne"

Brian O'Byrne
Employer Nominee