

**In the Matter of an Interest Arbitration
Under the *Hospital Labour Disputes Arbitration Act***

BETWEEN:

THE PARTICIPATING HOSPITALS

(the "Hospitals")

AND

ONTARIO NURSES ASSOCIATION

(the "Association")

(Central Issues)

Before:

Eli A. Gedalof, Chair
Brian O'Byrne, Hospitals Nominee
Kate Hughes, Association Nominee

Hearing Held: By videoconference on April 20 and 21, 2021.

Appearances

See Appendix "A"

AWARD

INTRODUCTION

1. This board of interest arbitration was duly appointed under the terms of the *Hospital Labour Disputes Arbitration Act* ("HLDAA") and in accordance with the March 8, 2021 Memorandum of Conditions for Joint Bargaining between the parties, to settle the central terms of the collective agreements between the Ontario Nurses Association (the "Association") and 131 Participating Hospitals (the "Hospitals"), represented by the Ontario Hospital Association (the "OHA"). The collective agreements between the Association and each of these Hospitals are composed of central terms, which are the subject of this award, and local terms which are negotiated and, if necessary, arbitrated, separately by the parties. The Association represents approximately 65,000 hospital full-time and part-time registered nurses ("RNs"), nurse practitioners

("NPs"), Registered Practical Nurses ("RPNs) and other health care professionals that are subject to the collective agreements arising from these central and local issues processes. This is the 19th round of central bargaining between the Association and Participating Hospitals.

2. The parties met in bargaining from March 8 through March 12, 2021 and March 22 through March 25, 2021, including with the assistance of a mediator on March 24 and 25, 2021. They were not able to resolve all of their outstanding issues but did reach agreement on several items which they request that this board incorporate by reference in this award. We therefore order that the terms of the renewal collective agreement shall consist of the terms of the expired collective agreement as amended by those agreed items and the terms of this award. Any proposals that are not agreed to or otherwise ordered here are deemed dismissed.

3. There are two forces that overwhelm the context within which this round of bargaining and interest arbitration take place, that should be acknowledged and emphasised at the outset.

4. The first contextual force is the ongoing Covid-19 pandemic. At the time of bargaining, almost four hundred thousand Ontarians had been infected with the virus, including over seven thousand health care workers. The pandemic continues and has claimed the lives of over twenty thousand Canadians, including one of the Association's members. There is no question that Nurses have borne a tremendous weight in providing essential and highly skilled care throughout this crisis and have been working under extremely challenging conditions. The Association emphasises the countless examples of individual sacrifice embodied by its membership. It is also not an overstatement, as asserted by the Hospitals, to say that this pandemic has massively disrupted Hospital operations, as they have worked to respond to the dynamic and overwhelming demands of responding to the pandemic. On these basic facts the parties do not disagree. Where they part company is with respect to the significance of this context to the assessment of their respective proposals.

5. From the Association's perspective, the pandemic has brought to a head and exacerbated long-standing systemic inequality. Nurses, argues the Association, are hailed as heroes of this pandemic and celebrated in words and various symbolic action, while their compensation structure leaves them lagging behind male comparators for the bulk of their career. Indeed, argues the Association, it is exceedingly well established that the economic impact of the pandemic has been overwhelmingly and disproportionately borne by women. The pandemic has also, argues the Association, brought to a head deficiencies in the health and safety and job security provisions of the collective agreement. According to the Association, the onset of the next

outbreak of infectious disease and the next global pandemic is a foregone conclusion, and now, not after it has already begun, is the time to strengthen protections. Further, the Association argues that there is a significant, ongoing and growing nursing shortage in the province that has gotten worse and will only continue to do so, at a time when patient acuity is going up and skilled nurses are needed more than ever. Now, argues the Association, is also the time to address these deficiencies and to grant their proposals to address a provincial recruitment and retention problem.

6. From the Hospitals' perspective, the global pandemic has required hospitals to mobilize and reassign their limited resources in order to provide services above and beyond their normal operations. The Hospitals maintain that they are further strained in responding to this crisis by years of underfunding and fiscal restraint. They have been operating under a variety of temporary funding and regulatory measures, including the remarkable and unprecedented suspension of parts of the collective agreements between the parties. They have temporarily canceled services they normally provide, moved patients throughout the system, and taken on non-traditional duties in atypical working environments in order to meet the demands of the pandemic. In this context, the Hospitals maintain that it would be entirely inappropriate to impose additional constraints on their ability to operate. Instead, the Hospitals argue that what is called for are modest and measured amendments to remove pre-existing barriers that frustrate the Hospitals' ability to reorganize their operations for greater efficiency. The kinds of breakthrough provisions sought by the Association, argue the Hospitals, are the opposite of what is required.

7. The second contextual force is the application of the *Protecting a Sustainable Public Sector for Future Generations Act, 2019*, more commonly referred to as "Bill 124". As discussed further below, where it applies, Bill 124 imposes a 3-year "moderation period" that limits increases to wages and total compensation to 1% in each year. In the prior round of interest arbitration between these parties the board, chaired by arbitrator Stout (the "Stout Board"), found that Bill 124 applied to these parties and that it was necessary to comply with the wage restraint provisions therein (*Participating Hospitals (Ontario Hospital Association) v Ontario Nurses' Association*, 2020 CanLII 38651 (ON LA)(the "Stout Award")). The term of the collective agreement arising from the Stout Award ran from April 1, 2020 to June 7, 2021 (one year from the date of the award in accordance with the minimum term under *HLDA*). The board awarded 1% annual across the board increases effective April 1, 2020 and April 1, 2021. The board also awarded monetary improvements equal to the residual of 1% of total compensation, i.e., the amount left over once having accounted for the wage increase, for the year commencing April 2020. The board did not, however, award the residual

amount from the 1% of total compensation for the year commencing April 2021, preferring to leave that issue to be decided by this board of arbitration.

8. The parties have agreed that the term of the collective agreement arising from our award will run from June 8, 2021 to March 31, 2023, which will bring the parties to the end of the moderation period under Bill 124. We will address below the Association's argument that this board ought not to apply Bill 124, and the Hospitals' argument that we must. We will also address the Association's argument that Bill 124 does not in any event preclude this board from adjusting the 25 year RN wage grid or from implementing a new NP grid, on the grounds that the current wage structure violates the *Ontario Human Rights Code*. The Hospitals oppose this argument on both jurisdictional and substantive grounds. What we wish to acknowledge by way of context, however, is that the intersection of Bill 124 with the ongoing pandemic and all of the strains it entails has created a collective bargaining environment in which nurses feel particularly aggrieved. According to the Association, the systemic inequality that is already baked into the nurses' compensation structure, an inequality that they say is made particularly acute by the pandemic, has been further exacerbated by the constraints of Bill 124. While other front line workers that are male-dominated, such as police officers and firefighters, are able to bargain wage increases and other monetary improvements beyond any 1% limit, nurses working on the very front line of this pandemic, cannot. The contradiction between hailing nurses as heroes while simultaneously denying them even normative compensation increases is, argues the Association, discriminatory, insulting and highly demoralizing.

9. In this context, the Association argues that if this board concludes that it must apply the constraints of Bill 124, then it must also grant the Association meaningful improvements in its other areas of priority, i.e., health and safety and job security. Viewed from the other end of the lens, the Hospitals argue that their proposals are necessary in order to permit them to operate efficiently and effectively with limited resources, and that the Association's proposals are either unnecessary, or would exacerbate the difficulties the Hospitals are already experiencing.

10. With this context in mind, we will provide a broad overview of the parties' proposals, before addressing the principles of interest arbitration, the application of Bill 124, and the application of these principles and the applicable legislation to the parties' proposals.

THE PARTIES' PROPOSALS

11. The Association identifies three proposed letters of understanding, each of which provide for improvements to the salary schedules for RNs or NPs, as

its top priority in this round of bargaining. In particular, the Association proposes to replace the current 10-step wage grid for RNs, which contains a top rate at 25 years, with a compressed 7-step grid. The new grid would allow nurses to reach the top rate in 6 years, instead of 25, which the Association argues is comparable to their male comparators under pay equity. The Association also refers to other public sector "first responders", such as police and firefighters, who reach their top rate at 8 years and thereafter receive additional "experience pay premiums". For NPs, extended class nurses with an expanded scope of practice, the Association proposes to introduce a single standardized 6-step wage grid with a top rate at 5 years. Currently, the wage grid for NPs varies from one hospital to another, with a variety of wage rates and steps. The Association further proposes that RNs and NPs be placed on these grids so that they receive a salary increase. In addition, the Association proposes a Long Service Pay Adjustment Letter of Understanding providing for a 2% increase to employee's wage rate at 10 years of service. With respect to all of these improvements, the Association argues that the current wage structure is in effect discriminatory and contrary to the *Human Rights Code*, and that these improvements are therefore exempted from the application of Bill 124.

12. The Association identifies improved job security as its second priority. In particular, the Association seeks to amend Article 10.12 of the Collective Agreement to restrict the Hospitals' ability to assign nursing duties and responsibilities to non-RNs, and to require that the Hospitals move toward attaining an average 70/30 percent full-time/part-time RN complement, and to prohibit any reduction in bargaining unit staff hours or full-time RN complement.

13. Finally, amongst its priority items, the Association argues that health and safety improvements are imperative, and that there is a demonstrated need to bring the collective agreement in line with, and give greater effect to, the precautionary principle. In particular, the Association proposes changes to Article 6.05 that would include a requirement that hospitals maintain a minimum 3-month supply of N95, equivalent or better respirators, and to expand the availability of this equipment to circumstances where there is a reasonable indication of the emergence of "an infectious disease, including an unknown infectious disease", which may not be a "pandemic". Further, the Association proposal would provide for salary continuation for employees during quarantine or self-isolation, and the provision of the names of such employees within one day to the Association. Finally, the Association proposes to incorporate into the Collective Agreement the expedited arbitration procedure provided for in the Stout Award, and to expand the application of that procedure to all individual and union grievances concerning personal

protective equipment, and not merely disputes arising from the government's current Directive #5¹.

14. In addition to these priority items, and contingent on the Association's position that Bill 124 ought not to be applied in this case, the Association seeks wage increases of 3% in the second year of this agreement, and improvements to a variety of monetary provisions. These proposals include substantial enhancements to premiums, meal allowance, call back, health and welfare benefits (including enhanced or new coverage for hearing aids, vision, extended health care coverage, PPE expenses, dental, benefits age 65 and over, EAP and mental health services), enhanced pregnancy and parental leave and an improved vacation entitlement. Among these proposals is a proposal to "clarify and codify" that the current reference in Article 17.01(c) to "Drug Formulary 3"—a term the Association maintains is no longer used in the industry—should be interpreted as including "the Compendium of Pharmaceuticals and Specialties (CPS) less over the counter medications". The Association submits that this proposal is cost neutral, while the Hospitals assign it a significant cost. The Association also proposes to amend Article 19.05 so that NPs are credited with RN experience when being placed on the wage grid, and new articles to recognize the time Nurse Practitioners are required to spend on professional development and to allow Nurse Practitioners to accept and retain preceptorship stipends paid directly by universities.

15. The Hospitals oppose all of the Association's proposals. They argue that all of the monetary improvements sought by the Association are subject to the strictures of Bill 124 and therefore, with the very limited exception of accounting for the residual amount of the 1% of total compensation left after wage increases, cannot be awarded by this board. For their part, the Hospitals propose to amend the existing layoff language at Article 10.08. In its current form, arising from an interest arbitration award by Justice Houlden in 1998 and as interpreted by various arbitrators over the years, the layoff language captures the reassignment of a nurse from their home area for more than one shift within the definition of "layoff". A layoff, in turn, triggers an obligation to make offers of early retirement, even in circumstances where a hospital is not seeking to downsize and where there is a vacancy within that nurse's skill set in which that hospital could place the nurse. The Hospitals seek to amend the provision so that they can effect short-term reassignments of nurses to meet patient need, merge or move patients between similar units or reassign

¹ Directive #5, Issued under Section 77.7 of the *Health Protection and Promotion Act (HPPA)*, R.S.O. 1990, c. H.7, is specifically directed toward Covid-19 and requires public hospitals to provide employees with PPE, including but not limited to N95 respirators, according to various stipulated criteria.

nurses to vacant positions, without resorting to layoffs. From the Hospitals' perspective, it makes no sense that in order to respond to changing needs, they are forced to lay off nurses and even offer them incentives to leave, when in fact the Hospitals actually wish to retain those very same nurses.

16. The Hospitals also propose to amend the work of the bargaining unit provision in Article 10.12(a) to provide greater flexibility in reassigning duties between full-time and part-time nurses, provided it does not result in the layoff of a full-time nurse. In conjunction with this proposal, the Hospitals also propose a Letter of Understanding providing for the parties to meet and review the complement of full-time and part-time RNs and identify possible enhancements having regard to a variety of factors including patient and scheduling needs.

17. In addition, the Hospitals propose to limit the application of the call back premium in Article 14.06; improvements which formed part of the Stout Award and which the Hospitals argue were not normative and would not have been freely bargained.

18. Finally, the Hospitals propose maintaining and renewing the Letter of Understanding awarded by the Stout Board establishing an expedited arbitration process for addressing PPE disputes specifically under Directive #5 for the term of this award.

THE PRINCIPLES OF INTEREST ARBITRATION

19. The principles upon which the parties rely and that guide the interest arbitration process are well-established. This board is of course bound to apply the criteria set out in the *HLDA*, which sets out the duties of the board and a non-exhaustive list of considerations at section 9 as follows:

Duty of board

9 (1) The board of arbitration shall examine into and decide on matters that are in dispute and any other matters that appear to the board necessary to be decided in order to conclude a collective agreement between the parties, but the board shall not decide any matters that come within the jurisdiction of the Ontario Labour Relations Board. R.S.O. 1990, c. H.14, s. 9 (1).

Criteria

(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. 1996, c. 1, Sched. Q, [s. 2](#).

20. Amongst these criteria, the Hospitals, while not making an "ability to pay" argument in the strict sense, emphasise the first three criteria. The Association emphasises the latter two, with a particular focus on the need to attract and retain qualified nurses in the face of what the Association asserts is an ongoing and steadily worsening nursing shortage. In addition to these criteria, the parties rely upon the always important principle of replication and, of particular significance to the Association's health and safety proposals and to both parties' proposals related to job security, demonstrated need. We will say more about these principles below. What is readily apparent in reviewing the parties' economic proposals, however, is the extent to which the application of Bill 124 is a threshold issue that limits to a very significant degree what it is even possible for this board to consider in this round. Arguments about ability to pay, impact on services, the state of and future prospects for the Ontario economy, whether comparisons to more generous settlements are or are not appropriate, and whether or not it is necessary to improve monetary terms in order to attract and retain nurses, all become academic if the most that can be done is to award 1% increases, which increases are not opposed by the Hospitals.

THE APPLICATION OF BILL 124 AND THE MONETARY PROPOSALS

21. In passing Bill 124, the government imposed strict limits on what parties covered by the Act can bargain, and on what boards of interest arbitration such as this one can order. Section 5(4) of Bill 124 explicitly provides for its application to every hospital within the meaning of the *Public Hospitals Act*,

which would include all of the Hospitals that are the subject of this award. In accordance with section 8 of Bill 124, the Act explicitly applies to trade unions such as the Association, who are certified or voluntarily recognized under the *Labour Relations Act, 1995*. In broad terms, then, there can be no compelling argument that the Act does not apply to these parties. Section 9 of Bill 124 imposes the three-year “moderation period” during which the following restraints, set out in sections 10 and 11, must be applied:

Maximum increases in salary rates

10 (1) No collective agreement or arbitration award may provide for an increase in a salary rate applicable to a position or class of positions during the applicable moderation period that is greater than one per cent for each 12-month period of the moderation period, but they may provide for increases that are lower.

Exception, certain increases

(2) Subsection (1) does not prohibit an employee’s salary rate from increasing in recognition of the following matters, if the increase is authorized under a collective agreement:

1. The employee’s length of time in employment.
2. An assessment of performance.
3. The employee’s successful completion of a program or course of professional or technical education.

Maximum increases in compensation

11 (1) During the applicable moderation period, no collective agreement or arbitration award may provide for any incremental increases to existing compensation entitlements or for new compensation entitlements that in total equal more than one per cent on average for all employees covered by the collective agreement for each 12-month period of the moderation period.

Same

(2) For greater certainty, an increase in a salary rate under [subsection 10 \(1\)](#) is an increase to compensation entitlements for the purposes of subsection (1).

Effect of cost increases

(3) If the employer’s cost of providing a benefit as it existed on the day before the beginning of the moderation period increases during the

moderation period, the increase in the employer's cost does not constitute an increase in compensation entitlements for the purposes of subsection (1).

22. There are limited exceptions to these restraints set out in sections 13 and 14, none of which apply to the proposals before this Board. There is also provision in section 15 for a Ministerial exemption from the strictures of the Act. The Association applied to the Minister for an exemption but it has not been granted.

23. In addition to limiting monetary increases to 1% of total compensation, Bill 124 also explicitly limits the jurisdiction of, among others, arbitrators and boards of arbitration such as this one, from inquiring into or making a decision "on whether a provision of this Act, a regulation or an order made under subsection 26(1) is constitutionally valid or is in conflict with the *Human Rights Code*" (s.29(2)). Further, Bill 124 provides the government with a number of oversight and enforcement mechanisms including the ability to invalidate an interest arbitration award or to withhold funding from non-compliant employers. To put it bluntly, therefore, when it comes to the application of Bill 124 in this proceeding, the parties' and this Board's hands are tied.

24. The Association has filed a constitutional *Charter* challenge to Bill 124 in court, which is the appropriate venue for such a challenge. It seeks to overturn the Act on two constitutional grounds—s.2(d) of the *Charter* (freedom of association) and s.15 of the *Charter* (equality rights). It argues, nonetheless, that this Board ought to issue an award without regard to Bill 124, in part for the reasons set out in its *Charter* challenge, but also in part because it argues that the application of Bill 124 is inconsistent with this Board's obligation to carry out its statutory mandate under *HLDA*, and the Act unduly interferes with the exercise of our expertise. Boards of interest arbitration, it argues, have ignored directions to impose wage restraints in the past where those directions have conflicted with the usual principles of interest arbitration. These arguments were rejected in the Stout Award in the previous round of interest arbitration between these parties. The Stout Award in turn cites the reasons in *Mon Sheong Home for the Aged v Ontario Nurses' Association*, 2020 CanLII 8770 (ON LA), which reads, at para. 16:

Neither can we simply ignore the strictures of Bill 124 in this case. As an administrative body, this board of arbitration is a creature of statute, carrying out the function assigned to us by the legislature. In this regard, the circumstances in which we find ourselves are not the same as those of the Albertyn board in *Casey House*, where Bill 124 was not yet law, and where both the future and potentially retroactive application of the Bill was not yet fixed. Neither are they the same as the circumstances of the Shime board in *McMaster*, where he found that it would be inappropriate to permit

government funding decisions alone to dictate the outcome of an interest arbitration where all of the relevant and appropriate considerations together supported a different result. In the case of Bill 124, we simply do not have such latitude; sections 10 and 11 dictate that, (subject to the exceptions set out in s.10(2) of the Act, which are not applicable in this case), no arbitration award may provide for an increase in salary or existing compensation entitlements of more than one percent. ONA has put forward several arguments with respect to the disruptive impact of this limit on long-established bargaining patterns. But these grounds are not a basis upon which Bill 124 permits this Board to circumvent the wage restraint provisions. These and other arguments may underly ONA's constitutional challenge to the Bill, but that is an issue the legislature has left to the courts.

25. The Association has raised substantially the same arguments as were addressed in the Stout Award and in *Mon Sheong*, and we find that we must dismiss those arguments for the same reasons. We pause here to note, however, that in *Mon Sheong*, the board ordered a re-opener in order to protect against the potential disruption to established bargaining patterns in the event that Bill 124 is ultimately overturned by the courts or otherwise found to be inapplicable. The Stout Award also provides a re-opener for substantially the same reasons. The Association has requested the same reopener here, and the Hospitals do not oppose that request provided it is on the same terms as provided for in the Stout Award. For the same reasons, we find it appropriate to award such a re-opener and it is reflected in the terms awarded below.

26. The Association has also, however, raised in these proceedings an additional argument that demands careful consideration. In particular, the Association has provided extensive argument and materials in support of its position that the current structure of the 25-year wage grid for RNs and the disparate wage grids applicable to NPs systemically discriminate on the basis of sex and are contrary to s.5(1) of the *Human Rights Code*. According to the Association, where it is necessary to award its proposals in order to remedy such discrimination, section 28 of Bill 124 permits this Board to do so. Section 28 reads as follows:

Rights not reduced

28 Nothing in this Act or in the regulations shall be interpreted or applied so as to reduce a right or entitlement under,

- (a) the [Human Rights Code](#);
- (b) [section 42](#) or [44](#) of the [Employment Standards Act, 2000](#);
- (c) Part IX of the [Employment Standards Act, 2000](#); or

(d) the [Pay Equity Act](#).

Further, citing *Association of Ontario Midwives v. Ontario (Health and Long-Term Care)*, 2018 HRTO 1335 (CanLII) and authorities such as *BC v. B.C.G.S.E.U. (Meiorin)*, [1999] S.C.R. 3, the Association argues that it is necessary to apply a liberal and purposive interpretation of human rights legislation that seeks to “transform” and “build conceptions of equality into workplace standards”.

27. The Association’s bargaining units are heavily female-dominated, ranging over 90% female. It argues that in comparison to male comparators, including but not limited to a composite male comparator based on three OPSEU paramedical classifications which the Association argues has already been agreed to by the OHA on behalf of the Hospitals in an ongoing pay equity process, the grids for RNs and NPs are discriminatory both because the wage rates are lower at each step, but also because it takes far longer for a nurse to reach the job rate: 10 steps over 25 years for nurses, with a 17-year lag between the 9th and 10th steps, compared to 7 steps over 6 years for their male comparators. According to the Association, the parties agreed to the composite comparator in 2012, it was approved and applied by the Pay Equity Commission in a January 15, 2013 decision arising at *Niagara Health System*, and the parties have not to date replaced it with a new male comparator. However, the Association also relies on a variety of hospital and non-hospital comparators, the majority of which are male dominated classifications, but some of which, especially the CUPE RPN classification, are not, to demonstrate that its 25-year grid is both discriminatory and an outlier.

28. The parties have been engaged in ongoing pay equity maintenance negotiations since 2012, but progress has been exceedingly slow. Central to the Association’s argument, however, is the assertion that even were the pay equity process complete, this would not address the systemic discrimination inherent in the wage grids, because it will still take nurses almost two decades longer than their male comparators to reach what the Association asserts is the “job rate”. In this regard the Association cites *CUPE Local 1999 v Lakeridge Health Corporation*, 2012 ONSC 2051 for the proposition that the *Pay Equity Act* is not a comprehensive scheme for eliminating sex discrimination in wage rates. In that case, the Divisional Court held that the *Pay Equity Act* required only equality at the job rate, or top rate on the grid, and did not require either compressing or harmonizing grids as between male and female comparators. It is significant in assessing the impact of the limited remedial scope of the *Pay Equity Act*, that prior to 2004, RNs reached their top rate at 8 years of service. In 2004, however, it was a board of interest arbitration that introduced a new 25-year rate, with the intention of addressing retention issues by incentivising nurses to hold off on retirement. However well

intended, the Association argues that the resultant grid structure now exacerbates systemic discrimination that will not be remedied through the pay equity process and which should therefore be corrected by this board.

29. The Hospitals oppose the Association's proposal to compress the grid on its merits, but maintain that it is in any event prohibited by Bill 124 and is based on a flawed reading of s.28. In particular the Hospitals argue that s.28 must be read together with section 29(2), which reads:

An arbitrator, arbitration board or tribunal shall not inquire into or make a decision on whether a provision of this Act, a regulation or an order made under [subsection 26 \(1\)](#) is constitutionally valid or is in conflict with the [Human Rights Code](#).

30. According to the Hospitals, s.29(2) is a clear prohibition on precisely what the Association seeks here to achieve. Section 10 limits annual increases in compensation to 1% of total compensation, and even if one were to find that absent greater adjustment the resultant wage rates would constitute discrimination under the Code, this board of arbitration is bound to apply section 10 notwithstanding any conflict with the *Human Rights Code*. Further, the Hospitals note that Bill 124 contains several exceptions and qualifications, such as section 10(2) which permits employees to progress through a salary range or grid on the basis of length of service, performance or by attaining additional qualifications. Had the legislature intended to create the kind of exception the Association seeks here, argue the Hospitals, it would have provided for it in a similar manner.

31. The Hospitals further argue that in any event, the circumstances in the instant case are distinguishable from those in the *Ontario Midwives* case. In that case, the tribunal found that there was a historical link between midwives' salaries and the salaries of certain family health doctors, with midwives salaries pegged at roughly 90% of the doctor's salaries. From 2005 onward, the relative salaries of midwives eroded and the government, as funder, failed to consider the gender-based implications of the failure to maintain this relationship. In finding that this failure was discriminatory and a breach of the *Code*, the Hospitals emphasise that in that case there was an established comparator and a single actor responsible for the failure to maintain equality. In the instant case, the OHA is not the funder for nurses, and it does not set the salaries for many of the comparators relied upon by the Association. Instead, there are here 131 employers who have agreed to bargain with the Association together, but who bear no direct responsibility for bargaining many of the comparators relied upon by the Association.

32. Further, the Hospitals maintain that the Association is seeking here to circumvent the parties' ongoing centralized pay equity process. The Hospitals dispute that there is an agreement that the 2012 composite male comparator relied upon by the Association is the appropriate and current pay equity comparator for the centralized pay equity process for RNs. Rather, the Hospitals maintain that the 2012 comparator formed a narrow part of an interim agreement between the parties which gave rise to the ongoing centralized pay equity process: a process in which the parties have bargained comprehensive terms of reference but in which the appropriate comparators remain to be determined. And while the Hospitals acknowledge that the Association may be frustrated by the pace of that ongoing process, they note that the parties have agreed that its outcome will be retroactive to April 2011. The appropriate course, argue the Hospitals, is to allow that process to reach its conclusion without interference.

33. Absent Bill 124, there would be no doubt that this Board retained the jurisdiction to compress the 25 year grid, to implement a new grid for NPs, or to award economic increases such as the 10-year retention bonus that the Association seeks here. As the Association correctly argues, boards of interest arbitration have awarded similar proposals (i.e. amended or compressed wage grids), looking to appropriate comparators and in order to address concerns of equality, both related to gender issues and in the sense of ensuring "equal pay for equal work" as between comparable positions. Certainly there is nothing in the Keller award to suggest that in awarding a 25 year step for purposes of promoting retention, the Board considered the impact of doing so on gender or pay equity in any manner. It is of course generally within the jurisdiction of a board of arbitration to revisit the outcome of prior awards and to address any unintended consequences of those awards. The basic principles of interest arbitration such as replication and the related concept comparability, together with demonstrated need, might drive such a result in those circumstances.

34. But it must also be acknowledged that the proposed new wage schedule and the mapping onto that new schedule sought by the Association would result in substantial wage increases well beyond anything that could be described as normative in collective bargaining, and certainly well beyond any increases contemplated by Bill 124. For example, the Association's new schedule would constitute an increase of over 11% to start rate, and over 18% to the three year rate. Absent a finding of a specific breach of the *Code*, committed by the 131 separate employers that constitute the participating hospitals before this board, and absent a finding that paragraph 28(a) of Bill 124 permits us to remedy such a breach by awarding increases above and beyond the allowable 1%, this Board is clearly precluded from awarding even the most modest version of this proposal.

35. On this latter point, it is not obvious to us that, having regard to paragraph 28(a) of Bill 124, an appropriate remedy for a breach of the *Human Rights Code* could not result in wage increases of greater than 1% per year during the Bill 124 moderation period. Certainly, permitting such an increase would appear to be the purpose of maintaining rights under the *Pay Equity Act* under paragraph 28(d), and it is difficult to see why one would draw a distinction between the rights under either Act. But in the final analysis, we do not find it necessary to decide this issue because in our view it is neither possible nor appropriate for us to conclude on the record before us that the 131 Participating Hospitals have committed an actual and specific breach of the *Code*. Neither, to be clear, would we find it possible or appropriate to conclude that they have not committed such a breach.

36. First, it bears noting that there is nothing inherently discriminatory in adopting a 25-year rate under a wage grid. The Association's argument is predicated on a finding that there is a pay equity gap to begin with. And while the Association argues that such a conclusion follows from the comparator to which the parties have agreed, there is a live dispute between the parties about whether that comparator is in fact appropriate. These parties have agreed to an ongoing pay equity process, and it would not be appropriate for this board to usurp that process. Any disputes over the appropriate pay equity comparators, and any disputes over the extent to which the parties have agreed to certain comparators within that process, should be determined within the process to which the parties have agreed. For this Board to award the Association's proposals would inescapably and inappropriately pre-empt the outcome of that process, and undermine, rather than give effect to, the parties' agreement. Such an outcome could not be said to replicate free collective bargaining.

37. Second, we simply do not have before us an evidentiary record upon which we could properly assess whether 131 separate employers have breached the *Human Rights Code*. Neither has this proceeding, which has been conducted in accordance with the procedure adopted by the parties for an interest arbitration, provided the parties with a full and fair opportunity to litigate such a complex issue of human rights, as would be required by the principles of natural justice. The Tribunal's decision in *Ontario Midwives* was based on an extensive record, established through a collaborative process in conjunction with the tribunal, over several years, that included numerous affidavits and expert reports, followed by approximately 50 days of testimony, resulting in thousands of pages of transcripts and extensive closing argument (see paras. 7-17). We do not say that such a laborious process is necessary in every case of an alleged breach of the *Code*, but the procedure adopted must be suited to the nature of the dispute. The procedure adopted by the

parties before us is entirely appropriate in creating an evidentiary record for an interest arbitration; a record that permits this Board to properly apply the principles of interest arbitration to the proposals before us. But it is not a record that allows us to determine an extremely complex “rights” arbitration, or upon which we could properly find 131 breaches of the *Human Rights Code*. And in the absence of such a substantive finding, Bill 124 clearly and unequivocally precludes awarding any compression of or advanced placement on the grid, and precludes awarding any long-service pay adjustment. In reaching this conclusion, we are explicitly not deciding the merits of whether the existing wage schedules are discriminatory, or whether equity considerations or the principles of interest arbitration would support an amendment to the wage grid. Those are issues that remain to be addressed in a different forum, or by a subsequent board of interest arbitration that is not constrained by Bill 124, as may be appropriate.

38. In light of our conclusion on the applicability of Bill 124, the remaining monetary issue to be determined is which of the Association’s outstanding monetary proposals fit within the residual of the 1% of total compensation and should be awarded. The parties initially joined issue over the correct costing of the Association’s proposals but were ultimately able to resolve those issues, based on an agreed costing of proposed premium increases. As the Association notes, it has routinely bargained increases to its night and weekend premiums on a periodic basis. Those premiums were not increased in the last round, and we find it appropriate to award them here. The increases awarded below reflect the maximum allowable annual increases in accordance with Bill 124, based on the parties’ agreed costing. We also note that while the term of this agreement commences June 7, 2021, the Hospital has agreed that in light of the unique timing issues arising from the Stout Award (which set terms for the period April 1, 2020 to June 6, 2020, but which deferred to this Board the residual of the 1% maximum annual increases allowed for under Bill 124 for the year commencing April 1, 2021), this Board may award this residual amount commencing April 1, 2021. We note that our willingness and ability to reach back into the term of the prior award is based on the unique circumstances of this case and the parties’ explicit agreement that we may do so.

39. Because the premium increases we are awarding exhausts the residual amounts available for monetary improvements under Bill 124, we are unable to award any of the Association’s remaining monetary proposals, outlined above. Even highly normative and modest improvements to health and welfare benefits—commonly awarded by past boards of interest arbitration between these parties—are beyond the scope of our jurisdiction under Bill 124. Neither can we consider proposals such as the vacation improvement proposed for long-service nurses, pregnancy and parental leave, or any other

monetary improvements. We are similarly precluded from awarding enhanced placement on the salary grid for NPs, which would also represent an incremental increase in compensation within the meaning of Bill 124. Neither, in the absence of a clear solution, do we find it appropriate at this time to make any orders with respect to what the Association refers to as the outdated reference to Drug Formulary 3 at Article 17.01(c) of the Collective Agreement. We find that the parties should have a further opportunity to bargain clarity around this issue.

40. Finally, we have considered the Hospitals' proposal to restrict the applicability of the call back provision. The enriched call back provision to which the Hospitals object formed a part of the residual of the 1% of total compensation ordered by the Stout Board in accordance with its determination that Bill 124 must be applied. It is noteworthy that that board specifically found that but for Bill 124, it would have awarded greater monetary increases. In this context, it would not be appropriate to roll back an aspect of that award a year after it was granted and while these parties continue to be bound by the strictures of Bill 124. We therefore decline to award that proposal.

THE JOB SECURITY PROPOSALS

41. As noted above, both parties have made proposals that fall under the broad heading of "job security". Neither party's proposals are novel, and the same or virtually the same proposals were made, and rejected, in the last round of interest arbitration.

42. In rejecting the Hospital's proposals, the Stout Award reads, at para. 45:

[47] The Hospitals seeks their own changes to job security language and in particular the unique definition of layoff found in article 10.08 of the Collective Agreement. The Hospitals note that the current language, as interpreted by the case law, establishes a barrier to the efficient operation of a hospital. We would note that this language was granted by Justice Houlden at a time of fiscal restraint, when a wage freeze was imposed. While we recognize the Hospitals' legitimate concerns, we are of the view that entertaining this proposal at this time of fiscal restraint is not appropriate.

43. The Hospitals argue that this reasoning is inconsistent with the history of the language at issue, given that the change awarded by Justice Houlden, i.e. the reference to a "single shift" not constituting a layoff, was actually intended to provide the Hospitals with greater flexibility, and not less flexibility in light of fiscal restraints. We nonetheless agree with the conclusion in the Stout Award. It is true, as the Hospitals argue, that rights arbitrators have

expressed some sympathy for the Hospitals in light of the highly restrictive interpretation of the layoff language that they have been compelled to adopt. But as articulated by Arbitrator Teplitsky in *SEIU and A Group of 46 Hospitals*, unreported, August 31, 1983, at p. 4, it is not the role of the interest arbitrator to judge whether the inclusion of such a provision is in the best interests of the parties:

Interest arbitrators attempt to emulate the results of free collective bargaining. As I wrote in an award between the Ottawa Police and the Board of Commissioners of Police dated September 10, 1980 at page 4: 'interest arbitrators interpret the collective bargaining scene. They do not sit in judgement of its results'.

44. The Hospitals' evidence does not establish such a compelling demonstrated need as to overshadow any other considerations. And in our view, the principle of replication in particular must trump any demonstrated need to amend the existing layoff language in the particular circumstances of this case. Whatever the original basis upon which this language was awarded, the fact is that it is now highly valued job security language to the Association's benefit, that has been entrenched in the collective agreements over many rounds of bargaining. The Hospitals seek substantial concessions from the Association but have offered nothing of substance in return to obtain those concessions. And in light of Bill 124, the Hospitals would be highly constrained in doing so in any event. In our view, this is what the Stout board meant when it said that it would not be appropriate to grant job security concessions in times of fiscal restraint. Absent a compelling demonstrated need, the kinds of bargaining concessions the Hospitals seek are generally gained through some form of *quid pro quo*, and here the Hospitals have offered nothing in exchange. Further, while we are clearly in a time of statutorily imposed restraint, the Hospitals have not put forward any comparators to suggest that parties have been bargaining such concessions. The principle of replication therefore militates strongly against awarding the Hospitals' job security proposals.

45. Neither have the Hospitals established a demonstrated need to amend the language in Article 10.12(a) guarding against the assignment of the work of full-time nurses to part-time nurses "for the purpose of eliminating full-time positions." The Association has consistently pursued expansion, and not contraction, of full-time nursing positions, as a priority. Absent a substantive and compelling basis for finding a demonstrated need, the principle of replication strongly militates against awarding such a concession.

46. Neither, however, would we award the Association's job security proposals at this time. The Association's proposal to further restrict the

assignment of work to other healthcare workers such as RPNs would, as the Hospitals argue, constitute an extraordinary breakthrough that is unlikely to be replicated in free collective bargaining, and for which there is no overwhelming demonstrated need. Neither would it be appropriate at this time to award further restrictions on the Hospital's ability to determine appropriate full-time and part-time complement, which is already constrained by Article 10.12(a). While we have not granted the Hospital's proposals to increase their flexibility in this regard, we do accept that in the context of an ongoing pandemic, where the Hospitals have a demonstrated need to respond to changing demands, it would not be appropriate to impose further constraints on complement. Further, nothing before us suggests that awarding such a proposal would replicate free collective bargaining at this time.

47. Nonetheless, the evidence before us does establish that complement and its associated consequences with respect to workload and burnout is a major issue for the Association's members and for both these parties, and there are live and ongoing disputes over the optimal ratio of full-time to part-time nurses in at least some hospitals and some units. The Hospitals have proposed a Letter of Understanding to provide for local discussions around complement. And while this letter falls well short of the Association's demands, we find that with the addition of language to ensure the discussions are focussed on both patient care and workload issues related to complement, the Hospital's proposal, as we have amended it, reflects an appropriate and incremental step in addressing this ongoing issue.

HEALTH AND SAFETY

48. The Association has proposed several changes to the health and safety language under the collective agreement directed toward solidifying the application of the precautionary principle (i.e. the principle that a hospital need not await absolute or scientific certainty before taking reasonable actions to reduce risk), already reflected in the Collective Agreement, ensuring nurses have reliable access to personal protective equipment, and expanding the application of an expedited grievance procedure for PPE disputes. The Association also seeks salary continuation for nurses who are required to self-isolate due to exposure to an infectious disease at work. This last element of the proposal would constitute a new monetary benefit that is outside the agreed-to 1% costing under Bill 124, however, and must therefore be rejected for the reasons already discussed. The remaining proposals merit careful consideration.

49. The Association seeks to amend Article 6.05(a) of the Collective Agreement in three significant ways. First, it seeks to specifically reference

the provision of “readily accessible personal protective equipment” as a reasonable action to reduce risk and protect employees. Second, in place of the obligation to maintain “adequate stocks” of N95 respirators, the Association seeks an amendment to require Hospitals to maintain a 3-month supply of “N95 or equivalent or better (and other personal protective equipment)”. Third, it seeks to extend the criteria for provision of this protective equipment from “reasonable indications of the emergence of a pandemic” by adding “or an infectious disease, including an unknown infectious disease.”

50. Further, in the prior round of interest arbitration, in a Supplemental Award in *Ontario Hospital Association v Ontario Nurses’ Association*, 2020 CanLII 84240 (ON LA), the Stout Board ordered a Letter of Understanding creating an expedited arbitration process for disputes relating to nurse’s access to PPE “as provided for in the current Directive #5” (the “LOU”). Directive 5 was issued by the Chief Medical Officer of Health under s.77.7 of the *Health Protection and Promotion Act* and sets out required precautions and procedures with respect to PPE when dealing with suspected, probable or confirmed COVID-19 patients or residents. The Hospitals propose to renew the LOU in its current form. The Association seeks to broaden the terms of the LOU to cover disputes related to accessing PPE generally (i.e. not only those disputes related to Directive #5), to permit the Association to raise disputes on its own behalf (i.e. not only those disputes raised by a particular nurse) and to incorporate those terms into Article 7 of the Collective Agreement.

51. The Association argues that there is a demonstrated need to strengthen the application of the precautionary principle. Citing its experience with SARS in particular and the recommendations arising from that outbreak, including in Justice Campbell’s SARS report, the impact on healthcare workers of the current pandemic and the fact that Hospitals are and can be expected to continue to be major sources of outbreak of infectious disease, the Association argues that its amendments are required in order to give meaning to the precautionary principle. Under the current provisions, it argues that its members will be effectively forced to wait for the next outbreak to find out whether the Hospitals will in fact supply the protection required prior to identifying the infection’s method of transmission. Particularly in the early days of an outbreak, it is essential, argues the Association, that its members have access to PPE without having to first invoke and wait for the outcome of Orders from the Ministry, or the litigation of grievances, especially under the typical timeframes under the grievance procedure. By the time decisions are made under those processes, it may be too late to prevent negative outcomes or to quickly access necessary equipment and in any event such disputes create uncertainty and disruption at times when order and certainty are most needed.

52. In the case of the current pandemic, the Association has provided an extensive account of the large number of grievances related to accessing PPE in the early days of the Covid 19 outbreak, before the LOU was in effect, many of which are still awaiting further dates with arbitrators. From the Association's perspective, it is inevitable that there will be another outbreak or pandemic, and now is the time to establish processes that properly enshrine the precautionary principle rather than waiting to react to the next pandemic. The Current LOU, restricted to the circumstances of Covid 19 and Directive #5 will not assist in addressing future outbreaks or pandemics. Further, even within the context of the current pandemic, the Association has challenged Directive #5 for its failure to recognize airborne transmission, a topic that continues to be scientifically controversial as reflected in numerous reports and studies cited by the Association. In the Association's submission, the proper application of the precautionary principles means nurses should be protected while the science continues to evolve. Further, in the words of the SARS Commission, healthcare workers such as nurses should also "be made to feel safe, even if this means continuing with levels of heightened precautions that experts believe are no longer necessary."

53. In response, the Hospitals argue that there is no demonstrated need to amend Article 6.05, and that the work refusal and complaint provisions of the *Occupational Health and Safety Act* are generally sufficient to address any concerns about unsafe work. In the normative day-to-day operation of hospitals, disputes over PPE are rare. During the pandemic such disputes have been largely resolved by settlement. The Hospitals further argue that in the context of the pandemic, Directive #5 appropriately balances stewardship and conservation of PPE while maintaining minimum safety standards. The Association's proposal, it argues, sets an arbitrary standard for maintaining stocks, which standard is indeterminate given fluctuating utilization rates, in circumstances where the Hospitals cannot necessarily control supply in any event. Maintaining these stocks would also give rise to logistical problems for the Hospitals, which are not set up as storage warehouses.

54. With respect to the proposed amendments to Article 7 and the incorporation and amendment of the terms of the LOU, the Hospitals argue that the Stout Board created a process that was tailored to the specific needs of the current pandemic, and that there is no demonstrated need to expand it and create a parallel grievance procedure for PPE disputes generally. Since the implementation of the LOU and at the time of the hearing in this matter, there had only been one dispute referred to the process. Further, the Hospitals argue that their willingness to renew the LOU for the term of the current agreement obviates any need to amend the Collective Agreement.

55. Having carefully considered both parties' submissions and supporting materials, we are satisfied that the Association has established a demonstrated need to strengthen the articulation of the precautionary principle in the Collective Agreement and in the LOU in order to ensure that nurses have ready access to appropriate PPE from the earliest possible days of the outbreak of an infectious disease. The experience of SARS and of the early days of the current pandemic support the Association's contention that access to this PPE should not be predicated on whether the outbreak is part of a "pandemic" specifically, and that the language should be amended to better reflect the precautionary principle in this regard. The evidence establishes that the majority of disputes are likely to arise in the earlier days of an outbreak, when there may be no consensus on whether what is emerging is a "pandemic" in particular and when the parties have not yet developed an alternative dispute resolution mechanism that is tailor-made to the particular outbreak, but where the precautionary principle nonetheless mandates immediate access to the appropriate PPE and a rapid mechanism for dispute resolution.

56. However, while we would grant the Association's proposals in part, for the reasons articulated by the Hospitals we do not find it necessary or appropriate to order that the Hospitals maintain a specific "3-month supply" of respirators. The current language requires that the Hospitals maintain adequate stocks, and any future disputes concerning the adequacy of a hospital's stockpile should be determined on the specific facts applicable at that time. Further, we find that the proposed reference to "an infectious disease, including an unknown infectious disease" is overly ambiguous and have adopted language that is more specific in addressing the demonstrated need.

57. Neither do we find it appropriate to incorporate the terms of the LOU into the collective agreement at this time. The grievance procedure under the LOU was only recently ordered by the Stout Board, and the parties have had very little experience with its operation to date. It is unlikely that the parties would agree in free collective bargaining to enshrine such a new and untested process in the collective agreement. Thus, while we find appropriate to expand the scope of the LOU to provide a more comprehensive mechanism for addressing PPE disputes, particularly in the early stages of any future outbreak of infectious disease, in line with the precautionary principle, it is premature to incorporate this procedure into the Collective Agreement at this time. Instead, the LOU should be appended to the Collective Agreement and is subject to renewal by the parties or a subsequent board of interest arbitration.

58. For all of these reasons, we award that the Collective Agreement shall consist of the terms of the expired agreement as amended by those terms previously agreed-to by the parties and as follows:

Terms Awarded

Term

June 7, 2021 to March 31, 2023.

Wages

April 1, 2022-1% increase across the board.

Premiums

Retroactive to April 1, 2021-increase night premium by \$0.23.

April 1, 2022-increase weekend premium by \$0.24.

Health and Safety

Amend second bullet of Article 6.05(a) as follows:

When faced with occupational health and safety decisions, the Hospital will not await full scientific or absolute certainty before taking reasonable action(s) **including but not limited to, providing readily accessible personal protective equipment** that reduces risk and protects employees.

Amend third bullet of Article 6.05(a) as follows:

Hospitals will ensure adequate stocks of the N95 respirator **or equivalent or better** (or such other personal protective equipment as the parties may in writing agree) to be made available to nurses at short notice in the event that there are reasonable indications of the emergence of a pandemic, **epidemic or outbreak of an infectious disease in the community served by the Hospital.**

Renew the Stout Letter of Understanding amended as follows:

...

2. Despite the grievance procedure found in Article 7 of the Collective Agreement, the following process shall be followed with respect to any grievance relating to a nurse's access to PPE at a Hospital. **as provided for in the current Directive #5.**

- If a nurse has any dispute relating to accessing PPE **as provided for in current Directive #5**, such nurse shall discuss the concern or dispute with her or his immediate supervisor. If the immediate supervisor does not resolve the concern or dispute within twenty-four (24) hours then the nurse or ONA may file a grievance.

...

NEW: Letter of Understanding Re: Optimal Complement of Registered Nurses (RNs)

The local parties agree to meet annually to review the complement of registered nurses (RNs). The Hospital and the Union will work together to identify units where patient care needs would be enhanced by a review of the complement of RNs, and to discuss how best to address those needs.

The parties will discuss the optimal full-time and part-time complement of RNs for the unit which meets its patient care needs. To assist the discussion, the parties will review the following:

- Acuity
- Agency hours
- Continuity of care
- Hours paid at premium
- Individual special circumstances
- Leaves of absences
- Patient census
- Professional development
- Scheduling practices
- Vacation scheduling
- Full-time/part-time complement
- Workload
- Professional Responsibility Workload Forms
- Staff turnover/Recruitment and Retention

Reopener

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

59. We remain seized in accordance with subsection 9(2) of the *HLDA*.

Dated at Toronto, Ontario, this 20th day of September 2021.

"Eli Gedalof"

Eli A. Gedalof, Chair

"I dissent in part"

Brian O'Byrne, Hospitals Nominee

"I dissent"

Kate Hughes, Association Nominee

APPENDIX "A"

APPEARANCES

For the Hospitals

Craig S. Rix, Hicks Morley LLP
David Brook, OHA
David McCoy, OHA
Sadia Bekri, OHA
Philip Cifarelli, OHA
Hilary Grice, OHA
Joyce Chan, OHA
Lisa Smith, Health Sciences North
Angela Hodgson, London Health Sciences Centre
Clarence Willms, Kingston Health Sciences Centre
Dean Osmond, Sioux Lookout Meno Ya Win Health Centre
Laura McGowan, Thunder Bay Regional Health Sciences Centre
Leah Martuscelli, Joseph Brant Hospital
Myfanwy Marshall, Centre for Addiction & Mental Health
Phillip Kotanidis, Michael Garron Hospital
Susan Leach, Arnprior Regional Health

For the Association

Diana Kutchaw, Labour Relations Officer (Interest Arbitration)
Darcell Bullen, Lecal Counsel (Interest Arbitration)
Beverly Mathers, Chief Executive Officer
Steve Lobsinger, Senior Executive, Negotiations/Chief Negotiator
Vicki McKenna, President
Cathryn Hoy, First Vice-President
Alan Warrington, RN, Chair, Hospital Central Negotiating Team
Kelly Latimer, RN, Hospital Central Negotiating Team Member
Carrie Doherty, RN, Hospital Central Negotiating Team Member
Rachel Muir, RN, Hospital Central Negotiating Team Member
Kate Magladry, RN, Hospital Central Negotiating Team Member
Ingrid Garrick, RN, Hospital Central Negotiating Team Member
Derek Montgomery, RN, Hospital Central Negotiating Team Member
Erin Ariss, RN, Hospital Central Negotiating Team Member
Grace Pierias, RN, Hospital Central Negotiating Team Member
Jo-Dee Brown, RN, Hospital Central Negotiating Team Member
Marilynn Dee, Manager/Team Lead, Labour Relations
Patrica Carr, Manager/Team Lead, Long-Term Care Non-Institutional
Matthew Stout, Manager, Labour Relations

Victoria Romaniuk, Administrative Coordinator, Office of the CEO
Sharleen Corrigan, Labour Relations Officer
Angel Furlott, Labour Relations Officer
Marie Haase, Labour Relations Officer
Brandon Walker, Labour Relations Officer
Dave Campanella, Labour Relations Officer (Economist)
Ryan FitzGerald, Labour Relations Officer (Benefits)
Tanya Beattie, LRO, Nursing Research/Nursing and Health Policy Officer
Andrea Sobko, Legal Counsel, Pay Equity

PARTIAL DISSENT

I agree with the Chair's disposition of many of the issues in dispute in this case. However, there are some issues where I part company with him and I will briefly deal with what I see as the most significant of these issues in this Partial Dissent.

The Participating Hospitals did not have many proposals before us (certainly much less than ONA) but these proposals were all carefully and intelligently drafted and the submissions before us, in support of the proposals, were thorough and persuasive. The Participating Hospitals' proposals, as a whole, consisted of modest and measured proposed changes whose purpose was to remove pre-existing barriers in the collective agreement that both frustrate and limit the Hospitals' ability to run their operations efficiently and effectively with limited resources. In my view, a clear demonstrated need was established by the Hospitals for their proposals and the proposals addressed that need and provided appropriate solutions to the need that was established.

In this regard I disagree with the Chair's reason for not granting the Hospitals proposals regarding job security. The Chair was of the view that the evidence adduced by the Hospitals "does not establish such a compelling demonstrated need as to overshadow any other considerations". Frankly, I don't know what more would have been needed in this case to establish a "compelling" demonstrated need. The standard that interest arbitrators have traditionally used is "demonstrated need" not "compelling demonstrated need". I would have retained the demonstrated need standard (which should apply equally to the proposals of both parties) and not applied what appears to be a different standard that sets the bar too high. In any event, in this case, I believe that the Hospitals made out a very strong case for having their proposals awarded and in my view they should have been awarded.

I wish to make one additional point regarding the Hospitals' proposals regarding 10.08(a) and 10.14(b). When the current language in 10.08(a) (dealing with reassignments) was awarded by the Houlden Board, the intent was to grant the Hospitals greater flexibility to avoid triggering layoffs. The current retirement allowance offers provision (Article 10.14(b)) was also awarded by the Houlden Board at the same time and was designed to mitigate the impact of layoffs by incenting nurses to leave the hospital voluntarily in order to avoid involuntary job loss resulting from a reduction of nursing staff complement. As a result of a series of rights arbitration awards between 2003 and 2012 the reassignment language that the Houlden Board awarded was turned upside down and a reassignment of a nurse for more than a single shift was held to constitute a layoff. Accordingly, a reassignment for longer than three months was a long-term layoff and offers of retirement allowance were triggered in circumstances where the hospital was not at all not seeking to reduce the nursing staff complement but instead was seeking to simply reorganize their operations and realign the existing workforce. In other words, the retirement allowance offers became triggered in situations neither envisioned nor intended when the language was awarded. In paragraph 33 of the Chair's award, he states: "It is of course generally within the jurisdiction of a board of arbitration to revisit the outcome of prior awards and to address any unintended consequences of these awards". In my view, we have before us a classic case of unintended consequences flowing from the Houlden award. As the Hospitals stated in their written submissions "Continuing to require hospitals to incentivize staff who are needed within the hospital to leave with payouts of scarce healthcare funding is unconscionable" I would have awarded the Hospitals' proposals.

The second issue I wish to address is the Chair's decision to amend the Stout LOU dealing with access to PPE as provided for in Directive #5. I disagree with what the Chair has done. We know that since this LOU was awarded almost a year ago, there has been only one dispute referred to the expedited process that this LOU established. This seriously calls into question the need to continue this process for the current pandemic. Yet despite this, the Chair decided to make amendments to this LOU with a view to ensuring that there is a dispute resolution process in place in the event there is some future pandemic. In my view, the *Occupational Health and Safety Act* coupled with Article 6.05 of the collective agreement (which the Chair decided to amend in a number of respects) address the issue of access to appropriate PPE which can then be enforced in a number of ways.

We were told that in the normative day to day operation of Hospitals, disputes over PPE are rare. We were also told that during the pandemic, such disputes have been largely resolved by settlement. The question then becomes why do the parties need the specific expedited process set out in the Stout LOU (which deals with disputes over access to PPE as provided in Directive #5) for a future pandemic or outbreak of an infectious disease. Who knows what that future pandemic or infectious disease will be; who knows what will be needed to deal with it; and who knows what an appropriate process to deal with disputes over access to PPE in these circumstances, should look like. In my view, and with the greatest of respect to the Chair, it just doesn't make a lot of sense, at this point in time, to make an award that a particular expedited process, that was only recently awarded by Arbitrator Stout in the last round, to deal with the particular circumstances of COVID-19 and Directive #5, should also apply to unknown events in the future when nobody knows, at this time, what they will look like and nobody knows what will be needed. I would have simply left the Stout LOU unchanged and added a clause to it that directed the parties to discuss what dispute resolution mechanism should be applicable, on a going forward basis, for dealing with disputes regarding access to PPE if, in future, a pandemic is declared.

Dated at Toronto this 20th day of September 2021.

Brian O'Byrne

DISSENT OF KATE HUGHES, UNION NOMINEE

1. While I agree with the Chair in this award that Bill 124 makes it unfortunately impossible for this Interest Arbitration Board to carry out our statutory functions under the *Hospital Labour Arbitration Disputes Arbitration Act* (“HLDA”) and to replicate free collective bargaining, I must respectfully dissent from the Chair’s award in two key areas of this award. It is my view that the Chair’s decision with respect to the important human rights proposal of the Association and his award on the non-monetary proposals around staffing language are both fundamentally flawed and wrongly decided.
2. While the Board’s hands, to repeat the Chair’s phrase, are “tied” due to the constraints of Bill 124, preventing us from awarding the proposals of appropriate salary and benefits increases for these Nurses, Nurse Practitioners and other hospital professions based on the clear demonstrated need, there is no bar in Bill 124 from awarding proposals based on the Ontario *Human Rights Code*. The Chair rightly notes that s. 28 of Bill 124 expressly states that nothing in Bill 124 reduces a right under the Ontario *Human Rights Code*. Nothing prevents this arbitration Board from applying and interpreting the *Human Rights Code* and nothing bars this Board from changing the grid structure on that basis.
3. The Association’s human rights grid proposal, its detailed written brief, many supporting exhibits and its oral argument, demonstrate that the lengthy grid has a discriminatory effect on its members; it is an issue squarely within the Board’s jurisdiction and Bill 124 permits a remedy under the *Human Rights Code*. As the SCC said while reviewing an arbitration decision in the case ONA referred us to, *District of Parry Sound and OPSEU* : “human rights establish a floor beneath which an employer and a union cannot contract”.
4. The wage grid at issue in this collective agreement is extraordinarily long and has the unfortunate effect of preventing a hospital nurse from reaching the top job rate for 25 years. This is in contrast other front line workers, such as police and firefighters, and the male comparators in the health sector, who reach a top grid rate in 6-8 years. Police, firefighters, and nurses are all deemed public “First Responders” as recognized in the *First Responders Day Act*. Police and firefighters are male dominated professions, as recognized by the Ontario Human Rights Commission and Tribunal; nursing is female dominated as recognized by many tribunals. We heard direct evidence that nursing in Ontario is over 91 % female. In the case of firefighters and police, we heard evidence that these predominately male workers are regularly given healthy increases on their wage grid, additional experience premiums of percentage pay at regular intervals above their grid by interest arbitrators as well as generous increases to their benefits

including mental health benefits. The grid in the central agreement has been expanded several times, including by other interest board awards, with the effect of delaying nurses from reaching the top job pay rate until they have worked for a quarter of a century. The Chair says that there is nothing on the face of the Keller interest arbitration award (the award that imposed the 25 year step on the grid) to indicate that the Keller Board had considered the impact of the extended grid on gender or pay equity at that time. I have no doubt that the intent in creating the long grid was not to discriminate or harm the nurses, but intent is irrelevant in human rights jurisprudence. It is the adverse effect that is relevant in considering systemic discrimination. ONA's argument was that this is systemic discrimination in the grid that is not apparent on its face. Citing well established jurisprudence ONA correctly argues that systemic, not formal or facial equality, is what is required under human rights jurisprudence in Canada. While the Keller board may not have considered effect, it is incumbent on this Board to now do so in face of the ONA's proposal to rectify the discriminatory effect.

5. The Chair declines to determine this human rights proposal. His first reason for doing so is he says that it will "pre-empt" the ongoing pay equity process. This is flawed reasoning as the human rights argument is not the same as the pay equity issues under the *Pay Equity Act*. Indeed the Chair himself cites the Divisional Court case of *Lakeridge Health Corporation* which held that the Pay Equity Tribunal did not have the power to change a grid. An interest arbitration board does have that jurisdiction and arbitration boards commonly award changes to the pay structure, including length of a wage grid.
6. As well, I disagree that ordering the grid length be changed to comply with human rights principles would "inescapably and inappropriately pre-empt the outcome of that [pay equity] process", as the Chair concludes. The pay equity process cannot change the grid structure. It could only change the pay of the one top job rate, which takes a nurse 25 years to achieve, and could change the designated male comparator. But until it does so the existing male comparator is in place, as confirmed by the Pay Equity Commission Review Services Decision (see Ex 265). The very broad statutory jurisdiction and duties of the Board under s. 9(1) of HLDAA cannot be applied in a manner inconsistent with the "human rights floor: identified by the SCC in the *Parry Sound and OPSEU*."
7. Second, the Chair declines to determine the matter as he believes we do not have "an evidentiary record upon which we could properly assess whether the 131 separate employers have breached the *Human Rights Code*". This reasoning is flawed in several ways. First this is a central process where the participating hospitals negotiate collectively through the Ontario Hospitals Association. None of the proposals are determined on the basis of evidence from each and every one

of the hospitals, and that has never been an expectation of the parties or interest arbitration Boards. In considering the need for health and safety changes in the collective agreement, for example, neither this Board nor the previous boards required evidence from each of the 131 hospitals to determine a proposal.

8. With respect, we had a sufficient evidentiary record. ONA's brief was extensive, at 296 pages with 412 supporting exhibits and case law; the evidentiary record specifically on the human rights proposal was lengthy, the written argument was detailed, and was supplemented by two days of oral legal argument. He stated it was not a record that "allows us to determine an extremely complex "rights" arbitration or upon which we could properly find 131 breaches of the Human Rights Code." This however is an interest arbitration issue, not a rights arbitration matter; an interest arbitration board in an agreed upon central process has the power of changing the grid in the central collective agreement, including the authority to order that a wage structure must be human rights compliant. A rights arbitration cannot do that—it cannot make an order changing a grid in the central agreement. Nor can a pay equity tribunal. This is the only forum in which the discriminatory impact of the central pay grid can be addressed.
9. Moreover, the Chair had the option of sending the matter back to the parties and to then hold a later hearing to allow for more fulsome evidence and argument, if necessary. Interest arbitrators can hear oral evidence with cross examination by the parties. They can, and often do, ask for more evidence on an issue. Indeed, in the last round between these parties, the arbitration board's June 8, 2019 award sent the health and safety issue of the pandemic Personal Protective Equipment back to the parties, and ultimately convened a further hearing resulting in the second award addressing that occupational health and safety issue. A human rights issue is no different.
10. Much of the evidence necessary, such as the structure and history of the grid, was not in contention and is set out in the parties' briefs and in previous decisions. Under the *Pay Equity Act*, the male comparator job rate is one which a RN's rate cannot go below, and the male comparator is in place until there is an agreement between the parties or an Order setting out a replacement maintenance agreement and new male comparator. There is no evidence that there is such a new order or new agreement; as such the previous agreed to male comparator remains, as set out in Exhibit 265. If the OHA does not agree that that these were the facts, or they took issue with ONA's position in substance, they could have provided the Board with evidence and made legal argument on the substance of the proposal. Instead, they primarily argued only that no human rights argument could be made due to Bill 124. The OHA had full procedural rights to be heard, and ONA should

not be prejudiced by strategic choices the OHA made in that regard. It is noteworthy that one of the OHA representatives at the hearing was the same one whose signature is on Exhibit 266, the parties Pay Equity Plan where the agreed to male comparator is set out. If it was contentious whether this Plan or the agreed male comparator was still in effect this could have been addressed by evidence, cross examination and legal argument at the hearing or, if necessary, at an additional day(s) of hearing.

11. The Chair cited the recent Human Rights Tribunal case, *Ontario Midwives*, where the Registered Midwives of Ontario's pay structure was found to be in violation of the Ontario *Human Rights Code*. This is a relevant case for ONA's legal argument but the Chair distinguished the case on the basis that the evidence there was "extensive" before that Tribunal. Not all human rights tribunal cases are that long and length or complexity of evidence is not a reason for an interest arbitration to not determine a matter in its jurisdiction.
12. The Chair claims we did not have a sufficient evidentiary record before us to determine the human rights issue. I disagree. We had 412 exhibits entered before us from ONA, many of which went to the human rights issue. We had ONA's extensive written brief of 292 pages and their oral argument. The OHA on behalf of the Participating Hospitals had full opportunity to respond to it, and to present their own evidence and legal argument. The hospitals choose to simply take the position at bargaining, and again at the hearing, that Bill 124 prevented any remedy under the Human Rights Code. That was a risky narrow position to take; they should not be rewarded for failing to put in their evidentiary record before this Board by having this Board refuse to determine an issue they have jurisdiction over on the basis that the evidentiary record was insufficient.
13. The Registered Midwives, unlike Registered Nurses, are not unionized and do not have access to the more expeditious arbitration process. that the Tribunal was their only forum for obtaining a remedy. This does not mean that unionized health professionals need go that route to have a human rights matter determined. Applying and interpreting the *Human Rights Code* is firmly within the jurisdiction of interest arbitrators.
14. While the Chair appears not to have made a finding on the OHA argument that Bill 124 prevents a proposal based on the Human Rights Code, he made opines that a new human rights compliant wage grid would likely result in wage increase beyond that contemplated by the 1 percent cap of Bill 124. This is surely the point of s. 28 of Bill 128 when it states nothing in Bill 128 is to be interpreted or applied to reduce rights under the *Human Right Code* or the *Pay Equity Act* . The wage

cap in Bill 124 is irrelevant to a human rights based argument as Bill 124 does not, and cannot, override the Human Rights Code.

15. The Chair defers this issue to a future arbitration Board or another forum. That would take years to have the issue heard. Delay is not appropriate in these circumstances. Nursing shortages and burnout of staff in hospitals is a crisis; it was in a crisis before the pandemic, publicly acknowledged by the OHA in their public report entitled "Hospitals on the Brink". The pandemic has now caused what ONA rightly called in these proceedings "a crisis within a crisis". Nurses are under unprecedented stress, suffering burnout, working long hours, working lengthy overtime hours after 12-hour shifts, working on units that are chronically short staffed and becoming increasingly short-staffed. This dire situation is widely acknowledged, and confirmed in the evidence in ONA's brief, not to mention the almost daily reports in the media and in Open letters from physicians, that nurses are leaving their Ontario nursing jobs in large numbers. The shortages, demonstrated by the unfilled vacancies at hospitals, were confirmed in the OHA disclosure and the exhibits before the Board. Under HLDAA s. 9(1) 5, this Board must consider these recruitment and retention issues and other relevant considerations. The pandemic crippling Ontario hospitals is surely a relevant consideration and nurses cannot wait for some undetermined future board to finally decide an issue that was squarely put before this Board.
16. In my view, the second flawed area in this award that I must address regards the Association's proposals on job security language. It is well known amongst interest arbitration board members that in times when compensation proposals cannot be awarded, that in order to replicate free collective bargaining, language improvements should be awarded. I would have awarded the ONA proposals in job security language and, in particular, the proposal for staffing at a ratio of 70% full-time nurses to 30% part-time nurses across the bargaining unit. The 70/30 ratio of full-time to part-time is well recognized as the appropriate ratio for nurses in Ontario by government, academics, and health care experts, as set out in the evidence. This is the percentage that experts have concluded leaves the best staffing ratio to allow flexibility to a hospital, to attract employees, and to allow for sufficient staffing ratios, especially given the reality of overcapacity patient numbers at many Ontario hospitals (even before the pandemic). It is noteworthy that Mr. Justice Marrocco in the Long Term Care Commission's report in April of 2021 repeated the urgent need for the 70/30 ratio in Long Term Care and it is equally needed in Ontario hospitals.
17. The Chair awarded the OHA proposal providing yet another Letter of Understanding telling the parties to meet to deal with identifying the well-known staffing problems. This LOU, even with small changes, does not address the staffing problems and adds little or nothing to the collective agreement as there

are already similar provisions for the parties to meet and talk. What nurses need is language that is meaningful and address problems by putting in place recognized best practices ratios; they do not need more window-dressing and yet another committee meeting to simply talk.

18. Nurses have had years of reports setting out the problems of staffing and nurse shortages, and there is much evidence of demonstrated need to improve the working conditions of nurses in Ontario. It is now a health care crisis due to a devastating pandemic, and nurses are at the breaking point. Talk is not enough. Nurses need real improvements in their working conditions or they will continue to talk with their feet and leave. Units and hospital beds will continue to have to close for lack of nurses. This is a crisis problem requiring immediate measures.
19. The Board was given evidence, including from the OHA disclosure documents, of high and growing overtime and call back costs. We were also given evidence, including from the independent body, the College of Nurses, that Ontario part-time nurses are seeking full time jobs but that the hospitals are primarily posting nursing positions as part-time positions. We were given evidence of Ontario nurses leaving the province and working elsewhere to get stable full-time employment. The evidence was that the majority of hospitals have insufficient full-time staff and are relying on part-time staff. Having sufficient full-time staff working at regular hourly rates, not overtime or call back rates, will also help to address hospital costs. It will also help the nurse who are exhausted and at the breaking point; they are working on units with insufficient staffing and with chronic and growing unfilled vacancies. The Board heard evidence of numerous professional responsibility workload complaints at hospitals documenting the significant safety problem of not having sufficient stable full time staff and the over use of agency nurses. There was more than ample demonstrated need before the Board to award the Association's language improvement proposals.
20. Nurses have had their constitutional right to strike taken away from them. Like the police and firefighters, nurses have been given instead the interest arbitration process that is said to make up for the lack of the right to strike and to replicate free collective bargaining. There is no doubt in my mind that nurses in Ontario, working in a chronically understaffed hospital system hit by a pandemic that is now in its fourth wave, would, if they could, exercise their right to strike when faced with life-threatening working conditions where their wages are unnaturally suppressed. A one percent increase for each of these years with no increase in benefits or improvements in their working conditions while they are putting their health at risk 24 hours a day, 7 days a week is untenable. But, such a insulting increase along with no real consideration of an important human rights matter and no language improvements is simply wrong. We heard evidence of other front line workers, such

as municipal police and firefighters who are at less risk during this lengthy pandemic have had significant wage increase and increase in benefits awarded by similar arbitration interest boards whose hands are not tied by Bill 124. Nurses are walking out of their jobs; I have no doubt they would walk a picket line. Experts and government policy for years has been to try to increase the percentage of full-time jobs to 70%, the percentage experts have concluded leaves the best staffing ratio to allow flexibility and to attract employees. To replicate free collective bargaining, and to implement the HLDAA criteria, an interest arbitration board has to recognize the risks, the stress and the difficult and 24/7 shift work of the workers in questions and improve their conditions to allow for sufficient recruitment and retention of the workers, especially when there is demonstrated need of a shortage of these workers. Interest arbitrations recognize this for similar 24/7 frontline workers, such as police and firefighters. The fact that they don't equally do so for health care professions is unfathomable.

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