Ontario Nurses' Association

Response to the Ontario Changing Workplaces Review Interim Report

Changing Workplaces Review
Employment Labour and Corporate Policy Branch
Ministry of Labour

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ONTARIO NURSES' ASSOCIATION
85 Grenville Street, Suite 400
Toronto, ON M5S 3A2
Phone: (416) 964-8833
Fax (416) 964-8864
Website: www.ona.org

INTRODUCTION

The Ontario Nurses' Association (ONA) is the union representing 62,000 front-line registered nurses (RNs), nurse practitioners (NPs), registered practical nurses (RPNs) and allied health professionals and more than 14,000 nursing student affiliates across Ontario, providing care across the health sector in hospitals, long-term care facilities, public health, the community, clinics and industry.

In September 2015 and February 2016, ONA provided submissions to the Changing Workplaces Review, which outlined for the Special Advisors the current realities of health care work and proposals for change to the *Employment Standards Act* and *Labour Relations Act, 1995* to ensure working conditions that enhance dignity and respect for nurses and allied health professionals.

The Special Advisors' Interim Report sets out a broad range of issues and options, which have been identified through the Changing Workplaces Review, and requests feedback on a number of issues to assist in the development of a final report. This submission provides feedback on the identified options and makes recommendations about what we consider to be high-priority issues in the health-care sector. In addition, we have attached a chart at Appendix 1, which outlines our support for one or more options suggested in the report with respect to the *Labour Relations Act (LRA).*

With respect to the *Employment Standards Act*, ONA has reviewed the submissions made by the Workers' Action Centre (WAC) in its report, "Building Decent Jobs from the Ground Up." ONA supports the WAC in its submissions on the Employment Standards sections of the interim report with one proviso. As noted in our original submissions, ONA represents a workforce that operates in a 24/7 environment. In negotiating collective agreements for its membership over the past 40 years, there has been extensive focus on establishing provisions dealing with hours of work and scheduling, which both provide full coverage for patient care, while at the same time placing limits on the detrimental impacts of working shift-work and weekends on its membership. ONA would be opposed to any measures that limit its ability to negotiate flexible schedules on behalf of its membership.

For ease of reference, our submissions and Appendix 1 follow the chapter and section headings of the interim report. We conclude our submissions with a summary of our principle recommendations.

4.2.2 RELATED AND JOINT EMPLOYERS

ONA commented on this issue in our earlier submissions. In the health-care system, we are facing fragmentation of the provision of health services in our communities. In our original submissions, ONA provided a pertinent example:

> The current definitions and jurisprudence dealing with "the employer" and "a related employer" simply do not reflect the organization of many private and public sectors.
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> For example, in the health-care system, the publicly-funding CCACs distribute work through a competitive bidding process between providers of "nursing services" for home care and care in ambulatory care clinics. As a result, the provision of nursing services is contracted out to for-profit companies, particularly

> in the ambulatory care sector, and not-for-profit organizations. These companies and organizations often then rely upon temporary agency nurses.
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> The organization of nursing services in the home care and ambulatory care is a hollow pyramid. The work is controlled by the CCAC, but the CCAC have fragmented the provision of nursing services to a network of "nursing service providers" who are subcontracted to provide either home care or ambulatory clinic services. The formal employment relationship of the nurses is with a private company, a not-for-profit organization, or a temporary agency.
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> In fact, the organization of work in the home-care sector is more akin to the construction industry with a network of contractors and subcontractors.
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> In ONA's submission, the current approach to certification creates a barrier to meaningful collective bargaining with the true employer, which ultimately directs the flow and distribution of nursing services. The current bargaining unit structure, based upon a single employer and single "workplace" means that ONA may be required to organize and negotiate with a small private company which is relied upon by the CCAC. Such a private company may rely upon temporary agency nurses to provide care. Often, the right to bargain to impasse leads to a loss of work to another agency.

For clarity, although the current role of CCACs will soon be transferred to LHINs, the above example and issues arising from it remain. As noted by the Special Advisors in the interim report, there are numerous challenges to organizing workers at the level of temporary help agencies, and unionization at the agency level is almost non-existent in Canada. That is certainly ONA's experience, and we strongly advocate for changes to the *LRA,* which would help address the inequities described above.

We support Option 2 identified in the interim report. A separate general provision should be added, in addition to section 1(4), providing that the Ontario Labour Relations Board (OLRB) may declare two or more entities to be "joint employers" and specifying the criteria that should be applied. The criteria could be along the lines of the example suggested in Option 2, but with a slight modification, e.g. where there are associated or related activities between two businesses and where a declaration *would facilitate* effective collective bargaining. We agree that the criteria should exclude the current requirement that there be common control and direction between the businesses. This test was formulated in the context of an economic and labour relations climate in Ontario, which we believe no longer exists. Also, the common control and direction test was developed in the context of the private sector and is, therefore, not easily applicable to the public sector. The public sector, and specifically health care, faces different types of challenges as described above.

While we do not oppose Option 3, we strongly feel that it does not go far enough and is, therefore, not an ideal option. The idea of common control and direction is outdated and increasingly irrelevant to the public sector.

We also do not oppose Option 4(a), as long as the definition of "entity directly benefitting" is broad enough to encompass the health-care context. For this option to be a useful model for the health-care sector, the rebuttable presumption must take into account that in health care it is the receiving institution or health care provider that is the employer for the workers from a temporary help agency.

With respect to Option 4(b), we are not opposed to this model for franchisees, but would go further and suggest that this type of model has applicability in other contexts, and specifically in the home care context. ONA submits that the CCACs/LHINs and the service providers they contract services from, as described in the example above, should be declared joint employers for all those working in the service providers' operations. Such a model would address many of the concerning trends we see in the home-care sector, other examples of which were outlined in our submissions dated February 25, 2016, attached as Appendix 2.

In this regard, we feel the need to emphasize that for a review of labour relations legislation in Ontario to be truly comprehensive, the *Public Service Labour Relations Transitions Act (PSLRTA)* must be taken into account. The *PSLRTA* is outside the scope of this review, and so we urge the government to mandate a separate and comprehensive review of labour relations in the health-care sector to deal with the unique challenges faced by health-care workers in Ontario. Such a review would necessarily require input from all stakeholders in the health-care sector, and we welcome this opportunity.

4.3.1.3 ACCESS TO EMPLOYEE LISTS

Once again, we reference our earlier submissions with respect to this issue. ONA stated in its original submissions:

> Once having established minority support, a union should have the opportunity to provide all employees in the potential bargaining unit with information regarding the union. The open communication approach adopted by the Ontario Labour Relations Board (the "OLRB," "the Board") in *Public Sector Labour Relations Transition Act ("PSLRTA")* cases should be applied to certification proceedings under the *Ontario Labour Relations Act* (the "Act").
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> During a fixed campaign period, unions, under *PSLRTA*, are allowed access to bulletin boards in the employer's workplace, a list of names, addresses and phone numbers of employees on the potential voters' list, information meetings at the employer's site/s as well as an information table on the employer's premises during the campaign period. See for example *OPSEU and Grand River*, *St. Thomas Elgin General Hospital, Rehabilitation Institute of Toronto v. CUPE, Local 1156* and *The Scarborough Hospital v. ONA*.[1]
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> Allowing the union the opportunity to fully communicate during the campaign period would further workplace democracy and would be a step towards leveling the playing field between the union and the employer. It would, in some measure, redress the intimidation, coercion and anti-union communications usually engaged in by employers during an organizing campaign. It would also counter the need for unions to engage in clandestine activities communicate with potential voters. In this age of information sharing, true workplace democracy requires open communication.

1 *OPSEU v. Grand River Hospital*, [2010] O.L.R.D. No. 2897; *St. Thomas Elgin General Hospital v. OPSEU, Local 152*, 235 C.L.R.B.R. (2d) 187; *The Rehabilitation Institute of Toronto v. Canadian Union of Public Employees, Local 1156*, 2000 CanLII 12710 (ON LRB); *The Scarborough Hospital v. Ontario Nurses' Assn.*, Local 111, 2000 CanLII 13588 (ON LRB).

We reject maintaining the status quo and strongly support Option 2 identified in the interim report. It is our recommendation that once a union has established minority support, it should be provided with access to employee lists with contact information. A right to access employee lists should also be provided with respect to applications for decertification. This is an important and necessary step to enhancing workplace democracy and allowing employees' voices to truly be heard.

4.3.3. SUCCESSOR RIGHTS

On this issue, we first and foremost note that any review of successor rights legislation in Ontario is incomplete without looking at the *PSLRTA.* More specifically, with respect to successor rights, it is our view that *PSLRTA* should be extended to cover all transfers of work within the health-care sector. Any current loopholes must be closed. As noted above, the *PSLRTA* is not within the scope of this review, and ONA feels this creates a large gap in the review that must be addressed by the government. We reiterate our call for a health-care specific review of all labour relations legislation in Ontario.

We have reviewed the options outlined in the interim report and reject maintaining the status quo. We firmly support Option 2, and would support the provision applying to as many different sectors as possible. We are not opposed to Option 3, but feel that it is vague in its current form.

4.3.4 CONSOLIDATION OF BARGAINING UNITS

In ONA's original submissions, we advocated for a change to the Board's powers regarding the consolidation of bargaining units. We stated:

> Section 7 of Bill 40 gave the Board the power to combine bargaining units where representation rights were held by the same bargaining agent with the same employer; that section was repealed by the Harris government. ONA supports the re-establishment of the Board's power to combine bargaining units and takes the position that the Board's power to vary existing bargaining units should be further expanded.
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> The purpose of Section 7 was to facilitate viable and stable collective bargaining through the creation of broader bargaining units. The thinking behind this provision was that broader bargaining units reduce the problems associated with fragmented bargaining and provide more efficiency, convenience, lateral mobility, common employment conditions and industrial stability. The vast majority of applications under Section 7 were brought by trade unions. This allowed trade unions to create broader and more diverse bargaining units, expanding units incrementally and organizing groups who were otherwise untenable as individual bargaining units. This power should be reinstated.
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> ONA further submits that the OLRB should be given the power to vary bargaining unit descriptions in original certificates granted by the Board and/or as amended by the parties through collective bargaining. Given the Board's jurisprudence, which prohibits the use of strike or lockout to press changes to the recognition clause of a collective agreement (or arbitration under HLDAA) and the lack of explicit Board power to do so, there is no effective way to adjust historical bargaining structures that are no longer reflective of current reality.

In ONA's supplemental submissions at Appendix 2, we provided an example of the proliferation of bargaining units which has resulted in part due to mergers between hospitals. As noted at page 13 of the submission, the UHN has 23 collective agreements covering 27 bargaining units. ONA itself has 4 separate bargaining units. We reiterate that this results in inefficiencies in the use of labour relations resources.

We recommend that there be an explicit power to revise, amend and consolidate bargaining units upon application of either party, provided certain conditions are met. We do not agree that it should be limited only to where the bargaining structure is "no longer appropriate," but should be flexible enough to include instances where bargaining units may be overly fragmented, or there may be other compelling labour relations reasons for such a review. Although it does not fit neatly into any of the options identified in the interim report, it is our view that our recommendation is a version of both Options 4 and 5. We feel that the *Canada Labour Code* can serve as a model to create a less restrictive provision, which allows flexibility in the OLRB's approach to amending or consolidating bargaining units. This can be done in section 114 or can be a separate provision altogether.

We reject maintaining the status quo, and although we support Option 2, in our submission, it is too narrow. The Bill 40 provisions were a step in the right direction, but the current labour relations reality in Ontario requires the legislation to provide a broader power to the OLRB as we have outlined. For the same reason, we support the introduction of a consolidation provision with a broader test than suggested in Option 3.

ONA has a particular interest in this issue, as was identified in the recent HLDAA decision of Chris Albertyn, in which he stated:

> *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 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.*[2]

It is the position of ONA that the OLRB should be given a clear mandate to review bargaining unit structures to ensure that they are the most appropriate in light of community of interest and labour relations realities.

4.6.1 BROADER-BASED BARGAINING STRUCTURES

ONA made fulsome submissions in this regard on February 25, 2016. We refer you to those submissions in their entirety, attached at Appendix 2.

[2] *Participating Hospitals v. Ontario Nurses' Association (Collective Agreement Grievance)*, [2016] O.L.A.A. No. 344

We have reviewed the options identified in the interim report and support Option 7. We believe that there is a need to create specific and unique models of bargaining for specific industries where the *Wagner Act* model is unlikely to be effective or appropriate because of the structure or history of the industry.

In our earlier submission, we outline the current structure of the health-care sector and provide a history of labour relations in the health-care sector. That outline provides the basis for why a unique model is desirable and, in fact, necessary for the health-care sector. We have also made specific recommendations in our earlier submission with respect to the sub-sectors within health care and we reiterate our call for broader-based bargaining structures to be put in place to replace the current fragmentation. We again submit that there be a central bargaining process at the provincial level, and it is our view that allowing the OLRB to review and consolidate bargaining units will help ensure that broader sectoral bargaining can be meaningful and successful. It is the position of ONA that, ideally, there should be one union to collectively represent nurses in this province regardless of their employment setting. Like physicians there is a community of interest amongst this group of professions that are providing essential services to Ontarians. Having one bargaining agent negotiating the terms and conditions of employment for the entire group would facilitate mobility and the achievement of health-care transformation, which has been identified as a priority by the government of the province.

In concluding our earlier submissions, we provided examples of existing precedents, which the government may draw upon when coming up with a specific model for sectoral bargaining in health care. We now call for a consultation with health-care stakeholders on what the appropriate model would look like.

CONCLUSION

ONA's principal recommendations are:

1. That there be a separate and extensive review of labour relations in the health-care sector, including an examination of bargaining structures and processes to reflect the significant restructuring that is occurring.

2. That the related employer provision be amended and the successor rights provisions of the *LRA* be expanded to reflect changes in the current labour relations realities in Ontario.

3. That the *LRA* be amended to ensure that unions are provided access to employee lists with contact information in respect to both organizing drives and decertification applications.

4. That the OLRB be required to re-examine the appropriateness of bargaining units upon application of an affected trade union or employer; this can be by express provision or a more general power using the federal labour relations board's previous practice under the *Canada Labour Code* as a guide.

5. That a unique model be created for broader-sectoral bargaining in the health-care sector in consultation with ONA and other stakeholders in the industry.