IN THE MATTER OF AN INTEREST ARBITRATION
PURSUANT TO THE *HOSPITAL LABOUR DISPUTES ARBITRATION ACT, R.S.O. 1990, C.H. 14*

BETWEEN

THE PARTICIPATING HOSPITALS
As represented by the Ontario Hospital Association

(the "Hospitals")

and

ONTARIO NURSES' ASSOCIATION

(the "Union" or "ONA")

BOARD OF ARBITRATION: **John Stout, Chair**
Brian O'Byrne, Hospitals Nominee
Kate Hughes, ONA Nominee

APPEARANCES:

For the Hospitals:
Craig Rix – Hicks Morley
David Brook – O.H.A, V. P., Labour Relations & Chief Negotiations Officer
David McCoy

For ONA:
Darcel Bullen – Legal Counsel
David Cheslock – HLDAA Specialist
Vicki McKenna – President
Cathryn Hoy – First Vice President
Beverly Mathers – Chief Executive Officer
Steve Lobsinger – Senior Executive, Chief Negotiator

HEARINGS HELD BY VIDEOCONFERENCE ON APRIL19 AND 20, 2020

BACKGROUND

[1] We were appointed by the parties pursuant, to the *Hospital Labour Disputes Arbitration Act*, R.S.O. 1990 c.H. 14, as amended ("*HLDAA*"), to resolve the outstanding issues between the parties with respect to a renewal of the central provisions of collective agreements between the Ontario Nurses Association ("ONA") and 131 Participating Hospitals in Ontario (the "Hospitals") represented by the Ontario Hospital Association (the "OHA").

[2] The Hospitals range from small rural general hospitals to very large tertiary care teaching hospitals and hospitals specializing in complex continuing care and rehabilitation, addictions and mental health.

[3] ONA represents approximately 68,000 Registered Nurses (RNs) and other allied health-care professionals employed and providing care at hospitals, long-term care facilities, public health, the community, industry and clinics. ONA represents the majority of RNs employed at Ontario hospitals. ONA represents approximately 63,890 of the Hospital's employees.

[4] The Hospitals and ONA have participated in central bargaining since 1975. In the central bargaining process, there are two levels of negotiations. The "central issues" are addressed at the central table. The issues that are not "central issues" are negotiated at the local level ("local issues") between the individual hospital and the ONA local union. The result of these two levels of bargaining are individual collective agreements between each Hospital and ONA that are comprised of the "central provisions" of the collective agreement and the "local provisions". In this Award, we are only dealing with the central issues that are to be included in the central provisions of the collective agreements between the Hospitals and ONA.

[5] The most recent round of bargaining concluded in Collective Agreements for the period April 1, 2018 until March 31, 2020. The central provisions were awarded by Central Board of Arbitration chaired by William Kaplan. (the "Kaplan Award").

[6] Subsequent to the issuing of the Kaplan Award, the Ontario Government enacted public sector wage restraint legislation, the *Protecting a Sustainable Public Sector for Future Generations Act, 2019* (*Bill 124*). Bill *124* was granted Royal Assent on November 7, 2019 and it applies to all hospitals in the province of Ontario. The legislation imposes a "moderation period" of three years. During the moderation period, no collective agreement or arbitration award may provide for an increase of greater than one percent (1%) in the salary rate for each 12-month period of the moderation period. In addition, no collective agreement or arbitration award may provide for an incremental increase to existing compensation entitlements or for new compensation entitlements that in total equal more than one percent (1%) on average for all employees covered by a collective agreement for each 12-month period of the moderation period. The one percent (1%) increase in compensation entitlements includes in its' calculation any increase in the salary rate that is limited to a maximum of a one percent (1%) increase each year.

[7] On January 13, 2020, ONA wrote to the Hon. Peter Bethlenfalvy seeking an exemption from the wage and compensation restrictions, pursuant to s.6(2) and s. 27 of *Bill 124*. ONA has not yet received a response to their request for an exemption. ONA and other trade unions have also filed constitutional challenges to *Bill 124* in the Superior Court of Justice.

[8] The Hospitals and ONA signed a Memorandum of Conditions for Joint Bargaining on February 10, 2020. The parties met in negotiations on February 10-14 and February 24-28, 2020. Mediation with Elizabeth McIntyre occurred on February 26, 27 and 28, 2020. The parties were able to agree on a number of central items during bargaining and in mediation. These agreed upon central items shall be included in the renewal collective agreement. It is noteworthy that the agreed upon items did not include any agreed upon monetary proposals.

[9] In late December 2019, the spread of a new corona virus disease was detected in Wuhan City, Hubei Province of China. The Chinese authorities identified the SARS-CoV-2 as the causative virus in early January 2020 and the disease was named corona virus disease 2019 ("COVID-19").

[10] On March 11, 2020, the Director General of the World Health Organization ("WHO") declared COVID-19 a pandemic. Since that time the number of cases globally has risen dramatically. As of April 13, 2020, there were 7,470 confirmed cases of COVID-19 in Ontario and 291 deaths.

[11] On March 17, 2020, the Government of Ontario declared a province-wide state of emergency pursuant to s. 7.0.1 (1) of the *Emergency Management and Civil Protection Act.* ("*EMCPA*"), closing all facilities providing indoor recreational programs; all public libraries; all schools; all licensed childcare centres; all bars and restaurants (except takeout and delivery); and all theatre and concert venues. Subsequently, the Ontario Government extended the restrictions to close all non-essential workplaces, public places, and to add restrictions on social gatherings. The Emergency Order was initially in place for 14 days, but it has been extended a number of times and presently is in effect until June 2, 2020, unless otherwise extended. Premier Ford has indicated that "we are facing an unprecedented time in our history", he is not wrong in his characterization of this global crisis.

[12] On March 21, 2020 the Solicitor General introduced a new regulation under 7.0.2(4) of the *EMCPA* in response to the COVID-19 crisis. This new regulation authorized health service providers, which includes hospitals, to identify staffing priorities and develop, modify and implement redeployment plans despite any other statute, regulation, order, policy or agreement, including a collective agreement. In effect, health service providers were given wide authorization to redeploy staff so that they can respond to the COVID-19 crisis without complying with the provisions of a collective agreement.

[13] The COVID-19 global pandemic has also created a severe economic downturn due to government imposed restrictions, including social distancing and forced business closures. As a result, unemployment has increased dramatically, and the economy has been plunged into a deep recession. In response, the Canadian Government has invoked massive spending to assist Canadians, including providing the Canadian Emergency Response Benefit. There can be no doubt that all levels of government will have less revenues and will incur higher expenses as a result of the COVID-19 crisis.

[14] The central issues remaining in dispute proceeded to videoconference hearing on April 19 and 20, 2020. At the hearing the parties filed extensive written briefs, with numerous exhibits, presenting their positions on the issues remaining in dispute. Neither party raised any issue or concerns relating to the jurisdiction of this Central Board of Arbitration to hear and resolve the central issues remaining in dispute. The Board met in executive session thereafter.

[15] ONA asserts three objectives in their submissions. Their top priority is to obtain additional job security language to protect nurses from layoffs, elimination of positions and agency use. ONA seeks to address current workload issues, work stress and health and safety issues, which together with COVID-19 has created what they characterize as a "crisis within a crisis." ONA also seeks improvement to benefit entitlements for their members. ONA has made several proposals for what they characterize as a "normative" monetary package.

[16] The OHA focuses their proposals on what they characterize as the removal of barriers to efficiency in an era of fiscal restraint that has persisted over many years of underfunding. The OHA seeks flexibility in the use of part-time nurses, the reassignment of nurses and altering the current layoff language. The OHA also seeks to eliminate the requirement to provide a retirement allowance before any layoff. The OHA has proposed a monetary package that they assert complies with the limits placed upon them by *Bill 124*.

STATUTORY AND OTHER CONSIDERATIONS

[17] In Ontario, trade unions and employers are required to bargain in good faith and make every reasonable effort to make a collective agreement, see s. 17 of the *Labour Relations Act, 1995* S.O. 1995, c.1 Sched. A (as amended). When a hospital and a trade union cannot agree upon a voluntary collective agreement, the matters in dispute are referred to interest arbitration pursuant to s. 4 of *HLDAA*. As an interest arbitration board,

we are tasked with making an award to resolve the outstanding issues as an alternative to free collective bargaining under which if pressed to an impasse the parties would be able to resort to economic sanctions in the form of a strike or lockout. The legislature has determined that hospital employees provide an essential service and society's need to ensure stable patient care must trump the right of free collective bargaining. As a replacement for free collective bargaining we are tasked with a broad discretionary mandate that is guided by the legislative criteria set out in *HLDAA*, which includes the following:

> **Criteria**
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> (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:
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> 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.

[18] Essentially interest arbitration is an extension of the bargaining process with an arbitrator or interest arbitration board acting as the final decision maker when the parties cannot agree to a voluntary settlement. The interest arbitration process is not a judicial or adjudicative process guided by a personal sense of fairness or social justice. As stated by Arbitrator Teplitsky Q.C. in his August 31, 1982 award between *SEIU and a Group of 46 Participating Hospitals*, "Interest arbitrators attempt to emulate the results of free collective bargaining…Interest arbitrators interpret the collective bargaining scene. They do not sit in judgment of its results."

[19] One area where we are confined in our discretion under *HLDAA*, is with respect to the term of a collective agreement. Subsection 10(10) of *HLDAA* dictates that except where the parties agree to a longer term of operation, our award shall remain in force for a period of one year from the effective date of the award. Subsection 10(11) provides that

except where the parties agree to a longer term, a collective agreement shall cease to operate on the expiry of a period of two years. In this case the parties cannot agree upon a term. Therefore we award a one year collective agreement commencing from the date of our award.

[20] In addition to the *HLDAA* statutory criteria, we are also bound by the limitations placed upon us by *Bill 124*. Section 29(2) provides:

> 29(2) 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*.

[21] As indicated earlier, *Bill 124* applies to all collective agreements between hospitals and unions representing their employees.

[22] ONA argues that we should not apply *Bill 124*. In our view, *Bill 124* clearly applies to the matter before us and we are constrained in our ability to provide for salary and compensation increases.

[23] We acknowledge that ONA, along with other trade unions have initiated a number of constitutional challenges to *Bill 124*. In addition, ONA has sought an exemption from the Minister. In the absence of being granted an exemption, or a court of competent jurisdiction declaring *Bill 124* invalid, we are bound by the salary and compensation restraints imposed by the legislation. This board of arbitration is clothed with jurisdiction pursuant to legislation (*HLDAA*), but we have also we have been restricted in how we exercise our jurisdiction by what is currently valid legislation (*Bill 124*).

[24] ONA argues that their proposal for a 15 year step is not captured by the 1% compensation limit found in *Bill 124*. ONA argues that we can add a new step to the wage grid after 15 years that will not run afoul of *Bill 124*, relying on subsection 10(2) of *Bill 124*, which provides as follows:

Exception, certain increases

10(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.

[25] We disagree with ONA's interpretation of subsection 10(2) of *Bill 124*. To add a new step to the wage grid would increase the total compensation above 1%, which would avoid the intent of the legislature to impose monetary restraint. *Bill 124* must be read in context and harmoniously with the scheme of the legislation and the intention of the legislature. The context and scheme of the legislation is wage restraint being imposed on certain public sector employees. The introduction of a new step to the wage grid would be inconsistent with the scheme of the *Bill 124* and undermine the intention of the legislature to impose wage and other compensation restraint. The purpose of the exemption relied upon by ONA is to preserve the right to move along existing salary grids or obtain an increase based on existing performance scales. The language was also necessary to clarify that the 1% wage increase was to be applied across existing salary grids and any wage increases based on movement on an existing wage grid does not count towards the 1% maximum total compensation. If it was the intention of the legislature to permit the parties or an arbitrator to introduce a new step in a wage grid, then they would have stated so in much clearer language. We are supported in our view by the recent award in *St. Peter's Residence at Chedoke (Thrive Group) and Niagara Healthcare and Service Workers Union, Local 302 affiliated with CLAC*, 2020 CanLII 33060 (ON LA).

[26] We note that the legislative criteria found in *HLDAA* provides this board of arbitration with general guidance, while granting us broad discretion to consider all relevant factors in coming to a decision. Arbitrator Burkett's words in *Corporation of the*

City of Toronto and Toronto Professional Firefighters Association, Local 3888, are instructive as to the application of statutory criteria to interest arbitration:

> Before considering the application of these criteria to the issues before us, it is important to observe that their application, as with the criteria found in other interest arbitration statutes, is not intended to cause a predetermined result. While requiring a board to put its mind to various factors that might be relevant to its ultimate determination, they do not abridge the broad discretion of an interest board of arbitration to consider and weigh all the relevant factors in any given case in coming to a freely determined result that is fair and reasonable in all the circumstances. The discretion given to an interest board of arbitration in this regard is fundamental to the functioning of an interest arbitration process that serves as an alternative to free collective bargaining under which the parties are able to resort to economic sanctions in the form of strike or lockout in support of their respective positions. Where the legislature, in its wisdom, decides that in the interest of the greater public good the right to free collective bargaining must be restricted to the extent that economic sanctions are not permitted, i.e. police, fire and health services, the alternative must be fair, impartial and transparent. This is why the statutory criteria, as found in the various interest arbitration statutes, including the Fire Protection and Prevention Act, do not remove the ultimate discretion of a board of interest arbitration to make a fair and impartial award that takes into account all relevant considerations.
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> If there is any doubt in this regard, reference need only be had to the judgements of the Supreme Court of Canada in *re: B.C. Health Services,* [2007] SCR 391, SCC 27 and *CUPE v. Ontario (Minister of Labour),* [2003] 1 SCR 539, 203 SCR 25. In the former, the British Columbia government passed legislation overriding certain collective agreement provisions applicable to employees in the health care sector. In reversing a number of its prior decisions, the Supreme Court found that Section 2(d) of the Charter guarantees a right to collective bargaining as part of freedom of association. Although the Court emphasized that the right is to a process and does not guarantee access to a particular statutory framework or to a particular result, the Court did find that "substantial interference" with collective bargaining will violate the Charter. It would be difficult to conclude that statutory interest arbitration parameters that robbed an impartial interest arbitrator of his/her essential discretion by, in effect, prescribing a particular result or even by narrowing the range within which a fair and reasonable result might otherwise fall would not run afoul of *B.C.Health*. After all, just as there can be no "substantial interference" with the right to free collective bargaining, there can be no "substantial interference" with free, fair and impartial interest arbitration where it is legislatively substituted for free collective bargaining.
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> Consistent with the foregoing, the Supreme Court had already found in 2003 in CUPE v. Ontario (Minister of Labour), supra that the Ontario Minister of Labour could not ignore the established list of mutually acceptable interest arbitrators and appoint retired judges to interest arbitration cases. The government of the day was unhappy with the results of interest arbitration in the health care sector. While acknowledging that retired judges would not necessarily lack impartiality, the Court concluded that interest arbitrators must also be independent and that independence in the interest arbitration sphere is guaranteed by training, expertise, and mutual acceptability. The Court went on to find that "the

> appointment of an inexpert and inexperienced chairperson to an interest arbitration board who is not seen as generally acceptable in the labour relations community is a deficit in approach that is both immediate and obvious." It is difficult to see how restricting the discretion of an expert, experienced and mutually acceptable interest arbitrator by means of formulaic criteria or other such limitations that affect the outcome would be any less a deficit in approach that is both immediate and obvious.
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> Given the foregoing, it is not surprising that the statutory criteria that govern interest arbitration generally, and in this case in particular, as neither exhaustive nor formulaic. Under the law, for reasons related to fundamental fairness, interest arbitrators are provided with a broad discretion to consider not only the statutory criteria but all other factors that are relevant and to provide an appropriate weighting. Such discretion is the necessary underpinning to an interest arbitration process that, as a substitute for free collective bargaining, is fair, impartial and transparent.
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> The application of the criteria must be on the basis of facts that are presented in any given case. However, there are certain principles that apply generally.

[27] The most important and guiding principle applicable to all interest arbitration proceedings is replication. The replication principle is succinctly summarized by Chief Justice Winkler in the case, *University of Toronto v. University of Toronto Faculty Assn. (Salary and benefits Grievance)* (2006), 148 L.A.C. (4th) 193 at paragraph 17, where he states:

> There is a single coherent approach suggested by these authorities which may be stated as follows. The replication principle requires the panel to fashion an adjudicative replication of the bargain that the parties would have struck had free collective bargaining continued. The positions of the parties are relevant to frame the issues and to provide the bargaining matrix. However, it must be remembered that it is the parties' refusal to yield from their respective positions that necessitates third party intervention. Accordingly, the panel must resort to objective criteria, in preference to the subjective self-imposed limitations of the parties, in formulating an award. In other words, to adjudicatively replicate a likely "bargained" result, the panel must have regard to the market forces and economic realities that would have ultimately driven the parties to a bargain.

[28] The application of the replication principle is an objective exercise, driven by the use of objective evidence, to assist in determining what the parties would have achieved in free collective bargaining. The subjective posturing of either party is neither helpful nor relevant to the exercise because it is easy for either party to take a hard line and refuse to bargain when there is no threat of a strike or a lockout.

[29] The objective evidence relied upon by boards of arbitration include evidence of relevant comparators, both internal and external, either freely negotiated or imposed by arbitration. Historical patterns are also relevant to the replication exercise. There is much room for debate on the final result, but interest arbitration is not an exact science and the appropriate outcome is one that falls within a reasonable range of what the parties would have agreed upon in free collective bargaining based on the relevant comparators. As stated by Arbitrator Teplitsky Q.C.in *SEIU and A Group of 46 Hospitals, supra*, …"the goal of compulsory binding arbitration is to ensure that the parties affected by the loss of the right to strike fare as well, although not better than, those parties whose settlements are negotiated within the context of the right to strike."

[30] The terms of the collective agreements between the Hospitals and the other major unions who bargain centrally in the hospital sector are relevant comparators. In the past, agreements affecting nurses in other provinces have also been considered relevant, see *Participating Hospitals and ONA*, March 5, 2007 (Albertyn). Consideration must also be given to historical similarities and differences between the treatment of employees in the sector. In this case, there is currently a strong relationship in wages between ONA and other professional hospital workers represented by OPSEU, as noted in the Kaplan Award. However, there are also historical differences between ONA, OPSEU and the other bargaining relationships in the sector. ONA enjoys different language and benefits that are tailored to their members' needs and their bargaining objectives and priorities. There are many examples of differences in language and benefits between ONA and the other hospital sector employees including OPSEU. Such differences include ONA's professional responsibility language, and the layoff and retirement allowance language that the Hospitals seek to change in this round of bargaining. More recently, Arbitrator Kaplan granted ONA coverage for mental health services that no other hospital employees enjoy. All this goes to say that replication does not equate with duplication. There is no set formula or predetermined outcome. All objective evidence must be weighed to come to a fair, impartial and transparent award.

[31] One other arbitral principle requires some comment and that is the concept of a demonstrated need. Once again, the exercise is an objective one that relies primarily on objective evidence of needs and not the subjective desires of one party. It is incumbent upon a party seeking "breakout language" to prioritize their demands and establish the required demonstrated need, see *Participating Hospitals and SEIU,* November 10, 2010 (Burkett).

[32] Turning to the matter before us, we begin by noting that the Hospitals have not made an ability to pay argument. Frankly, such an argument is not necessary in the circumstances that we have before us where we are legislatively constrained in our ability to grant wage and other monetary increases.

[33] ONA seeks a general wage increase of 2% across all steps of the wage grid and a new 15 year step that is 2% above the previous 8 year step rate. The other hospital sector employees have already settled for the next two years with OPSEU receiving 1.75% increases in 2020 and 2021 respectively, while SEIU, CUPE and Unifor are receiving increases of 1.60% in 2020 and 1.65% in 2021. Under normal circumstances, applying replication, we would have awarded a wage increase of at least 1.75% to keep nurses in line with other hospital employees who already settled their collective agreements for this period of time. However, we are constrained by the application of *Bill 124* and we can only award a 1% salary increase for each twelve month period of the moderation period.

[34] Subsection 10 (13) (b) of *HLDAA* permits us to award compensation retroactive to the day upon which the previous collective agreement ceased to operate. Therefore we award a 1% across the board wage increase effective April 1, 2020. The first year of the *Bill 124* three year moderation period will begin on April 1, 2020. In light of the fact that the renewal collective agreement will operate for a period of one year from the date of our award, we are also awarding a second 1% increase effective April 1, 2021, which will be the start of the second year of the moderation period. This will ensure that the nurses receive this increase in a timely manner. We are not awarding any additional

compensation for the second year of the moderation period beginning April 1, 2021. We leave it to the parties to negotiate any additional compensation for the second year of the moderation period. If the parties cannot agree, then the next interest board of arbitration can address that issue.

[35] ONA has also made a number of monetary proposals, which cumulatively are well above the 1% total compensation limitation imposed by *Bill 124*. There is also a dispute as to the proper and appropriate costing methodology given the *Bill 124* limitations. While both ONA and the Hospitals' costing include statutory benefits (CPP, EI WSIB and EHT) in the base number for determining total compensation, only the Hospitals include the additional increase in statutory benefits in the computation of the cost of the 1% increase in wages. In our view, if the statutory benefits are included in the base number, resulting in a larger number for determining the 1% total compensation, then it is only fair and reasonable to include the increased costs of statutory benefits in the calculation of the cost of the 1% wage increase. Therefore we find that the 1% wage increase results in a 0.938% increase in total compensation. This leaves very little room for any other monetary increases.

[36] As indicated above, we are of the view that the additional step proposed by ONA would be included in the calculation of the 1% total compensation, which would be above the 1% total compensation permitted under Bill *124*. In the normal course, we would have likely provided other modest increases to premiums and benefits, keeping in mind the principles of comparability, total compensation and most importantly replication. A review of the summaries of collective agreement changes negotiated/awarded since 1980 reflects a pattern of monetary improvements in each round of bargaining, including the most recent one resolved by Arbitrator Kaplan, where he awarded additional language and a new mental health services benefit not enjoyed by any other hospital sector employees. We note that the other hospital sector unions did not obtain any significant language or other monetary increases when they resolved their most recent collective agreements.

[37] The Hospitals point out that awarding the $0.10 increase to the night shift premium and the $0.10 increase to the weekend premium, as sought by ONA, would bring the total compensation increase to 0.999%. We are of the view that in these extremely unusual times, where total compensation is limited to 1%, ONA would be able to achieve the monetary proposals that they give the most priority and significance to for their members. In this case, the increase to the call back premium in article 14.06 from time-and-one-half to two times regular straight time is a priority identified by ONA and tied to their RN fatigue, staffing and scheduling concerns.

[38] We acknowledge that the other Ontario hospital sector employees only receive time-and-one-half for call backs. However, as stated above, there are many differences between the compensation of other hospital sector employees and nurses. We note that nurses in Alberta and British Columbia enjoy double time as a call back premium. In these extremely exceptional and unusual circumstances, we are of the view that similar compensation for Ontario nurses should be awarded. We also note that containment of this additional cost is something that the Hospitals can accomplish if they schedule and staff properly so that they do not need to call back nurses to work after they have completed their regularly scheduled tour.

[39] The cost of the increase to the call back premium is 0.058% and that only leaves enough available to grant ONA the percent in lieu of 13% for nurses over the age of 75. The total of all monetary based on the Hospital's costing is 0.999%. As indicated earlier, we are deferring to the next round of bargaining any increase in the 1% total compensation that would be available pursuant to *Bill 124* for the second year of the moderation period, which would become effective April 1, 2021.

[40] The Hospitals seek to end the offer and payment of retirement allowances in circumstances where there is no permanent reduction in a nurse's hours of work. This is a cost savings monetary proposal, which we find inappropriate to consider at this time in light of the monetary constraints placed upon us by *Bill 124*.

[41] ONA has also proposed re-opener language to be included in case they are successful in challenging the constitutionality of *Bill 124* or they are successful in being granted an exemption from the Minister. We agree that a re-opener is appropriate for essentially the same reasons as provided by Arbitrator Gedalof in *Mon Sheong Home for the Aged and ONA* 2020 CanLII 8770 (ON LA). Accordingly, we shall remain seized of all monetary proposals. In the event that ONA is successful in having *Bill 124* declared unconstitutional by a court of competent jurisdiction, or if the legislation is amended, repealed or if ONA is granted an exemption. In the event that the constraints found *in Bill 124* are altered or abridged in any manner, both parties shall have the opportunity to address how this board of arbitration should exercise their discretion in light of any such legislative changes.

[42] Turning to the non-monetary proposals, we note that ONA has made a number of proposals relating to job security. One of ONA's proposals relates to the ongoing issue of hospitals utilizing agency nurses. The dispute relating to the use of agency nurses has been ongoing for quite some time. The dispute began in the aftermath of the SARs outbreak in 2003. ONA filed an unfair labour practice against a number of Greater Toronto Area (GTA) hospitals. ONA and the responding hospitals agreed to a rights arbitration that was placed before Arbitrator Kaplan, see *Sunnybrook & Womens' College Health Sciences Centre v. ONA* (2004), 133 L.A.C.(4th) 91. Arbitrator Kaplan noted that the use of agency nurses varied significantly between hospitals across the province, with the most significant use being in the GTA. It was noted that Scarborough Hospital used no agency nurses and St. Michaels' Hospital used very little agency nurses. Interpreting the collective agreement language found in article 10.12(b) (as it was in existence at the time), Arbitrator Kaplan found that the use of agency nurses by hospitals was only permitted on an *ad hoc* basis. Arbitrator Kaplan imposed a threshold limit for *ad hoc* agency use and a financial penalty for usage above that threshold. The hospitals were directed to make their "best efforts" to reduce their usage of agency nurses below 2%. Subsequently on March 5, 2007, a board of arbitration chaired by Arbitrator Albertyn awarded a new article 10.12(c) that specified the limits of agency nurse usage, consistent with the Arbitrator Kaplan's award. On September 7, 2016 a different board of arbitration chaired by

Arbitrator Albertyn increased the penalty payable to ONA for the use of agency nurses (from $0.38 to $0.62) and decreased the threshold on usage (from 2% to 1.5%).

[43] The Hospitals point out that current agency use is limited to 38 hospitals with the vast majority of hospitals utilizing no agency nurses. The Hospitals maintain that the data does not support an argument that hospitals are using agency nurses in order to create a "contingent workforce".

[44] The evidence clearly demonstrates that the usage of agency nurses continues to be high in the GTA, which is where the issue originally arose. More troublesome is the fact that some hospitals that had little or no agency usage are now amoung the highest users of agency nurses (Scarborough Hospital and St. Michael's Hospital). The one bright spot is that North York General Hospital has been able to completely eliminate the usage of agency nurses. This chair has dealt with three rights arbitrations involving the excessive use of agency nurses at GTA hospitals. Two of those rights arbitration cases were settled, the third resulted in an award, see *Humber River Hospital and ONA* 2019 CanLII 54735 (ON LA). In *Humber River Hospital and ONA*, *supra,* the hospital was found to have engaged in extensive use of agency nurses well beyond the *ad hoc* usage permitted under the Collective Agreement. While Humber River Hospital had made efforts to reduce agency usage, it was also found that they had not made "best efforts." So while agency usage is not widespread across the province, it is still a significant issue in the GTA, where a large portion of the province's population resides and a large number of ONA's members work.

[45] ONA's proposal, as drafted, in our view goes too far. The proposal appears to entirely eliminate the use of agency nurses, except with ONA's written approval. There seems to be an acceptance that some use of agency nurses may be appropriate on an *ad hoc* basis. The problem occurs when a hospital becomes reliant on agency nurses so that they become, as characterized by Arbitrator Kaplan, a "parallel contingent workforce in the workplace." We are of the view that some clarification of the language is required to ensure that the usage of agency nurses is keeping with the intent of the parties as

interpreted in the arbitral jurisprudence. We take our direction from the *Humber River Hospital and ONA*, *supra*, award and therefore order a clarity note to provide as follows:

> For clarity: The use of agency nurses is limited to *ad hoc* single shift coverage of vacancies due to illness or leaves of absence. Any other usage of agency nurses requires the Union's written consent.

[46] ONA has also made a number of other proposals relating to job security that we are dismissing without prejudice to future bargaining. In our view, the changes being sought by ONA are not appropriate for what is essentially a roll-over one year collective agreement. That being said we do wish to comment on the proposal for changes to the article 13.01 (filling all posted shifts). ONA has presented some evidence of issues relating to the scheduling of nurses at a few different hospitals. ONA asserts that scheduling gaps at hospitals have led to increased overtime, premium and professional responsibility issues. We note that scheduling is generally provided for in the local provisions of the Collective Agreement. We would expect that the parties first address scheduling issues at a local level. If there is clear evidence of either a widespread problem that demonstrates a need for attention or if the problem persists and can't be adequately addressed at the local level, then it may be appropriate to address the issue with central language. We also note that we are hopeful that the increase in the call back premium will provide an incentive for proper and adequate staffing.

[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.

[48] ONA has also made a language proposal for an amendment to article 16 by adding 16.11 (granting vacations). ONA points to 113 grievances across the province

where nurses are challenging the denial of vacation time as providing a clear demonstrated need for language to address the issue.

[49] We agree with ONA that nurses, like any other employee, are entitled to take their vacation. Unfortunately we cannot discern from the evidence before us whether nurses are being denied their allotted vacation time or simply being restricted as to when they may take their vacation time. Many of the grievances appear to be for peak or high demand periods for vacation time; in the summer, attached to long weekends, or around other holidays. Most of the grievances also reference local scheduling provisions.

[50] Article 16.09 of the central provisions of the Collective Agreement provides that "scheduling of vacations shall be in accordance with the schedule of local provisions." We just do not have enough evidence to determine whether or not this is a local issue or something that needs to be addressed centrally. We are also very concerned that any change to the central language may have negative implications on current local provisions and practices. We believe that this issue needs to be first addressed at the local level and if the problem persists then it may well call for an amendment to the central provisions.

[51] One final proposal needs to be addressed and that is the last minute proposal of ONA to amend the language found in article 6.05, which is based on events relating to the current COVID-19 global pandemic.

[52] We acknowledge the Hospital's objection to this new proposal that was tabled on April 9, 2020, only ten days before the arbitration. The parties agreed in the MCJB that they would submit to one another the position(s) that each would be advancing to arbitration by no later than March 6, 2020. We are of the view that this agreement between the parties reflects the general principles found in *Ontario Cancer Institute (Princess Margaret Hospital) and ONA*, unreported June 19, 1989. In *Ontario Cancer Institute (Princess Margaret Hospital) and ONA*, *supra,* Arbitrator Burkett agreed with the reasoning of Arbitrator Swan in *The Regional Municipality of Peel and ONA*, unreported April 30, 1985, where it was found that the good faith bargaining provision found in the *Labour Relations Act*, (currently the *Labour Relations Act, 1995*) read together with the

provisions of *HLDAA* mandated that new proposals should not be entertained for the first-time at interest arbitration unless there exists compelling justification in the form of a material change in circumstances during the course of bargaining.

[53] There can be no doubt that there has been a material change in circumstances in the time between March 6, 2020 and the delayed hearing of this matter on April 19 and 20, 2020. On March 11, 2020 the WHO declared a global pandemic of the disease COVID-19. The Chief Medical Officer of Health for Ontario (CMOH), Dr. David Williams, has issued Directives pertaining to the practices and procedures in hospitals and the supply of personal protective equipment (PPE). ONA asserts that they have filed multiple grievances and complaints with the Ministry of Labour related to inadequate PPE.

[54] ONA's new proposal is crafted to address issues that are currently unfolding during the COVID-19 pandemic. The central collective agreement provisions currently contain language relating to PPE that was crafted after the 2003 SARs crisis and awarded in the March 5, 2007 award of an arbitration board chaired by Arbitrator Albertyn. The current language was awarded in an environment that contemplated an area specific pandemic and not a global pandemic that would put strains on supply chains around the world. The proposed language is an amendment that appears closely related to the language found in the current CMOH Directive #5.

[55] We would not normally entertain such a late proposal; however these are not ordinary times. Rather these are extra-ordinary circumstances involving an unprecedented material change in circumstances that provides a compelling justification to entertain this new proposal. However, we are incredibly concerned about the parties not having an opportunity to discuss this issue and engage in bargaining prior to the hearing. We are also concerned that we do not have all the necessary information before us to make a fair and reasonable determination as to whether there is a demonstrated need for the proposed language. Therefore, we are remitting this issue back to the parties for a maximum period of 90 days. ONA may refer the matter back to us earlier if Directive #5 is substantially altered to the extent that it adversely affects the right of nurses to

determine, based on a point-of-care risk assessment ("PCRA"), the appropriate health and safety control measures and PPE they require, including access to an N95 respirator. If the parties are unable to resolve the issue and the matter is brought back before us, then the parties are to file written submissions and the board will then determine if they require oral argument.

[56] One final matter needs to be addressed, before we set out our Award. The Hospital's nominee has raised an issue for the first time at the 11th hour, after this chair circulated what was to be the final draft award and requested the nominees' dissents. The Hospitals' nominee asserts that compensation was not a matter in dispute because the Hospital agreed to the night shift premium and weekend premium increases sought by ONA. According to the Hospitals' nominee, we have no jurisdiction pursuant to s. 9(1) of *HLDAA* to award anything other than 1% for wages and the two premium increases identified by the Hospitals. The Hospitals' nominee's position is based on an assertion that the Hospital accepted ONA's proposals to increase the night shift and weekend premiums.

[57] We disagree with the Hospitals' nominee's position that we lacked jurisdiction to address all the monetary issues.

[58] It is noteworthy that the sophisticated parties never raised this "jurisdictional issue" before or during the hearing. The parties agreed to a Memorandum of Conditions for Joint Bargaining, dated February 10, 2020, which required in section 1(c) that each party to submit to one another the position(s) that each will be advancing to arbitration and "those central issues remaining in dispute" shall be submitted to the Central Board of Arbitration. The parties complied with this obligation and their respective positions reflected the premiums and all other monetary matters as matters remaining in disputes for this Board to resolve. The parties also provided us with the "agreed upon items" from direct bargaining, which also did not include any agreement on monetary issues. The written briefs submitted to this board of arbitration included extensive submissions on the monetary issues in dispute. Counsel made lengthy and detailed oral submissions on all

monetary issues including their proposed costing. ONA's proposals were characterized as normative and asked that we not apply *Bill 124*. The Hospitals asked that we apply *Bill 124* and award their proposed package of a 1% general wage increase and the two premiums sought by ONA. At no point in time did either counsel indicate an agreement on any monetary issues. The parties were extremely far apart on monetary issues, including the costing of each proposal. At best, there was an acknowledgement that there were overlapping proposals. However, it was clear that ONA was not willing to accept the Hospital's monetary proposal.

[59] This Central Board of Arbitration was not constrained by any agreement between the parties on monetary issues nor was there an agreement to final offer selection. All monetary proposals clearly remained in dispute and the parties made extensive submissions at the hearing. This Central Board of Arbitration has broad discretion to consider and weigh all relevant factors to make a fair and impartial determination on the matters in dispute, including the monetary proposals. When this chair advised the nominees of his intention to find that *Bill 124* applied and that the Hospitals' costing was going to be accepted, he invited the nominees to provide their opinion on how the monetary proposals ought to be addressed. At that point, ONA's nominee advised that the call back premium proposal was a priority relating to the understaffing, scheduling and workload issues that were at the heart of ONA's submissions. The chair accepted ONA's priority and awarded it based on all relevant considerations, including those specified in *HLDAA* and the Hospital's costing of that proposal. While there may have been some overlap in the monetary proposals, there was no agreement or *ad idem* on any of those issues. The monetary proposals remained in dispute and we clearly have jurisdiction to resolve that dispute.

[60] Finally, we note that collective bargaining is a fluid exercise. It is not uncommon for parties to leave monetary issues to be negotiated at the end of bargaining and for the monetary issues to be agreed upon as a package. It does not lie within the power of one party to cherry pick from the monetary package of proposals it likes best without the

agreement of the other party. Interest arbitration is an extension of bargaining and that is how it played out in this case.

AWARD

[61] After carefully considering the submissions of the parties, we hereby order the parties to enter into renewal collective agreements that contains all the terms and conditions of the predecessor central collective agreement provisions, letters of understanding, and appendices, save and except as amended by this award as follows:

- **Term:** The term of the renewal collective agreement, shall be for one year from the date of this award.

- **Agreed to items:** Any previously agreed upon items shall be included in the renewal collective agreements.

- **Article 10.12 (c):** Amend to include the following clarity note.

  The use of agency nurses is to be limited to *ad hoc* single shift coverage of vacancies due to illness or leaves of absence. Any other usage of agency nurses requires the Union's written approval.

- **Article 14.06:** Effective April 1, 2020 amend to provide double time for call backs.

- **Article 17.01 (g) Health and Welfare Benefits:** Effective April 1, 2020 amend to provide 13% in lieu for nurses over age 75.

- **Wages:**

  - Effective April 1, 2020 – 1%
  - Effective April 1, 2021 – 1%
  - Retroactive compensation in accordance with Article 19.10 of the Collective Agreement.

[62] Unless specifically addressed in this award, all outstanding proposals are dismissed without prejudice to future bargaining.

[63] We remain seized in accordance with subsection 9(2) of *HLDAA* until the parties have signed new collective agreements. We also remain seized with respect to the ONA health & safety proposal and with respect to a re-opener 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.

Dated at Toronto, Ontario 8th day of June 2020.

John Stout – Chair

"Partial dissent attached"	"Dissent attached"
Kate Hughes - ONA Nominee	Brian O'Byrne – OHA Nominee

DISSENT OF THE UNION NOMINEE KATE HUGHES

Registered Nurses are critically needed in Ontario hospitals more than in the last hundred years. RNs are working under more stressful conditions than ever before.

For this reason, I must dissent from the Chair's award on many issues. While the Board's hands are unfortunately tied on monetary issues because of the Bill 124 wage restraint legislation imposed on this Board, this is all the more reason to award at this time much needed improvements in the language of the collective agreement.

Registered Nurses need relief from the current hospital understaffing, untenable workload, long hours and the very real health and safety dangers they face every shift. To do so changes need to be made to the central hospital collective agreement to address these problems and to implement the *HLDAA* criteria to retain and recruit the much needed RNs. Proposals were made by ONA that would have ensured shift schedules were fully staffed by hospital RNs and hospital units were not "working short", to ensure an appropriate balance of full and part time RNS, to increase the ability of nurses to actually take their earned vacation and time off to address burnout, and to address the critical health and safety crisis RNs on the front line face without delay. I am disappointed that they were not awarded in this decision at this critical time for nurses in Ontario.

ONA termed, in its submissions, the present nursing reality as a "Nursing Crisis within a Crisis" and the evidence before this Board demonstrates that they were not exaggerating. Not only are RNs very much at the front-lines and in danger daily in the most serious health care emergency in the last hundred years, but this COVID-19 pandemic has occurred on top of the pre-existing Ontario crisis of hallway nursing. This Board heard evidence in the recent Report of the Premier's Council, entitled "Hallway Health care; a System under Strain", of the critical problems in Ontario hospitals including hospitals trying to operate at a much higher than planned for high patient census, "staffing shortages" and health care provider burnout" which were publicly acknowledged as requiring immediate resolution.[1] This report alone is demonstrable evidence of the need in the central Ontario Hospital collective agreement to make changes address the nursing shortages, workload, stress and burnout.

Similarly, a report from the OHA itself, Exhibit 54, entitled "A Sector on the Brink" also outlines the strain on nursing and other staff and, with the growing and ageing population, the "increasingly complex health care needs that require a highly specialized form of care"[2]. Clearly this is not the time in Ontario to reduce Registered Nurses staffing levels

[1] Exhibit 53 First Report from the Premier's Council, 2019, "Hallway Health care; a System under Strain" at page 11

[2] Ex 54 OHA report" A Sector on the Brink" at pages 3-5

or replace them with less educated, trained or experienced staff given the increasing acuity and complexity of hospital care. It is the time to put in measures to recruit and retain more RNS and to put in provisions to give them relief from long hours, stress, and health and safety dangers. Given these problems are acknowledged both by the OHA and the Ontario government, clearly at this time there is demonstrable need to address working conditions for Registered Nurses and award language proposals to retain and recruit RNs.

What is particularly troubling is while at the same time the government was acknowledging the crisis in hospital health care and the "burnout" and shortage of nurses, it introduced wage restraints on hospital nurses. In November 2019 the Act "*Protecting a Sustainable Public Sector for Future Generations Act" (*known as "Bill 124") restrained free collective bargaining and the powers of interest boards of arbitration by capping the compensation of certain public sector employees, including hospital Registered Nurses, to a maximum of 1% of total compensation. As a result, this *Act* prevents this Board from awarding the monetary increases that hospital Registered Nurses most certainly would have received in free collective bargaining or an interest board award by way of salary, benefits and other monetary increases.

However, many other public sector workers, most notably in male dominated workplaces, such as firefighters, police and municipal workers and others are expressly excluded from the adverse effects of this wage restraint legislation. The Board heard that historically police were paid less than nurses and now are paid considerably more, despite the fact that nurses are also in a dangerous profession subject to violence and are now being on the front lines of caring for highly infectious patients with emerging deadly viruses. Bill 124 widens this pay inequity.

Bill 124 is an inconsistent patchwork that makes little sense and, while not expressly referencing *HLDAA*, makes it impossible for an Interest Board to carry out its statutory mandate to apply the *HLDAA* criteria. There is no doubt that, but for the imposition of this wage restrain legislation, free collective bargaining or an interest arbitration award would have resulted in improvements to compensation and other improvements to this collective agreement in a number of ways given the *HLDAA* criteria and the pattern of ONA bargaining and interest awards over the last four plus decades.

The Ministry has still at the time of this award not responded to the ONA request for hospital nurses to be exempt from the *Act*, although the application was made in mid-February and other exemption requests have already been responded to in short order. The Board heard evidence that the Ontario Premier publicly stated on March 30, 2020, when asked about ONA's Charter challenge to Bill 124 and capped compensation to nurses, that "if it was up to me, I'd just give them the bank" and he claimed he would "sit down and review" their salaries when "we get through this". We shall see whether the

Premier will put money where his mouth is but, in the meantime, it is most frustrating being on a board of Arbitration pursuant to *HLDAA* and not being able to grant RNs the compensation they normally would be awarded under *HLDAA*.

Where I primarily dissent with the Chair's award is that, while our hands are tied on monetary matters by Bill 124 this round, the Board is not restrained on non-monetary matters. It is clear from the evidence of the history of at least 18 rounds of ONA bargaining that ONA hospital nurses have always been able to bargain or have awarded both monetary increases and improved non-monetary proposals of language improvements, including breakthrough language. ONA is the leader in this health care sector with respect to the language of their central collective agreement.

In particular, as the history of ONA bargaining and interest awards confirms, in the rounds where Boards have been restrained by wage restraint legislation ONA has instead always received significant language improvement. This history has many examples, including that the Scott, Thorne and Houlden rounds were all during years of wage restraint legislation in Ontario, and these Boards awarded significant collective agreement language improvements , such as unique lay off language, improvement on vacations and other leaves, call-back and job security language improvements as well as significant " break through" or novel provisions such as credit for previous experience at other hospitals and work assignment restrictions in accordance with professional responsibilities. Even in non- wage restraint rounds ONA has been awarded on the basis of *HLDAA* criteria break through provisions such as additional superior layoff language, improvements to sick leave and other provisions and breakthrough benefits such a dental implant benefits and new mental health services that the other unions still do not have in their collective agreements.

Following the *HLDAA* interest award pattern for ONA, this Board should have awarded a number of the requested proposals to address significant problems at hospitals with staffing and burnout, job security and nursing shortages, as necessitated by the demonstrated evidence in the Premier's report and the many other exhibits. While the Chair awarded clarification language on agency use, which hopefully will alleviate improper use of agency nurses by some hospitals and improve patient safety by reducing unnecessary agency usage, and at the same time reduce the additional cost to the hospitals of agency use, he did not award other much needed language proposals.

One such proposal is ONA's requested language change based on the evidence of the disturbing pattern of hospitals' posting unit schedules for nurses "with holes", meaning no nurses assigned in the upcoming schedule for shifts. This leads to improper agency use but also leads to unacceptable situations of nurses having to work on shifts with reduced number of colleagues—part of the trend of units "working short" and hospitals not filling vacancies. This is unsafe for patients, leads to more nurse burnout and is untenable in

these days with hospitals having patient census well over capacity. This could have easily been awarded this round in this stressful time with demonstrated evidence of high census and overcapacity hallway nursing.

I would have also awarded language changes to stop the disturbing trend of reducing the number of full- time RN nursing jobs. To recruit and retain the much needed RNs, hospitals need to put in a number of provisions including providing RNs with the security and benefits of full time work. Having to working in more than one health care facility is hard on the nurse and unsafe in infection control terms. We heard evidence that many Ontario hospitals have over used part- time positions and not filled full time vacancies and are understaffed, which is very concerning particularly given the rising Ontario population, not only rising in numbers but also in age and acuity. Proper staffing with appropriate numbers of full- time RNs is a significant recruitment and retention issue, as acknowledged by Sunnybrook hospital in the evidence that we heard that they claim to have 70% full time positions in their public promotions to try to recruit more nurses to their hospital. We also heard evidence of Ontario hospitals losing nurses to other jurisdictions. Detroit hospitals for instance have a stream of nurses crossing the border and Ontario has the lowest number of RNs per capita in Canada.

I also dissent on the dismissal of the proposal for the 15-year step on the salary grid. Filling the hole in the grid between 8 and 25 years' experience is long overdue and needed to retain experienced nurses. In my view Bill 124 should not be read narrowly; the Act is full of express and implied exemptions. As confirmed in the Hansard discussions[3], there were exemptions that were implied and not fully set out in the *Act* that was rushed through. Section 10(2) of the Bill can and should be read to not prevent the parties or a Board from adding a new step on the grid, which would be exempt from the 1% total compensation restriction. The drafters knew that new steps have been often ordered by Boards of Arbitration, the history of ONA/OHA awards have several examples for instance of new grid steps based on years of employment. The drafters of the *Act* expressly stated in section 10(2) that the Bill does not prohibit an employee's salary rate from increasing given the employee's length of time in employment, which is what a grid step for 15 years of employment would do.

ONA's vacation proposal was also not awarded and in my view should have been, with minor modifications to the proposed language to ensure consistency with local language. The Chair said he had not heard enough evidence to award the proposal. But the evidence was of dozens of grievances across the province dealing with over 340 days of vacation days denied by participating hospitals and in all 12 months of the year, not just summer or peak holiday times. Given how hard nurses are working between the crisis of

[3] Hansard Transcript 2019-Oct-28 Legislative Assembly of Ontario; Statement of the Honourable Michael Paras regarding Protecting a Sustainable Public Sector for Future Generations Act

hallway nursing and then being on the front-line of dealing with a novel and deadly virus, the least we can do as an interest board is put in provisions so that nurses can actually take their hard earned vacation days to recharge. This is consistent with our statutory obligations to award provisions try to address recruitment and retention issues in hospitals. Now more than ever we need to retain and recruit nurses. As we heard, and confirmed in the recent reports in exhibits, nurses are exhausted and burned out. They are being called back in growing numbers at end of shifts, denied vacations and redeployed out of their units to screen and care for COVID-19 patients under the emergency measures often with inadequate Personal Protection Equipment ("PPE"). Time off is crucial to deal with burnout, retainment issues, and for safety reasons. It should have been awarded.

Lastly it is unacceptable that the health and safety provisions dealing with infectious diseases was not awarded immediately. These provisions cannot wait the 90 days the Chair gave the hospital to respond to ONA's proposals in his award. They are urgent matters that arose in an extraordinary change of circumstances post the mediation days. The parties have now had many weeks to discuss the issues but the issues remain unresolved. The nurses need these provisions which will lead to better access to proper PPE, and in turn worker and patient safety, without any delay. Every day more and more nurses are becoming sick with hospital acquired cases of COVID-19; this is unacceptable both for the health and safety of the staff and patients. This tragedy would have been significantly different if the hospitals had not breached the precautionary principles that a *HLDAA* board in 2004 added to this collective agreement. Now in the time of COVID-19 and the new reality of emerging viruses and light of the disappointing fact that the Participating Hospitals have put nurses at risk by not stockpiling enough PPE contrary to the clear provisions of the collective agreement, further provisions are required. There is no shortage of demonstrable evidence requiring N95 or superior PPE for RNs caring for suspected or confirmed positive COVID-19 patients. Given the speed and unknown means of transmission of this deadly virus, the provisions and the resulting PPE are needed now, not in 90 days. COVID-19 does not wait 90 days and neither should the nurses have to wait for better health and safety provisions in their collective agreement to protect the health and lives of themselves, their families and their patients.

May 29, 2020

Kate Hughes, Union Nominee

DISSENT

I strongly disagree with the Chair's overall award in this case.

While I agree that a 1% wage increase for the period April 1, 2020 to March 31, 2021 is appropriate, I am opposed to everything else the Chair awarded.

I will outline the reasons for my disagreement with each of the awarded items in turn but will spend most of this Dissent dealing with the Chair's award of the Call Back proposal of ONA. I will also comment on the proposals of the Hospitals which were all dismissed by the Chair. Finally, I will comment on various obiter statements that the Chair made in his award which, in my view , were neither necessary nor helpful to the process generally.

1. CALL BACK

Let me start with some context and background. As noted above, the Chair awarded a 1 % wage increase. This constituted a total compensation increase of 0.938% for the group of 131 Participating Hospitals as a whole. Bill 124 puts a limit of 1% on any wage increase and it also puts a limit of 1% on the total compensation increase (which includes the 1% wage increase.) The Chair and I both agreed (and so did the Hospitals) that we should award a total compensation increase of approximately 1% but not more than 1%. To get to this 1% total compensation figure we had 0.062% to work with. The question then became where do we go from here.

In bargaining and at arbitration, ONA made the following proposals::

1. Increase the night shift premium by 10 cents per hour.This is exactly the same proposal made by the Hospitals. The cost would be 0.031%

2. Increase the weekend premium by 10 cents per hour. This is also exactly the same proposal made by the Hospitals. The cost would be 0.030%.

3. Increase the evening premium by 10 cents. The cost would be 0.04%

4. Increase the call back rate from time and one half to double time. The cost would be 0.058%

5. Provide for 13% in lieu of benefits for nurses working past age 75. The cost of this would be 0.003%

6. Increase the Massage Therapy allowance by $50. The cost of this would be 0.013%

7. Increase the Physiotherapy allowance by $50. The cost of this would be 0.010%

8. Increase the Chiropractic allowance by $50. The cost of this would be 0.010

9. Increase the allowance for dealing with Mental Health issues from an annual amount of $800 to an unlimited amount. The cost of this would be 0.602%

10. Increase Benefits coverage for Full-time nurses to age 75 and include Life Insurance coverage. The cost of this would be 0.018%

Following a period of bargaining and mediation and being aware of ONA's proposals, the Hospitals proposed at arbitration that we award a 10 cent per hour increase in the night shift premium and a 10 cent per hour increase in the weekend premium. The cost of the night shift premium increase would be 0.031% and the cost of the weekend premium increase would be 0.030%. The two items combined constituted a 0.061% increase in total compensation.

We were told that during both the bargaining that had taken place as well as the mediation, ONA never indicated what its priority was in terms of which proposal or proposals should be awarded. Furthermore at the hearing ONA, likewise, did not indicate to us whether they had a priority and, if so, what it was.

The Chair decided to award ONA's call back proposal. I totally disagree with that decision. In my view, what should have been awarded was the 10 cent per hour increase to the night shift premium and the 10 cent per hour increase to the weekend premium which both parties had proposed. The purpose of interest arbitration is to replicate what the parties would have freely negotiated. Obviously, if both parties put forward the same proposals on night shift and weekend premiums and are apart on all other compensation items, it stands to reason that they would agree on those items in free collective bargaining. Furthermore, in my view since they were proposing the same thing there was no dispute between them on what should happen with respect to the night shift premium and the weekend premium. As such, it cannot be said that these two items constitute "matters that are in dispute" between the parties under Section 9 (1) of the Hospital Labour Disputes Arbitration Act. As noted above the cost of these two items was 0.061%. When we add that to the wage increase of 0.938%, we get a total compensation increase of 0.99%. Because each and every one of ONA's other proposals, if awarded, would put the total compensation over 1%, we cannot, under Bill 124, award any of them. This includes the call back proposal.

In my view, the Chair's failure to award the 10 cent per hour increases to both the night shift premium and the weekend premium and his awarding , instead, of ONA's call back proposal constitutes a jurisdictional error.

The Chair points out at paragraph 56 of his award that my argument regarding jurisdiction was raised at the 11th hour.

The argument, put simply was that under Section 9 (1) of HLDAA, a Board of Arbitration only has jurisdiction to decide on "matters that are in dispute" between the parties. My view was that the night shift premium increase and the weekend premium increase were not matters in dispute and simply should have been awarded since both parties wanted them. As a result of awarding them no other proposals could then be awarded since to do so, would put the total compensation over 1%.

Let me say at the outset that I make no apologies for having raised this argument at what the Chair called the 11th hour. When it became obvious that the Chair was rejecting all of the other arguments against ONA's call back proposal (which I will elaborate on in the next section of this

Dissent) I decided, after carefully thinking about the matter, that the jurisdiction argument was valid and since it involved jurisdiction, the "hour" at which it was raised should make no difference. Furthermore, I have always been a proponent of Yogi Berra's immortal words "it ain't over till it's over".

The Chair says at paragraph 58 of his award that the parties were apart on the costing of each proposal. With respect, that is not correct. There was no dispute on what the cost of the ten cents per hour night shift premium increase was nor what the cost of the ten cents per hour weekend premium increase was.

The Chair also says at paragraph 58 that "it was clear that ONA was not willing to accept the Hospitals monetary proposal". That is true but only in the sense that ONA wanted not only everything the Hospital was proposing but they also wanted more. At no time did ONA express that their numerous monetary proposals were a package that had to be accepted as a package, failing which all bets were off. They just proposed a whole bunch of items and never indicated what, if any priorities they had. We were told that the same thing happened at direct bargaining and also at mediation - ONA never indicated what priorities, if any, they had.

When the Chair decided that Bill 124 was applicable and that he was going to apply it (contrary to ONA's wishes) we quickly agreed that the wage increase would be 1% (which was the maximum allowed by Bill 124) and since that amounted to a total compensation increase of 0.938%, we agreed that we had an additional 0.062% to work with to bring the total compensation up to 1% (which was the maximum allowed by Bill 124).

The question then became what do we award.

My answer was simple and spontaneous. We award the two items - the night shift premium increase and the weekend premium increase - that both the Hospitals and ONA wanted.

While, initially, I didn't express the view that I saw this as a jurisdictional issue, there was no doubt about what my position was - we should award the two items that both parties were asking for. There was consensus on those items. Unfortunately, the Chair didn't accept that position.

At the 11th hour when thinking about what to write in my Dissent, I became convinced that this was not just an exercise in applying the principle of replication but it was also a jurisdictional matter and hence I raised it with the Chair. He agreed to consider it and he has considered it and has indicted why he doesn't agree with my position. I do not agree with the conclusion he reached.

I have no idea why he said what he said in paragraph 60 of his award. Yes, everything he said in that paragraph is true. However nothing in that paragraph reflects what happened in our case. ONA's various monetary proposals were never put to us (or to the Hospitals) as being a package. Furthermore, neither the Hospitals nor I have engaged in "cherry picking from the monetary package of proposals it likes best without the agreement of the other party". First I want to stress again that ONA's monetary proposals were never put forward as being a package. How can they be when the total compensation value of that list of items far exceeds the legislated cap in Bill 124? Secondly, there was no cherry picking. Rather, what we had was the Hospitals actually

proposing two things - a night shift premium increase and a weekend premium increase - and ONA actually proposing ten things, two of which were the night shift premium increase and the weekend premium increase which happened to be exactly the same as what the Hospitals proposed.

Our job was to decide the matters in dispute between the parties.

In my view neither the night shift premium increase proposal nor the weekend premium increase proposal were "matters in dispute" since both parties were proposing exactly the same thing. If ONA's proposals with respect to these two items had been part of a package, the situation would have been different because ONA would then have been saying that you have to agree to all of our package or else there is no agreement. In other words, in dealing with a package proposal, the other party can't cherry pick what it likes from the package. However, that is not our case. ONA never put forward a package proposal. As a result of that, it was surely incumbent on this Board to say that both ONA and the Hospitals wanted the same thing i.e. the night shift premium increase and the weekend premium increase and since they did then, obviously, those two items were not "matters in dispute" between them.

I will now set out my views as to why, on the merits, ONA's call back proposal should not have been awarded. In my view, the awarding of that proposal was ill advised, inconsistent with interest arbitration principles and jurisprudence and just plain wrong

In making decisions in interest arbitration cases, Boards look at a number of principles with the most important being replication. At paragraph 27 of his award the Chair states:

"The most important and guiding principle applicable to all interest arbitration proceedings is replication"

I agree with that statement.

At paragraph 28 of his award the Chair makes the following statement:

"The application of the replication principle is an objective exercise , driven by the use of objective evidence, to assist in determining what the parties would have achieved in free collective bargaining"

I agree with that statement.

So far so good.

Now let's look at the evidence in this case:

1. The current call back provision provides for pay at the rate of time and one half for all hours worked by a nurse who has completed her regular shift but has then been called back to work outside her regularly scheduled working hours. There is a minimum guarantee of 4 hours at time and one half. I should note that casual part time nurses are not entitled,

under the collective agreement, to receive call back pay and so it is only full time and regular part time nurses who are eligible to receive it.

2. In the last fiscal year 52 out of the 131 Participating Hospitals did not utilize call back for their ONA bargaining unit nurses.

3. All other hospital sector employees in Ontario receive time and one half for call back. Most also receive the minimum guarantee of 4 hours at time and one half. For others the minimum guarantee is either less than 4 hours or doesn't exist.

4. In support of its proposal for double time for call back , ONA told us that the nurses' collective agreements in B.C and Alberta both provide for double time. ONA did not tell us what the minimum guarantees were in those provinces.

5. ONA did not refer to any collective agreement in Ontario, in any sector, that provided for double time for call back.

6. At page 181 of its brief that was filed at the hearing, ONA made the following statements in support of its proposal:

"Call back premium pay recognizes that an RN has finished work and then made themself ready to work on short notice after being off duty. In effect, such premium compensates the RN for working long hours and limiting their off duty activities and free time.

Increasingly, call back premium pay also helps safeguard against employer abuse whereby call back is used in place of adequate staffing and as part of a "just-in time" staffing model, which leads to less rest time for RNs and lower quality of patient care overall".

7. The Hospitals were very much opposed to this ONA proposal. The Hospitals made the following statements at page 9 of Tab 6 of their brief that was filed at the hearing:

" hospitals operate in a 24/7 environment where an element of unpredictability exists with respect to staffing due to the evolving nature of its operations, such as patient census and needs.

As an urgent need arises , hospitals may find themselves in a situation which necessitates filling unexpected staffing needs through the use of standby and call back provisions. When having to resort to these provisions, premiums are attached."

Amongst other things, the Hospitals also stressed that there was no demonstrated need for the proposal ; the proposal would represent a "significant breakthrough" and that "interest arbitration is not the place to create such a precedent".

8. The cost of this proposal was $3,290,637 - an increase to total compensation of 0.058%.

The Chair decided to award ONA's proposal. At paragraph 37 he states:

> "We are of the view that in these extremely unusual times, where total compensation is limited to 1%, ONA would be able to achieve the monetary proposals that they give the most priority and significance to for their members. In this case, the increase to the call back premium in article 14.06 from time-and-one-half to two times regular straight time is a priority identified by ONA and tied to their RN fatigue, staffing and scheduling concerns."

At paragraph 38 he states:

"We acknowledge that the other Ontario hospital sector employees only receive time-and-one-half for call backs. However, as stated above, there are many differences between the compensation of other hospital sector employees and nurses. We note that nurses in Alberta and British Columbia enjoy double time as a call back premium. In these extremely exceptional and unusual circumstances, we are of the view that similar compensation for Ontario nurses should be awarded. We also note that containment of this additional cost is something that the Hospitals can accomplish if they schedule and staff properly so that they do not need to call back nurses after they have completed their regularly scheduled tour."

With respect, these reasons do not hold water.

First, the Chair seems to give deference to ONA's views because his opinion is that Bill 124 has impeded their ability to freely negotiate. That, however, is the function of the courts to determine, not this Chair. If the courts find that Bill 124 should be struck down, then there is the full ability to address any remedial concerns through the reopener that the Chair has awarded. It is premature to lay judgment on whether Bill 124 is a just law and, frankly, that is not a matter that falls within the jurisdiction of this Chair, in any event.

Second, with respect to what is stated at paragraph 37, there is no way that ONA would have been able to achieve their call back proposal in free collective bargaining, even had they made it clear from the outset of bargaining that it was a priority item for them. The Hospitals were adamantly opposed to it and we know that ONA never expressed it as a priority item during the negotiations between the parties; it was not expressed as a priority item during mediation and it was not expressed as a priority item at the hearing.

Third, as the Chair himself pointed out, replication is the most important principle in interest arbitration and, in applying that principle , you have to look at objective evidence. Included as a major component of this exercise is looking at relevant comparators. We were not referred to a single collective agreement in Ontario that had double time for call back. Not one! The only agreements we were referred to by ONA as having double time were the nurses' agreements in B.C and Alberta.

However, it is important to point out what ONA did not tell us about the B.C and Alberta call back provisions. The nurses' agreements in those 2 provinces have minimum guarantee provisions but they are not as generous as what the current agreement for the nurses in Ontario provides. In B.C call back is at the rate of double time with a minimum guarantee of 2 hours at double time.

Hence a B.C. nurse is guaranteed a minimum of 4 hours pay each time she is called back. In Alberta, call back is at the rate of double time with a minimum guarantee of 3 hours. An Alberta nurse is therefore guaranteed a minimum of 6 hours pay each time she is called back. In Ontario at the present time, call back is at the rate of time-and-one-half with a minimum guarantee of 4 hours at time-and-one-half for 4 hours. Accordingly an Ontario nurse is currently guaranteed a minimum of 6 hours pay each time she is called back.

Call backs occur because a particular urgent need has arisen. It has been my experience in dealing with many call back cases over the years that call backs, generally, do not last for a particularly long period of time. They usually involve an unexpected event that requires the immediate presence of a nurse to deal with a specific problem. Generally, they do not last for the full guaranteed minimum period – rather the call back lasts, in most cases, for a couple of hours, sometimes for less than that. That is why unions bargain the guaranteed minimum clause. They say that it is not worth an employee's time and effort to come back to the hospital for an hour or 2 and therefore if the hospital wants them to agree to come back , it has to make it worth their while and 4 hours at time-and-one-half (i.e 6 hours pay) for 1 or 2 hours of actual work was deemed to be a sum that was "worth their while".

By awarding double time for call back, the Chair has increased the minimum guarantee to 8 hours pay (i.e 4 hours at double time). Not even the 2 provinces he has relied upon have such a generous minimum guarantee. B.C only has a minimum guarantee of 4 hours pay and Alberta has a minimum guarantee of 6 hours pay. Notwithstanding ONA's failure to tell us about the minimum guarantee provisions in the B.C and Alberta agreements, I brought those provisions to the Chair's attention. However, he doesn't appear to think they are very relevant in looking at replication since he still has gone ahead and awarded double time with a minimum guarantee of four hours. In my view the minimum guarantee provisions are very relevant if B.C and Alberta are going to be considered. (It is my view, however, that the B.C and the Alberta nurses' agreements are not relevant and the Chair should not have taken them into account in the first place. I will have more to say about this issue shortly. My point at this stage is simply that if it is appropriate to take the B.C and Alberta provisions into account, why didn't he take into account the minimum guarantee provisions of the B.C and Alberta call back clauses)

The most important aspect of any call back clause is what it provides by way of a minimum guarantee. Sure, B.C has call back at the rate of double time but their minimum guarantee is only 2 hours at double time . Hence a nurse in B.C who comes back for 2 hours is guaranteed a total of 4 hours pay. In contrast, a nurse in Ontario who comes back for 2 hours is , at the present time, guaranteed 6 hours pay. The objective evidence simply does not support what the Chair has awarded and I repeat that there is no way, looking at this objectively, that the Hospitals would have agreed to ONA's proposal even if it were appropriate to look at the B.C and Alberta situations..

I now want to address the issue of relevant comparators since the Chair has relied on the B.C and Alberta nurses' agreements as justification for awarding double time for call back. At paragraph 30 of his award the Chair states:

"The terms of the collective agreements between the Hospitals and the other major unions who

bargain centrally in the hospital sector are relevant comparators. In the past, agreements affecting nurses in other provinces have also been considered relevant, see Participating Hospitals and ONA, March 5, 2007 (Albertyn)."

In my view agreements affecting nurses in other provinces are not relevant comparators. Period. I don't read the Chair's statement quoted above as saying that they are – he simply points out that in a 2007 award between these parties Mr. Albertyn did consider them relevant. However, he relies on the Alberta and B.C agreements to support his award of double time for call back. I really don't know whether he considers "agreements affecting nurses in other provinces" relevant comparators or not or whether it is only nurses agreements in Alberta and B.C that are relevant comparators. If the latter, what makes Alberta and B.C nurses' agreements so special that they can be looked at (and in this case relied upon to support his call back award) while the nurses' agreements from the other 7 provinces are, presumably, not so special and are therefore not relevant? In my view the nurses' agreements from all of the other provinces are not relevant. If I am wrong on that and they are relevant, then the agreements from the other 7 provinces should also be looked at and we know that these agreements do not support what ONA is looking for and what the Chair has awarded. I don't believe that the mere fact that B.C and Alberta have double time for call back constitutes compelling objective evidence of why the Hospitals in our case would have agreed to ONA's proposal had they been obliged to resolve their dispute in free collective bargaining rather than interest arbitration. In the last 2 rounds of interest arbitration between these parties I have been the Hospitals' Nominee and both Boards have neither relied upon nor determined that nurses' agreements from other provinces were relevant. comparators. Obviously, the overall circumstances including the economic situations, vary from province to province. I view Chair Albertyn's 2007 award as an outlier which has not been followed.

I would just note that in the last round of interest arbitration, Chair Kaplan rejected ONA's assertions regarding comparisons with other provinces and found:

"…there is a governing pattern in central hospital settlements and awards, and while it might be appropriate in some circumstances to depart from it - in cases of demonstrated need backed by compelling and convincing evidence - this is not one such case…..For an interest arbitration board to deviate from replication in a central agreement covering virtually every hospital in the province, demonstrated need backed by convincing evidence is essential"

I also want to comment on the Chair's statement in paragraph 37 of his award that ONA's call back proposal was tied to their "RN fatigue and staffing and scheduling concerns" and his statement at paragraph 38 that "Containment of this additional cost is something that the Hospitals can accomplish if they schedule and staff properly so that they do not need to call back nurses to work after they have completed their regular schedule".

First, with respect to the paragraph 37 statement, it is true that ONA did assert what the Chair wrote. However, assertions are one thing. Proof is quite a different thing. ONA led no evidence to prove their assertions. They just made general broad brush statements without backing them up with proof. The Hospitals argued that there was no demonstrated need for the proposal and I completely agree with them.

Second, with respect to the paragraph 38 statement there is no evidence to support this. The Chair is suggesting that call backs are the end result of improper scheduling and staffing by the hospitals. There was no evidence whatsoever before us showing that hospitals were improperly or inappropriately using call backs when they should have been doing something different in terms of staffing and scheduling. A call backs occurs, as the Hospitals pointed out, where an urgent unexpected or unpredictable situation arises which necessitates having to bring back a nurse to deal with such a situation. This is an entirely different issue than some of the other issues raised by ONA in this proceeding. Accordingly, in my view, there is no proper basis for the Chair to suggest that paying double time for call back will suddenly alleviate or eliminate the need for call back. Put simply, there is no demonstrated need for this proposal and it should not have been awarded

Another issue that I want to comment on in relation to the awarding of ONA's proposal for call back is the Hospitals' assertion that ONA's proposal, if awarded, would constitute a significant breakthrough. I don't think there can be any doubt that it is, in fact, a breakthrough provision. No employees in the Ontario hospital sector have this and we were not referred to ANY collective agreement in Ontario in any sector that has double time for call back. The only agreements we were referred to that have double time were the B.C and Alberta nurses' agreements but even then, their respective minimum guarantee provisions would not be as good as minimum guarantee provision that is contained in the provision the Chair has decided to award. Hence it can be said that the provision that the Chair has awarded breaks new ground. NO one has a provision as generous as the one the Chair has awarded.

At paragraph 30 of his award, the chair addresses the concept of "demonstrated need" in interest arbitrations and also how proposals for "breakout language " should be dealt with by an interest arbitration board. This is what he said:

"One other arbitral principle requires some comment and that is the concept of a demonstrated need. Once again, the exercise is an objective one that relies primarily on objective evidence of needs and not the subjective desires of one party. It is incumbent upon a party seeking "breakthrough language" to prioritize their demands and establish the required demonstrated need. See Participating Hospitals and SEIU, November 10, 2010 (Burkett)"

I agree with those statements.

I would also add that the interest arbitration jurisprudence supports the view that breakthrough provisions are best left to the parties to craft themselves through give and take of bargaining rather than being awarded by interest arbitrators. In this regard I refer to paragraph 26 of an award of the present Chair dated March 6, 2019 in a case involving IESO and The Society of United Professionals. The paragraph reads:

"Another general principle applicable to interest arbitration is the acceptance that interest arbitration is a conservative exercise whereby arbitrators are reluctant to be creative by awarding "radical changes" or "breakthrough" measures or provisions. Arbitrators, quite rightly, are generally of the view that creativity and breakthrough measures are best left to the parties to craft through the give and take of bargaining, see Independent Electricity System Operator and the

Society of Energy Professionals , unreported award of M. Picher dated December 17, 2019."

In a 1981 paper entitled "The Ontario Experience with Interest Arbitration: Problems in Detecting Policy" which appeared in Relations Industrielles , volume 36, Number 1, 1981, George Adams, one of the leading experts in labour law made the following comment:

"Interest arbitration is, however, a blunt and conservative instrument. Solutions to complex problems are not easily achieved and breakthrough bargaining is unsuited to it"

In my view the Chair should have followed the principles referred to above and not even dealt with (except to dismiss it) ONA's breakthrough call back proposal. Even if he did decide to deal with it (which he obviously did) he should then have followed the advice of Mr. Burkett in the award which he quoted from at paragraph 30 of his award, namely, "It is incumbent upon a party seeking "breakout language" to prioritize their demands and establish the required demonstrated need". In the instant case ONA never indicated that its call back proposal was a priority for the union or its members. Furthermore, as I have pointed out above no demonstrated need based on objective evidence has been established by ONA. ONA led no evidence whatsoever.to establish that double time was necessary.

Furthermore, as noted above, casual part time nurses are not eligible for call back pay and during the last fiscal year 52 of the 131 Participating Hospitals didn't even utilize call back for their ONA bargaining unit nurse. By way of contrast, the night shift premium increase and the weekend premium increase would have benefitted a very high percentage of the nurses at the 131 Hospitals. All of the 131 Participating Hospitals are open 24/7 , 365 days a year. All have night shifts and weekend shifts and while a relatively few nurses have a Monday to Friday day time schedule, the vast majority of nurses work shifts and weekends.

At the very least, in my view, if the Chair was not prepared to award what was obviously the most appropriate proposals - the night shift premium increase and the weekend premium increase - he should have sent the issue of what additional monetary proposal(s) to award back to the parties so that they could determine where the 0.062% was to be spent and he could have remained seized to deal with that matter if they could not agree. That is what Arbitrator Jesin did in a recent case involving CUPE and Villa Columbo Homes for the Aged (May 4, 2020).

In summary, it is my view that ONA's call back proposal would never have been agreed to in free collective bargaining and the Chair should not have awarded it. The Hospitals were adamantly opposed to it; it is a breakthrough provision; there is no other Ontario collective agreement that has such a proposal and ONA failed to establish any demonstrated need for it. While the Chair says all the right things in terms of what interest arbitration principles are to be applied – replication and demonstrated need based on objective evidence (as well as the need to prioritize a breakthrough provision) - the problem is that when he gets around to applying those principles, he simply doesn't apply them.

2. AGENCY NURSES

In my view, no demonstrated need existed for the "clarity note" the Chair has decided to issue.

The evidence was that in the last fiscal year that ended March 31, 2020, only 35 of the Participating Hospitals used agency nurses. 96 did not use agency nurses at all. Of the 35 Hospitals that did use agency nurses, it appears that ONA 's concerns were with 10 hospitals (9 of which were in the GTA) although the 10th ranking hospital in terms of actual agency hours utilized is really not that high compared to the others in the group and probably isn't much, if any, of a concern.

The Chair points out in paragraph 42 of his award that the dispute relating to the use of agency nurses has been ongoing since 2003. He points to an award of Arbitrator Kaplan in 2003 that said that the use of agency nurses was only permitted on an ad hoc basis. Mr. Kaplan also imposed a threshold limit for ad hoc agency use with a financial penalty for usage over the threshold. The penalty for usage over the threshold was increased from 38 cents per hour to 62 cents per hour in an interest arbitration award of a Board chaired by Arbitrator Albertyn between these parties on September 7, 2016.That same Board also lowered the threshold for usage to 1.5% from 2%.

Despite ONA's concerns about the use of agency nurses, they don't appear to have done much about it. The Chair points out that he has dealt with 3 rights arbitration cases involving what he referred to as excessive use of agency nurses at GTA hospitals. We know that one of the Hospitals was Humber River because an award was issued in 2019 . The Chair summarizes that case at paragraph 44 of his award. I have read the award (which was put before us) and it is very comprehensive. It sets out in plain language what the hospital did wrong and what it should have done and what it should be doing in future. The other 2 agency nurses cases that the Chair had before him were settled. Other than the Humber award there have been no arbitration awards involving the agency nurses language in the collective agreement since the Kaplan award in 2003

Before our Board ONA sought to have awarded a proposal that would entirely eliminate the use of agency nurses. The Chair rightly, in my view, found that such a proposal went too far and he rejected it. But then he comes up with a clarity note and awards it. I fail to see why this is needed let alone justified. ONA doesn't appear to be having any problems with 121 out of the 131 Participating Hospitals. As for the others, the Humber decision has articulated a clear roadmap as to what can be done and what can't be done. If ONA feels that a Hospital has violated the collective agreement then it can file a grievance and if they prove their allegations they will be entitled to appropriate remedies which is what happened at Humber. Finally, even though we had evidence before us concerning the number of hours that agency nurses worked at Hospitals in the last fiscal year, there was no evidence put before us regarding the circumstances and context of that work. Hence no conclusions could be drawn as to whether some or all or none of that usage violated the agreement.

3. ONA's LATE PROPOSAL

I will hold off saying anything about this issue pending the outcome of the negotiations between the parties. It may very well happen that this issue comes back to us for determination on the merits and I will wait to see what ultimately transpires before deciding whether I need to say anything more. I do, however, wish to make a comment regarding the Chair's decision to allow ONA to bring this issue back before the Board earlier than 90 days from the date of the award if the Government were to substantially alter Directive No. 5. The reason that this proposal is being sent back to the parties to bargain about it, is that there was no previous opportunity to bargain

about it given the late filing of the proposal and the fact that the Hospitals didn't have an opportunity to properly consider the proposal and conduct such research and other information gathering as parties typically do when they prepare for bargaining. If, in the expert opinion of the Chief Medical Officer of Health and pursuant to his powers under the Health Protection and Promotion Act, there is a change to the Directive is deemed appropriate, that does not change the fact that the proposal was filed late; that there was no chance to bargain it and that the Hospitals still need an opportunity to properly consider the proposal, and do their research and preparation for bargaining. It doesn't seem fair to me to potentially force the Hospitals back before the Board to argue this proposal without having an opportunity to properly prepare.

4. % IN LIEU FOR NURSES OVER 75

As noted previously, I would have awarded the night shift premium increase and the weekend premium increase which would have meant that we have reached the maximum allowable total compensation increase of 1%. No demonstrated need was established the % in lieu proposal which the Chair decided to award. The only reason he awarded it was to top up the total compensation to 1% since the awarding of ONA's call back proposal didn't quite get us to that 1%. figure. I don't consider that to be a proper reason for awarding the proposal.

5. SECOND YEAR WAGE INCREASE

Since the collective agreement covered by this award will run for 14 months, the Chair decided to give a wage increase of 1% effective April 1, 2021. (month 13). I would not have done that. The Chair points out at paragraph 13 of his award that the global pandemic has created a severe economic downturn and that "there can be no doubt that all levels of government will have less revenues and will incur higher expenses as a result of the COVID-19 crisis. In these circumstances, I believe that the better approach would have been to leave it to the parties themselves in their next round of bargaining to determine all compensation matters for the period beginning April 1, 2021 (and failing agreement, for the next interest Arbitration Board to make that determination).

6. HOSPITALS' PROPOSALS

I am very disappointed that the Hospitals' proposals were not seriously considered at all. They were very meritorious and a demonstrated need for them was clearly established. If a one year rollover agreement was most likely what would have happened had the parties been required to settle their differences in free collective bargaining, then it would have (and should have in this case) worked both ways.

7. OBITER COMMENTS

I am concerned about the numerous obiter dicta comments that are scattered throughout the award. In my view it is fine to give reasons for why certain proposals were awarded or not awarded if it is felt that this is necessary in all the circumstances but I feel that going beyond that to speculate about what might be appropriate in different times and circumstances is neither necessary nor

helpful to the process generally.

Dated at Toronto, this 8th day of June, 2020

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Brian O'Byrne