IN THE MATTER OF AN INTEREST ARBITRATION

Between:

The Participating Hospitals

(Represented by the Ontario Hospital Association)

and

ONA

Before: William Kaplan, Chair
Brett Christen, OHA Nominee
Phil Abbink, ONA Nominee

Appearances

For the OHA:

Craig Rix, Counsel, Hicks Morley, Barristers & Solicitors

David Brook (Spokesperson) – V.P., Labour Relations & Chief Negotiations Officer, OHA
Carol Hatcher (Chair) - Chief Nursing Executive, Humber River Hospital
Rebecca Officer - V.P. Human Resources and Organizational Culture & Development, Bruyere
Myfanwy Marshall – V.P. People & Experience, Centre for Addiction and Mental Health
Bryan McNevin - Manager People Services, Collingwood General and Marine Hospital
Julia Marchesan - HR & Workforce Wellness Executive, London Health Sciences Centre
Phillip Kotanidis - Chief Human Resources Officer, Michael Garron Hospital
Sarah Jane-Irvine - Chief Human Resources Officer, Norfolk General Hospital & West Haldimand General Hospital
Clarence Willms - Chief Human Resources Officer, Providence Care
Sue Rogers - VP Clinical Operations and Chief Nursing Executive, Sault Area Hospital
Dean Osmond - Chief Executive Officer, Sioux Lookout Meno-Ya-Win Health Centre
Suzanne Madore - Chief Operating Officer and Chief Nursing Executive, The Ottawa Hospital
Robin Ross - Director Labour Relations, Unity Health
Mandy Madill - Director Labour Relations, University Health Network
David McCoy - Director Labour Relations, OHA
Phil Cifarelli - Consultant Labour Relations, OHA
Joyce Chan - Consultant, Labour Relations, OHA
Adrian Di Lullo - Consultant, Labour Relations, OHA
Louci Apkarian - Consultant, Labour Relations, OHA

For ONA:

Wassim Garzouzi, Counsel, Raven Law, Barristers & Solicitors
Julia Williams, Counsel, Raven Law, Barristers & Solicitors

Steve Lobsinger RN - Chief Negotiator
Marilynn Dee RN - Manager II – Negotiations Hospitals
Rachel Muir RN - Region 2 Full-Time Representative Chair
Erin Ariss RN - President
Bernie Robinson RN - Interim President, Region 2 Vice President
Angela Preocanin RN - First Vice-President
Andrea Kay RN - Chief Executive Officer
Monique Storozuk RN - Region 1 Full-Time Representative
Jason Dupras RN - Region 1 Part-Time Representative
Kate Magladry RN - Region 2 Part-Time Representative
Serge Ganzburg RN - Region 3 Full-Time Representative
Jane Penciner RN - Region 3 Part-Time Representative
Laurie Rogers RN - Region 4 Full-Time Representative
Elizabeth (Betty) Audibert RN - Region 4 Part-Time Representative
John Lowe RN - Region 5 Full-Time Representative
Jo-Dee Brown RN - Region 5 Part-Time Representative
Patricia Carr RN - Manager II – Negotiations LTC/Community
Ronda Sawyer RN - Region 1 Labour Relations Officer
Adriana Breen RN - Region 2 Labour Relations Officer
Michael Levey RN - Region 3 Labour Relations Officer
Adele Churchill - Region 4 Labour Relations Officer
Marie Haase RN – Region 5 Labour Relations Officer
David Cheslock RPN - Region 3 Manager, Labour Relations
Kayla Sanger - Legal Counsel, HLDAA / Interest Arbitration Specialist
Dave Campanella - Economist, Labour Market Research, Collective Agreement Analysis
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Victoria Romaniuk - Manager Administration, Office of the CEO
Dawn Armstrong RN - Region 1 Vice President – Observer
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Alan Warrington RN - Region 5 Vice President – Observer
Todd Davis - Region 4 Manager, Labour Relations
Robert McGregor RN - Region 5 Manager, Labour Relations

The matters in dispute proceeded to a hearing in Toronto on May 2 & 3, 2023. The Board met in Executive Session on June 15, 2023.

Introduction

This interest arbitration was consensually convened to settle the terms and conditions of the central collective agreement between the Participating Hospitals – represented by the Ontario Hospital Association (OHA) – and the Ontario Nurses' Association (ONA). Notice to bargain was given on January 5, 2023. Bargaining took place in January and February, with mediation following in March. The matters in dispute proceeded to a hearing held in Toronto on May 2 & 3, 2023. The Board met in Executive Session on June 15, 2023. ONA represents approximately 65,000 Registered Nurses (RNs) and Nurse Practitioners (NPs) – both full- and part-time (49,580 FTE) – and other health professionals providing frontline health care at 127 Participating Hospitals located across Ontario, rural and urban, teaching and specialist, and they range in size from small – less than 10 nurses – to very large – more than 3000 nurses. This award will set the terms and conditions of the twentieth central collective agreement between these parties.

Statutory Criteria

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

> 9 (1.1) In making a decision or award, the board of arbitration shall take into consideration all factors it considers relevant, including the following criteria:
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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.

The parties have agreed that a *HLDAA* term applies: April 1, 2023 to March 31, 2025.

ONA Submissions

Summary

In ONA's view, two issues were front and centre in this interest arbitration, and they were inter-related: the need to address a severe RN shortage and to catch up on overall compensation that has fallen behind over the past decade, a situation made even more untenable by continuing high inflation and its corrosive impact on spending power. The solution to these problems included long overdue and meaningful pay increases, grid adjustments, introduction of long-service recognition pay, and enhanced premiums. In addition, penalty provisions were necessary to discourage the ongoing and excessive use of agency nurses; an unbelievably expensive stopgap measure to staff hospitals but one that, perversely, made recruitment and retention of RNs even more challenging. A Nurse Practitioner (NP) grid was also a bargaining priority.

ONA reviewed various interest arbitration criteria – both statutory and normative – in support of its submissions including recruitment and retention, appropriate comparators, the economic situation in Ontario, the extent to which services may have to be reduced, ability to pay along with gradualism and demonstrated need. Application of each of these criteria led to the immediate, indeed inevitable, conclusion that all ONA's compensation proposals were fully justified and should be awarded.

Recruitment and Retention

It was almost beyond debate, in ONA's submission, that the Participating Hospitals were unable to attract and retain sufficient numbers of RNs. The evidence in support of this proposition was everywhere. Indeed, it was described in detail in the OHA's own publication, *Practical Solutions to Maximize Health Human Resources* (*Practical Solutions*), in growing numbers of hospital

emergency room closures never previously seen in Ontario and skyrocketing waiting lists for urgent surgical procedures, in payment of incentives such as increased overtime – outside the provisions of the collective agreement – to attract and retain nurses, and in the huge expansion in use of agency nurses, paid a multiple of the collective agreement grid rates. Other individual hospital efforts to attract and retain nurses included raffles, swag, visits by therapy dogs, BBQs, recognition of long-service employees, manicures, massages and free snacks. All these steps established, with clear, cogent and compelling evidence, a staffing crisis in need of immediate and meaningful attention.

The assertion of a serious recruitment and retention problem was not, ONA observed, based on anecdotal evidence. It was fully outlined in *Practical Solutions*. Moreover, the OHA's Fall 2022 *Health Human Resources Workforce Survey* showed a tripling of the RN vacancy rate since March 2018: the all-hospital vacancy rate (both full- and part-time) was 10.27% on October 1, 2022; the RN and RN Speciality Rate was 14.78%, up from 4.9% on March 31, 2018. To be sure, some new positions had been created, but that was not, in ONA's view, the principal cause of the nurse shortage. Resignations and a huge increase in turnover were the most important contributors. A March 31, 2018 hospital resignation rate of 4.98% had more than doubled to 10.93% as of September 30, 2022. *Practical Solutions* reported that exhaustion and impossible workloads led to the burnout of experienced late career nurses who were voting with their feet leaving frontline clinical practice or, far too often, the profession altogether (although sometimes returning to the workplace they just left as much more highly paid agency nurses). Of course, ONA pointed out, these departures – whatever their proximate cause – adversely affected the nurses who remained by increasing their workloads creating a vicious circle of even more nurses who then decide to leave.

The miscellaneous measures that had been put in place ranging from doubling overtime to swag and BBQs, ONA observed, were not working. The same could be said about government initiatives including *The Temporary Reimbursement of Fees for Internationally Educated and Inactive Nurses*, the *Community Commitment Program for Nurses* (offering a $25,000 incentive for nurses who have not practised in Ontario for the last six months but who make a two-year commitment to do so), and a $5000 retention bonus to existing nurses in return for them agreeing to remain working in Ontario. Even with all of these and other initiatives, nurses – the unequivocal data demonstrated – continued to leave hospital health care, with significant numbers returning to work as agency nurses at a multiple of their previous pay.

Indeed, the use of agency nurses by the Participating Hospitals was particularly telling. In 2003 (*Sunnybrook & Women's College & ONA* (133 LAC (4th) 91), ONA grieved a large increase in agency nurse employment largely brought about by recruitment and retention challenges. The award concluded that while agency nurses could be used, a parallel contingent workplace was prohibited by the collective agreement. Nevertheless, many of the Participating Hospitals were regularly employing agency nurses – in fact, were putting them on schedules – because the staffing crisis left them with no other choice. The immediate result was completely predictable: agencies could, with their higher pay and benefits, attract nurses from the Participating Hospitals, and then return them to the hospitals to work side-by-side with their former colleagues but with superior terms and conditions of employment (including more attractive shifts). Unless agency nurse usage was forestalled and left for true emergencies, the recruitment and retention crisis would inevitably deteriorate even further. A number of examples describing this insidious circle were provided including a frank October 6, 2022 press release – a typical example in ONA's view of a pervasive system-wide situation – issued by the South Bruce Grey Health Centre

Chesley hospital site (SBGHC) announcing an eight-week emergency room closure due to a critical shortage of nurses:

> … there have been multiple times over the last 3 weeks where the ED had to close for several full days on short notice due to the overall shortage of nurses.
>
> …
>
> In order to keep services operational, SBGHC has relied on the use of agency nurses to fill vacant shifts. This approach is not an ideal or preferred solution, as agency nurses are costly and not committed to our hospital sites. In addition, our nurses do not feel valued when the agency nurses are making more money for doing the same work. SBGHC would much rather be putting the extra cost spent on agency nurses into the pockets of our own staff, who have worked tirelessly to support our organization and our communities. The unfortunate reality is that without using agency nurses at this time, the organization would be looking at additional closures and reductions.
>
> Active recruitment continues for nurses to come and work at SBGHC, however, the pool of available nurses is very limited in the current environment across the province.

Other examples were also provided.

The money that was being spent on agency nurses, ONA argued, was disturbing for many reasons. At the very least, public funds were being diverted from addressing the staffing crisis and were barely successful in even providing a short-term fix. In the 2020-2021 fiscal year, the Participating Hospitals reported spending $38,350,956 on agency nurses, in 2021-2022, $70,978,158 and in 2022-2023, $173,669,808 (with the numbers for 2022-2023 probably an undercount for reasons explained in the ONA brief, reply brief and at the hearing). Agency hours grew from 449,608 in 2020-2021, to 1,183,358 in 2022-2023 (or, according to the OHA, 1,259,183). Moreover, at one time agency nurse use was a Greater Toronto Area phenomenon; now it was ubiquitous across the province, urban and rural, as was fully detailed in the ONA submissions and illustrated by another statistic: In 2020-2021, 31 Participating Hospitals reported using agency nurses; two years later, 77 (and that was with some Participating Hospitals not reporting).

The fact was, ONA submitted, all the Participating Hospitals were struggling with RN shortages. Quite clearly, the various *ad hoc* measures to incentivize RNs to work even harder established this, as was further illustrated when skyrocketing overtime was examined. The Participating Hospitals paid overtime – some hospitals well in excess of the negotiated collective agreement multiplier – because they had to; it was the only way to meet staffing needs. In 2016-2017, the Participating Hospitals reported 1.75 million hours of overtime, in 2018-2019, 2.19 million, and in 2021-2022, 3.42 million (at a cost of $277,656.162).

Recruitment and retention is a *HLDAA* criteria. The Participating Hospitals could not recruit or retain, and compensation was the main reason why. The conclusion was inescapable, ONA argued, that there were nurses available – agency nurse usage established that – just not ones willing to work at the current rates. Instead of the various *ad hoc* measures to incentivize RNs to work more, the money would be better directed to improving the terms and conditions of employment by addressing staffing, and also workload, and that would, in turn, encourage RNs to stay at their jobs and, for those who had left, to return to work. Spending large amounts of money – hundreds and hundreds of millions of dollars – on agency nurses and overtime – to give just two examples that partially and at best inadequately met short-term staffing needs at great cost to morale and with no hope of retaining or recruiting – was not a strategy with any real likelihood of actually addressing the problem. All ONA's compensation requests were, accordingly, fully justified by this criterion alone.

Relevant Comparators

In ONA's view, the proper application of *HLDAA* and other interest arbitration criteria required examination of relevant comparators which included nurses in other Canadian provinces, Ontario

agency nurses and nurses employed in private hospitals, nurses in the United States and the United Kingdom, and other frontline professionals. Turning first to other Canadian nurses, ONA noted that the Financial Accountability Office (FAO), an Ontario government-appointed body that provides independent analysis of the province's finances, trends in the provincial economy, and related matters, concluded that Ontario currently has the lowest nurse wage rates in all of Canada. Ontario had dropped from fifth place in 2012 to last place in 2022. Not surprisingly, another cause of the RN shortage was nurse migration to other places in Canada and abroad that offered better pay and working conditions; a situation that was not abating notwithstanding various government initiatives (earlier described). Likewise, and as above, agency nurses were better compensated, often substantially so. This private sector comparator was especially apposite with the private sector nurses doing the exact same job in the exact same workplace side-by-side with Participating Hospital RNs but receiving substantially more money.

Other frontline service workers, for example, police and fire, received substantially more compensation, a situation which ONA argued was inappropriate as Participating Hospital RNs were very similarly situated: professionals providing life-saving uninterrupted essential services to the community. Accordingly, police and fire were relevant comparators, and their terms and conditions of employment were appropriately considered in determining the outcomes for RNs. This led to the conclusion that the requested salary and other compensation increases were justified not to mention long overdue. The same could be said about nurse settlements in the United States and the United Kingdom, and information about that was set out in the ONA brief (notably the number of Ontario nurses seeking licensure in the United States has doubled in the last five years). Appropriate comparators did not, in ONA's submission, include service and clerical workers employed by the Participating Hospitals. Comparable classifications had to be

considered; or stated a little differently, similar employees doing similar work. That could not be said about the service and clerical employees who were different employees – albeit of the same employer – doing very different work.

The Economic Situation in Ontario and the Municipality where the Hospital is located

The impact of inflation, ONA argued, was profound, and it established demonstrated need for a substantial across-the-board increase, together with many other improvements. Before 2010, annual wage increases for RNs exceeded the rate of inflation, but since 2011, inflation has outpaced increases to Participating Hospital salaries in every single year leading to an overall decline in real wages. In 2022, the situation deteriorated further. Inflation for 2023 has been estimated at 3.6%; Scotiabank came in higher with a 4.2% projected increase, BMO Capital Markets at 4.1%. Any award, ONA urged, had to take inflation into account, and also needed to consider Ontario's burgeoning revenues and surpluses, making general wage and other compensation increases completely affordable. In ONA's estimation, the province was "flush with cash, including an additional $4.4 billion in federal health funding…How the province chooses to spend that money, is simply a question of priorities."

Extent to which Services May Have to be Reduced

Services, ONA observed, have been reduced, and it referred to its submissions set out above: emergency room closures, surgical waitlists, etc., all because of a lack of RNs to do the work. Services have been reduced because the Participating Hospitals cannot attract full- and part-time staff and instead misspent many hundreds of millions of dollars on overtime and agency nurses. In ONA's view, a careful and sustainable allocation of resources – money spent on attracting and retaining Participating Hospital RNs – would result in an expansion of services, not a reduction.

Ability to Pay

The Participating Hospitals did not assert inability to pay. And ONA did not dispute that the Participating Hospitals faced budgetary constraints, but pointed out it has been long established that public sector employees do not bear the responsibility of subsidizing essential services by accepting, or having awarded, substandard wages. It was also a well-accepted principle that government funders cannot determine interest arbitration outcomes by limiting funding, for to do so would undermine the overall independence of the interest arbitration process. More importantly, the objective data about agency nurse and overtime spending established that there was money available. The issue was not lack of funds, but their allocation.

Gradualism and Demonstrated Need

ONA did not necessarily disagree with received wisdom to the effect that there should be no major breakthroughs or gains through interest arbitration without demonstrated need. But ONA's proposals were not breakthroughs – they were the minimum that was required after a decade of wage decline, to catch up to other Canadian nurses and private sector colleagues including agency nurses and nurses at non-Participating Hospitals, such as Shouldice, for example. Moreover, there was demonstrated need. There was a recruitment and retention crisis – the data about that was categorical – and there was an economic crisis with inflation that left nurses with less and less spending power even though there was a pre-existing pattern of their wages, at the very least, keeping up with inflation. The *ad hoc* adjustments and government programs were ineffective, to put it bluntly. The time was, therefore, long past for substantial general wage increases and other adjustments to tackle the nursing crisis head-on and, in that way, ensure future sustainability.

The ONA Proposals

ONA proposed the following:

1. Revised Wage Grid, eliminating the Start and First Year rates, and 12% general wage increase on April 1, 2023 and 6% on April 1, 2024. Add Long-Term Service Entitlements: 14 years – 2%, 21 years – 4% and 28 years – 6%.
2. Overtime at two times regular rate and two-and-one-half times on a paid holiday.
3. Substantial increases in shift premiums and restructuring of weekend premiums from $3.04 per hour to one-and-one-half times the straight hourly rate.
4. Increase percentage in lieu for part-time nurses.
5. Create a six-step grid for Nurse Practitioners.
6. Introduce salary continuation for nurses unable to work due to exposure to a communicable disease and/or required to quarantine and/or as required by law.
7. Introduce an 8-week vacation entitlement at thirty years of service.
8. Introduce a Health Spending Account at $1000.00.
9. Extend LTD coverage to age 80.

ONA also proposed a number of non-monetary changes including additional penalty payments for use of agency nurses and increased notice for shift change.

Submissions of the Participating Hospitals

Summary

There was no doubt, the Participating Hospitals observed, that the last several years have been extremely challenging for Ontario's hospitals and the nurses who worked in them. Prior to the COVID-19 pandemic, a history of restrained provincial funding required hospitals to implement

efficient staffing models and deliver quality care while collective agreement rules and restrictions severely limited the hospitals' ability to quickly respond to changing needs. Faced with the pandemic and its unprecedented demands in terms of volume and complexity, Ontario's hospitals were pushed beyond capacity, and this, of course, led to an extraordinary toll on individual workers. While capacity has increased – new beds were added when the pandemic began and more than 3000 additional beds were announced in 2022 with 1700 of those already up and running – the Participating Hospitals were confronted with RN shortages reflected in emergency room closures and a backlog of surgical and other procedures. Growth in capacity and demand has far outstripped available human resources in the short and medium term.

While staffing shortages could be easily described – there were not enough health care workers to meet demands – the solution to this situation was much more complicated, as was generally the case with intractable problems. Money was not a panacea; changing some of the unduly restrictive collective agreement work rules that left the Participating Hospitals unable to properly deploy human resources could, however, immediately begin to address staffing shortages and provide essential services to the people of the province. Now was therefore the time to address antiquated collective agreement requirements that frustrated the efficient delivery of services and the sensible deployment of nurses to meet urgent needs; collective agreement provisions that increased and exacerbated turnover, cost and instability.

To be sure, compensation was a component of a larger health human resources strategy and with that in mind – and paying attention to economic reality, available and anticipated funding and financial sustainability – the Participating Hospitals proposed wage increases of 3% in each year of the term, and improvements to the shift premiums. Increases of this kind were fully in line

with prevailing healthcare settlements and otherwise. The various compensation increases requested by ONA were unaffordable and unfunded.

ONA's Proposals

ONA's proposals did not reflect funding realities. As important, they would not work in addressing recruitment and retention. There were vast human resource challenges in Ontario's hospitals. Spending unprecedented and excessive amounts of money on nurse compensation would not solve staffing shortages because of one central fact: there were not enough nurses in the province to fill the growing demand, in hospitals and elsewhere. A pay raise would not solve that, as was illustrated by the introduction of the 25-year rate and, more recently, the government-funded COVID-19 $5000 bonus: after the 25-year rate was put into place, retirements went up, while the one-time bonus did not impact retention. Compensation was important, but the fact was that terms and conditions of employment were only one part of the equation: addressing recruitment and retention required a multi-pronged approach – set out by the Participating Hospitals in their brief and reviewed at the hearing – with the active participation of numerous stakeholders beyond ONA and the Participating Hospitals.

The Criteria

Hospital Funding

Also germane, the Participating Hospitals argued, were interest arbitration criteria, both statutory under *HLDAA*, and normative, most importantly replication: replication of free collective bargaining. Neither unions nor employers should be advantaged by the substitution of adjudication for strike/lockout. It was important to be realistic about possible outcomes – and pursuing – as ONA was doing here – a long list of completely unobtainable and unaffordable

fiscal objectives in the hope that some would be awarded was not an approach to be encouraged, particularly in the context of a short collective agreement term in uncertain economic times and, as was well known, insufficient funding. Hospitals must operate within the confines of the funding provided to them: that was one of the applicable labour market realities. Economic increases cannot be passed on to the consumer. Available funding was not sufficient to cover existing obligations; there was no ability to pay for increases beyond what the Participating Hospitals had on offer. As well, ONA's proposals were not established by the normative application of the governing principle that required establishing demonstrated need.

Economic Conditions

The rate of inflation, while relevant, did not assist in replicating free collective bargaining given these parties and their long-established bargaining patterns. Simply put, there was no history of matching wage increases to inflation – and that history was applicable here – and where high inflation is not persistent, its role in replication was diminished. Moreover, hospital funding was not indexed to inflation and so inflationary increases were, by definition, unfunded. In addition, arbitrators were on record – and had been for some time – that interest arbitration outcomes could not fully ameliorate against inflation. The Participating Hospitals cited with approval the observations of Arbitrator Hayes in *Homewood Health Centre & UFCW* (unreported award dated June 1, 2022) that "the harsh reality is that no-one can expect to be fully immunized from the negative impacts of extraordinary inflation. This award does not come close," (at para. 31, a finding that was adopted, also with approval, in other cases cited by the Participating Hospitals).

The overall economy was relevant, and the evidence established that the outlook was uncertain. In fact, the normal economic indicators suggest that there would, at best, be slow economic

growth with the real possibility of a recession during the collective agreement term (possibly because Bank of Canada interest rate hikes to control inflation might over-correct). On the other hand, inflation had begun to fall, making it less of an applicable factor in these proceedings especially if the trend continued and projections of dropping down to the 2% benchmark were achieved next year. In further support of this submission, reference was made to various factors suggesting troubling economic times ahead including the projected slowing of real GDP growth, statistics indicating declining employment growth and rising unemployment, the inversion bond yield curves and, more broadly, other disturbing economic developments such as recent and well-known large bank collapses.

While the overall economic situation provided important context, so too did the economic health of the province. Government deficits were the order of the day, and while the plan was to bring the budget in balance, that relied on increased revenue spurred by economic growth. In the meantime, there was a significant debt burden – and the high interest rates that came with it increasing the cost of borrowing – which directly impacted the government's ability to boost program spending. Ontario's debt level has gone from $281.1 billion in 2013, to a projected $435.5 billion in 2023. There was no way around it: public funds were under pressure, would remain so for the foreseeable future (and throughout the entire term of this collective agreement), and that impacted funding to Ontario's hospitals. In the current economic environment additional increases to government deficit spending – and therefore monetary allocations to fund the ONA demands to the Participating Hospitals – were not possible (made even more difficult as both health care costs and patient acuity resulting from an aging populace continued to rise). Even so, the Participating Hospitals had been and would continue to advocate for increased funding.

To the extent that additional funds were and are available, they have been targeted for various measures such as increasing capacity (pre-pandemic, Ontario, for example, had fewer acute hospital beds than any other Canadian province and all but one of the OECD member countries), reducing surgical backlogs and enhancing emergency services. While the government announced an increase to hospital base funding on March 23, 2023, it has not yet been divvied into priorities and there was no reason to believe that paying for ONA increase would necessarily be among them. Announced additional federal investments in Ontario health care of $4.4 billion – to be allocated over the next three years – while welcome, have likewise yet to be allocated. In the meantime, the Participating Hospitals had to operate in an economic environment where their costs continued to increase, and where none of its funding was indexed to inflation. The Participating Hospitals had to live within their means, and those means made the ONA asks completely unaffordable such that they should not be awarded.

Recruitment and Retention

The Participating Hospitals agreed: "there is currently a nursing shortage in the Ontario hospital sector." Where the Participating Hospitals and ONA parted company, however, is whether massive collective agreement increases to compensation had the potential to fix it. To answer that question, one had to understand the causes of the problem; a necessary first step prior to proposing any solutions. And the cause of the problem, in the view of the Participating Hospitals, was the increase in capacity illustrated through the growth in the number of hospital beds. There were 1749 new beds added between 2020 and 2021, the largest one-time increase since 2005. The Participating Hospitals have responded to this by hiring an additional 7.3% of nurses between 2016 and 2023 (46,466 to 49,580 full-, part-time and casual), and further capacity initiatives were underway.

In normal circumstances, the Participating Hospitals pointed out, capacity increases would be accompanied by broader pre-planned health human resource recruitment and realignment to ensure adequate staffing. The exigencies of the pandemic prevented this. More time was needed to train and certify new nurses to catch up. Moreover, context mattered. There were currently 9,310 RN hospital vacancies or 15.46% (out of a total headcount of approximately 60,000), but this had to be understood as resulting from capacity growth as well as from individuals moving intra-hospital. Indeed, while overall turnover rates were higher than pre-pandemic, numbers had begun, in 2023, to decrease; retirements rates had only slightly increased compared to pre-pandemic, and while resignations had gone up compared to pre-pandemic, they had recently begun to dip. Significantly, the overall hospital nursing workforce was larger. It was also important to bear in mind that labour market shortages were commonplace across most Canadian workplaces. An important contrast in comparing RN vacancies with the general Canadian rate of 4.8% was that private sector employers can raise wages to attract staff, an option that is unavailable to the Participating Hospitals because of funding constraints imposed by the provincial government (and government funding was actually insufficient to even meet even ongoing operational needs).

In the meantime, the Participating Hospitals remained the employer of choice, and since 2017, as already noted, RN employment had grown (in large part because of the more than 8000 nursing preceptored placements). The most recent Ontario budget had allocated funding to hire an additional 200 preceptors, and the Participating Hospitals had made specific proposals to create preceptored placements that would, in turn, alleviate the staffing crunch. (Along with other initiatives such as Enhanced Extern Program, and the Learn and Stay Grant, both as detailed in the Participating Hospital brief and at the hearing.) The Participating Hospitals asked that these

proposals be kept carefully in mind. It was obvious that more RNs would do a lot to improve the staffing situation – that was where resources should be directed – not to unaffordable and unfunded compensation increases. Given that there were only 1,879 RNs not currently employed – according to College of Nurses data – it was unlikely that compensation increases would be sufficient to incentivize them to return to the workplace, and the numbers involved would not significantly address the overall current vacancy deficit. Other data established that there has not been an exodus of nurses from Ontario's health care system: losses from RNs leaving the province ranged from .11% to .35% of total headcount between 2018 and 2022 (with more younger nurses choosing to leave compared to other age groups with mid-career departures relatively stable). Newer vintage nurses could be incentivized to stay in a variety of ways, including by the Board awarding another one of the Participating Hospitals proposals for a New Grad Guarantee Letter of Understanding that would provide more placement opportunities for new graduates in hospitals to build skills and competencies.

It was true enough that some of the Participating Hospitals had introduced various temporary incentives to encourage current employees to work additional shifts, or to economically incentivize new applicants through referral and signing bonuses. This was done to address a present-day supply problem, one that would, slowly but surely, begin to be addressed as the other broader based strategies to train and recruit more RNs came into place. Notably, most of these incentives were offered to address specific short-term staffing challenges such as summer vacations and the Christmas holidays. It was not even clear that referral and signing bonuses were successful (establishing that money alone, if at all, would not solve recruitment and retention). Insofar as agency nurses were concerned, they were only hired as a last resort; intended to address urgent staffing situations, not out of any desire to rely "on exorbitantly priced

agency nurses instead of hiring bargaining unit staff." The volume of work performed by agency nurses was a tiny percentage of RN work performed in the Participating Hospitals and, notably, less than a third of the Participating Hospitals made any use of them at all.

The bottom line, according to the Participating Hospitals, was that a multi-stakeholder process involving multi-faceted province-wide initiatives was where attention should be placed to address staffing, not granting requests for unaffordable, unfunded compensation. One thing was for certain: increasing compensation as proposed by ONA was not an effective vehicle to increase nursing supply and would not achieve the stated objective.

Participating Hospitals Proposals

Proposals of both ONA and the Participating Hospitals had to be considered through the lens of total compensation and that included the impact of inflation and associated roll-up payroll costs. Bearing all of this in mind, the Participating Hospitals proposed wage increases of 3% in each year of the two-year term, some modest improvements to the evening, night and weekend premiums, the mentorship premium, the student supervision premium and introduction, in year two, of a $100 health spending account. The Participating Hospitals costed their increases in each year at 2.997% and 3.006% in contrast to 25.536% and 5.65% calculated for the ONA proposals.

Discussion

This Board of Interest Arbitration is subject to *HLDAA*, which sets out the criteria we are to consider in determining outcome. Specific criteria are listed and have been carefully considered. In addition, the Board must review "all factors it considers relevant," not just the enumerated

ones. Accordingly, overall context matters and, in general, that is one in which compulsory interest arbitration is imposed because a legislative decision has been made to substitute adjudication rather than strikes and lockouts as the means to reach a collective agreement. Hospital nurses may not strike; and the Participating Hospitals may not lock them out for public policy reasons that are self-evident. In this compulsory interest arbitration regime, our overriding objective is to replicate what the parties would have agreed to in free collective bargaining where there is the right to strike or lockout. Neither party is to be advantaged or disadvantaged by the substitution of an interest arbitration regime.

Application of the Criteria

Recruitment and Retention

Under *HLDAA*, a Board of Interest Arbitration is to consider the employer's ability to attract and retain employees. The evidence presented establishes that there is truly a nursing recruitment and retention crisis in Ontario's hospitals: *Practical Solutions* – an OHA report – is unequivocal about this. That is why it recommended "robust retention strategies," and "immediate funding to bolster staffing models." *Practical Solutions* corroborates ONA's submissions: ONA members are leaving their jobs because vacancies were not being filled, creating unmanageable workloads leading to burnout and exhaustion driving employees from the workplace. The evidence referred to in this award unambiguously establishes that there are historic numbers of vacancies, which generally take a very long time to fill, and the suggestion that this can mostly be explained by employees moving intra-hospitals is not generally supported in the evidence. Increased capacity with staffing not yet catching up is only a small part of the explanation.

Hospitals are using agency nurses because they are compelled to do so. Hospitals are offering inducements, outside the collective agreement, because that is the only way in which they can meet their staffing needs: that is also the only explanation for the incredible expansion in overtime, and for hiring agency nurses at double or triple the collective agreement rates; because compensation is a, if not the, key driver in attracting employees. The Participating Hospitals repeatedly acknowledged in their brief that "there is currently a significant gap between hospital capacity and nursing supply."

Practical Solutions says it best:

> In our discussions with members and system stakeholders, it has become clear that workforce issues are at a tipping point – solutions are needed immediately.
>
> …
>
> **HHR Issues at a Critical Point**
>
> Our members have suggested that exhaustion and ongoing workloads have led to burnout of experienced, late career nurses who have decided to leave frontline clinical practice or the profession entirely. There is anecdotal evidence to suggest that some nurses are leaving hospitals to work for agencies and/or other health care facilities (e.g., public health, surgical centres, independent health facilities) or leaving the industry entirely for a more balanced lifestyle. Members felt that these issues affecting nursing care are a risk to the delivery of the most critical services in EDs, operating rooms, and intensive care units. Some hospitals and other health providers have no alternative but to fill vacancies by relying more on agency staff than in the past, often spending significant dollars doing so.
>
> In northern hospitals, utilization of agency nurses combined with a heavy reliance on locum physicians is significantly impacting patient care – concerns were raised that some of these professionals do not have the necessary cultural and/or Indigenous training needed to work within these regions. With limited HHR supply in these environments, aggressive recruitment efforts by staffing agencies and increasing top-ups are driving up hospital costs. Many hospitals report that they are spending inordinate amounts of time, energy and dollars trying to recruit permanent or semi-permanent staff.
>
> **HHR Issues Are Impacting the Delivery of Care**
>
> Many hospitals are dealing with an abundance of one-two sick day calls and an increased number of staff, including physicians, taking extended sick leaves. Members reported that the increased amount of sick time leave is impacting the ability of hospitals to deliver care in specific programs. For example, we have heard about shuttering of neonatal intensive care units, birthing units and surgical wards.
>
> There are also growing concerns that HHR issues are impacting the operations of EDs. Most recently, several hospitals within rural and northern communities have considered potential closures to their EDs because of a lack of nurses in the region. Others have had to scale down or close other programs to staff their EDs or other critical areas of care.

A review of the ED metrics (November 2021) shows increases in ambulance offload times, time to physician assessment of patients and wait times for patients being admitted to an inpatient bed. These increases are being observed all while ED volumes remain relatively low, when compared to previous years. Hospitals and ED physicians have indicated that these increases are due, in part, to HHR challenges, as well as the increasing complexity of care which is in turn straining hospital resources.

Profound Challenges to Operating Essential Services in Rural and Northern Communities

For hospitals in small, rural, and remote communities, the challenges to safely operate and provide essential programs and services are now insurmountable given their long-standing HHR concerns. Currently there are more than 300 physician vacancies within rural and northern communities. Hospitals are doing their best to maintain services and keep hospitals open, however significant gaps in nurse and physician coverage are putting hospitals at risk for poor outcomes and creating disincentives to recruitment efforts. *To avert a crisis, there is an immediate need for practical solutions to maximize capacity in the short, medium and long-term* (emphasis ours).

As stated in *Practical Solutions*: "To avert a crisis, there is an immediate need for practical solutions to maximize capacity in the short, medium and long-term." Another OHA publication, *Challenges and Concerns about Future Health Care Workforce Supply* recommends: "Providing immediate funding to bolster staffing models to enable the hiring of at least 10,000 registered nurses…Providing immediate funding to bolster staffing models would create more manageable workloads for staff, help increase retention rates, and allow hospitals to better respond to patient needs." The vast expansion of overtime and agency nurse usage – demonstrated by a truly astonishing growth in both – establishes a true recruitment and retention problem, and it is one that is normatively addressed by compensation increases.

Among the best means to recruit and retain, and to incentivize individuals to enter a profession, is compensation. We simply cannot conclude that the other incentives to retain and presumably motivate staff – described above – will be successful in retaining (and motivating) nurses given the demonstrated shortages, as documented in the OHA's *Practical Solutions* and elsewhere.

Understandably, the province is offering a variety of policies and programs to address this issue. In the meantime, the Participating Hospitals suggest that compensation increases will not solve

these problems, but this submission is not persuasive in a context when many of their members are doing the opposite: using financial incentives to attract and retain staff, and the government is adopting and backstopping this same approach. Wage increases can reasonably be expected to keep people in the workforce, incentivize people who have left to return (including RNs who have let their registration lapse together with the almost two thousand RNs the College of Nurses records as not currently employed), and attract future employees. We have borne in mind that the Participating Hospitals, as they acknowledge in their brief, are competing for nurses "within a competitive labour market."

Having said all of that, we also agree that a multi-faceted approach involving all relevant stakeholders is necessary in the short, medium, and long-term. However, our task is to determine the appropriate outcome in settling this collective agreement and we conclude that the Participating Hospitals' proposals of a general wage increase of 3% in each year together with extremely minor premium adjustments and the introduction of small healthcare spending account, will not be effective in addressing recruitment and retention. (Mentorship and student supervision premiums are discussed further below.)

The Economic Situation in Ontario and the Employer's Ability to Pay

The Participating Hospitals argued that there is no guarantee that any awarded increases will be funded and urged us to keep that in mind. However, after carefully reviewing these submissions, we have concluded that this is not a factor to be considered in determining outcome. The Province cannot determine the results of independent interest arbitration through its funding allocations; that would fetter the independence of this process, which is to replicate free

collective bargaining and arrive at an independent award after having applied the statutory and normative interest arbitration criteria.

The economic situation is relevant, however. The FAO in its May 31, 2023 *Ontario Health Sector: 2023 Budget Planning Review* estimates that the province has allocated a total of $4.4 billion more than what is necessary to fund existing programs and announced commitments from 2022-23 to 2025-28. There is, however, a sobering flip side: the FAO also projected that if all hospital employees were awarded retroactive compensation (under Bill 124 reopeners), hospital spending could increase by an additional $2.7 billion over this period. At the same time, recent Federal Government GDP updates establish reasons for optimism about the overall economic situation, and high employment augers well for recovery, not recession.

Considering the economic context includes reviewing the impact of inflation on wages. It is indisputable that nurses have seen their spending power eroded by inflation, with increases in the cost of living now baked into consumer prices. Some economists predict recession, other economic indicators indicate otherwise, suggesting positive signs of recovery. In considering what to award we have, of course, reviewed the two previous reopener awards decided weeks before submissions were made in this case.

The Earlier Reopener Awards

There are two ONA Bill 124 reopener awards: (*ONA & Participating Hospitals*, unreported award of Stout dated April 1, 2023 and *ONA & Participating Hospitals*, unreported award of Gedalof dated April 25, 2023). In our view, the first of the two earlier ONA reopener awards did not, in awarding an additional 1%, consider the impact of inflation, and to the extent that it did it

is fair to say that this was not reflected in the result. The second ONA award is a different matter: it unequivocally indicated that "soaring inflation" had been considered and in addition to a requested wage increase, a change was made to the grid worth approximately 1.75%, positively impacting approximately half the bargaining unit (and, by and large, the most senior nurses). Nevertheless, neither of these awards addressed inflation in any meaningful manner (and the data is categorical: nurse wage rates have fallen substantially behind). Free collective bargaining, on the other hand, has begun to reflect persistent high inflation in outcomes.

Replicating Free Collective Bargaining

Settlements outside of healthcare have not generally been considered or applied in determining central hospital awards. On the one hand, the unions assert that the dramatically changed economic landscape means that they must be reviewed, while on the other, they are rejected as comparators by the Participating Hospitals as either relevant or useful. Most recently, in *CUPE/OCHU & SEIU & The Participating Hospitals* (an unreported Bill 124 reopener award dated June 13, 2023), attention was turned to this issue and it was determined that in the current context – with high and persistent inflation – it was both appropriate and necessary to broadly consider collective bargaining settlements from groups not traditionally referred to.

That conclusion followed an earlier decision reached in like circumstances: In *Participating Hospitals & OPSEU,* unreported award of Gray dated November 4, 2009 (the Gray Award), an arbitrator was asked by the Participating Hospitals in a central OPSEU case to consider settlements from outside health care – economic settlements from the Ontario and federal governments, teachers, municipal police, the OPP, firefighters, LCBO, municipalities, and energy – in support of its submission that a central pattern settlement not be followed, but

reduced, because of a severe economic downturn. The Gray Award did just that: it considered settlements from across the economic landscape and declined to follow the central ONA award which would have otherwise set (a higher) general wage increase. This approach has even earlier antecedents: the last time inflation was high and persistent.

In *Participating Hospitals & CUPE* (unreported award of Weiler dated June 1, 1981), the arbitrator reached a number of conclusions that we follow (because the Board in that case, like the Gray Award and the Board in this one, had to address extraordinary economic circumstances). The Weiler Board held that the appropriate standard for decisions in this sphere should be drawn from external collective bargaining between sophisticated union and management negotiators whose bargains are shaped by real economic forces: "The parameters of change in the Hospital system as a whole must be drawn from and be compatible with the external world of collective bargaining in the Province" (at 6). Summarily stated, in extraordinary circumstances it is entirely appropriate to look at settlements from sectors not normally considered. Having done so, we find that the best evidence of free collective bargaining is the recent OPG and PWU settlement – authorized by Ontario's Treasury Board – and the also recent settlements between the Government of Canada and PSAC covering 155,000 core public servants and employees of the Canada Revenue Agency (ratified by both parties in June 2023). For whatever reason, including possibly happenstance, in terms of the numbers, these settlements – again freely negotiated in strike/lockout regimes – are identical.

In OPG and PWU, wage increases of 4.75% and 3.5% were agreed upon for 2022 and 2023, along with signing bonuses of $2,500 in each year, not to mention other significant compensation improvements. In the federal government PSAC settlement, the parties agreed on the exact same

percentage general wage increases for 2022 and 2023, along with a $2,500 signing bonus, and some other (more modest) compensation improvements. These two settlements are extremely instructive and have informed our view of how to best replicate free collective bargaining in this round. These settlements are among the best evidence available of free collective bargaining in a high and sustained inflation environment. They fall far short of what ONA has requested – and they do not fully immunize against inflation – but our job is to replicate what the parties would have done in free collective bargaining because we follow free collective bargaining. The last time significant inflation so dramatically affected spending power, arbitrators, like Professor Weiler in the case earlier cited, awarded double-digit increases. But in doing so the Weiler Board was following free collective bargaining outcomes, not leading them.

It is our view that freely bargained outcomes are the touchstone, and in the federal sphere they were achieved after relatively lengthy strikes. We conclude that these voluntarily negotiated outcomes covering so many employees in the quasi-public and public sector are the best guide for setting compensation in current circumstances. Our job, to repeat, is to replicate free collective bargaining, and to ensure that the parties end up no better and no worse than if their right to strike and lockout had not been curtailed. Obviously, these settlements are most important for determination of the general wage increase in 2023. Notably, in neither of these settlements was recruitment and retention a factor, which it most definitely is in this proceeding. Replication of free collective bargaining and determination of wage increases is more challenging for 2024.

Overall Approach

As is well known, the Participating Hospitals were unable to pursue any of their non-monetary collective bargaining objectives in the two ONA reopeners because jurisdiction in those proceedings – the situation in all reopener awards – was and is limited to compensation. This is not those cases. And, free from Bill 124 reopener jurisdictional constraints, the Participating Hospitals have advanced some non-monetary proposals to target staffing – to provide for limited redeployment of nurses without it being characterized as a layoff – which, in our view, are quite properly awarded, albeit with modifications (as set out below). This award must do what it can to address recruitment and retention in both its monetary and non-monetary results.

Accordingly, this award has been crafted to respond to the three most important issues/interest arbitration criteria requiring attention: replication of free collective bargaining, recruitment and retention and the economy, in particular the impact of inflation on real wages. The purpose of the award is to make targeted adjustments, both monetary and non-monetary, within the context of a two-year term that is already underway to address urgent and compelling staffing needs and to provide fair compensation adjustments reflecting free collective bargaining. The award also addresses lacunae arising out of the grid adjustments in the second ONA reopener.

We have, therefore, replicated free collective bargaining by awarding general wage increases of 3.5% in 2023 and 3% in 2024 and have also made adjustments – given recruitment and retention – to the grid building upon the second ONA reopener. The award takes inflation into account and is an acknowledgement of the incontrovertible evidence that for more than a decade inflation has greatly outpaced RN rates (and that current inflation was inadequately considered in the two recent ONA reopeners and needed, in any event, to be reflected in this award as it continues to

significantly erode spending power). We have also increased premiums for Mentorship, Student Supervision and Team Leader as each of these functions is critical to the professional development of new nurses. We have, however, made no adjustments to any of the shift premiums as they are already best in class.

Notably, there are over 9000 RN vacancies across the Participating Hospitals. In our view, it makes no sense to require a hospital to hire an agency nurse rather than redeploy a member of staff for a short-term reassignment. Likewise, it is completely counter-productive to pay nurses to leave employment when both parties are agreed that there is an RN shortage. Stated somewhat differently, we have attempted to provide the Participating Hospitals with some relief so that they can make short-term staffing reassignments without risking an adverse legal outcome: an arbitral award determining that something more than a partial or single shift reassignment is a layoff and that the layoff provisions in Article 10.14(b) then come into effect. Steps need to be taken to enable the Participating Hospitals to avoid overtime and hiring agency nurses, and this is in the mutual interest of both parties. We are firmly of the view that in the midst of a nursing shortage – and ONA correctly described this as a crisis – collective agreement provisions that deem a reassignment of more than one day a layoff, and then financially incentivize nurses to leave employment as the layoff provisions come into effect, are counter-productive to shared goals and the public interest.

However, the fact is that under Article 10.08, anything more than a partial or single shift reassignment of nurses from their area of assignment has – as a result of the case law – been construed as a layoff. In case after case, arbitrators have concluded that even where, for example, a unit was briefly closed for renovations and the nurses were temporarily reassigned, that that

was a layoff or, in another example, where a unit was closed and the nurses provided with similar work with similar shifts at the same hospital, that that too was a layoff. Article 10.14 requires hospitals to make offers of early retirement to incentivize departures during the layoff process – including layoffs resulting from a process that began following reassignment of a nurse for more than one shift in circumstances where the hospital has neither the intention nor the desire to reduce workforce, but merely to realign it. The data establishes that the Participating Hospitals are trying to grow the ONA bargaining unit, not reduce it: there are four thousand more RNs working in the Participating Hospitals in 2023 than were present in 2020, and those numbers will only continue to expand (barring truly unforeseen developments and contrary to every single projection).

Hospitals need the ability to temporarily reassign for more than a single or partial shift without doing so being construed as a layoff. On the other hand, highly valued job security language – admittedly introduced when layoffs were a fact of life – can only be impaired to the minimum extent possible. Our award has attempted to balance these interests in addressing the recruitment and retention crisis in a context where job security interests remain front and centre and where overall compensation has been meaningfully addressed.

The award provides hospitals with additional flexibility to deal with short-term reassignments without triggering a layoff and everything that would flow from it. The award gives the Participating Hospitals the ability to redeploy nurses while maintaining valued seniority protections. Surely the parties would agree that it is nonsensical to offer early retirement packages and severance pay to nurses who are actually needed in the workplace. The provisions awarded are not a concession (an unlikely outcome in replicating free collective bargaining in the

current context) and they must be viewed in the context of an award that has fully recognized compensation as highly motivating when it comes to recruitment and retention.

We have declined ONA’s invitation to introduce penalty provisions for agency nurse use.

In our view, penalty provisions are an issue that the parties should agree about – as was previously the case – or the Legislature should act. We agree with the Participating Hospitals and ONA that the best practice is to hire RNs and, in the words of the Participating Hospitals not to rely: “on exorbitantly priced agency nurses ….” Notably, *Practical Solutions* called on the government to establish governing rules including price controls. This was repeated in the OHA’s *Short-Term Actions to Address Health Human Resource Challenges*. ONA’s proposal for further transparency on use of agency staff, however, has evident merit and has been awarded with revisions.

There are approximately 500 NPs in 70 of the Participating Hospitals and we acknowledge that a common grid has been an ONA priority in earlier bargaining rounds. We are declining to award an NP grid, or any of the other NP proposals (noting that a minimum start rate is already in place). Obviously, the general wage increase applies to all NP rates.

The pandemic established demonstrated need for isolation pay, and we have awarded a new collective agreement provision that will provide nurses who have been exposed to a communicable disease with salary continuation when they are required to quarantine because of their hospital’s policies, or as required by law, or by direction of Public Health.

Award

Grid

Effective April 1, 2023 and prior to the general wage increase, amend grid as follows:

Start:	$36.65
1 Year	$37.57
2 Years	$38.51
3 Years	$40.24
4 Years	$42.05
5 Years	$44.15
6 Years	$46.36
7 Years	$48.68
8 Years	$52.53

Wages (after new grid)

April 1, 2023:	3.5%
April 1, 2024:	3.00%

Percentage in Lieu

Effective April 1, 2024 add 1%: Move to 14-10.

Mentorship and Student Supervision Premiums

Effective date of award increase to $2.

Team Leader Premium

Effective date of award increase to $4.

Isolation Pay

Effective date of award:

Employees who are absent from work due to a communicable disease and required to quarantine or isolate due to (i) the employer's policy, and/or (ii) operation of law and/or (iii) direction of public health officials, shall be entitled to salary continuation for the duration of the quarantine.

Layoff

Effective 30 days following issue of award:

10.08 Layoff – Definition and Notice

(a) A "Layoff" shall include a reduction in a nurse's hours of work and cancellation of all or part of a nurse's scheduled shift.

Cancellation of single or partial shifts will be on the basis of seniority of the nurses on the unit on that shift unless agreed otherwise by the Hospital and the Union in local negotiations.
A ~~partial or single shift~~ reassignment **of 4 consecutive shifts or less** of a nurse from her or his area of assignment will not be considered a layoff.

The parties agree that the manner in which such reassignments are made will be determined by local negotiations.

(b) A "short-term layoff" shall mean:

i) A layoff resulting from a planned temporary closure of any part of the Hospital's facilities during all or part of the months of July and August (a "summer shutdown") or during the period between December 15th and January 15th inclusive (a "Christmas shutdown"); or

ii) A layoff resulting from a planned temporary closure, not anticipated to exceed six months in length, of any part of the Hospital's facilities for the purpose of construction or renovation; or

iii) Any other temporary layoff which is not anticipated to exceed three months in length.

(c) A "long-term layoff" shall mean any layoff which is not a short-term layoff.

(d) The Hospital shall provide the local Union with no less than 30 calendar days' notice of a short-term layoff. Notice shall not be required in the case of a cancellation of all or part of a single scheduled shift, provided that Article 14.12 has been complied with. In giving such notice, the Hospital will indicate to the local Union the reasons causing the layoff and the anticipated duration of the layoff and will identify the nurses likely to be affected. If requested, the Hospital will meet with the local Union to review the effect on nurses in the bargaining unit.

(e) **Process to Avoid Permanent or Long-Term Layoffs**

i) **Where in the Hospital's determination there will be one or more layoffs of a permanent or long-term nature, the Hospital shall provide the Union and all nurses on the affected unit(s) with no less than thirty (30) calendar days written advance notice. The advance notice will describe the unit(s), reasons causing the layoffs, number of nurses that would be laid off and a list of vacant positions and any positions not yet posted to be used as transfer opportunities that may be filled in order to avoid the layoffs.**

ii) **In accordance with seniority, the Hospital will offer those nurses on the unit(s) and within the classification(s) where the proposed layoff(s) would otherwise occur the opportunity to elect to be transferred to a transfer opportunity provided that the nurse is qualified to perform the available work. A nurse's election must be provided to the Hospital in writing within the advance notice period in Article 10.08(e)(i). The number of nurses so transferred shall not exceed the number of nurses who would otherwise be subject to layoff.**

iii) **If the number of nurses who voluntarily elect to transfer to a transfer opportunity within the advance notice period in Article 10.08(e)(i) is less than the number of nurses who would otherwise be subject to layoff, transfers will occur in reverse order of seniority provided that the nurse is qualified to perform the available work and the transfer does not result in a reduction of the nurse's wage rate or hours of work, is located at the nurse's original work site or at a nearby site in terms of relative accessibility for the nurse and is on the same or substantially similar shift or shift rotation.**

Where more than one nurse is to be transferred in order to avoid a layoff, nurses shall be entitled to select from available transfer opportunities in order of seniority. The number of nurses so transferred shall not exceed the number of nurses who would otherwise be subject to layoff.

iv) **The Hospital bears the onus of demonstrating that the forgoing conditions have been met in the event of a dispute. The Hospital shall also reasonably accommodate any reassigned employee who may experience personal hardship arising from being reassigned in accordance with this provision.**

v) **A transfer of a nurse to a transfer opportunity under this article is not a layoff and also need not be posted.**

(f) Notice

Following the completion of the process under Article 10.08(e), in the event of a proposed layoff at the Hospital of a permanent or long-term nature within the bargaining unit, the Hospital shall:

i) Provide the Union with no less than five (5) months written notice of the proposed layoff.

ii) Provide to the affected employee(s), no less than four (4) months written notice of layoff or pay in lieu thereof.

NOTE: Where a proposed layoff results in the subsequent displacement of any member(s) of the bargaining unit, the original notice to the Union provided in (i) above shall be considered notice to the Union of any subsequent layoff.

In the event of the elimination of a vacant position or in circumstances where the Hospital decides not to fill a vacated position, the Union will be provided with notice at the time the decision is made.

The Hospital shall meet with the local Union to review the following:

iii) The reasons causing the layoff/elimination.

iv) The service which the Hospital will undertake after the layoff/ elimination.

v) The method of implementation including the areas of cut-back and the nurses to be laid off.

vi) Any limits which the parties may agree on the number of nurses who may be newly assigned to a unit or area.

10.09 Layoff – Process and Options

(a) In the event of a layoff, nurses shall be laid off in the reverse order of seniority provided that the nurses who are entitled to remain on the basis of seniority are qualified to perform the available work. Subject to the foregoing, probationary nurses shall be first laid off.

(b) Nurses shall have the following entitlements in the event of a layoff.

Prior to implementing a short-term layoff on a unit, nurses will first be offered, in order of seniority, the opportunity to take vacation day(s), utilize any compensating/lieu time credits or to take unpaid leaves in order to minimize the impact of a short-term layoff.

i) A nurse who has been notified of a short-term layoff may:

(A) Accept the layoff; or

(B) Opt to retire if eligible under the terms of the Hospital's pension plan as outlined in Article 17.04; or

(C) Elect to transfer to a vacant position, provided they are qualified to perform the available work; or

(D) Displace the least senior nurse in the bargaining unit whose work they are qualified to perform.

ii) A nurse who has been notified of a long-term layoff may:

(A) Accept the layoff; or

(B) Opt to retire if eligible under the terms of the Hospital's pension plan as outlined in Article 17.04; or

(C) Elect to transfer to a vacant position provided that they are qualified to perform the available work; or

(D) Displace another nurse in any classification who has lesser bargaining unit seniority and who is the least senior nurse on a unit or area whose work the nurse subject to layoff is qualified to perform.

iii) In all cases of layoff:

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

(B) Where a vacancy occurs in a position following a layoff hereunder as a result of which a nurse has been transferred to another position, the affected nurse will be offered the opportunity to return to their former position providing such vacancy occurs within six (6) months of the date of layoff. Where the nurse returns to their former position there shall be no obligation to consider the vacancy under Article 10.07. Where the nurse refuses the opportunity to return to their former position the nurse shall advise the Hospital in writing.

(C) No reduction in the hours of work shall take place to prevent or reduce the impact of a layoff without the consent of the Union.

(D) All regular part-time and full-time nurses represented by the Union who are on layoff will be given a job opportunity in the full-time and regular part-time categories before any new nurse is hired into either category.

(E) Full-time and part-time layoff and recall rights shall be separate.

(F) Casual part-time nurses shall not be utilized while full-time or regular part-time nurses remain on layoff, unless the provisions of Article 10.10 have been complied with or unless the matter is covered by local scheduling.

(G) No new nurses shall be hired until all those nurses who retain the right to be recalled have been given an opportunity to return to work.

(H) In this Article (10.09), a "vacant position" shall mean a position for which the posting process has been completed and no successful applicant has been appointed.

(I) The option to “accept a layoff” as provided in this Article includes the right of an employee to absent themselves from the workplace.

(c) i) Where there are vacant positions available under Article 10, but the nurse is not qualified to perform the available work, and if such nurse is not able to displace another nurse under Article 10, the nurse will be provided with the necessary training up to sixteen (16) weeks’ training to enable the nurse to become qualified for one of the vacant positions. In determining the position for which training will be provided the Hospital shall take account of the nurse’s stated preference.

ii) When nurses would otherwise be recalled pursuant to Article 10 but none of the nurses on the recall list are qualified to perform the available work the Hospital will provide necessary training up to sixteen (16) weeks to nurses, in order of seniority, to enable them to become qualified to perform the available work.

iii) Where a nurse receives training under this provision, they need not be considered for any further vacancies for a period of six (6) months from the date they are placed in the position.

…

10.14 (b) **Where a nurse would otherwise be laid off as a result of a permanent reduction in her or his hours of work following the process in Article 10.08(e), ~~B~~b**efore issuing notice of long-term layoff pursuant to Article 10.08(**f**)(ii), and following notice pursuant to Article 10.08(**f**)(i), the Hospital will make offers of retirement allowance in accordance with the following conditions:

i) The Hospital will first make offers in order of seniority on the unit(s) and within the classification where layoffs would otherwise occur.

ii) The Hospital will make offers to nurses eligible for retirement under the Hospital pension plan (including regular part-time, if applicable, whether or not they participate in the hospital pension plan).

iii) The number of retirements the Hospital approves will not exceed the number of nurses who would otherwise be laid off.
A nurse who elects a retirement option shall receive, following completion of the last day of work, a retirement allowance of one (1) week's salary for each year of service, to a maximum ceiling of thirty-five (35) weeks' salary.

iv) If a nurse(s) on the unit referred to in paragraph (i) does not accept the offer, the Hospital will then extend the offer, in order of seniority, to eligible nurses in the same classification in the unit where a nurse who has been notified of a long-term lay-off elects to displace in accordance with Article 10.09 (b) ii) (D) and one subsequent displacement. The Hospital is not required to offer retirement allowances in accordance with this provision on any subsequent displacements i.e., the offer shall follow the displaced nurse, to a maximum of two displacements.

NOTE: For the purposes of this provision, Charge Nurse and Team Lead shall be considered as within the same classification as a "General Duty RN", or any other classification agreed by the parties.

Agency Nurses

Effective date of award:

(e) The Hospital will provide the Union, on a quarterly basis, with satisfactory reporting respecting the use of agency nurses as follows**:** and the percentage that use represent of total bargaining unit hours worked (RN).

i) Agency nurse hours worked per unit.
ii) Total bargaining unit hours worked per unit.
iii) Percentage of agency nurse hours worked per unit.
iv) Total agency nurse hours worked hospital-wide.
v) Total bargaining unit hours worked hospital-wide.
vi) Percentage of total agency nurse hours worked hospital-wide.

The Union may, at its expense arrange for an audit of the information provided and the employer will cooperate in that audit process.

LOU: Supernumerary Positions (Nursing Graduate Guarantee) and Internationally Educated Nurses

Effective date of award:

Delete Paragraph 3.

Amend Paragraph 9:

Such nurses can apply for posted positions during the supernumerary appointment but may not transfer to a permanent position before the end of the supernumerary appointment.

LOU: Supernumerary Positions-Nursing Career Orientation (NCO), Initiative for Internationally Educated Nurses (IENS).

Effective date of award:

Delete Paragraph 2.

Amend Paragraph 8 (formerly 9):

Such nurses can apply for posted positions during the supernumerary appointment but may not transfer to a permanent position before the end of the supernumerary appointment.

Conclusion

At the request of the parties, we remain seized with respect to the implementation of our award.

DATED at Toronto this 20th day of July 2023.

"William Kaplan"

William Kaplan

I dissent. Dissent Attached.

Brett Christen, OHA Nominee

I dissent. Dissent Attached.

Phil Abbnik, ONA Nominee

DISSENT

I respectfully dissent from the Award of the Chair dated July 18, 2023 (the "Award") and the monetary items awarded therein.

The Award covers a two-year period from April 1, 2023 to March 31, 2025 and follows two re-opener awards (the "Re-opener Awards") chaired by Arbitrator Stout and Arbitrator Gedalof, respectively, which together cover a three year period (the "Stout Re-Opener" and the "Gedalof Re-Opener"). The Re-opener Awards addressed compensation issues not addressed in awards issued when the Protecting Sustainable Public Sector for Future Generations Act, 2019 ("Bill 124") was in effect (the Ontario Superior Court declared Bill 124 to be unconstitutional and of no force or effect in November 2022). Under the Re-Opener process, there was no opportunity for the hospitals to negotiate any trade offs against the monetary gains sought (and obtained) by the Union.

As noted by the Chair, the Union's arguments for greater compensation and benefits relied very heavily on the on-going shortage of nurses to fill available vacancies or, in terms of HLDAA criteria, recruitment and retention. The Award details some of the measures adopted or recommended by the Government of Ontario, some Participating Hospitals and the OHA to deal with the identified recruitment and retention issues. The Chair correctly notes that the solution to the issue is a multi-faceted one and one which cannot be achieved solely through increases to compensation and benefits. To state the obvious, increases in compensation cannot attract nurses to vacancies where there are insufficient nurses in Ontario to fill those vacancies nor do such increases in any way assist hospitals in matching available staff to hospital units which are experiencing short or long-term staff shortages.

In the present proceeding, as part of the multi-faceted approach to improving recruitment and retention, the Participating Hospitals made considered, reasonable and targeted proposals, which together, were designed to respond reasonably to the economic and funding environment facing hospitals and to assist hospitals in addressing staffing shortages by enabling the efficient short-term movement of available staff to enhance patient care in other areas of the hospital, by reducing expenditures on expensive severance packages in circumstances where the hospital is not reducing bargaining unit staff, and by assisting hospitals in restructuring staffing on units to provide enhanced patient care. The Participating Hospitals also proposed modest amendments to existing Letters of Understanding Re: "Supernumerary Positions (Nursing Graduate Guarantee) and Internationally Educated Nurses" and "Supernumerary Positions – Nursing Career Orientation (NCO), Initiative for Internationally Educated Nurses (IENS)" to enhance the utility of these programs, which facilitate the recruitment of new and internationally trained nurses into hospital vacancies.

The Award grants these Participating Hospital proposals, albeit with some modification, in furtherance of the stated goal of the Award to ameliorate staffing issues in the hospitals. There can be no reasonable objection to the award of these items in the present circumstances facing hospitals, where similar language exists in another central agreement, and in a proceeding in which the Union's request for non-normative monetary enhancements rested almost exclusively upon the recruitment and retention criteria. The amendments to the collective agreement language granted in the Award are exactly the type of trade off which would occur in free collective bargaining in exchange for monetary enhancements and are fully justified on the basis of replication. In mature bargaining relationships, the rule in free collective bargaining is "give to get"; unions achieve monetary gains in exchange for addressing legitimate employer needs for flexibility or other

similar goals. The plethora of interest arbitration awards in the hospital sector which ignore this reality while paying lip-service to the principle of replication do not represent an approach to be endorsed.

Even setting aside a replication analysis, the Participating Hospitals' proposals were fully and amply supported by demonstrated need. The proposals, in one form or another, have been advanced on many occasions in past negotiations and should have been granted long before the present Award.

My issue with the Award, then, is not with the general approach undertaken. It is clear that the Chair undertook a careful and thorough review of a massive amount of data and other information which was submitted to the Board by both parties. Rather, my objection is that the Chair erred in balancing the trade-offs appropriately; the monetary items awarded to the Union are simply too great for the modest hospital proposals awarded in exchange. In particular, the grid adjustments and ATB increases awarded exceed, in my view, what would have been achieved by the Union in free collective bargaining, particularly given the tremendous fiscal pressures hospitals operate under.

I understand that the on-going recruitment and retention issues relating to nurses are unique in the hospital sector and, as noted repeatedly by the Chair, the Award is a product of that fact. However, in my view, more modest compensation increases were warranted particularly having regard to the appropriate and traditional hospital sector comparators and the principle of total compensation.

I also strongly disagree with the Award's increase to the percentage in lieu of benefits for part-time employees by 1% effective April 1, 2024. The payment in lieu of benefits has been expressed by the parties as a percentage of wages rather than as a set amount so that the payment to part-time

employees would grow as the base of the calculation (wages) increased. By choosing the percentage formula, the parties have determined, in my view, that there is no need to increase the percentage itself. In any event, as a result of the ATB increases and increases to the grid awarded, the in lieu amount received by part-time employees will significantly increase over the two year period covered by the Award. Given this fact, I don't feel that this change is supported by replication and also that it should not have been awarded having regard to the principle of total compensation.

Dated July 20, 2023

Brett Christen
Nominee of the Participating Hospitals

Dissent of Union Nominee

For the first time, an interest arbitration board has recognized the severe recruitment and retention crisis facing Ontario hospital nurses together with the devastating impact of persistent multi-year inflation on wages in a meaningful way. Significantly, the award moves Ontario's nurses from second to last place in Canada to first place. More needs to be done, but this was an important first step.

Also significant is the award of isolation pay for infectious diseases. Path-breaking and unprecedented, though clearly much needed, this will improve the resiliency of the healthcare system in the event of future pandemics, and quite fairly provides compensation to nurses who are not permitted to work to protect their colleagues and patients.

I do, however, have concerns about the Chair's decision to award significant changes and wholesale additions to the reassignment and layoff language. In my view, there was no demonstrated need for these changes, and to the extent they would have occurred in the context of free collective bargaining, one would expect that even more significant increases in compensation would have been negotiated for ONA to have agreed to any alteration of this valued and longstanding language. I also note that there is the risk of a perverse impact resulting from these amendments. The Chair's explanation for these changes is to allow the Hospitals flexibility to staff their operations as needed. That said, Nurses who apply for and accept a position on a specific unit do so because they want to work on that unit. Having done so, and in many cases having developed considerable expertise in their chosen area of specialization, there is the real risk that transferring them to a different area of practice without their consent will undermine the steps the Chair has taken to address retention and recruitment. Obviously, the impact of these changes needs to be carefully monitored and, if need be, appropriately addressed in future rounds.

I am disappointed that the Chair has not awarded a centralized NP grid, which was a priority for ONA. Every other grid in the ONA central agreement is centralized, and the local grids for special classifications are pegged to the grid. Based only on the principle of comparison, NPs doing the same work for the same kind of employer should be paid the same. I anticipate that this will remain a priority for ONA and expect that this proposal will be awarded in the near future.