In the Matter of an Interest Arbitration

BETWEEN:

PARTICIPATING HOSPITALS

(The "Hospitals")

AND

CANADIAN UNION OF PUBLIC EMPLOYEES

(the "Union")

(Local Issues)

BEFORE:

Eli A. Gedalof, Chair
Brian O'Byrne, Hospitals Nominee
Joe Herbert, Union Nominee

APPEARANCES: See Appendix "A"

Hearings Held: September 25, 2018 (RPN Wage Adjustment Coordinated Submissions), October 4, 19, 26 and 30, 2018, November 1, 6, 8 and 14, 2018, December 6, 7, 18 and 19, 2018, February 14 and 28, 2019, March 1, 2019 and April 13, 2019.

Executive Sessions: March 23 and 24 and April 27 and 28 and May 2 and 7 2019.

AWARD

Introduction

1. This board of interest arbitration was convened pursuant to the terms of the *Hospital Labour Disputes Arbitration Act,* R.S.O. 1990 c.H 14, as amended ("*HLDAA*") to determine local collective bargaining issues between the Participating Hospitals identified in Schedule "A" (the "Participating Hospitals") and Canadian Union of Public Employees, Local Unions of OCHU/CUPE, also identified in Schedule "A" (the "Local Unions").

2. Bargaining between the various Participating Hospitals and CUPE and its Local Unions is divided between "central issues" and "local issues" in accordance with the Memorandum of Conditions for Joint Bargaining signed June 16, 2017. On April 22, 2018, the parties entered into a Memorandum of Settlement resolving the central issues. The settlement of the central issues included annual wage increases of 1.4%/1.4%/1.6%/1.65% effective each September 29 from 2017-2020.

3. This Board of arbitration was appointed to determine the local issues that the parties were not able to otherwise resolve. We conducted 17 days of hearing between September 25, 2018 and April 13, 2019. For the most part, although there was significant overlap between the issues arising at many of the different hospitals, each Participating Hospital and each Local Union made its own freestanding submissions on their specific issues. The exception was with respect to the Local Unions' proposal for a global Registered Practical Nurse ("RPN") wage adjustment, to create an 8-year rate set at 75% of the rate for ONA represented Registered Nurses ("RN"). On September 25, 2018, the parties made coordinated submissions with respect to the RPN wage adjustment issue, which submissions were adopted by each of the Participating Hospitals and Local Unions. In some cases, these submissions formed the totality of the representations made by the local parties, but in many cases the Participating Hospital and Local Union also provided site-specific materials and submissions in support of their position.

4. Consistent with the manner in which the issues were argued before us, we will begin by addressing the coordinated RPN Wage Adjustment submissions, with reference to the supplementary Local materials and submissions where appropriate. We will then address the remaining Local Issues.

5. In addressing all of the issues before us, we have had regard to all of the materials before us which, in light of the number of hospitals and local unions, were voluminous. We have also had regard to the established principles of interest arbitration and the jurisprudence filed by the parties in support of the applicability of those principles. Without limiting the foregoing, we have had particular regard to the principles of replication, total compensation and demonstrated need. This last principle is of particular significance where a proposal deviates from established bargaining patterns in the sector.

6. We have also had regard to the statutory criteria set out in s.9 of the *HLDAA,* which reads as follows:

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

7. The various local parties were able to resolve a number of issues either prior to the hearing or in the course of the hearing. The local agreements shall consist of the terms of the expired agreements, as amended in accordance with the agreements of the parties and this award.

8. Any Union or Hospital proposals that have not been agreed to and are not explicitly addressed by this award are deemed dismissed.

RPN Wage Adjustment

Overview

9. RPNs form approximately ¼ of CUPE's Participating Hospital membership. The Union proposes the creation of an 8-year RPN rate of $33.51 to be added to the wage grid at each of the Participating Hospitals effective September 29, 2017, after the application of the general wage increase. The

new rate would thereafter be subject to the across the board increases already negotiated for 2018-2020. The Union's intention is to set the job rate for RPNs at 75% of the established rate for RNs under the ONA central hospital agreement. There is currently no centrally established job rate for CUPE represented RPNs, and the extent to which the proposed increase would raise the job rate for RPNs therefore varies to some degree amongst the various locals. On average, however, RPNs earn approximately 65% of the RN job rate, and the adjustment sought by the Union is in many cases in excess of 10%. In almost all cases, the proposed rate would constitute a substantial increase beyond the negotiated annual increases for those nurses with 8 or more years of service.

10. In broadest terms, the Union argues that this correction to RPN compensation is required because of the substantial and increasing overlap between the work performed by RPNs and RNs. The Union argues that the substantial gap between RN and RPN compensation is unwarranted given the similarity in the jobs they perform. Indeed, the Union argues that Ontario is an outlier when it comes to RPN compensation, in that it is a leader in expanding the scope of practice of RPNs, while its wage rates more closely resemble those provinces that have maintained a far more restricted scope of RPN practice. In other provinces where RPNs have a robust scope of practice, RPN rates range from 71% to 82% of the RN rate.

11. The Hospitals object to the Union's proposal on both technical and substantive grounds. The Hospitals argue that as a local issues board, we have no jurisdiction to order a standardized provincial wage for RPNs. The Union, argue the Hospitals, is seeking to gain a windfall on top of the wage increases obtained at the central table, in violation of the principle of total compensation. They further argue that an RPN wage adjustment has not even been bargained for at a local level and that in seeking to tie itself to the RN wage rate, the Union is seeking to avoid having to bargain altogether. I note in this regard that while both parties agree that there was no substantial local bargaining with respect to an RPN wage adjustment, each side alleges that it was the other that was responsible for this refusal.

12. Further, the Hospitals object to the manner in which the Union's current proposal was brought forward. The Union's initial proposal was to increase the existing job rate to 75% of the ONA 8-year rate; it was not until shortly before the first day of hearing in this matter that the Union proposed that the rate fall on a new 8-year step on the grid. The Hospitals argue that this change in position violates the conditions for joint bargaining, which required the exchange and vetting of proposals well in advance of the commencement of this proceeding. Ultimately, the Hospitals argue that there is an onus on each local union to establish that there are local conditions that would warrant

adjusting the RPN rate beyond the previously negotiated annual increases. In the absence of such local conditions or any demonstrated need for an RPN wage adjustment, the Employer argues that the Union has failed to meet its onus.

13. The Union disputes that there is anything improper in amending a proposal that has been vetted and is undoubtedly a local issue, particularly to make it more moderate in the face of opposition. The Union further maintains that the Hospitals cannot on the one hand refuse to bargain or arbitrate the RPN wage adjustment centrally (despite the Union's persistent requests to do so), and then object to the Union pursuing it at the local issues arbitration, including as a common issue, based on the comparability of RPNs to RNs across the province.

Union Argument

14. The Union's proposal arises out of a significant legislative and arbitral history and it is helpful to briefly (and by no means exhaustively) summarize this background in assessing each parties' position.

15. The Union traces the evolution of the RPN classification from its antecedent the Registered Nursing Assistant (RNA) created in 1939. RNAs worked subordinate to RNs, who would delegate to them basic care for stable patients. According to the Union, by 1976 RNAs performed approximately 52 percent of the RN skills.

16. In 1991, with the introduction of the *Nursing Act, 1991* and the *Registered Health Professionals Act, 1991*, RNAs were renamed RPNs, and recognized as "nurses". At this time, RPN education was a 3-semester certificate program (compared to either a 6-semester diploma or 8-semester degree for RNs), and the scope of RPN practiced remained relatively restricted. By 2005, RPNs required a 4-semester diploma, while the RN education shifted to an exclusively 8-semester degree program.

17. The major change relied upon by the Union, however, occurred in 2009 when the College introduced new practice guidelines expanding the scope of RPNs autonomous practice, and introducing the "three factor framework" for determining which category of nurse is competent to care for a given patient. The three factors are, in broad terms: 1) Client (complexity, predictability and risk of negative outcomes); 2) Nurse (the particular skills, knowledge and experience of the individual nurse); and, 3) Environment (practice supports, consultation resources, stability and predictability of the environment). These factors considered together form a continuum, such that the more acute the patient, the less skilled, knowledgeable or experienced the nurse and the less

stable the environment, the less likely it is that care can be provided autonomously by an RPN. Conversely, argues the Union, an experienced and skilled RPN with appropriate supports may provide care for a client with significant acuity, in circumstances where a less experienced RN might not be capable of doing so.

18. In terms of the current entry to practice guidelines, the Union identifies 100 competencies expected of RNs, of which 90 are also expected of RPNs. The Union argues that as a result of this paradigm shift, there is now a 90% overlap between the roles of RNs and RPNs, and a substantial number of strategies and interventions that were formerly the exclusive jurisdiction of RNs that are now performed by RPNs. This shift, argues the Union, is reflected in surveys completed by its members at 51 of the local hospitals, and in the increasing proportion of RPNs as compared to RNs in the hospitals (from 4.5 RNs per RPN in 2007/08 to 3.9 in 2014/15 and an estimated 3.4 by 2021/22). Following the coordinated submissions and in the course of arguing the specific circumstances of many of the local hospitals, the Union also filed materials in support of its claim that: a) RPNs routinely fill in for RNs; b) in some instances serve as charge nurses; c) are in many cases expanding their role in the hospital working on wards where they were previously excluded; d) are performing more complex interventions; and e) are mentoring junior RNs and taking on preceptorships.

19. The Union also relies heavily on comparative data for RN and RPN (a.k.a. Licenced Practical Nurses) compensation across Canada. The Union's comparative analysis reveals that in other provinces where practical nurses practice autonomously (Saskatchewan, Manitoba, Alberta, Quebec and soon British Columbia), practical nurses earn a higher percentage of the RN salary (between 71% and 79%) than do Ontario's RPNs (at approximately 66%). The Union argues that while Ontario has been a leader in expanding the autonomous practice of RPNs and generally pays higher wages than other provinces in the hospital sector, it has lagged in adjusting RPN salaries in particular, both in real dollar values (other than in comparison to Quebec) and as a percentage of the RN salary. Instead, Ontario's rates compare to those remaining provinces where the practice of practical nurses remains restricted. Similarly, the Union argues that compared to the wage difference between two-year and four-year educated nurses in the United states, the "wage penalty" imposed on RPNs in Ontario is inordinate.

Hospitals Argument

20. As noted above, the Hospitals argue that this board should refuse to entertain the proposed RPN wage adjustment, because the Union had not proposed that the adjustment RPN wage rate be implemented at a new 8-year

step on the wage grid until shortly before the arbitration in this matter began. The inclusion of this new proposal, argue the Hospitals, is a breach of the Memorandum of Conditions between the parties.

21. The Hospitals emphasise that the RPN wage adjustment is a local issue, and cite several awards finding that local issues boards must address the particular needs and circumstances of the particular local parties in issue. The Hospitals argue that those boards that have ordered RPN wage adjustments in the past have lost sight of this important distinction and improperly treated the Union's proposal as a central issue. Why, ask the Hospitals rhetorically, should one hospital have to bear the costs of an RPN wage adjustment, in the absence of compelling local circumstances, particularly when the gap between its rates and those of another hospital frequently arises from pay equity circumstances that may not exist at that first hospital.

22. Further, the Hospitals argue that those boards have failed apply the correct principles of interest arbitration and instead applied a subjective standard in determining whether the spread in wage rates was "justified", or whether there is some perceived "unfairness". The result of this inappropriate arbitral intervention, argue the Hospitals, has been a complete lack of local bargaining. Further, efforts to create a standardized RPN wage rate (i.e. to eliminate the spread across hospitals) are futile in light of pay equity and local bargaining. In any event, argue the Hospitals, while pay equity has resulted in some hospitals paying higher RPN rates, there is no widespread pay gap of the nature that Arbitrators have addressed in the past, and CUPE is not relying on the spread as justification for its proposal in this round of interest arbitration.

23. Applying the usual interest arbitration criteria, the Hospitals argue that CUPE has not made any case for an RPN wage adjustment at the local level. This, argue the Hospitals, is the conclusion Arbitrator Kaplan reached in the last round of CUPE Local Hospital interest arbitration, and the facts have not changed since then. At the local level the hospitals did not dispute that the role of the RPN has evolved over time, but did not agree that RPNs were filling in for RNs in the widespread manner that the unions alleged. While the local hospitals did not accept the premise of the Union's argument, they also challenged the utility of the surveys prepared by CUPE, noting that they did not reveal the frequency with which RPNs performed any of those functions. In general, the local hospitals maintained that there was a material difference between the manner in which they deployed RNs and RPNs, notwithstanding the undisputed overlap between many of the functions any given nurse might perform on any given day.

24. Central to the Hospitals' argument on the merits is their position that there is no evidence of difficulties in recruitment and retention or demonstrated need. Neither, argue the Hospitals, has the Union established any basis for a "tie-point" between RNs and RPNs, for looking to RN/RPN wage ratios across the country, or for adopting RN rates as a comparator for RPN rates at all, particularly at the local level. Adopting these comparators would run counter to the principle of replication. Further, RPNs have received the benefit of the across the board increases arising from the central agreement, and those increases already represent a substantial cost to the Hospital. To superimpose a further wage increase of the magnitude sought by the Union for such a large group of employees would result in inordinate cost, reduction of services and strain on the hospital system in still-challenging economic circumstances, and would violate the principle of total compensation.

Arbitral History

25. Both parties referred to the legacy of interest arbitration awards addressing RPN wage adjustments, but characterized the significance of those awards to the Union's current proposal quite differently. I will therefore briefly summarize those awards and the manner in which they addressed the RPN wage adjustment before addressing the Union's current proposal.

1977—The Burkett Award (1)

26. In *Ontario Nurses' Association and The Wellesley Hospital,* April 4, 1977 (Unreported) (Burkett), in the context of setting wage rates for RNs under an ONA collective agreement, Arbitrator Burkett found that the RNA classification was the appropriate "tie-point" for determining the appropriate rate for RNs. He reached this conclusion in part because RNs and RNAs are in the same work group and further because as a classification found in the private sector the RNA rate was presumed to reflect private sector clarifications. But Arbitrator Burkett also found that the parties had an established practice of bargaining a differential of approximately 74-75% between the two classifications. The parties had freely bargained a differential of 75% in 1975, the last year for which ONA and the hospital had bargained wages. Arbitrator Burkett therefore awarded increases in 1976 and 77 to that would maintain that differential.

1985-86—The Burkett Award (2)

27. In *Participating Hospitals and Canadian Union of Public Employees and 68 Local Unions*, October 10, 1986 (Unreported) (Burkett), Arbitrator Burkett determined the central issues for the September 29, 1985 to September 28, 1986 collective agreement. In that award, Arbitrator Burkett awarded across

the board increases to all of the CUPE classifications on the basis of a number of factors, including the fact that those increases would reflect the "prevailing level of settlement in the community", and at the same time "maintain the historical relationship between the average wage paid to these hospital employees and the Industrial Composite and the rate paid to the R.N.A. as a percentage of that paid to the R.N."

1989-91—The Stanley Award

28. In *71 Participating Hospitals and Canadian Union of Public Employees and Its Participating Locals,* October 30, 1989 (Unreported) (Stanley), Arbitrator Stanley was also determining the central issues and awarded across the board increases. This appears to be the first round in which the Union proposed a standardized wage rate for RNAs. The Union also proposed moving away from a comparison to the start rate for RNs, since ONA had bargained an expansion to its wage grid resulting in depressed start rates and greater compensation in later years. Arbitrator Stanley looked to a number of factors, including RN rates and the rates of OPSUE represented PNAs working in a variety of government run institutions, in addition to general economic and settlement data. He awarded across the board increases to all classifications (other than Laboratory Technologists) intended to, among other considerations, re-establish a fair relationship between the RNAs and RNs, effectively restoring the 75% differential that had eroded over the previous years.

2001-04—The Carrier Award

29. In the 2001-04 round of bargaining, CUPE again sought an RPN wage adjustment through the creation of a common end rate tied to the ONA RN rate. The board of arbitration for Local Issues, chaired by Arbitrator Carrier, issued an interim award addressing just this issue in *The Participating Hospitals and Canadian Union of Public Employees,* February 25, 2004 (Unreported). Arbitrator Carrier's award was influenced by the award of Arbitrator Kaplan in *The Participating Hospitals and Service Employees International Union,* October 7, 2003 (unreported) in which Arbitrator Kaplan looked to the commonality of RPN functions across the sector and recent settlements substantially raising the base rate in some hospitals, and found that the disparity between the lowest and highest paid RPNs was not justified. Arbitrator Carrier found that the Kaplan award established a "norm" for RPN wages, and agreed that the current spread between the lowest and highest paid RPNs was excessive. He therefore adopted the same minimum rate as was awarded to the SEIU. Arbitrator Carrier did not rely on a tie-point between the CUPE RPN and ONA RN wage rates.

2004-06-The Albertyn Award

30. In the 2004-06 round of bargaining, the parties again addressed the Union's proposal to establish a standardized provincial RPN rate through the local issues arbitration chaired by Arbitrator Albertyn in *The Participating Hospitals and Canadian Union of Public Employees,* 2007 CanLII 2090 (ON LA). CUPE argued that the board should re-establish a standardized RPN wage rate as existed in the mid-80s, and that the board should restore the ratio between RPN and RN wages. Arbitrator Albertyn rejected the proposal to create a standardized central RPN rate for several reasons, including the fact that CUPE does not represent all RPNs in the province (unlike ONA and the RNs) and because pay equity and RPN wage adjustments are addressed locally[1]. The result, found Arbitrator Albertyn, is that any effort to create a standardized RPN wage rate could be easily destabilized at the local level, including through further increases mandated by pay equity. Arbitrator Albertyn did find that if there continued to be a significant disparity between the highest and lowest paid RPNs, it would be appropriate to gradually narrow that gap over time. However, he found that given the substantial correction awarded by Arbitrator Carrier in the prior round, and given that there was no demonstrated need to raise salaries in order to recruit RPNs, it was not necessary to grant a further increase in that particular round.

2006-09-The Briggs Award

31. In 2006-09, the Union again sought an RPN wage adjustment, although in this round it did not seek a standardized rate, but rather sought to raise the minimum RPN job rate. Arbitrator Briggs, in *Participating Hospitals and Canadian Union of Public Employees,* August 4, 2009 (unreported) (Briggs) found that at that time there was a 13.2% spread between the highest and lowest paid CUPE represented RPNs. This, she concluded, was too great a spread. In reaching her conclusion, Arbitrator Briggs also noted that (at p.7):

> In arriving at our conclusion we have taken into account the educational background, licensure requirements as well as the duties and responsibilities of RPNs. We have compared these elements against those of other hospital workers and their wage ranges from the data provided by the parties. We have also considered the various settlements of other Hospitals and the Union regarding wages for RPNs. We also considered the request for maintenance of internal equity, general fiscal restraint and the current severe economic environment. We have also taken into account the principles of replication and demonstrated need. This analysis has led

[1] Arbitrator Albertyn notes, as CUPE argued in the instant arbitration, that pay equity could be conducted on a central basis, if the parties so chose, but finds that in the absence of such an agreement it constitutes an impediment to the creation of a standardized RPN wage rate.

> us to find that a wage increase for RPNs is appropriate yet this award provides neither the level of increase urged by the Union nor the level of restraint urged by the Hospitals. We note in passing that of the four settlements put before this Board, three yielded both higher end rates and longer periods of retroactivity for RPNs.

In the result, Arbitrator Briggs awarded a 5% increase to the end rate effective June 1, 2009, after the last of the centrally established economic increases for that round.

2009-13-The Petryshen Award

32. In *Participating Hospitals and Canadian Union of Public Employees*, February 10, 2012 (unreported) (Petryshen), Arbitrator Petryshen addressed another CUPE proposal for an RPN wage adjustment. Again, CUPE sought a minimum end rate intended to close the gap between both the lowest and highest CUPE RPN rates and between RPN and RN rates. Arbitrator Petryshen found that the differential between the highest and lowest CUPE RPN rates continued to be "too wide a spread for a group of professional employees that have a high degree of commonality in function." With respect to the RN comparator, Arbitrator Petryshen noted:

> We are also influenced by the general erosion of RPN rates in relation to RN rates of pay. Although there are obvious differences between RNs and RPNs, these two classes of professional employees have a close association. This reality was referenced most recently by Arbitrator Albertyn in the CUPE interest award referred to previously. Although we do not suggest that there should be a magic tie point for RN and RPN rates, we are convinced that it is appropriate to adjust the RPN rates in light of their erosion in relation to RN rates in the hospital sector, particularly given that RPNs generally now perform tasks previously performed only by RNs.

33. Consequently, Arbitrator Petryshen increased the minimum job rate for CUPE represented RPNs such that the spread between the highest and lowest rates was reduced to $1.34 per hour. In so doing, Arbitrator Petryshen rejected the argument that he was treating a local issue as though it were a central issue, noting that he was simply conducting the same comparative analysis that interest arbitrators conduct routinely.

2013-17—The Kaplan Award

34. The last local issues arbitration board prior to the current round was chaired by Arbitrator Kaplan, in *Participating Hospitals v CUPE, Local Unions*, 2015 CanLII 43930 (ON LA). In that round, CUPE first proposed to address RPN wages rates in the same manner that it has proposed before this board

of arbitration, i.e., with the introduction of an 8-year step on the RPN wage grid set at 75% of the ONA RN rate. Also as before this board, CUPE relied on the fact that RPNs are now performing virtually all of the nursing functions performed by RNs, and are doing so autonomously. The Hospitals opposed the proposal on the grounds that the proposal was not properly a local issue, would amount to an increase of 2.31% of total compensation, and on the grounds that there was no demonstrated need and no difficulties whatsoever in recruitment and retention. Arbitrator Kaplan rejected the proposal, referring to the basis upon which previous wage adjustments had been granted, and the absence of any current basis for awarding further adjustments:

> In our view, given the commonality in function across this classification, large gaps in rates for RPNs were completely unjustified. For all intents and purposes, however, those gaps – "the enormous spread" no longer exists. Currently, 56 of the participating hospitals where this issue arises pay $28.55. Nineteen pay between $28.61 and 29.90. One hospital, Mattawa General, pays $30.18 and another, North Bay General, pays $32.72 (with these two high and outlier rates, the participating hospitals submit, resulting from pay equity not free collective bargaining). It would be completely inconsistent with, indeed contrary to, the arbitral intervention to date, clearly directed at removing the unjustified gaps, to bring all participating hospitals up to the top rate enjoyed by employees at a single hospital even if doing so was proposed in the context of establishing a percentage wage relationship between RPNs and RNs because of commonality in scope and autonomy in practice.
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> The union's request is denied.

35. The Union argues that in determining that the spread between CUPE RPN rates no longer warranted further wage adjustments, Arbitrator Kaplan failed to address the proposal and the argument that was before him, which was based on the unwarranted disparity between the wages paid to RNs and RPNs given the substantial overlap in the work they perform.

36. I do not read Arbitrator Kaplan's award as having misconstrued the Union's argument, particularly in light of the fact that he identifies that argument at page 2 of his reasons. Rather, I think a fair reading of the award is that Arbitrator Kaplan rejected the position that the disparity between RN and RPN wage rates warranted increasing RPN wage rates in the absence of other compelling factors. Historically, one such compelling factor was the inordinate spread between the RPN wage rates at the various hospitals, and Arbitrator Kaplan found that as that problem had now been effectively solved further intervention was not required.

37. Subsequent to the parties' initial coordinated submission on the RPN wage adjustment, Arbitrator Kaplan issued his award in *Service Employees International Union v Participating Hospitals*, 2019 CanLII 23931 (ON) determining the SEIU local issues. Both parties provided the board with written submissions addressing this award. Like CUPE here, the SEIU also sought an RPN wage adjustment to include an 8-year rate set at 75% of the RN rate. The union founded its position on, among other factors, the increased accountability, responsibility and scope of practice of RPNs and the historical relationship between RPN and RN rates, in addition to relying on higher RPN rates at three of the participating hospitals and the principle of replication. The hospitals opposed the proposal on the grounds that in light of the local conditions, and the absence of any locally-based justification for the wage adjustment, none of the normal interest arbitration criteria supported granting the wage adjustment. There was no evidence of difficulty in recruiting and retaining RPNs, and no basis for finding that RN's were an appropriate comparator.

38. Arbitrator Kaplan rejected the proposal. He accepted that as a local issue, the determination of whether a wage adjustment is appropriate must be based on local conditions (p.6). He found, as he did in his prior CUPE local issues award, that the parties had abandoned any adherence to a historical ratio or "tie-point" between RPN and RN rates. Arbitrator Kaplan accepted that the RPN scope of practice had increased over the years and that RPNs now perform many of the same job functions once performed exclusively by RNs (although he also found that RNs now also perform duties once performed exclusively by doctors). However, he found that having regard to the normative interest arbitration criteria there was no case to be made for the union proposal. He noted in particular that there was no evidence of difficulties in either recruitment or retention. Neither was there any evidence to support increases under the replication principle. While a small number of hospitals had bargained higher rates, the differences were relatively small compared to the substantial wage increase sought by the union, were not based on RN rates, and did not create the kind of gap would give rise to a "catch-up" adjustment at large (p.7).

39. Perhaps most significant is Arbitrator Kaplan's reasoning in rejecting the RN rate as an appropriate comparator for the purpose of establishing the RPN rate. As this issue is central to the parties' arguments before this Board, I set that reasoning out in full as follows (at pp.8):

> The best comparator, of course, for an RPN is another RPN. That is not to say that one ignores other wage outcomes in the hospital sector, and RN outcomes are certainly worth careful consideration. But when ONA adjustments have taken place, both at the 8- and 25-year rates, while

> memorialized in awards, this was effectively the result of free collective bargaining and a shared recognition that there was a real problem in recruitment and retention that needed to be addressed. Both of these factors are completely absent here and these outcomes cannot, therefore, form the basis for an RPN wage increase. In terms of sectoral replication, it is fair to say that in general, and with extremely limited exceptions, RPN rates outside of hospitals are invariably much lower than those here.
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> Simply put, RN collective bargaining outcomes do not drive RPN collective bargaining outcomes and vice versa. The terms and conditions of RN collective agreements do not mirror the terms and conditions of RPN collective agreements. This is reflected in the agreements these parties have reached. For example, it is legally and factually significant that a comparison of negotiated RN and RPN ATBs over many years amply illustrates this point – completely different outcomes, and in contractual language as well. All of the criteria are important, but replicating free collective bargaining is the main mission of the interest arbitration process.
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> It is worth emphasizing, and among the reasons for this decision denying the union request – as the Participating Hospitals pointed out – is that there is no evidence whatsoever, again for decades, evidencing either mutual agreement or dispositive and governing arbitral recognition of a ratio relationship between the RPN and RN rates; a relationship that in any way informs compensation. The actual fact of the matter is that an enormous spread between hospital RPN rates was earlier found to be unjustified, and then corrected. The gap between hospital RPN rates has been almost completely narrowed as it was an unjustifiable given commonality of core functions (even while acknowledging that deployment of RPNs varies considerably at the Participating Hospitals and not all RPNs work to their full scope). But that is not the basis for establishing a system-wide RPN/RN ratio in a local process on an issue that is, as agreed, a local one where local conditions need to be considered even if the matter is argued in a single submission. It is also worth taking note that the cost of the proposal – and this was not contested by the union – was equivalent to a 2.887% wage increase across all employees covered by the central collective agreement. Given the cost, compelling evidence responsibly and satisfactorily satisfying some of the governing interest arbitration criteria would have to be present, but it is not. Accordingly, and for all of these reasons, the union request for RPN adjustments at the Participating Hospitals is denied.

40. CUPE argues that Arbitrator Kaplan's reasoning is flawed, and that in any event this board has received evidence that distinguishes this case from the circumstances before Arbitrator Kaplan. Further, CUPE argues that it is by far the larger bargaining agent and has set the bargaining patterns in the sector. It is CUPE that has historically taken the lead in collective bargaining,

and SEIU that has followed. In its submissions, CUPE provided many examples of this historical pattern, including with respect to RPN wage adjustments. This board, argues CUPE, ought to decide the case before it on its own merits and not follow the SEIU outcome where the recognized pattern is in fact to do the reverse. In this regard, CUPE argues that the evidence before this board shows that there has been a significant increase in the overlap between RN and RPN scope of practice, proved on a hospital by hospital basis, including specific examples of RPNs replacing RNs, mentoring RN students, and in some instances taking on the role of charge nurse. CUPE argues that it has provided evidence of RPNs providing more complex and autonomous care than ever before at each individual hospital.

41. CUPE also argues that Arbitrator Kaplan erred in attaching any greater significance to the fact that the RPN wage adjustment is a local issue than to recognize that it is only local "by definition", because the parties could not agree to make it central.

42. With respect to Arbitrator Kaplan's conclusion that the SEIU had failed to make any case for the wage increase on the basis of replication, CUPE argues, citing *P.A.M. Gardens Non-Profit Housing Inc. v. Brick and Allied Craft Union of Canada,* 2018 CanLII 13736 (ON LA) (Nyman), that the correct approach to replication is to look to the manner in which the related RPN/RN classifications are dealt with across Canada. In every province but Ontario where RPNs have an autonomous scope of practice, CUPE argues that RPNs are compensated between 71% to 79% of the RN rate. On this comparator, CUPE argues that Ontario RPN rates have fallen below any reasonable ratio, and the replication principles supports the increases sought. To the extent that this argument was not put clearly before Arbitrator Kaplan, CUPE argues that the case should be further distinguished.

43. The Hospitals do not suggest that the Kaplan SEIU award is necessarily determinative of this matter, or dispute that this matter should be decided on its own merits. However, they maintain that as an award dealing with an identical proposal supported by the same or similar arguments, it ought to be given significant weight. Further, they maintain that Arbitrator Kaplan has properly identified the applicable principles of interest arbitration, and that the application of those principles cannot be distinguished on the basis of the facts before this board. The Hospitals specifically dispute the suggestion that the award mischaracterizes the significance of the wage adjustment as a local issue, or that there is a material distinction between the nature of the "local" evidence before this board versus the evidence before Arbitrator Kaplan. Local issues, argue the Hospitals, must be addressed at the local level in accordance with the established principles of interest arbitration. The Hospitals argue that

to abandon these criteria that govern the interest arbitration exercise in favour of "whatever criteria they deem to be compelling" is untenable.

Decision

44. In assessing whether or not to award an RPN wage adjustment, I reject the Hospitals' jurisdictional and preliminary arguments that this board ought not to consider the proposal. The bargaining structure adopted by these parties necessitates that specific wage adjustments be addressed at the local level, and there is no principled basis for precluding the Union from seeking a common outcome for each of its locals. Whether that common outcome can be justified at each of the local hospitals in light of the local conditions is another matter, but the distinction between central and local issues does not preclude the Union from seeking that outcome.

45. Neither is there anything improper in the Union seeking further wage increases for specific classifications on top of the central across the board increases. Again, the need for the Union to pursue the wage adjustments locally arises from the manner in which the parties have agreed to divide local and central issues. It cannot be said therefore that the Union has improperly sought to obtain a windfall on top of the central compensation award. However, it is also the case that in assessing whether or not to grant the wage adjustments, the principle of total compensation requires that this Board consider the costs to the Hospitals of the central wage increases. In other words, the wage increases in the central award do not preclude the Union from seeking further targeted wage adjustments, but they are clearly relevant to whether or not those adjustments should be granted.

46. Finally, I also find that the manner in which the Union has pursued the RPN wage adjustment ought not to preclude us from granting it. I am troubled by the absence of any evidence of meaningful local bargaining with respect to this issue. Interest arbitration is an alternative to strike/lockout: it is not intended to serve as an alternative to bargaining at all. However, on the basis of the materials before us, I would not attribute the failure to bargain this issue to CUPE in particular. Rather, it appears to arise from the structure of central and local bargaining and equally each party's desire to protect their strategic interests. This is not a case of unilateral intransigence. Neither do I find anything improper in the manner in which the Union amended its proposal to move the wage adjustment to the 8th year. This kind of softening of an existing proposal is not of a nature that would undermine either the central/local vetting process or the interest arbitration process in general.

47. I also accept, as the Union has argued and the Hospitals have not disputed, that this board must decide the case that is before it. As will be

apparent, I am persuaded by the reasoning in Arbitrator Kaplan's recent SEIU award. As an award dealing with the same class of employees in the same sector and addressing the identical issue, there can be no doubt that Arbitrator Kaplan's award warrants serious consideration. Nonetheless, had CUPE made out a compelling case for an RPN wage adjustment, the fact that it was not awarded to the SEIU would not preclude my granting that proposal here. However, having carefully considered all of the evidence before us, including the materials presented with the coordinated submissions together with the representations of the local parties, I find that I must reach the same conclusion for substantially the same reasons.

48. In terms of the status of the RPN wage adjustment as a local issue, I have no difficulty concluding that it should not be awarded unless it is warranted at the local level. I accept the Union's characterization that the only distinction between local and central issues is whether or not the parties happen to have agreed to include or exclude the issue from the central table (as opposed to a principled distinction based on the nature of the issue itself). But the absence of an agreement to deal with the issue centrally is nonetheless a significant fact. When parties agree to bargain central terms, they effectively agree to throw their lot in together. Central proposals must necessarily be weighed against the aggregate circumstances of the group that is bargaining together. The end result might differ, even significantly, from what would be warranted if one considered the circumstances of one particular member of the group in isolation. That is the nature of central bargaining. In local bargaining, there is neither a need nor any compelling reason to adopt such an aggregate approach. Rather, local parties must necessarily bargain in the context of their own specific circumstances.

49. This is not to say that the same considerations could not militate in favour of the same result across locals. Indeed, that is essentially what CUPE argues should happen here, and in this respect the distinction between local and central bargaining as a matter of jurisdiction is something of a red herring. Neither do I suggest that the locals should be considered as islands unto themselves. Arbitrators routinely look to the outcomes at associated bargaining units in applying the principle of replication at the local level. But the ultimate outcome must be warranted at the local level.

50. At the core of the dispute between the parties is whether RN rates should be the determinative comparator in setting RPN wage rates, and whether it is appropriate to look outside the province and consider RPN wage rates and the relationship between RPN and RN rates across the country in setting rates in Ontario. The Union argues that three post-2001 Arbitrators have found it was "fully appropriate to compare RPN and RN wage rates." In

my view, this characterization overstates the significance of the RPN/RN comparison in those awards.

51. As summarized above, it is clear that the RN "tie-point" comparator has not been a factor in either settlements or arbitral outcomes for decades. Where the tie-point was applied by Arbitrators, they did so specifically because it had been adopted by the parties themselves in free collective bargaining. That is no longer the case, and while CUPE seeks to restore a tie-point between RN and RPN compensation, it does not (and cannot) seek to justify it on the basis of bargaining patterns as it did in the past. Since 2001, Arbitrators have at best referred to RN compensation as one consideration among many in setting RPN wage rates. But reading those decisions as a whole, it is clear that in each case where increases were awarded, those increases arose primarily from comparisons of RPN (not RN) compensation across the hospital sector as a whole, with no substantial analysis or reliance on RN compensation in support of the outcome. The bottom line is that there is no evidence before us to establish that adopting an RN comparator, in the absence of any other factors supporting a wage adjustment, would in any way replicate the outcome of free collective bargaining. In this regard I agree with and adopt the reasoning of Arbitrator Kaplan. Neither is there anything before us to support adopting extra-provincial comparators in replicating the outcome of local collective bargaining of for RPN wage rates. For the same reasons articulated by Arbitrator Kaplan above, I find that the evidence does not support the conclusion that RN collective bargaining outcomes drive RPN collective bargaining outcomes.

52. Arbitrators have long recognized that wage adjustments can be an appropriate response to difficulties with recruitment and retention. In this regard, the Union presented limited evidence at a small number of hospitals that it argued supported a need for increased wage rates to address difficulties in recruitment. In all cases, this evidence was contested by the local hospital, who maintained that they were the employer of choice for RPNs in their local area and that any difficulty in recruiting was limited to RNs, and not RPNs. Having considered all of this evidence, including the evidence filed by the Hospitals with the coordinated submissions as well as the representations at the local level, I cannot find that there are significant difficulties in recruitment and retention such as would support a wage adjustment.

53. Having considered the evidence as a whole, I find that CUPE has not established grounds for an RPN wage adjustment at any of the local hospitals. The Union has undoubtedly established that there is a significant degree of overlap in the duties of RNs and RPNs, and that the role of the RPN has evolved over time. But the fact remains that RPNs and RNs are different classifications within the hospitals, with substantially different educational requirements. The

overlap between duties and the manner in which RNs and RPNs are deployed is not complete and the distinctions continue to be significant at the macro level. It is also clear that other factors that drive compensation, such as recruitment and retention, do not necessarily apply equally to RNs and RPNs. CUPE firmly believes that the gap between RN and RPN compensation grossly overvalues the distinctions between the two classes of nurse. Clearly, CUPE believes that this wage gap is unfair. But it has not identified any basis, statutory or otherwise, upon which this board of interest arbitration ought to intervene to address this perceived unfairness. The considerations that motivated prior boards to adjust RPN wage rates are absent here. Even considering RN compensation as one factor among several warranting consideration, there is no evidence to suggest that the relationship has changed materially since those prior adjustments were awarded. Were we to grant an adjustment now, we would not be replicating the outcome of free collective bargaining, or applying any of the principles of interest arbitration, statutory or otherwise, as we are required to do. Rather, we would be imposing our own value judgment as to what would constitute a fair reflection of the distinction between the two classes of nurse. That is simply not the role of the interest Arbitrator. Further, in light of the fact that any wage adjustment would be on top of the across the board increases already achieved at the central table, the principle of total compensation militates against any additional wage adjustment in the absence of other compelling factors.

54. For all of these reasons, we decline to award an RPN wage adjustment.

Other Issues

55. While no issues other than the RPN wage adjustment were dealt with on a coordinated basis, there were 2 other issues that arose at several different local hospitals where we have concluded that local conditions warrant a common outcome.

56. The evidence before us establishes that the uniform allowance at a number of the local hospitals has fallen well behind the cost to employees of purchasing uniforms. Arbitrator Kaplan reached a similar conclusion in the most recent round of SEIU local hospital interest arbitration, increasing the uniform allowance there to $150 for full-time and $100 for part-time employees. The evidence before us also establishes that CUPE has succeeded in freely bargaining increases to the uniform allowance for both full-time and part-time employees at a number of locals in this round of bargaining. In its proposals, CUPE has generally sought to increase the quantum to $160 and to collapse the distinction between full and part-time employees, a result it has achieved through free collective bargaining at several of its locals. While the evidence does not warrant collapsing the distinction between full and part-

time employees at those hospitals where it continues to exist, it does warrant a significant increase to the quantum of the uniform allowance where CUPE has argued for the proposal in front of this board, as reflected below. In all cases the increases shall be implemented in the first full pay period following the date of this award, with prorating, and except where specifically identified without otherwise amending the existing language or pre-requisites.

57. The second such issue is preceptorships. In the last round of CUPE Local Hospital interest arbitration, CUPE was awarded preceptorship language in each local where it had an outstanding proposal. In this round, the Union has sought slightly modified language at a number of additional locals, and in some instances to increase the quantum of the premium. We are satisfied that in circumstances where this language has been agreed-to or ordered across the sector, and where there is evidence that RPNs are taking on an increased role in supervising students at the local level (and in some instances are receiving the premium even absent language in the collective agreement), both the principles of replication and demonstrated need warrant granting preceptorship language where it does not exist. We would not, however, depart from the standard language that has been agreed-to or ordered across the sector or increase the premium in this round. Instead we order the inclusion of the language and premium as ordered in the prior round of interest arbitration, in those hospitals where CUPE has argued for its inclusion before us.

58. In addition to the RPN wage adjustment which CUPE seeks for almost all of its local bargaining units, the Union has sought wage adjustments with respect to over 65 separate classifications in over 15 separate bargaining units, not including adjustments arising from harmonization of merged bargaining units, which are dealt with in supplementary awards. In each case, we have considered all of the principles of interest arbitration, including the statutory considerations, with a particular eye to the principle of replication and the identification of appropriate comparators (including considering whether there are established bargaining and interest arbitration patterns and looking to the nature and geographic location of the hospital), and having regard to the principle of total compensation and any particular local conditions (including whether there are demonstrated issues of recruitment and retention and internal equity).

59. We note in particular, and as reflected below, that several of the wage adjustments related to certain paramedical classifications where, as a result of established bargaining patterns, Arbitrators have looked to OPSEU comparators in the hospitals. Where appropriate and consistent with the findings in Briggs, Petryshen and Kaplan awards cited above, we have also looked to the OPSEU comparators. In some instances, the established tie-

point between the CUPE and OPSEU rates were not maintained through recent rounds of bargaining. In my view, these lapses reflects structural differences in the CUPE and OPSEU agreements from that round, (including two years of zero across the board increases in the case of OPSEU and reduced across the board increases in subsequent years for CUPE with the payment of lump sums), rather than any abandonment of the OPSEU comparator by the parties. While we have found a return to the OPSEU rates appropriate we have, as have prior boards, made allowances for the transition to the higher rates.

60. A common theme raised by many of the local hospitals, and argued most comprehensively by the *Scarborough Health Network* was the argument that many of the wage adjustments sought would disrupt the existing pay equity balance, and could in many cases result in cascading pay equity increases to other classifications. The hospitals raised particular concern where the adjustment related to a classification with few incumbents (and therefore a relatively modest immediate cost to the employer) but which could be a pay equity comparator for other highly populated classifications. In some instances, the hospitals argued that as an interest arbitration board with no pay equity jurisdiction, granting the wage adjustments sought and therefore rendering the hospitals non-compliant with pay equity would exceed our jurisdiction. The Union vociferously opposed these arguments, arguing that to rely on pay equity to artificially restrain wage rates for a male comparator in order to avoid having to pay a predominantly female job classification a higher wage is to subvert pay equity's very purpose. The parties referred to decisions in *North Bay Police Services Board and North Bay Police Association,* 2005 CanLII 63782 (ON LA) (Snow), *West Park Hotel v. S.E.I.U. Local 204*, 1992 CanLII 8578 (ON SCDC) *London & District Service Workers, Local 220 and Women's Christian Assn.,* 1996 CarswellOnt 1279 (OCA) ("*Parkwood*"), in addition to decisions finding that parties have contravened the *Pay Equity Act* when agreeing to wage increases that violated their existing pay equity plan, all of which I have carefully reviewed and considered.

61. In my view, pay equity legislation does not raise a jurisdictional impediment to granting the wage adjustments sought by the Union. Both parties agree that we do not have the jurisdiction to determine pay equity outcomes (and we do not have before us anything approaching the information we would require to make those determinations in any event). We do, however, have the unequivocal jurisdiction to determine whether the principles of interest arbitration warrant granting individual wage adjustments. Where those outcomes have pay equity implications, those issues can be dealt with by the parties and, failing agreement, a tribunal of competent jurisdiction. In granting wage adjustments in this award, we do not purport to override pay equity or the statutory obligations of the parties under

the Act. The circumstances here are therefore distinguishable from the circumstances in *Parkwood.* The legislative provision in that case specifically fixed compensation at the rates in effect on a particular date, and the Court found that it was therefore not open to an arbitration board to order a different amount (at para 29). That is not the circumstance here. In this case, if the statute requires further pay equity adjustments as a result of wage adjustments granted here, then the obligation rests with the parties to ensure that they are in compliance with those statutory obligations. It would be absurd to conclude that this board's jurisdiction to carry out its explicit statutory function could be ousted by the mere mention of an issue that all parties agree falls outside of our jurisdiction, particularly where there is no impediment to the parties addressing that issue themselves or, absent agreement, addressing it in the appropriate forum.

62. Where the Union has established a compelling basis for a wage adjustment, the mere fact that that adjustment could result in pay equity increases for others ought not to preclude granting the increase. I agree that to adopt such a principle would constitute a failure to carry out our function under *HLDAA* while subverting the principles of pay equity.

63. However, the fact that pay equity does not preclude us from granting wage adjustments does not mean that pay equity considerations are irrelevant. In many cases the relationship between classifications in the hospitals before us have arisen from extensive (and in some cases repeated) job evaluation and pay equity processes. It is in my view entirely appropriate and important to carefully consider the significance of this internal balance when determining whether there are compelling reasons to disrupt that balance through the grant of a targeted wage adjustment. Internal equity is clearly a factor that drives collective bargaining outcomes and we would be remiss to ignore it entirely.

64. With all of the above in mind, we direct the following:

Geraldton District Hospital

Uniform Allowance-***Increase quantum for full-time employees only to $150. Status Quo* for part-time and casual employees.**

Preceptorship-***Replicate the language ordered in the 2013-17 Interest Arbitration***

Sioux Lookout Meno-Ya Health Centre

Northern Health Travel Grant

65. CUPE has put forward a compelling basis on both the principles of replication and demonstrated need for its proposal to reinstate a Northern Health Travel grant provision that was, from CUPE's perspective, removed from the 2013 collective agreement under a misapprehension concerning the scope and significance of local bargaining. The Employer has recently agreed to an amended version of a similar provision with another bargaining agent, the terms of which we find most appropriate. In all the circumstances, we order the inclusion of the following provision:

> Northern Health Travel Grant
>
> ***A full-time employee will be granted two days off with pay to attend a personal, medical or dental appointment which is a referral from a family physician or dentist to see an out-of-town specialist. A full-time employee will be granted one day off with pay to attend with a spouse or their child, medical or dental appointment which is a referral from a family physician or dentist to see an out-of-town specialist. The employee will supply a copy of the Northern Ontario Travel Grant or equivalent documentation to verify the appointment.***

Notre Dame Hospital

> Uniform Allowance-***Increase quantum to $150 for Full-Time and $100 for Part-Time*****.**

Hornpayne Community Hospital

> Uniform Allowance-***Increase quantum to $150 for Full-Time and $100 for Part-Time*****.**

Trillium Health Partners

> Distribution of Overtime***-K.9 Distribution of Overtime to read:***
>
> ***Overtime will be offered in rotating order of seniority within the classification within a pay period, among those available who normally perform the work. It is understood that overtime will be offered to full time employees prior to being offered to part time employees.***
>
> Uniform Allowance***-Increase quantum to $150 for Full-Time and $100 for Part-Time.***

Hawkesbury And District General Hospital

Preceptorship***-Include a preceptorship provision replicating the language ordered in the 2013-17 Interest Arbitration.***

West Nipissing General Hospital

Uniform Allowance***-Increase quantum to $150 for Full-Time and $100 for Part-Time.***

Meal Allowance***-Increase quantum for employees working four (hours) or more beyond his or her regular scheduled shift to $9.***

Winchester Memorial Hospital

Meal Allowance-***Increase quantum to $9.***

Preceptorship-***Amend R-2 (a) and (b) to replicate the preceptorship provision ordered in the 2013-17 Interest Arbitration.***

Pembroke Reginal Hospital

Parking-***Increase maximum rate to $22 per pay period in the 'paid parking' lots.***

Paramedical Wage Adjustments—***All adjustments effective September 29, 2017 and inclusive of the 2017 1.4% general increase. Retroactive to September 29, 2018.***

- MRI Technologist-**$42.65**
- Occupational Therapist-**45.13**
- Physiotherapist-**$45.13**
- Rehabilitation Assistant-**$27.56**
- Pharmacy Technician-**$29.47**

Cornwall Community Hospital

Uniform Allowance- ***Increase quantum to $150 for Full-Time and $100 for Part-Time*.**

Preceptorship-***Include a preceptorship provision replicating the language ordered in the 2013-17 Interest Arbitration.***

Queensway Carleton Hospital

Uniform Allowance-***Increase quantum to $150 for Full-Time and $100 for Part-Time*.**

Preceptorship-***Include a preceptorship provision replicating the language ordered in the 2013-17 Interest Arbitration***

Cardiology Technologist (E.C.G.) Wage Adjustment-***Increase job rate to 32.76 effective September 29, 2017, inclusive of the CUPE General Wage Increase for that year.***

Hamilton Health Sciences and CUPE Local 7800 (Service, Office and Clerical)

Meal Allowance-***Increase quantum to $9.00*.**

Uniform Allowance-***Increase quantum for full-time employees to $12.50 per month.***

LOU-Responsibility Pay West Lincoln B Ward Complex Continuing Care—***Renew LOU***

66. Both parties also have outstanding proposals with respect to scheduling additional shifts. It is clear from the representations before us that the current system of scheduling additional shifts is not working. For example, the Hospital notes that between August 2-16, 2018 it needed to fill 2,848 shifts, requiring 8, 158 phone calls. The current system has also given rise to almost 200 grievances since the commencement of the expired collective agreement. The hospital has clearly established a demonstrated need for change, a fact which is acknowledged to some degree by the Union's counter-proposal. The three most significant differences between the parties' proposals are: i) the application of the provision to casual employees; ii) the frequency with which employees can indicate their willingness to work additional shifts, the total number of hours they are willing to work and their availability (whether twice or year or before each schedule); and, iii) the application of the provision to employees on temporary assignments (whether based on their home position or on their temporary assignments).

67. Having considered all of the parties' submissions, I find that an incremental approach to this problem is warranted, so as not to disrupt the *status quo* more than is required to address the demonstrated need. If necessary, the parties are of course free to further address the problem in a subsequent round of bargaining. In all the circumstances, and in an effort to break the existing deadlock while providing the parties with an opportunity to craft their own language, we order that the collective agreement shall include a provision that reflects the Union's proposal with respect to the casual

employee issue and the Hospital's proposal with respect to the application of the provision to employees on temporary assignments. We remain seized and if the parties are not able to resolve the remaining issues in dispute with respect to this proposal it shall be remitted to us within three months of the date of this award.

Hamilton Health Sciences and CUPE Local 7800-01 (Trades)

Meal Allowance-***Increase quantum to $9.00*.**

Huron Perth Healthcare Alliance

Preceptorship-***Include a preceptorship provision replicating the language ordered in the 2013-17 Interest Arbitration***

Markham Stouffville Hospital

68. The remaining outstanding issue at Markham Stouffville Hospital is CUPE's proposal to eliminate the existing float holiday and substitute remembrance day as a fixed holiday in its place. In support of its proposal, CUPE relies on a consistent line of arbitral awards including *The Participating Hospitals and The Canadian Union of Public Employees,* December 19, 1989 (unreported) (Thorne), *The Participating Hospitals and Canadian Union of Public Employees*, May 3, 2004 (unreported) (Carrier), *Participating Hospitals and Canadian Union of Public Employees,* August 4, 2009 (unreported) (Briggs) and *Participating Hospitals and Canadian Union of Public Employees,* September 21, 2012 (unreported) (Petryshen). While I accept that there is a cost attached to this proposal, there is a clear and established pattern in the sector of this bargaining agent successfully converting float to fixed holidays, the principle of replication strongly supports granting this proposal and I find that there are no other factors that would warrant departing from the norm in this instance.

Paid Holidays**- *Effective January 1, 2020 Delete 1 Float Holiday for Full-Time and Part-Time employees and substitute Remembrance Day*.**

North Bay Regional Health Centre and Mattawa General Hospital (Paramedical)

69. CUPE seeks a wage adjustment for the paramedic classifications at both hospitals. As noted by prior boards of interest arbitration, these paramedics are differently funded than the Hospitals' other employees (in this case the Nipissing DSSAB) and the majority of paramedics in the province are

employed by municipalities. Arbitrators have therefore looked to comparators outside the hospital sector in setting wage rates for paramedics employed by the Hospitals.

70. CUPE here seeks to narrow the gap between the current paramedic wage rates at the Hospitals and the top rates for municipal paramedics in Durham, and seeks increases of 2.5% in each of the four years of this agreement in order to achieve that result. The Hospitals oppose the request, arguing that the general wage increases obtained through central bargaining are entirely sufficient, the rates obtained through those general increases maintain the Hospitals' paramedics in line with settlements generally, and that there is no demonstrated need for further increases.

71. I see no basis for dramatically increasing the rates at this hospital to approach parity with the highest paid paramedics in the province at this time, particularly in light of the settlement trends in the sector more broadly. I would, however, seek to maintain the comparability established by the prior board of interest arbitration. I therefore order the paramedic rates (Paramedic 1 at North Bay and Paramedic at Mattawa) adjusted as follows, together with the equivalent increase to the related Paramedic 2 and Team Leader classifications where applicable, so as to maintain the existing differentials:

Paramedic Wage Adjustment

Effective September 29, 2017-$38.32
Effective September 29, 2018-$38.96
Effective September 29, 2019-$39.62
Effective September 29, 2020-$40.27

All increases are inclusive of the general wage increase, and retroactive to all current and former employees within sixty days.

North Bay Regional Health Centre

Work Schedules***-Amend T.05 c) to read:***

No shifts shall be added to the schedule after it has been posted, without verbal confirmation from the Employee that they will accept the shift.

LOU-12 Hour Extended Tours***-Status quo/Maintain Existing LOUs***

Hôpital Glengarry Memorial Hospital

72. For the same reasons as articulated above with respect to Markham Stouffville Hospital, we will also award CUPE fixed holidays here. However, as the Hospital notes, the combination of fixed holidays proposed by CUPE (adding both Remembrance Day and Easter Monday) do not align with the existing fixed holidays the Employer has agreed to with another bargaining agent or with several other comparators. We therefore order the following:

> Article 8.01 – Paid Holidays (FT & PT)***-Effective January 1, 2020 Delete Employee's Date of hire (first day of work) and float holiday and substitute 3rd Monday in June and Remembrance Day.***

Hospital for Sick Children

73. For the reasons articulated above we would also grant CUPE's proposal to substitute fixed holidays for the two existing float holidays:

> Article G.01-Holidays and G.02 Float Days-***Effective January 1, 2020 Delete Article G.02 and amend article G.01 to delete reference to Two Floating Holidays and substitute Easter Monday and Remembrance Day.***

CONCLUSION

74. We remain seized as identified above and in accordance with s.9 of the *Hospital Labour Disputes Arbitration Act*.

Dated at Toronto, Ontario, this 26th day of May, 2019

"Eli Gedalof"

_____

Eli A. Gedalof, Chair

"I dissent"

_____

Brian O'Byrne, Employer Nominee

"I dissent"

_____

Joe Herbert, Union Nominee

DISSENT

I disassociate myself from this award.

One reading the award, might reasonably wonder how a matter could proceed on some sixteen days of hearing after the coordinated RPN issue was argued in September of 2018, and end with a result that merely increases the quantum of the uniform allowance to the level of the Kaplan SEIU award; raises the meal allowance to a level $1.00 *less* than was awarded by the Local Issues board in the 2009-2013 round, and; repeats the previous Local Issues award on preceptorship, while providing only a small number of other collective agreement changes. The answer to that query is that wage adjustment proposals of the union, to various classifications not mentioned in the award, constituted a large part of the robust cases presented at various hospitals across the province. In a fashion entirely unprecedented for Local Issues awards between these parties, these proposals have been systematically ignored in the award and very obviously dismissed as a class, resulting in an outcome that is severely imbalanced, again in an unprecedented fashion. I make this comment in contrast to the frequent acknowledgment in dissents to prior Local Issues awards between these parties, that acknowledge a Chair's effort to reach a balanced and fair result Regrettably, the outcome of this award is not one reflective of that goal.

Wage Adjustments

I will deal with the dismissal of the RPN adjustment proposal separately below.

At many of the hospitals where the parties appeared before this board, the union made proposals for wage adjustments that go individually unmentioned. Except for Pembroke Hospital in relation to a small number of employees in professional classifications usually represented by OPSEU; a handful of employees in a like classification at Queensway Carleton Hospital, and; paramedics at North Bay and Mattawa, all of the union's proposals for wage adjustments, without regard to comparability, have been dismissed. I will deal with the most egregious example, Hospital for Sick Children, separately below.

The union's proposals for wage adjustments concerned various classifications from entry level Aide classifications, through to trades. By my count, some **62** such proposals were made at 16 different hospitals throughout the province. In almost every case these proposals were supported by OHA wage surveys for hospitals in the same region, of the same type (e.g. community or teaching), and of the same size. From that data, the board was able to make assessments in respect of comparability and thus replication.

By noting that there were 62 such classifications at issue which do not include lightly populated 'OPSEU-related' professional classifications or paramedics, I am not suggesting that the mere making of a number of proposals by the union should be a guarantee that some number should be accepted. But the opposite is also true. Those proposals deserved assessment on their merits, which has occurred in every prior Local Issues awards, but not in this one. Instead, every one of them has been dismissed, indicative of their dismissal as a class. The result is an extraordinarily one-sided and imbalanced award.

The arbitrator purports to address this result at paragraphs 62-63. If I may paraphrase paragraph 62, it states that if a bald argument be made that a wage adjustment to a male-dominated classification should be denied solely on the basis of pay equity, that argument cannot be sustained. This of course, should be obvious as it would subvert the legislative structure of the *Pay Equity Act*. But the arbitrator continues to say that while such an argument cannot be sustained in its bald version, it should nonetheless receive favour in assessing wage adjustments. In my view, the same subversion of the legislative structure then enters through the back door, having been supposedly denied entry through the front. It makes little sense to say that wage proposals for male-dominated classifications should not be dismissed flatly by virtue of their pay equity implications, but that the pay equity implications should nonetheless be considered in order to arrive at the same result.

At paragraph 63, the arbitrator accepts a commonly-made, and otherwise commonly rejected employer argument that to award wage adjustments would undermine what he calls “internal equity” and “internal balance”. First of all, it is the arbitrator’s own unsupported conclusion that the status quo represents “balance” and “internal equity”. In few if any cases was the board provided with such evidence of balance and equity. Instead, there is merely the status quo, where wage rates bear a percentage relationship to other wage rates, as any two numbers bear a relation to each other. But that does not create ‘balance’ or ‘equity’, and rarely was evidence provided that would suggest that external comparability should be outweighed by some greater ‘internal good’.

The arbitrator writes “Internal equity is clearly a factor that drives collective bargaining outcomes and we would be remiss to ignore it entirely”. It is not all apparent where the arbitrator sources his purported knowledge of what “drives collective bargaining outcomes” in the hospital sector. Certainly no such evidence has been provided to this board in respect of the hospital sector. *But more importantly, what has been ignored entirely, is external comparability*. While I note above that the union, having proposed 62 wage adjustments at 16 different hospitals, was not guaranteed a result simply by the number of such proposals, it is extraordinary indeed that of those proposals, *based upon the best evidence of comparability,* not a single one succeeded. What has been ignored instead of internal “balance” and ‘equity”, whether existent or not, is comparability itself. This result is most egregious at the Hospital for Sick Children.

Hospital for Sick Children

The first collective agreement at the Hospital for Sick Children, was the result of an arbitration award by R. Joyce some thirty years ago. In that award, the arbitrator accepted an obviously flawed employer argument that because hospital sector bargaining occurs provincially, therefore wages should be set at the level of the provincial mean rather than the Toronto mean. In my dissent at the time, I noted the obvious flaw. If Toronto rates, which were

significantly higher, were negotiated on the basis of the provincial rather than local mean, there would be no difference in rates at all between Toronto and the rest of the province, as there clearly was. Since that time, employees at HSC have generally worked for wages considerably less than those paid at other Toronto-area hospitals where employees are also represented by CUPE.

A significant improvement to that situation was made in respect of trades classifications in the 2009-2013 Petryshen award. In this round, the union sought adjustment to numerous classifications, including the most lowly paid aide classifications. A dietary aide at HSC for example, receives wages comparable to those negotiated in remote rural areas of Ontario. Indeed the hospital relied upon rates of pay at Hornepayne Ontario, a community of 980 people some 1,100 km. away with a cost of living of course, far lower than Toronto. When compared to Toronto-area hospitals, the lack of comparability is clear.. For example, Housekeeping Aides and Dietary Aides at HSC are paid $21.45 per hour, more than $1.00 hour less than at University Health Network a few steps away, and significantly less than the comparability data evidenced was normative for CUPE-represented Toronto-area hospitals.

Ignoring comparability to the detriment of the most economically disadvantaged employees, as occurs in this award, is something that brings no credit to the interest arbitration process. The arbitrator's claim to have examined and applied local comparability, as is required at s.9 (1.1)4 of the *HLDAA*, is entirely inconsistent with the result at Hospital for Sick Children, and elsewhere. The data before the arbitrator indicated a clear disparity in wage rates when HSC rates are compared to those at other Toronto hospitals. And while it is obvious that paying normative rates costs an employer more than does paying sub-normative ones, that surely cannot be the basis for repudiating, as this award does, the comparability principle.

RPN Adjustment

My views on this issue are set out in my dissent to the award in the prior round. In Ontario, while the nursing profession has moved toward what is now a single scope of practice, influenced by three-factors (including the nurse, whether RN or RPN), collective bargaining results for RPN wage rates have not kept up with the transformation of the practice. Instead, RPN rates have been affected by two other things – first, comparison to other male-dominated male classifications in the same bargaining unit rather than to RN's with whom they now share a scope of practice, and second; narrowing the gap between RPN's. When compared to other provinces, RPN's in Ontario bear a salary relationship to RN's that appears in provinces where RPN's practice under the supervision of RN's, notwithstanding that in Ontario they practice autonomously. In provinces where RPN's practice autonomously, like Ontario, RN and RPN rates bear a closer relationship.

It is not enough for arbitrators to trace the history of RPN wage adjustments in the hope of demonstrating that RPN rates and RN rates have developed separately. As the practice of nursing becomes more uniform, that is exactly the problem, rather than a solution.

The evidence before the board was supportive of this increased overlap in the practice of nursing. For example, at one hospital we heard that senior RPN's at the commencement of a shift are substituted for more junior and less experienced RN's.

In my view an adjustment to the RPN rate was warranted and ought to have been awarded.

Dated at Ottawa, this 26th day of May 2019.

Joe Herbert
Union Nominee

SCHEDULE "A"

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October 26, 2018-Toronto

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October 30, 2018-Sudbury

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November 6, 2018-Ottawa

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November 8, 2018-Sudbury

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December 7, 2018-Ottawa

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December 18, 2018-Hamilton

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Participating Hospitals Relying Only on Coordinated Submissions

Almonte General Hospital
Arnprior Regional Health
Espanola General Hospital
Kingston Health Sciences Centre
North Shore Health Network
Perth & Smith Falls District Hospital
Red Lake Margaret Cochenour Memorial Hospital
Renfrew Victoria Hospital
Riverside Health Care Facilities
St. Joseph's Health Centre Guelph
William Osler Health Systems