IN THE MATTER OF AN INTEREST ARBITRATION BEFORE ARBITRATOR KAPLAN PURSUANT TO THE *HOSPITAL LABOUR DISPUTES ARBITRATION ACT*, SO 1990

BETWEEN:

PARTICIPATING HOSPITALS
(REPRESENTED BY ONTARIO HOSPITAL ASSOCIATION)

Employer

and

ONTARIO NURSES' ASSOCIATION

Union

WRITTEN BRIEF
PRESENTED IN TORONTO, ONTARIO ON MAY 2-3, 2023

RAVENLAW LLP

1600-220 Laurier Avenue West
Ottawa, Ontario, K1P 5Z9

Telephone: 613.567.2901
Facsimile: 613.567.2921

WASSIM GARZOUZI
JULIA WILLIAMS

COUNSEL FOR ONA

Presenting:	Wassim Garzouzi - Legal Counsel, RavenLaw LLP Julia Williams - Legal Counsel, RavenLaw LLP
ONA Team:	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 Steve Lobsinger RN - Chief Negotiator 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 Marilynn Dee RN - Manager II – Negotiations Hospitals 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 Ryan FitzGerald - Member Benefits Specialist Victoria Romaniuk - Manager Administration, Office of the CEO Dawn Armstrong RN- Region 1 Vice President – Observer Karen McKay-Eden RN - Region 3 Vice President – Observer Alan Warrington RN - Region 5 Vice President – Observer Todd Davis - Region 4 Manager, Labour Relations Robert McGregor RN - Region 5 Manager, Labour Relations

CONTENTS

1. INTRODUCTION

This arbitration is held pursuant to the *Hospital Labour Disputes Arbitration Act* ("*HLDAA*") to finalize the terms and conditions of the twentieth central collective agreement between the Ontario Nurses' Association ("ONA" or the "Union") and the Participating Hospitals (the "Employer" or the "Hospitals").

BARGAINING TIMELINE

Notice to Bargain:	January 5, 2023
Joint Bargaining:	January 30, 2023 to February 3, 2023; February 27, 2023 to February 28, 2023
Mediation:	March 1-2, 2023
Arbitration:	May 2-3, 2023

TERM

The parties have agreed that the *HLDAA* term shall apply:

April 1, 2023 to March 31, 2025

THE PARTIES

THE UNION

ONA is Canada's largest nurses' union.

The membership consists of 68,000 nurses and health-care professionals, as well as 18,000 nursing student affiliates.

ONA members provide essential, frontline care, in hospitals, long-term care, public health, the community, clinics, and industry.

THE WORKERS

This arbitral award affects the terms and conditions of employment of approximately 65,000 Registered Nurses ("RNs"), Nurse Practitioners ("NPs"), and health professionals working in frontline care at 131 of Ontario's 140 public hospitals.

RNs and NPs comprise the largest professional group providing direct clinical care in Canada's hospitals. In a data table by the Canadian Institute for Health Information ("CIHI") entitled, "Who's taking care of you in Canada's hospitals?" the answer, overwhelmingly, is nurses. In 2020-2021, 44% of all hospital hours worked, and 70% of all acute inpatient units and emergency service hours worked, were worked by an RN or an NP.[3] No other group of hospital workers came close: Licensed/Registered Practical Nurses (13%); Therapeutic Service Providers (21%); Personal Support Workers (11%); Technicians (9%); Other (3%). For this reason, references throughout the Union's Brief and the supporting materials to "a staff crisis" and "staffing shortage" almost invariably means a nursing staff crisis and a nursing staff shortage.

Without exaggeration, hospital care in Ontario would grind to a halt without the frontline clinical care provided by ONA nurses. ONA represents the overwhelming majority of all RNs employed by hospitals in Ontario: 98.9%. According to the CIHI, in 2021 (the last year of published data) there were 64,579 RNs were working in hospitals in Ontario. That same year, the Employer reported an ONA membership head count of 63,890. In 2022, the head count was 65,144. These 65,144 ONA nurses work in public hospitals that serve roughly 97% of the province's population. Virtually every ONA nurse is responsible for direct patient care.

Of the 65,144 ONA nurses, 98.8% (64,331) are RNs. At present, the bargaining unit consists of 38,742 full-time and 26,402 part-time members. The membership is 92.4% female. Currently, there are 524 NPs working at 78 hospitals. Like RNs, the overwhelming majority of NPs are female (92.4%) and are working in direct patient care (99.2%).

According to the CIHI, as of 2021, 60.5% of Ontario's hospital RNs were over the age of 40 (39.5% were between the ages of 25 and 39). These percentages track closely with the placement of ONA members across the current wage grid. Although a nurse can enter the profession at any age, a lower position on the wage grid typically overlaps with the younger age group. At present, 56.8% of ONA members have achieved 8 years of service or more, representing a highly experienced and skilled corps of hospital nurses:

STEP	% of Members at STEP
Start	8.3%
1 Year	6.4%
2 Years	5.8%
3 Years	5.5%
4 Years	4.9%
5 Years	4.5%
6 Years	3.7%
7 Years	3.8%
8 Years	55.8%

THE EMPLOYER

The 131 Participating Hospitals, listed in Appendix "A" of the *Memorandum of Conditions for Joint Bargaining* are represented by the Ontario Hospital Association ("OHA") and signify "the Employer" for the purposes of the renewed Collective Agreement.

The Participating Hospitals are public hospitals responsible for delivering healthcare to Ontarians. There are currently 140 public hospitals in Ontario under the umbrella of the OHA, of which 131 make up the Participating Hospitals that are a party to this agreement As noted above, these hospitals service roughly 97% of Ontario's population.

UNION INTEREST IN THIS ROUND OF BARGAINING

This round of bargaining is about wages.

The context in which the parties have entered this round of bargaining demands a wage "catch-up" and other compensation outcomes that far exceed the status quo that has emerged between these parties since 2010. The nursing shortage and the parallel decline in nurse wages over the last decade are problems that can no longer be ignored. The solution—meaningful wage grid adjustments and pay increases—can no longer be delayed. While the Union maintains that all its remaining bargaining proposals advance the common interests of the parties, the issue of under-compensation is an urgent priority.

Wages matter. The RN wage catch-up, and other compensation measures proposed by the Union, are tailored to address a decade of declining real wages and Ontario's non-competitive wage rates. The Union's proposed wage grid adjustments, general wage increases, long-service entitlements, and pay premiums are justified in the current context.

In this round, the bargaining context is unlike any other. The outcome of this interest arbitration must reflect that.

SUMMARY OF UNION PROPOSALS

ISSUE	ARTICLE	PROPOSAL
WAGES		
a. GRID ADJUSTMENT	19.01(a)	Eliminate entry-level rates
b. GENERAL WAGE INCREASE	19.01(a)	12% (2023); 6% (2024)
c. LONG-TERM SERVICE ENTITLEMENT	NEW	2% at 14 Years 4% at 21 Years 6% at 28 Years
STANDARD OVERTIME	14.01; 14.04; 14.09	Two (2) times the hourly rate for standard overtime and paid holiday; Two (2) times the hourly rate for time off in lieu pay
SHIFT AND RESPONSIBILITY PREMIUMS		
a. WEEKEND, NIGHT, & EVENING PREMIUMS	14.10; 14.15	$2.50 (evening) $3.88 (night) One and one half (1.5) the hourly rate (weekend)
b. MENTORSHIP & SUPERVISION PREMIUMS	9.08(a); 9.08(c)	$2.50 (supervision) $2.50 (mentorship)
c. GROUP, TEAM, AND LEADERSHIP PAY	19.04(d)	$5.00
AGENCY USE		
a. PENALTY FOR AGENCY USE	10.12(c)	$2.50 per hour for all agency use; 1.5% cap on *ad hoc* use per individual hospital unit; group, unit, or team leader pay for staff nurses working with agency nurses
b. DISCLOSURE OF AGENCY USE	10.16(e)	Hours of agency use per unit, percentage per unit, and hospital wide total
PART-TIME NURSES		
a. PT % IN LIEU	19.01(b); 19.01(c)	15% (without pension) 11% (with pension)
b. 48 HOURS NOTICE OF SHIFT CHANGE	14.12	48 hours notice for part-time and casual
NURSE PRACTITIONERS		
a. NP WAGE GRID – HARMONIZATION	NEW	Central Grid
b. RECOGNITION OF RN EXPERIENCE	19.05(b)	RN experience applicable for NP grid placement
c. NON-CLINICAL HOURS /CONTINUING EDUCATION	NEW	Dedicated non-clinical hours for NPs
HEALTH & WELLNESS		
a. ISOLATION PAY	NEW	Salary continuation during mandated self-isolation
b. VACATION	16.01; 16.04	8 weeks at 30 Years 8-week entitlement – 16%
c. HEALTHCARE SPENDING ACCOUNT	17.01(c)	$1000
d. LTD PREMIUM TO AGE 80	12.01	75% of billed premium up to age 80

PRINCIPLES OF INTEREST ARBITRATION: LEGISLATIVE AND COMMON LAW CRITERIA

The Board's deliberations in this matter are governed by consideration of certain criteria dictated by statute and long-standing precedent.

REPLICATION

"Replication means, for good or for ill, no matter which party is advantaged, awarding free collective bargaining outcome."

The fundamental and overarching principle of interest arbitration is the concept of replication. Arbitrators must decide what best approximates the agreement that the parties would have reached in a system of free collective bargaining, with the right to strike or lockout. As the Chair of this Board noted in 2020:

> Replication means, for good or for ill, no matter which party is advantaged, awarding free collective bargaining outcome. That is a basic tenet.

As this remark suggests, replication is not about evenly splitting the difference. Most importantly, replication is not a speculative exercise. It is an evidence-based exercise. In order to approximate the agreement the parties would have reached in free bargaining, the Board must weigh the objective evidence that favours the awarded outcome:

> Returning to the concept of replication, it is essential to realize that a board of arbitration is not expected to embark upon a subjective process for divining what might have happened if collective bargaining had run its course. Arbitrators are expected to achieve replication through an analysis of objective data from which conclusions are drawn with respect to the terms and conditions of employment prevailing in the relevant labour market for work similar to the work in issue.

In regards to public employees, such as hospital nurses, the Board's job is not to rule on what is the most prudent or "correct" public policy. Rather, the Board's job is to replicate—for good or for ill—the likely bargained result. In order to do so, "the panel must have regard to the market forces and economic realities that would have ultimately driven the parties to a bargain."

"Replication is the default, subject to context."

In the 2018 interest arbitration award between the parties, the Board, chaired by Arbitrator Kaplan ("the Kaplan Board (2018)") observed that the governing principle

of interest arbitration is replication, subject to context. In 2018, the Board found there was insufficient evidence that the Employer was facing a recruitment and retention problem and determined that the "context" was dictated by hospital sector comparators advanced by the OHA.

Between 2020 and 2022, the bargaining context shifted with the COVID-19 pandemic. While the general public was being asked to show its appreciation for healthcare heroes, the real value of nurse wages continued to decline. Meanwhile, the cost of living soared and hospital nurses were exiting frontline positions at record rates. And yet, none of this context mattered. The context was completely overshadowed by Bill 124, which capped wage increases at a time when more was being demanded of nurses than ever before.

Both of the interest arbitration Boards subject to Bill 124 (the "Stout Board" in 2020; and the "Gedalof Board" in 2021) declared that the Boards' hands were tied by the legislative cap on compensation growth. General wage increases were awarded at 1%, 1%, and 1%, and minimal improvements were made to other aspects of total compensation to ensure the total amount awarded did not exceed the compensation cap.

Indisputably, the bargaining context has shifted considerably since the Kaplan Board decision in 2018.

The bargaining context for hospital nurses in 2023 includes the following: (i) three years of wage restraint legislation that has been declared unconstitutional, but left its mark, (ii) a system-wide nurse staffing crisis; (iii) rampant use of agency nurses to fill vacancies, (iv) accumulating overtime costs, (v) a non-competitive wage grid, (vi) high inflation, and (vii) over a decade of depreciating wages.

Each of these contextual factors will be highlighted throughout the Union's Brief. And, each of these contextual factors will be underscored with the objective evidence that informs the replication of free bargaining.

STATUTORY CRITERIA

Evidence of the "relevant labour market" that informs replication is typically found within a set of common criteria. In an award governed by *HLDAA*, a non-exhaustive list of criteria that must be considered is listed within the statute.

The Hospital Labour Disputes Arbitration Act (HLDAA)

According to the *HLDAA*, a board of arbitration must consider all relevant factors in making a decision or award. "All relevant factors" include, but are not limited to, the following:

> 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.

These *HLDAA* factors overlap with the common law factors of "recruitment and retainment", "comparability", "harmonization", and "demonstrated need".

The Union's submissions will examine each of these factors in reverse order. The Union submits that the objective data relevant to each factor supports the conclusion that the Union's proposals best replicate a free-bargaining outcome.

RECRUITMENT AND RETENTION

"The employer's ability to attract and retain qualified employees."

At present, there is a critical nursing shortage in Ontario that is the result of both recruitment and retention problems. Not enough new nurses are entering the profession to meet the current demand, and too many nurses are leaving the hospital sector, the jurisdiction, and/or the profession entirely. According to the Ontario Ministry of Health's May 2022 "Health Human Resources Overview", a heavy focus on recruitment and retention is required to head off chronic nursing shortages. In other words, the Employer needs to attract new nurses, as well as retain its existing complement of nurses—and it needs to do so now.

In 2018, the Kaplan Board observed that "overwhelming and largely uncontradicted evidence" about difficulties with recruitment and retention is necessary for the Board to make substantial wage adjustments over and above normative outcomes. In that case, the Board found that the evidence of a recruitment and retention problem was lacking.

In 2023, the evidence that the Employer is having difficulty attracting and retaining nurses is devastating. The evidence of difficulties with recruitment and retention is also largely uncontradicted because much of the evidence of a recruitment and retainment problem comes directly from the Employer.

In February 2022, in an OHA report entitled, "*Practical Solutions to Maximize Health Human Resources*", the OHA identified staffing concerns as the most urgent and pressing issue emerging from the COVID-19 pandemic:

> HHR [health human resources] has become the biggest issue for hospitals in the short and medium-term. In our discussions with members and system stakeholders, it has become clear that HHR issues are at a critical point—solutions are needed immediately"

While the staffing crisis exists across multiple health care professions, "nursing, specifically speciality nursing in areas of mental health, ICU, emergency room and the OR, by far present the biggest challenge within the system. This "biggest challenge within the system" is not a localized issue. Rather, the "HHR challenges are being felt across the entire system impacting the care continuum and patient flow." The problem is both rural and urban. New articles over the last year provide snapshot of how extensive the current problem is:

- *Rural Ontario Communities hit hard by ER closures, hospitals face staff challenges, Toronto Star*, dated November 2, 2022: "The South Bruce Grey Health Centre, which runs the Chesley hospital, closed the community's emergency room in early October, citing "critical nurse shortages"."

- *Emergency department closure caught Norfolk paramedics by surprise*, dated November 3, 2022: "The recent 24-hour closure of Norfolk County's only emergency department due to a lack of nurses caught Norfolk paramedics off guard."

- *Lapointe shares health care concern on shortage of workers*, dated November 3, 2022: "The issue has been raised several times in recent months by health workers in Sudbury, such as unionized employees of the Greater Sudbury Paramedic Service who spoke up just two weeks ago of the need to hire more paramedics because the shortage of nurses is resulting in longer wait times for ambulance service. The shortage of nurses has also been recently addressed by Nickel Belt MPP France Gélinas, the party's health critic, who spoke against Ontario Bill 124, which puts a cap on wage increases for nurses and personal support workers."

- *'Capacity Pressures': Brampton and Mississauga hospital ERs experiencing high patient volumes*, dated October 28, 2022: " 'Like many hospitals, William Osler

Health System (Osler) is currently experiencing capacity pressures. Our Emergency Departments are seeing a high number of patients waiting for an in-patient bed, higher than usual acuity, an increase in patients with influenza-like illnesses and patients with COVID-19, as well as ongoing staffing challenges, all resulting in longer than usual wait times,' Osler said in a statement.

- *'Staggering' number of Ontario emergency department closures revealed by Star analysis*, dated February 21, 2023: "Hospital emergency departments across Ontario were forced to close 158 times in the past year, resulting in some 4,430 hours — the equivalent of 184 days — when the urgent care needs of many communities could not be met locally. The scale of emergency department closures we've seen in the last year is completely unprecedented. There has never been anything remotely close to this. 'It's staggering,' says Natalie Mehra, executive director of the Ontario Health Coalition, a non-partisan public health-care watchdog. 'These closures are, without question, a risk to the lives and health of people. No one can deny that.' In almost every case, the reason given for the closures was a lack of adequate staffing. 'This is really, really bad and it talks to the health-care workers crisis,' she said, adding that she speaks regularly with nurses in her northern Ontario riding (Nickel Belt) who say they feel disrespected by the government's controversial Bill 124. 'They're discouraged and burnt out.' Dr. David Gomez, a general surgeon at St. Michael's Hospital in Toronto who has studied how ED closures can influence potential access to emergency care in Ontario, says the provincial government has tied the hands of hospital administrators with legislated caps on nursing wages.

- *We calculated the number of Ontario's ER closures this summer. Here's what we found* dated September 16, 2022: "The 86 closures found by the Star — likely an undercount since not all emergency department closures get widespread attention — fly in the face of the provincial government's recent messaging that Ontario's health-care system is not in crisis. Frank Vassallo, CEO of Kemptville District Hospital, said labour shortages are the result of a combination of staff calling in sick due to COVID-19 and other viruses, staff finally taking vacation that they deferred during the worst of the pandemic, and nurses retiring or leaving the profession for quality-of-life reasons. 'Nurses that remain in the system are fatigued … they're burned out from pandemic care. They're not up to taking extra shifts,' said Vassallo, noting that his hospital currently has 15 Registered Nurse (RN) positions vacant, representing a 37.5 per cent vacancy rate, and four Registered Practical Nurse (RPN) positions open, a vacancy rate of 16 per cent. The hospital most recently closed its emergency department from 7 p.m. to 7 a.m. from Aug. 31 to Sept. 5.

- *The Huron Perth Healthcare Alliance is looking for nurses*, dated October 31, 2022: "The numbers fluctuate regularly, so [CEO] Williams explained it's difficult to put a number on exactly how many nurses the Alliance would need to fill all of the positions, but he believes the hospitals in Clinton and Seaforth are short six to eight nurses in their Emergency Departments. And it's not just Emergency Departments, it's through all areas and throughout the Alliance. 'Right now we have 54 open registered nursing positions across the HPHA and we have 25 practical nurses,' he

said. 'So, almost 80 nursing positions that we are actively trying to fill across the organization and within the same period we've filled 57 RN positions.'

- *Thunder Bay hospitals to use $25K incentive to attract nurses*, dated January 25, 2023: 'There are significant health human resources pressures both provincially and regionally, and we are not immune to these challenges,' said Jeannine Verdenik, the hospital's vice president for people and culture. 'While we hired many personnel in 2022, the challenges of recruitment are not going away, so this incentive will help fill some of the nursing vacancies we currently have moving forward.' Last fall the two city hospitals reported they had 195 openings for RNs, RPNs and nurse practitioners between them.

- *Five things that could help Ontario recruit and retain health-care workers*, dated August 5, 2022: At the Queensway Carleton Hospital, the vacancy rate for registered nurses, registered practical nurses and personal care assistants is 17.5 per cent. "In raw numbers, we had an average of 156 vacancies over the last quarter. Specialized areas like OR and surgery continue to be the most difficult to recruit for. Staffing is certainly the biggest challenge we face," said spokesperson Ann Fuller. The Ottawa Hospital is experiencing pressure on emergency room staffing due to COVID-related absences, vacations, staff fatigue and burnout, said spokesperson Rebecca Abelson. Periodic COVID outbreaks have also had an impact.

- *Surgeries at for-profit orthopedic clinic already impacting hospital staffing, some insiders say*, dated March 21, 2023: "This newspaper has spoken with a source inside the hospital, who said an upcoming plan to address backlogged cancer surgeries at The Ottawa Hospital was curtailed because of concerns that nurses would not be available to manage patients."

- *Short hundreds of nurses, London hospital bumps overtime pay by 30%*, dated April 26, 2023: The region's largest hospital is boosting overtime pay for nurses, a stopgap measure to address a shortage of the front-line workers amid other recruitment strategies to fill about 500 nursing positions. "Nursing is a critical component of health care. We rely so significantly, and are so grateful for, the expertise our nurses provide," Heather Lokko, LHSC's corporate nursing executive, said Tuesday. "We are experiencing significant challenges in recruitment and retention, as is happening globally. We need to implement a variety of strategies to address those challenges." LHSC has 388 active postings for registered nurses. Of those, 321 are true vacancies filling an existing position and the others are additional posts necessary for future workforce planning.

- '*This is not about funding or money': Closing of this Ontario ER is another symptom of crisis in nurse staffing*, dated April 29, 2023: "Enormous pressure" caused by staff shortages, has caused a rural Ontario hospital to close it's emergency room permanently and it is the latest example of the deepening human resource crisis in health care, nursing advocates say. The decision was directly related to staffing

> shortages, said Carolyn Plummer, president and CEO of HHHS. The dire need for nurses and physicians existed before and was exacerbated by the pandemic, Plummer said, but it turned into "a near-constant crisis in the last 18 months, causing enormous pressure," on the existing staff.

The above collection is only a sample of all that has been reported on the nursing staff shortage over the last year and a half.

Evidence of Vacancies and Turnover

The evidence of a retention and recruitment problem is not simply anecdotal. The reported vacancy rates at Ontario hospitals demonstrate the extent of the Employer's retention and recruitment problem. OHA members have reported a substantial increase in vacancy rates.[35] The OHA's "Health Human Resources Workforce Survey" (Fall 2022) showed a vacancy rate for RNs that had tripled since March 31, 2018:

Vacancy Rate (FT & PT Permanent Positions)	on Mar 31, 2017*	on Mar 31, 2018*	on Mar 31, 2019*	on Mar 31, 2020*	on Oct 20, 2021**	on Mar 1, 2022**	on Oct 1, 2022**
All Hospital	5.57%	3.93%	3.70%	4.24%	8.09%	8.84%	10.74%
RN & RN-Specialty (Total)	6.89%	4.90%	4.81%	4.85%	11.73%	12.63%	14.78%

The OHA has been clear that the nurse shortages are not being driven by the creation of net new positions alone. That is to say, the problem is not simply a recruitment issue. Nurses are also resigning from existing positions at abnormally high rates, meaning there is also a significant retention problem:

> During the pandemic, there have been significant investments and opportunities for hospitals to hire additional staff to respond to COVID-19 through creating net new positions. Both factors [i.e., resignations and creation of new positions] have resulted in an overall increase in the number of vacancies that have to be filled in hospitals in a completive labour market.
>
> An increase in turnover coupled with the need to fill net new positions in a competitive environment poses a real challenge to providing care.

> Survey results indicated that there was an increase in employee turnover during this time (September 2020 to October 2021), largely due to resignations, when compared to pre-pandemic levels.

By Fall 2022, a more recent OHA Survey showed that the resignation rate has continued to increase. From September 2021 to September 2022, the resignation rate climbed from 9.82% to 10.93%:

Resignation Rate (FT & PT Permanent Positions)	Apr 1, 2016 - Mar 31, 2017*	Apr 1, 2017 - Mar 31, 2018*	Apr 1, 2018 - Mar 31, 2019*	Apr 1, 2019 - Mar 31, 2020*	Oct. 1, 2020 - Sep 30, 2021**	Mar. 1, 2021 - Feb 28, 2022**	Oct. 1, 2021 - Sep 30, 2022**
All Hospital	4.23%	4.67%	4.98%	5.61%	8.19%	10.07%	10.11%
RN & RN-Specialty (Total)	4.62%	4.98%	5.40%	5.73%	9.82%	10.40%	10.93%

In contrast, the resignation rate from April 1, 2016 to March 31, 2017 was 4.62%.

In February 2022, the hospitals reported to the OHA 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." The exodus of experienced nurses from Ontario hospitals continues:

> The OHA data shows that as of the end of February 2022, the Ontario-wide hospital turnover rate for nurses was 14.47 per cent — a 72 per cent increase since 2020. (This rate includes only permanent positions and does not include internal transfers or where employees moved, such as to another hospital or health-care provider.)
> …
>
> The OHA data shows turnover is largely driven by resignations, which have more than doubled since 2016. Nurses who've spoken with the Star say the increase in workload, combined with pressures of providing care in multiple COVID waves, is leading to burnout as they cover more shifts in tougher working conditions.
> …
>
> This, in effect, leads to a positive feedback loop: The more people leave, the bigger the workload for those who stay, which in turn leads to more people wanting to leave.

In the current climate of staffing chaos and subpar wages, nurses are leaving Ontario hospitals. While some nurses may be leaving the profession entirely, this is not universally the case. Some nurses are simply moving to other provinces

where wages and salary progression are better.[44] Some nurses are leaving the country to work in the United States:

> A part of this exodus is Emily Pyke, an ER nurse in Toronto, en route to Florida after what she described as a year of stressful shifts and unsafe patient ratios, caring for as many as six patients at one time.
>
> Pyke says she's emotionally drained and worried about being put in a position where a patient could have a negative outcome.
>
> "As a nurse, you go into the profession, you want to help people. You want to make a difference and sometimes you feel like with such lack of resources and everything, you're not able to do your job the way you want to even though everyday you're trying 110 per cent," she said.
>
> "With cost of living, all of that, it's impossible to continue to work with such a wage," Pyke said.
>
> Damilola Ola-Adigun, a NICU nurse who previously worked in Toronto, told CTV News she now works in Syracuse, New York.
>
> Ola-Adigun said she didn't realize how strained Ontario's health care was until she worked in the U.S.
>
> "Everyday you go to work, you're working understaffed, your license is on the line," Ola-Adigun told CTV News in an interview.
>
> "In America, there's a lot more support and incentive. They understand that you have a life, you have kids, and that's the biggest benefit," she said.
>
> "I was mind-blown by the amount these nurses are allotted to come into work when they're not supposed to. It shows the respect they have for them. I've never seen that in Ontario. I've never seen that in Toronto. You want me to come back? There's no way," she said.

The province, in response to these retention problems has begun offering incentives to nurses who have left the profession entirely or have left the profession in Ontario to work in another jurisdiction. The *Temporary Reimbursement of Fees for Internationally Educated and Inactive Nurses* aims to reimburse inactive nurses their costs for having their nursing license reinstated. The *Community Commitment Program for Nurses* offers a $25,000 incentive for nurses who have not practiced in Ontario in the last 6 months and are willing to make a two-year commitment to working in Ontario. These incentives are in addition to the Ontario

government's $763-million dollar initiative to pay existing Ontario nurses retention bonuses of $5000 to remain working in Ontario.

What is abundantly clear is that experienced hospital nurses are leaving the hospital sector at a rate that is unsustainable. Hospitals are using temporary agencies at an increased rate to make up the shortfall of staff nurses. Staff nurses, in turn, are leaving staff positions for those very agencies, exacerbating the shortage:

> We are now hearing from many of our members that new, "pop-up" agencies are promising health care workers, primarily nurses, substantive bonuses and higher wages which is disrupting the sector. Some health care workers are purportedly quitting their full-time jobs only to turn around and be hired by agencies and then deployed to work at the very same workplace/positions where they were originally employed. Given the competitive environment to recruit talent, agencies are reportedly paying agency nurses two times their salary and are charging hospitals as high as $1,000 a day for select nurses during high vacancy periods."

For public sector employers, the ability to attract employees from the private sector, and keep employees in the public sector, is an important consideration. Right now, the reverse is happening:

> Since Anna Seto quit her nursing job at UHN and joined an agency, she's noticed a "drastic improvement" in her well-being and mental health. She was one of the first health workers in Ontario to get COVID on the job during a hospital outbreak in April 2020 and spent most of the pandemic working one of its most demanding jobs: nursing in the ICU.
>
> By April 2022, Seto was feeling overworked, deeply burnt out and disrespected. Health-care workers were facing backlash from the public, she struggled to get time off and the government's refusal to repeal Bill 124 — which capped nurses' salary increases — felt like a "slap in the face."
>
> Seto also said that at times nearly half of the nurses in her ICU were from agencies — and getting paid twice as much. Meanwhile, the agency nurses sometimes added to the workload of staff nurses, who had to show them the ropes or help them access medication storage rooms that require a staff ID.
>
> "Morale was low," Seto said. "It felt like we'd worked through this entire pandemic — seeing so many people die, saving as many lives as we possibly could — and at the same time there was no recognition of that."
>
> Seto said she and at least two other nurses from her ICU quit for agency work in the spring. She said she now gets paid nearly double what she used to make at UHN,

> sometimes while literally working the same job — her very first shift as an agency nurse was at her old ICU at Toronto Western.

Reliance on Agency Nurses is Further Evidence of a Recruitment and Retention Problem

The parallel workforce predicament created by agency use was not unforeseen.

In 2003, the Union filed an unfair labour practice complaint and multiple grievances against the Employer regarding the use of agency nurses during the SARS outbreak (see *Sunnybrook and Women's College Health Sciences Centre v ONA (Re)* [*Sunnybrook*]). In that case, the Union was concerned about the growing use of non-bargaining unit nurses supplied by agencies and the imposition of separate terms and conditions for agency nurses as compared to bargaining unit members. Arbitrator Kaplan found that a recruitment and retention problem was, in part, creating an increased reliance on agency nurses:

> As a result of job market forces and the difficulties experienced by some hospitals in retaining and recruiting permanent employees, as well as sick leave usage, some hospitals have made use of Agency nurses to fill ongoing vacancies and shortages in the bargaining unit rather than restricting their use to *ad hoc* shift coverage, narrowly defined.

Arbitrator Kaplan allowed the Union's grievances. In doing so, he determined that the Collective Agreement between the parties limited the use of agency nurses to "*ad hoc*" use and found that the "Collective Agreement [did] not permit the creation of a parallel contingent workforce in the workplace."

The Collective Agreement limitations on agency use are incredibly important. When agency use is *ad hoc* the work, although it pays more, is precarious—shifts are sporadic and regular income is unpredictable. The more that agencies are used, the more that agency work becomes steady and predictable. A parallel workforce emerges that shadows permanent staff and are able to establish their own free-market terms and conditions of employment, such as higher wages, added perks, and regular schedules.

In March 2022, Quinte Health Care ("QHC") confirmed that agency nurses were being pre-scheduled for regular work hours and being provided with 6-week or 4-week schedules in advance. This resulted in agency nurses being scheduled prior to QHC issuing an overtime callout to permanent staff. In a communique to ONA, QHC admitted:

> QHC acknowledges that we have not been able to schedule agency nurses for ad hoc single shift as outlined the central collective agreement, Article 10.12 (c). Due to the competitive external environment and inability to retain agency staff if they are only scheduled one shift at a time, it is necessary to provide these nurses with short term schedules or they will leave to seek work elsewhere.

At the same participating hospital site, in June 2022, a member reported that all of the agency nurses working in the Intensive Care Unit ("ICU") were issued onsite staff parking passes, leapfrogging permanent RN staff who have been told onsite parking is unavailable.[56] Between fiscal year 2021-22 and fiscal year 2022-23, agency hours at QHC went up by 631%: from 8964 hours for fiscal year 2021-22 to 65,539.20 hours for the first three quarters of 2022 (April 2022 to December 2022).

The growth in agency hours means agencies can attract more and more nurses away from permanent full-time and part-time staff positions. As agency work becomes stable, predictable, and better compensated, the recruitment and retention problems grow.

The Use of Agency Nurses has Reached a Tipping Point

The growing reliance on agency nurses over the last four years has created a recruitment and retainment problem that is now self-perpetuating. The inability to attract and retain staff nurses to fill vacancies has meant that the Employer is turning to external, private sector agencies for nurses, and it is doing so at an unprecedented rate. The agencies, in turn, are offering nurses higher wages and other incentives that make working as an agency nurse more attractive than permanent staff positions. The result is that the Employer's "cure" for the staffing problems is part of what is driving the problem itself.

According to the OHA:

> 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.

At the same time:

> There are simply not enough licensed health care providers in the system – nurses, doctors, medical lab techs, etc. – to continue to provide the level of service that has been provided to date. For nursing specifically, the shortage is being amplified by the incentive to work as an agency nurse.

Reliance on agency nurses has gone up significantly since fiscal year 2020-2021. In 2020-22, the Hospitals reported spending $26,947,021 on agency nurses. In 2021-22 that spending rose to $52,910,106. In the last recorded fiscal year, 2022-23, the numbers reported exceeded the previous two fiscal years combined: $131,741,841.

2020-21: $26,947,021

2021-22: $52,910,106

2022-23: $131,741,841

The amounts for fiscal years 2021-22 and 2022-23 are undercounts: (i) some of the participating hospitals only reported costs for the first and second quarters of 2022-23, and (ii) several additional hospitals reported hours, but did not disclose costs. There are 325,938 agency hours reported but not costed for 2021-22, and 289,490 agency hours reported but not costed for 2022-23. There are an additional 7 hospitals that reported agency use under Article 10.16 in 2022-23, but have provided no costs, and 13 that reported agency use (and hours) under Article 10.16 in 2021-22, but have provided no costs.

Not surprisingly, the increase in agency spending parallels the increase in agency hours:

2020-21: 224,556.5 hours

2021-22: 542,901.48 hours

2022-23: 1,085,547.8 hours

Not only have agency nurse hours significantly risen, but the use of agency nurses is now ubiquitous across the province and amongst the participating hospitals. At the time of the *Sunnybrook* decision in 2004, the use of agency nurses was significantly concentrated in the Greater Toronto Area ("GTA"). This is no longer

the case. Agency nurses are being used in all corners of the province, rural and urban.

In the **North**, the OHA has noted that the use of agency nurses is particularly worrisome:

> In northern hospitals, utilization of agency nurses…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.

At Temiskaming Hospital in New Liskeard, Ontario, agency hours more than tripled between fiscal years 2021-22 (8,487 hours) and fiscal year 2022-23 (28,165 hours). At Nipigon District Memorial, northeast of Thunder Bay, the Hospital went from zero agency hours in 2022 to 1276 hours in 2023 (to date).

In the **West**:

> 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.

From April to December 2022, South Bruce Grey Health Centre had recorded 8434.33 hours of agency use. The total cost for the same period, including accommodation and travel for agency nurses was $1,327,277.09. In the fiscal year ending in 2022, 11 part-time RNs resigned, and 4 full time RNs resigned. From April 2022 to January 2023, an additional 7 RNs resigned.

At Norfolk General Hospital, agency hours went from zero hours in 2020-21, to 7567 hours in 2021-22, to 9411 hours for only the first three quarters of the 2022-23 fiscal year.

In the **South**:

> Hamilton's hospitals are short more than 2,000 staff. The unprecedented crisis has nearly tripled in under a year from 675 vacancies at Hamilton Health Sciences (HHS) and St. Joseph's Healthcare in July 2022….Now, St. Joseph's alone has 632 job openings — 364 of them in nursing…HHS started paying nurses double in August to work outside of their regularly scheduled shifts to fill critical staff shortages…Over the pandemic, both St. Joseph's and HHS started using nurses from agencies that provide temporary staff — a last-resort measure neither had relied on for many years before that.

At Hamilton Health Sciences, agency use increased by 558% from fiscal year 2021-22 (721.5 hours) to fiscal year 2021-23 (4748 hours).

In the **East**:

> Robert Alldred-Hughes, president and CEO of Glengarry Memorial, told the Star the hospital has not been required to close its ED since October thanks to staff working additional hours, agency nurses being brought in and a continued focus on recruiting nurses to fill vacancies. He noted that staffing 'does remain fragile'.

At Glengarry Memorial, the cost of agency use went from $0 in 2020-21, to $255,394.10 in 2021-22, to $578,461,69 in 2022-23.

At Kemptville District Hospital, the hours went up from 564.29 in 2020-21, to 1149 hours in 2022-23, to 5044.38 hours in fiscal year 2022-23 up to March 11, 2023.

In the **GTA**:

> In its last fiscal year ending March 2022, the University Health Network, Canada's largest research and teaching hospital network, has already spent $6.7 million on agency nurses — a significant jump compared to 2018, when it spent $1.035 million…. The staffing issues facing hospitals across the province are particularly severe at UHN, one of the few — and sometimes only — care centres for acute COVID cases and other serious illnesses, said president and CEO Dr. Kevin Smith. "Our staff are particularly worn down," he said.

At University Health Network, agency hours climbed from 5,868 in 2020-21 to 57,168 in 2022-23.

At William Osler Health System, agency hours climbed from 58,150 in 2020-21 to 70,444 in 2021-22. By the end of the September 2022 (Q2), WOHS was reporting

60,512 agency hours—already double the number of hours recorded for the same period the previous fiscal year (27,837).

In total:

2020/21: 24 Hospitals

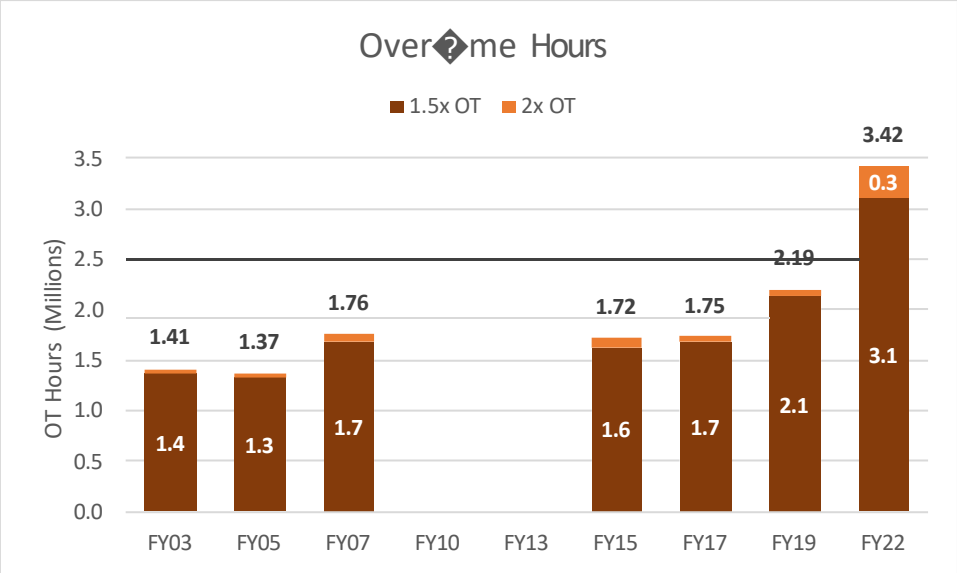
2021/22: 45 Hospitals

2022/23: 65 Hospitals

While the use of agency nurses is evidence of a recruitment and retainment problem. The reverse is not true. Even hospitals reporting zero agency hours have confirmed that they are dealing with severe nurse shortages. As recently as April 26, 2023, London Health Sciences Centre ("LHSC") announced that it is offering nurses double-time for overtime as one strategy to address its nurse shortage. According to the OHA disclosures from LHSC, this measure has been in place since November 18, 2022. LHSC claims it is short about 500 nurses, has 388 active postings for RNs, and is facing "significant challenges in recruitment and retention." As of March 2023, LHSC has reported zero agency use.

Excessive Overtime is further Confirmation of a Nurse Shortage

In addition to agency nurse use, overtime use has also skyrocketed in the last three years. The heavy reliance on overtime is evidence that there are not enough permanent staff in the system to fill schedules in order to meet operational needs. When staffing is precariously low, the Hospitals must turn to the existing complement of nurses to fill scheduling gaps. In fiscal year 2016-2017 the Employer recorded 1.75 million hours of overtime. In fiscal year 2018-2019 that number was 2.19 million. For the fiscal year ending in March 2022 that number was 3.42 million hours:



An increase in spending on overtime has accompanied the increase in hours. Between fiscal year 2021 and fiscal year 2022, there was a 70% increase in overtime costs reported by the Hospitals, for a total of $277,656,162 spent on overtime in fiscal year 2021-2022.

Despite the significant increase in overtime hours, there are indications that the Employer is still struggling to fill all the overtime hours it needs to fill. Some hospitals have offered nurses overtime rates that are above the rates offered in the collective agreement. Even at these high rates, many nurses are declining overtime shifts:

> Frank Vassallo, CEO of Kemptville District Hospital, said labour shortages are the result of a combination of staff calling in sick due to COVID-19 and other viruses, staff finally taking vacation that they deferred during the worst of the pandemic, and nurses retiring or leaving the profession for quality-of-life reasons. 'Nurses that remain in the system are fatigued … they're burned out from pandemic care. They're not up to taking extra shifts,' said Vassallo, noting that his hospital currently has 15 Registered Nurse (RN) positions vacant, representing a 37.5 per cent vacancy rate, and four Registered Practical Nurse (RPN) positions open, a vacancy rate of 16 per cent. The hospital most recently closed its emergency department from 7 p.m. to 7 a.m. from Aug. 31 to Sept. 5.

If regular staff decline overtime, this leaves the Employer with the option of offering better wages to recruit and retain more permanent staff or turning to agency nurses to maintain operations. Unfortunately, the Hospitals are choosing the latter. The fact that the Employer can and does hire nurses from external agencies—at quadruple the cost of a staff nurse—is evidence that an external supply of nurses exists, but the working terms and conditions of staff nurses are inadequate to entice nurses to take up permanent positions. Instead, the opposite is happening.

Staff nurses are moving out of permanent positions and taking up positions with agencies. Meanwhile, agency hours are becoming more readily available, and wages are significantly higher. As noted earlier in these submissions, this only exacerbates the recruitment and retention problem.

Conclusion

The evidence that the Employer is facing a massive recruitment and retention problem is overwhelming. Vacancy rates, resignation rates, agency use, and overtime use all point to an abject failure to recruit nurses into vacant staff positions and retain current staff. This evidence, which speaks to the "context" in this round of bargaining, supports the Union's position that its proposals—and not the Employer's—replicate a free-bargaining outcome.

RELEVANT COMPARATORS

"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."

In this round of bargaining, the Union is arguing for "catch-up" and movement towards parity with the same professionals doing the same work. For that purpose, there are several relevant comparators—both intra-provincially and interprovincially—that the Board should consider in its deliberations. The Union's comparators are consistent with the criteria in *HLDAA* that calls for a comparison between employees in the public and private sectors, and the nature of the work performed.

Relevant comparators provide some of the most objective data in support of replicating a free bargaining outcome. They are the terms and conditions of employment prevailing in the labour market for similar employees doing similar work. The Union submits that its proposed comparators—both private and public—are consistent, not only with similar employees doing similar work, but with identical employees doing identical work. In fact, some of examples provided by the Union involve the same work, in the same workplace, by the same employee.

These relevant comparators include:

1. Nurses in Other Provinces
2. Agency Nurses & Private Hospital Nurses in Ontario
3. Other Frontline Professional Groups in Ontario
4. Nurses in the United States (US) and United Kingdom (UK)

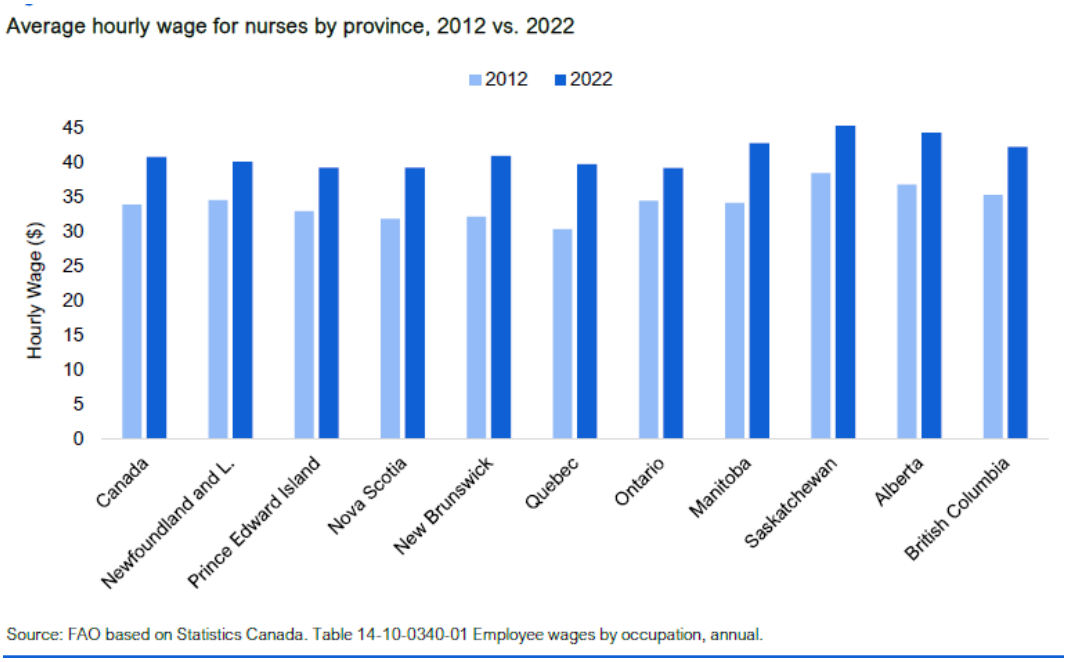
Nurses in Other Provinces

The relevant labour market for RNs and NPs encompasses the labour market in other provinces. Nursing is a mobile profession. Although some nurses may have advanced training in particular areas (e.g. Intensive Care, Emergency, Surgical etc.) an RN or NP is a category of professional whose skills and qualifications are virtually identical across all Canadian jurisdictions. These are not similar workers doing similar work, they are the same workers, doing the same work.

Consequently, the terms and conditions of employment—and in particular, the wages—of nurses in other provinces are an important measure of whether the terms and conditions of employment for nurses in Ontario's hospitals are competitive enough to entice and keep nurses working in Ontario hospitals.

According to the Financial Accountability Office, which published a report on Ontario's health sector spending in February 2023, Ontario currently has the lowest wages for nurses in Canada:

> In 2012, wages for nurses in Ontario were fifth highest after Saskatchewan, Alberta, British Columbia, and Newfoundland and Labrador. However, Government of Ontario wage restraint policies over the last 10 years resulted in average wages for Ontario nurses in 2022 that were lower than in any other province:



Source: FAO based on Statistics Canada. Table 14-10-0340-01 Employee wages by occupation, annual.

The inescapable conclusion is that nurses in Ontario have fallen significantly behind their counterparts in other provinces, despite Ontario's higher cost of living. The decline in Ontario's competitive wage rates *vis a vis* other provinces has mirrored the decline of real wages for hospital nurses in Ontario, which began in 2012.

The result of this parallel decline is that Ontario is losing existing nurses to other provinces. Likewise, when new Ontario graduates enter the profession there is a considerable incentive to take their work out of province:

> An investigation by CTV News has found that Ontario's nurses are leaving the province's healthcare system in droves.
>
> …
>
> "A lot of people want to leave. I'm considering leaving too," says Josie, an ER nurse at the Pembroke Regional Hospital.
>
> "One of my good friends is actually getting ready to go out to Alberta in two weeks," she says. "She just took a contract out there for a travel (nursing) company. She's going to make more money than here and travel a little bit.
>
> "Why work here when I could go work in another province and make three times as much money?"

New nurses graduating in Ontario can look to other provinces offering higher wages and better working conditions. An April 22, 2023 article in the Toronto Star examined this issue:

> Samantha Bulchand is at a crossroads in her life.
>
> She'll be graduating from the U of T nursing school in June, and as she stands on the cusp of her career and scans the state of the profession, two things become abundantly clear.
>
> First: She and her classmates are very, very much in demand.
> …
>
> Second: Some places are swinging for the fences. They are much further along the path of providing attractive working environments for nurses, both new and mid-career, than others.
>
> And that means jurisdictions such as Ontario, that are currently seen as lagging, are going to have to step up their efforts or potentially see their nursing crises devolve into drawn-out battles of attrition, with workers in some cases seeking better options elsewhere.
>
> > 'No one really wants to put themselves in a position where they think that they'll struggle with burnout or anything like that," says Bulchand, 25, currently finishing up a placement at Mount Sinai Hospital in Toronto. "And the world of

> nursing is really great in the sense that we can really work anywhere. And a lot of the hospitals and outpatient clinics are really in need.'

The fact that Ontario is losing nurses to other provinces means the terms and conditions of employment for hospital nurses in other provinces are highly relevant.

The government of Ontario knows this and, consequently, has begun offering recruitment incentives, such as the Community Commitment Program for Nurses. The Program offers a $25,000 cash incentive in exchange for a two-year commitment from nurses, who have not been employed as a nurse in Ontario in the last six months, to take up a nursing position in Ontario.

Given that the Employer is clearly competing with other provinces for the same workers, the terms and conditions of employment of those other workers are highly relevant.

The Union's rationales for its outstanding bargaining proposals draw from the following (mostly central) collective agreements between nurses' unions in other provinces and their employers:

Province	Relevant Comparator Groups
Alberta	United Nurses of Alberta and Alberta Health Services
Saskatchewan	Saskatchewan Union of Nurses and Saskatchewan Association of Health Organizations Inc.
British Columbia	Nurses' Bargaining Association and Health Employers Association of BC
New Brunswick	New Brunswick Nurses' Union and Treasury Board Group: Nurses, Part III
PEI	Prince Edward Island Nurses' Union and Health PEI
Newfoundland and Labrador	Registered Nurses' Union Newfoundland and Labrador and Treasury Board
Nova Scotia	Nova Scotia Council of Nursing Unions and Nova Scotia Health Authority*
Manitoba	Manitoba Nurses Union and Shared Health Employers Organization*

*Agreements in Manitoba and Nova Scotia vary by region (i.e., no defined central agreement)

Agency Nurses & Private Hospital Nurses in Ontario

The relevant labour market for RNs and NPs in Ontario includes the private labour market. At present, the private market is dominated by temporary employment agencies that are deploying nurses to hospitals at unprecedented rates.

The *HLDAA* is explicit that interest arbitration boards must compare employees with comparable employees in the private sector:

> 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.

This is not a concept that is unique to HLDAA. In *Association of Law Officers of the Crown* (2000), an interest arbitration board found that government lawyers' salaries "should be substantially increased to redress or reduce a significant and growing salary disparity with their private sector counterparts." The board found that one of the reasons that lawyers working in the private sector were relevant comparators to crown attorneys was that law is a highly regulated profession, requiring identical training and qualifications across the public and private sectors:

> [G]iven the identical training and qualifications—the same duties and responsibilities—we are of the view that Ontario private sector lawyers' salaries are a relevant consideration and are useful to the determination of the salaries of Ontario public sector lawyers' salaries. Whether working for the people of the province or for private sector clients, the professional profile for both groups is the same, as are the governing professional obligations"

Clearly, the terms and conditions of employment of identical professionals should be compared. This is the case even when there is no demonstrable retention issue:

> Market conditions for lawyers are relevant, and while attrition among Association members is not great, it is appropriate to compare lawyers with lawyers.

The Union submits that just as it is appropriate to compare lawyers with lawyers, it is equally appropriate to compare nurses with nurses.

Like public and private lawyers in Ontario, public and private nurses in Ontario receive identical training, have identical qualifications, have the same duties and responsibilities, have the same professional profile, and are governed by the same professional obligations and regulatory body. In short, there is no better comparator than the same professional, doing the same job.

In the case of nurses, the comparison can be taken one step further. The private sector nurses in this case (i.e. agency nurses) are doing the same job, with the same qualifications, at the same location as their public sector counterparts. In some cases, it is not only the same job and the same location—it is the same person doing the job. This is because public sector nurses are resigning from hospitals at an unprecedented rate, and at least some of those nurses are migrating to agencies. Agencies are competing with the Hospitals to attract the same workers. The OHA has noted "aggressive recruitment efforts by staffing agencies." These include reports that:

> Some health care workers are purportedly quitting their full-time jobs only to turn around and be hired by agencies and then deployed to work at the very same workplace/positions where they were originally employed. Given the competitive environment to recruit talent, agencies are reportedly paying agency nurses two times their salary and are charging hospitals as high as $1,000 a day for select nurses during high vacancy periods."

One former public sector ICU nurse in Toronto described this very scenario. The nurse explained that "she and at least two other nurses from her ICU quit for agency work in the spring. She said she now gets paid nearly double what she used to make at UHN, sometimes while literally working the same job — her very first shift as an agency nurse was at her old ICU at Toronto Western."

The migration of public nurses to private agencies is evidence that nurses are willing to keep working in hospitals when they are offered higher wages, despite widespread professional burnout. The wages that agencies are offering RNs, to do

the same work, in the same working environment, is a strong indication of what the "going rate" for a hospital nurse in the free market might be:

> Guidance must be sought from the market existing in the community in which the relationship exists and the work is performed if a fair resolution to the dispute is to be achieved. The position of the union must prevail in this dispute because it reflects the standard existing in like relationships with respect to similar work, not because of anything intrinsic to the union submission that makes it attractive in an assessment of the two bargaining postures. The strength of the union position is that it reflects the going rate.

For all of these reasons, agency nurses in Ontario are a valid comparator group for the purpose of replicating free bargaining between the parties. To be clear, the Union's proposals will not bring public sector nurse wages anywhere near to parity with their private sector counterparts. However, as in *Association of Law Officers of the Crown*, the Union's proposals will move compensation for hospital nurses closer to the more competitive compensation standards in the private sector.

For the same reasons, the Union submits that nurses working in private hospitals/facilities are a relevant comparator group. Once again, the comparison is direct: nurses to nurses. Once again, you have the same professional, doing the same job. As noted above, the vast majority of RN and NPs working in Ontario are working in public hospitals. However, private hospitals and health facilities, although rare, do exist. The terms and conditions of employment for nurses at these hospitals and facilities provide another data point of what the same professionals are receiving in the private sector for the same work. In these submissions, the Union will direct the Board to private sector counterparts, represented by ONA, at Shouldice Hospital.

Other Frontline Professional Groups in Ontario

In addition to comparing nurses with nurses, the Union submits that it is relevant to compare nurses with other frontline professional groups in Ontario.

Police and firefighters are similar employees doing similar work to hospital nurses. All three groups consist of front-line professionals providing uninterrupted essential services to the community. For the last 10 years, the Employer has disputed the relevance of police and firefighters as comparator groups. However, at one time—when the RN wage grid exceeded the police and firefighter wage grids—the Employer viewed police and firefighters as relevant comparators. In 2005, the Employer made the following submissions before the interest arbitration board chaired by Arbitrator Keller (the "Keller Board"):

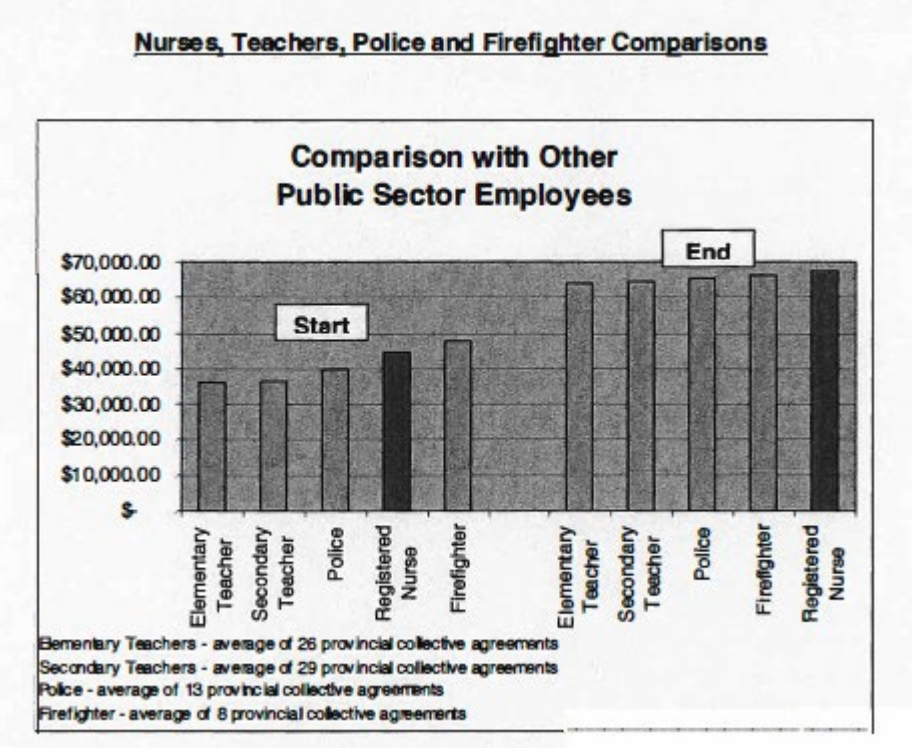
> The Hospitals suggest that it is relevant to look at nurses' wages in comparison to other public sector professionals such as teachers, police and firefighters. While it is

extremely difficult to assess and compare these groups in detail, all of these professionals perform vitally important functions in society. Their relative worth to the community cannot really be measured.

Chairman Weiler in his arbitration for SEIU and 46 Hospitals dealt with the question of a proper comparison for salaries in an arbitration setting when he stated:

> 'In the final analysis, Ontario hospital workers are entitled to compensation which is equitably related to what other Ontario workers (and taxpayers) earn. Appropriate guidelines for the hospital sector as a whole must be drawn from free collective bargaining conducted outside the shadow of binding arbitration (whether for hospital workers, policemen, firefighters or what have you).'

The Employer went on to provide graphs and tables illustrating that RNs were competitively remunerated when compared to teachers, police, and firefighters. At the time, the top rate for RNs exceeded every other professional group and offered the highest entry level salaries, with the exception of firefighters:



Numerical Data

	Start	End
Elementary Teacher*	$35,950.96	$64,055.15
Secondary Teacher*	$36,423.62	$64,417.34
Police	$39,971.77	$65,182.46
Registered Nurse	$44,851.95	$67,457.81
Firefighter	$47,667.63	$66,308.38

*Note: Teacher's Salaries use the start of the A or A1 range (Teacher without a degree) and the end of the B or A2 range (Teacher with a Bachelor's degree).

ONA submits that these occupational groups continue to represent valid public sector comparators. The only thing that has changed since the Employer last argued that teachers, police, and firefighters were relevant comparators is that the wages of police and firefighters have, over the course of the last decade, surpassed nurse salaries.

Nurses in the US and the UK

In addition to the above comparator groups, the working conditions of nurses in the US and the UK are relevant. The global reach of the COVID-19 pandemic has created an international community of nurses experiencing similar issues on both sides of the Atlantic. Burnout, a lack of respect in the form of unfair wages, and heavy turnover have led to sea changes in jurisdictions where nurses retain the right to strike. Not only do these jurisdictions offer insight into the conditions under which nurses would strike in a "free-bargaining scenario", the improvements to the terms and conditions of employment for nurses in these jurisdictions is a lure for Canadian nurses seeking better options than Ontario hospitals offer.

The issues experienced by nurses in Ontario—high rates of burnout and leaving the profession—are not unique to Ontario. While nurses in other jurisdictions are not, strictly speaking, comparators, it is important to situate Ontario nurses in their global context.

A global study of nurses in 2020 showed that nurses have "high burnout symptoms prevalence warranting attention". This analysis was concluded shortly before the COVID-19 pandemic which, as numerous other studies have shown, has only exacerbated nurse burnout. One significant study found that, globally, "[m]ore than a quarter of healthcare workforce who served during the COVID-19 pandemic

developed mental health problems", with PTSD being the most common mental health disorder followed by anxiety, depression, and distress.

An April 2023 study on nurse burnout and stress has shown that, in the United States alone, approximately 100,000 nurses left the workforce during the pandemic.

Just as the pandemic has had similar effects on the mental health of nurses worldwide, so too has inflation caused financial stress on nurses around the world.

Crucially, in jurisdictions where nurses have the right to strike, they have achieved contracts with significant gains in recent months. For example, National Health Service ("NHS") workers recently rejected an offer of a 5% salary increase. The membership voted, instead, to go on all-out strike, including emergency departments, intensive care units, and cancer care units.

In October 2022, the Governor of New York announced a 4.5% increase for RNs in state agencies, increasing the starting salaries from $90,000 to $108,000, depending on location. In January 2023, nurses who went on strike at two major New York City hospitals ratified contracts that included salary increases of 19% over three years, a commitment to hire more nurses, and new provisions to enforce staffing levels.

The New York situation is of particular relevance because New York has a streamlined process for the recognition of Canadian RN licenses. Data shows that, over the last five years, the number of nurses going to the United States has doubled:

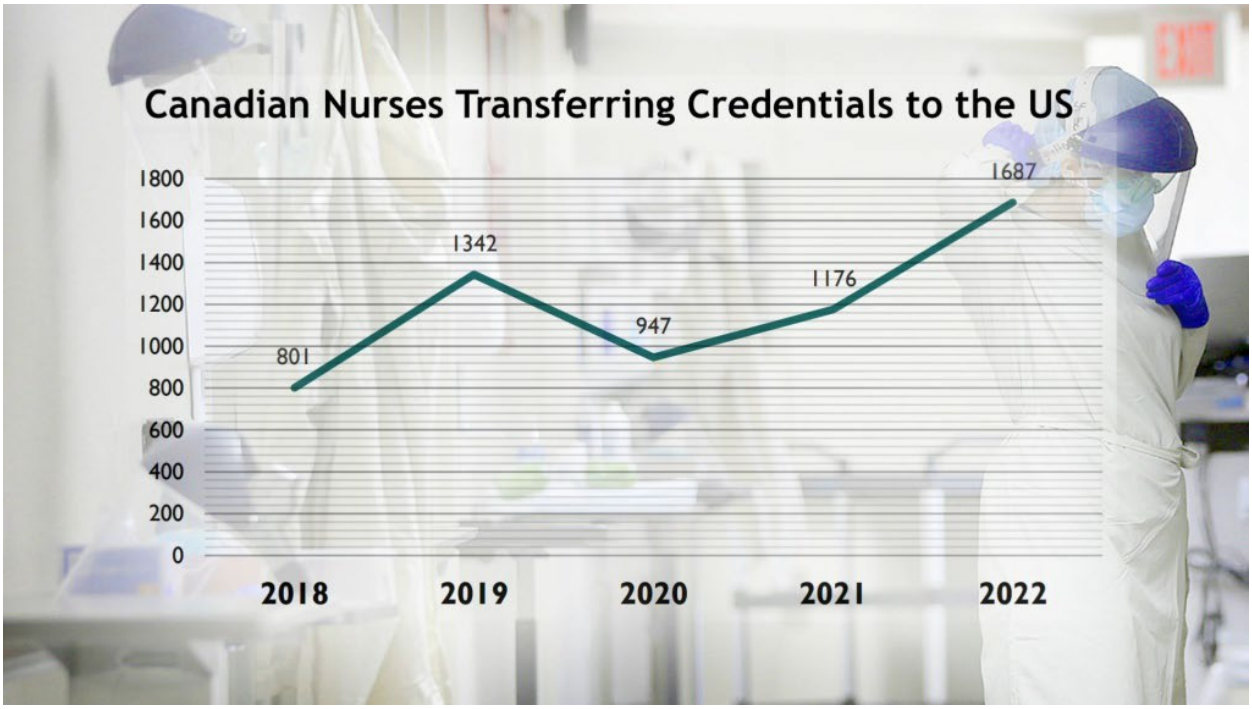


Image: Commission on Graduates of Foreign Nursing School,

In October 2022, the Michigan Nurses Association ratified a new deal with the University of Michigan Health that includes 22.5% wage increases over the life of the contract. The nurses will receive 7.5% in 2022, 6% in 2023, 5% in 2024, and 4% in 2025. These wage increases are in addition to a $5000 ratification bonus and a $2000 retention bonus.

The wage improvements in Michigan (Ann Arbour) are important because Canadian nurses routinely cross the border to take up positions in Detroit and its surrounding areas:

> An estimated 1,600 nurses who live in Essex County work in Michigan, and hospitals in Detroit make it with worth the daily border crossing with hefty wages and big bonuses.
>
> The Henry Ford Health System, one of several Detroit hospital organizations, currently offers up to US $15,000 in bonuses. It's planning a recruitment event Sept. 1 at the Ciociaro Club.
>
> "We need to compete with Detroit handing out bonuses," said Windsor Regional Hospital CEO David Musyj. "So we're maybe a little unique compared to other jurisdictions."

Clearly, the global situation is not just relevant to these proceedings as a matter of academic interest, but Canadian nurses are simply choosing, in the face of lower wages, to work in other jurisdictions.

Other Ontario Hospital Sector Groups are Weak Comparators

The Employer commonly looks to service/clerical bargaining units represented by SEIU and CUPE as relevant comparators within the hospital sector. The Union disputes the relevance of these groups.

The *HLDAA* clearly instructs boards of arbitration to consider comparable employees, not comparable employers. Comparability is not determined by looking at bargaining units doing different work for the same employer. A group becomes a comparator if they are similar employees, doing similar work.

While the groups represented by SEIU and CUPE include workers for the same employer, they are not similar workers doing similar work. Despite this crucial distinction, central bargaining for nurses has been artificially restrained by comparing RNs and NPs to different workers doing different work.

If nurses and other hospital workers represented by SEIU and CUPE are "similar employees doing similar work" there would be an argument for wage parity for all hospital workers. The reason why wage parity does not exist across these disparate groups is that these groups represent different employees doing different work, albeit for the same employer. At best, these groups must be regarded as weak comparators and given little evidentiary weight.

THE ECONOMIC SITUATION IN ONTARIO

"The economic situation in Ontario and in the municipality where the hospital is located."

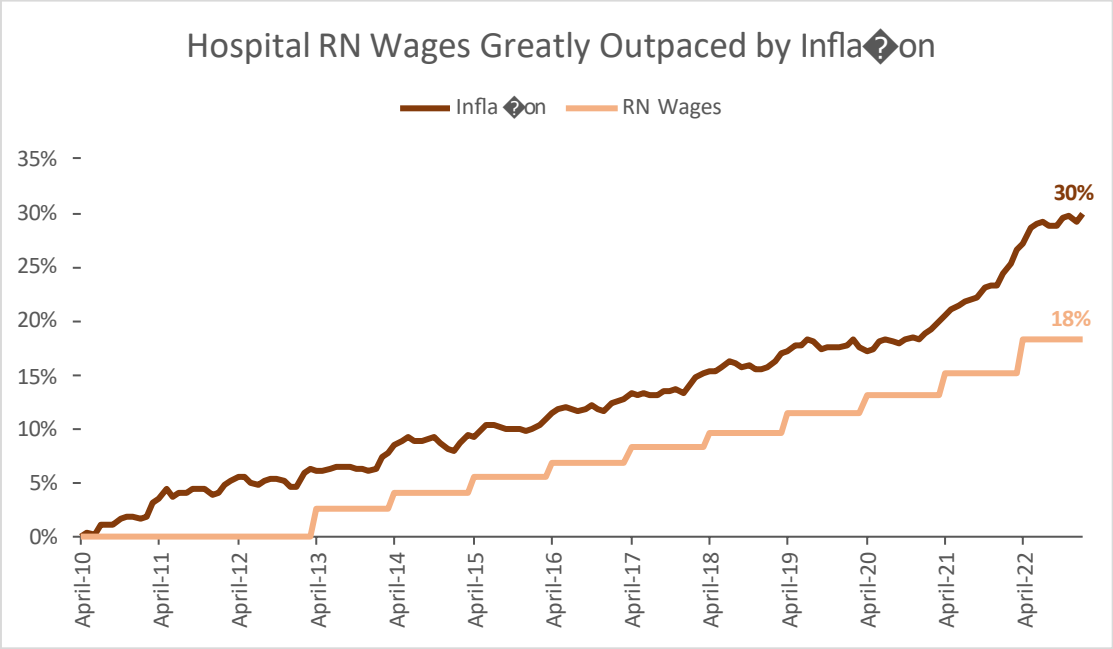
Inflation

Inflation, and associated cost of living increases, are highly relevant in establishing a demonstrated need for wage "catch-up". In *Association of Law Officers of the Crown v Ontario*, the rising cost of living, and an accompanying decline in real wages, was evidence in support of a wage catch-up award of 7.5% in year one of the agreement and 22.5% (total) in year two of the agreement:

> In addition, and further justifying a substantial increase, when both private sector and public sector settlements are considered as a whole, the conclusion is inescapable that lawyers represented by the Associations have, in recent years, fallen significantly behind. Any doubt about that is put to rest in reviewing accepted economic indicators. The absence of any real improvements to wages for government lawyers since 1991 has been accompanied by actual and substantial

losses in spending power due to significant increases in the cost of living, to refer to just one such indicator supporting an increase (and there are others).

Hospital nurses in Ontario, in 2023, now find themselves in a very similar situation to crown attorneys in 2000. As illustrated below, prior to 2010, annual wage increases for nurses exceeded the rate of inflation. From 2011 to 2022, inflation has outpaced increases to public hospital nurse salaries in every year:

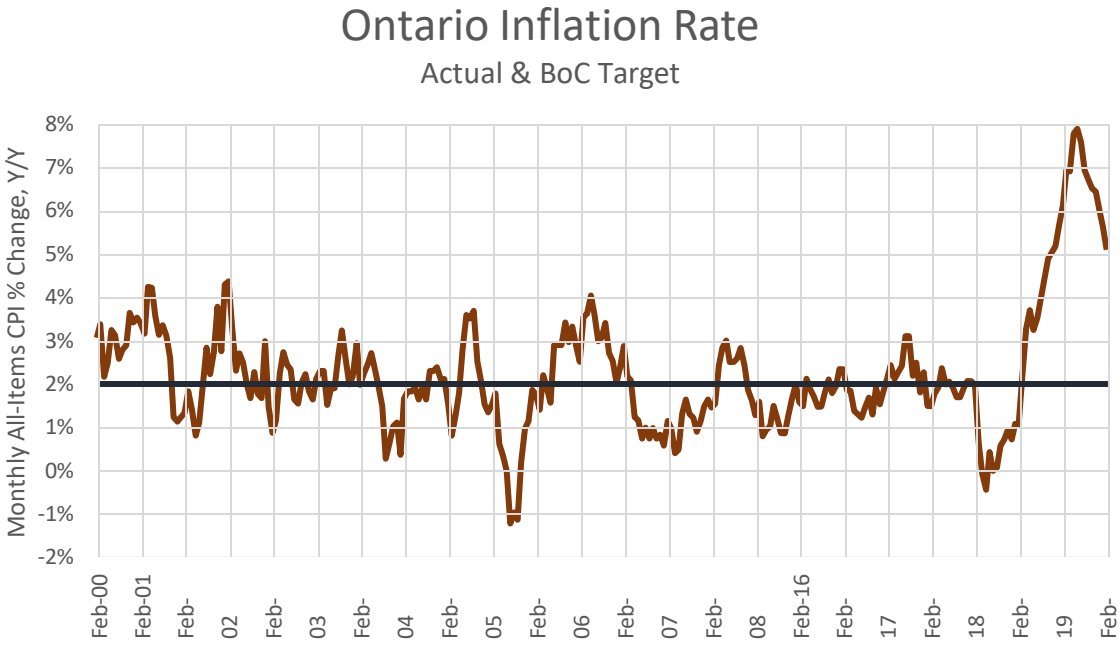


The result has been a decade of decline in real wages.

In the last year, the real value of RN wages has only worsened. In June 2022, Ontario's year-over-year inflation rate peaked at 7.9%. June's figure was the highest recorded in forty years and spurred a series of aggressive interest rate hikes by the Bank of Canada. Although the inflation rate has fallen in subsequent months, inflation remains significantly above the Bank of Canada's target rate of 2%. The year-over-year inflation rate in February 2023 was 5.1%.

The provincial government now anticipates an inflation rate of 3.6% in 2023, up from the 2.5% it had projected in the 2022 budget. The two major banks that provide public forecasting of provincial inflation rates, both expect the inflation rate

in 2023 to be higher. Scotiabank forecasts a 4.2% inflation rate in 2023, and BMO Capital Markets anticipates inflation of 4.1%.



Provincial Revenues

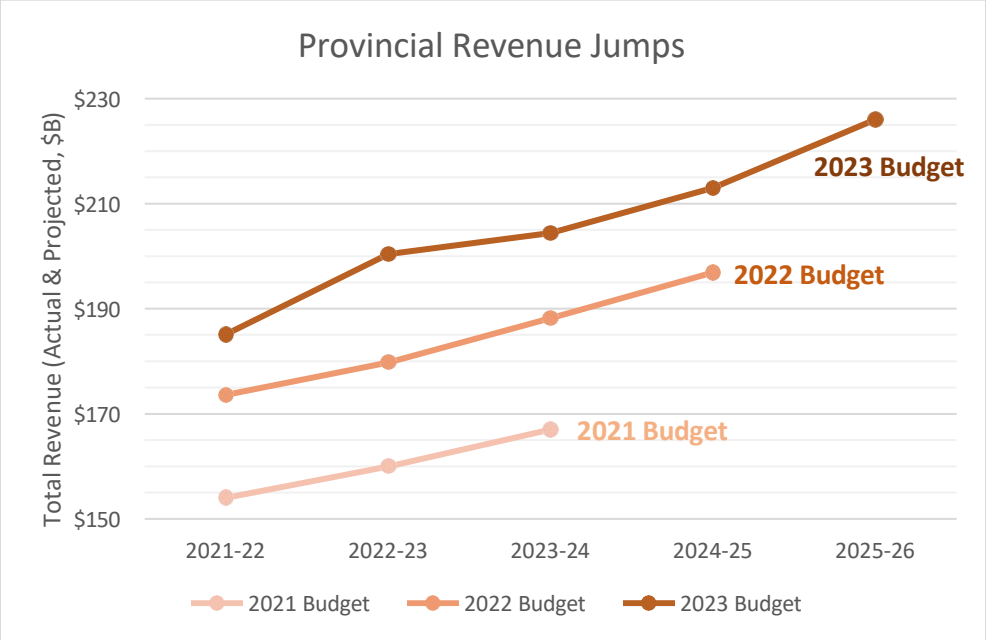
Revenues flowing to the provincial government have ballooned over recent years. In the last fiscal year (2021-22), total revenues were $31.1 billion higher than anticipated in the 2021 budget—a remarkable 20% boost. In fact, despite the 2021-2022 fiscal year having ended more than 100 days prior to its release, actual revenues for that year were $11.5 billion higher than what was anticipated in the 2022 budget.

For the current fiscal year, the 2023 budget projects total revenue to be $204.4 billion. That is $16.2 billion more than expected in the 2022 budget, and $37.4 billion—or 22% more than in the 2021 budget.

The 2023 budget projects the revenue increases to continue, with revenue growth of 4.2% in 2024-25 and 6.1% in 2025-26.

Incredibly, these massive jumps in provincial revenues have transpired despite the government's own attempts to aggressively lower revenues. Analysis by the Canadian Centre for Policy Alternatives[130] shows that, since passing their first

budget document in November 2018, the Conservative government has erased $8.2 billion in annual revenue for 2022-23. That figure is set to increase to $8.5 billion for 2023-24, as the recently passed 2023 budget contained another $295 million in tax cuts for this fiscal year.



Expenses have not followed suit. As laid out in the 2023 budget, both total expenses and program expenses for 2023-24 are only slightly higher than previously expected - $5.6 & $5.8 billion, respectively, higher than in previous budget.

In other words, the province is flush with cash, including an additional $4.4 billion in federal health funding over the next three fiscal years. How the province chooses to spend that money, is simply a question of priorities.

THE EXTENT TO WHICH SERVICES MAY HAVE TO BE REDUCED

"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."

The overwhelming evidence is that hospital services have already been reduced for reasons that have nothing to do with funding and taxation levels. Services have been reduced because the Employer cannot attract and retain the staff that are essential to providing the service. According to the OHA:

> There are simply not enough licensed health care providers in the system – nurses, doctors, medical lab techs, etc. – to continue to provide the level of service that has been provided to date. For nursing specifically, the shortage is being amplified by the incentive to work as an agency nurse.

The OHA's comments are telling. While there is a shortage "in the system" (i.e., a lack of internal supply), there is an external supply (i.e. agencies) that are not only supplying workers to maintain services, but are poaching workers from within the system. The Union's proposals specifically address the retention and recruitment problem by encouraging a more sustainable allocation of the resources that are already in the system. Consequently, awarding the Union's proposals will result in an expansion of services, not a reduction.

ABILITY TO PAY

"The employer's ability to pay in light of its fiscal situation."

The OHA, while not explicitly making an "inability to pay" argument, will no doubt argue that budgetary constraints support its own monetary proposals. This argument has no more relevance today that it did in 1976 when Arbitrator Shime observed that public sector workers should not bear the responsibility of subsidizing essential services by accepting substandard wages:

> In the public sector...the employer, as the government, is required to provide services to the community it is elected to represent and these services cannot be evaluated on a balance sheet or profit and loss statement in the same manner as a private sector company. Indeed many services, to name a few - the distribution of pension and welfare cheques, the providing of hospital or firefighting services, the supervision of health and sanitation can neither be considered nor assessed in the same manner as a private business. Also, there are many public sector activities that operate at a loss, but are considered necessary for the vital operation and well-being of the community. […] [E]ach member of the community should bear his or her share of the required public service without the necessity of the employees bearing the unfair burden of substandard wages or working conditions.
>
> In sum, I determine that on balance, if the community needs and demands the public service, then the members of the community must bear the necessary cost to provide fair and equitable wages and not expect the employees to subsidize the service by accepting substandard wages.

This sentiment was echoed two years later in an interest arbitration concerning public health nurse represented by ONA. In that case, the interest arbitration board observed that:

> In the *Wellesley Hospital* award Chairman Burkett noted that, while equity is determined by the parties in free collective bargaining, in compulsory interest arbitrations, equity must flow from 'community compensation standards'. He took the view, amply supported by authority, that <u>if the taxpaying public, through the legislation, determines that it requires an uninterrupted service then it must be prepared to pay those who provide the service commensurate with community standards</u>.

The province has signaled its willingness to do what the market demands to retain and bring in more nurses. In August 2022, the Premier declared: "[H]e's throwing 'everything and the kitchen sink' at the [nurse shortage] problem."

The Employer has demonstrated an ability to pay private agency nurses for an unprecedented number of hours at double, triple, and quadruple the hourly rate of a staff nurse. It has also demonstrated an ability to pay overtime rates well above the current rate in the collective agreement.

The Employer also had the ability to increase the wages of its top executives by an average of 9% over the last two recorded years. The salaries of OHA executives also rose significantly during the same time period. In 2022, one OHA executive received a 22% raise. Another received a 14.3% raise. Presumably these executives perform important work and find it reassuring to have their service recognized with fair wages.

The point to be made is not that hospital and OHA executives are comparable to nurses; rather, that failure to bring nurses into hospitals and keep nurses in hospitals, by paying them more, is not a question of lack of funds, it is a question of how those funds are being allocated. The Employer's wage proposals will not boost permanent staffing. It is a proposal that will keep wages and working conditions stagnant. The evidence overwhelmingly suggests that the status quo is no longer supportable.

OTHER CRITERIA

GRADUALISM & DEMONSTRATED NEED

An accepted principle of interest arbitration—typically cited by the Employer—that there should be no major breakthroughs or gains through interest arbitration without a demonstrated need.

First, the Union's proposals this round, if fully awarded, would not amount to any "breakthroughs". The Union's proposals this round are the minimum that is required—after over a decade of wage decline—for nurses in Ontario to catch up with their private sector counterparts and colleagues in other provinces.

Second, it is hard to envision how the demonstrated need could be any greater than it is in this round of bargaining. The system is in crisis and nurses are carrying the human cost of that crisis.

While the OHA has declared, unequivocally, that it "needs to establish innovative and aggressive ways to enhance supply," its member hospitals are touting recruitment and retention efforts that include raffles, hospital swag, walking groups, visits by therapy dogs, staff BBQs, celebrations for long-service employees, mini-manicures, mini-massages, and free snacks.

At this point, it is abundantly clear that the ice cream sandwiches, therapy dogs, and mini-manicures are not working.

It is time for the Employer to acknowledge that significant adjustments and catch-up wages are required to reverse the nursing crisis and ensure future sustainability.

It is time to give nurses the wages, premiums, and supplementary benefits that the free market has demonstrated they are worth.

It is time to give hospital nurses their dignity back.

The remainder of the Union's Brief will address specific rationales for each of its outstanding proposals, beginning with wages.

2. WAGES

[RN WAGES]

UNION PROPOSAL

***Revised* Wage Grid**

- Eliminate Non-Competitive "Start" and "1 Year"
- Re-name Grid "Step 1" to "Step 7"
- 12.0% ATB: April 1, 2023
- 6.0% ATB: April 1, 2024

Classification – Registered Nurse			
	1-Apr-22 (expired)	**1-Apr-23 (12.0%)**	**1-Apr-24 (6.0%)**
~~Start~~	$35.52	~~$35.52~~	--
~~1 Year~~	$35.69	~~$35.69~~	--
Step 1 ~~2 Years~~	$36.28	**$40.63**	**$43.07**
Step 2 ~~3 Years~~	$38.07	**$42.64**	**$45.20**
Step 3 ~~4 Years~~	$39.87	**$44.65**	**$47.33**
Step 4 ~~5 Years~~	$42.12	**$47.17**	**$50.00**
Step 5 ~~6 Years~~	$44.39	**$49.72**	**$52.70**
Step 6 ~~7 Years~~	$46.65	**$52.25**	**$55.39**
Step 7 ~~8 Years~~	$50.85	**$56.95**	**$60.37**

***NEW* Long-Term Service Entitlements**

An employee with **14 years' experience** will receive an additional **2**% added to their **straight time** hourly rate.

An employee with **21 years' experience** will receive an additional **4**% added to their **straight time** hourly rate.

An employee with **28 years' experience** will receive an additional **6**% added to their **straight time** hourly rate.

EMPLOYER POSITION

- Opposed

RATIONALE FOR UNION PROPOSAL

The Union submits that its RN wage proposal replicates what the parties would have agreed to if the parties had the ability to resort to a strike or lockout.

Since 2010, nurses have seen the real value of their salaries steadily erode. Recent events—the COVID-19 pandemic, Bill 124, and high inflation—have turned the stagnation of RN wages from a persisting concern to a crisis. By offering the worst salaries in Canada, Ontario hospitals are struggling to attract and retain RNs. Instead, millions of dollars that could be directed towards a permanent and stable workforce are being spent on a parallel workforce: agency nurses.

That nurses are angry with the terms and conditions of their employment—and their wages in particular—should come as no surprise. In April 2021, in the midst of Bill 124, the interest arbitration Board chaired by Arbitrator Gedalof spotted the gathering storm:

> What we wish to acknowledge by way of context, however, is that the intersection of Bill 124 with the ongoing pandemic and all of the strains it entails has created a collective bargaining environment in which nurses feel particularly aggrieved.

"Aggrieved" is an understatement.

Between 2020 and 2022, while nurses were being lauded as health care heroes, the government removed their right to freely bargain wages. Morale plummeted. A wave of resignations followed. For those nurses that have remained working in hospitals, exhaustion and burnout have increased. The Hospitals are scrambling to maintain base staffing levels. The OHA has documented that many nurses have reached the end of what they are willing to bear:

> 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.

Given the current collective bargaining context, the Union submits that in a free bargaining scenario its members would have settled for nothing less than the wage gains proposed by the Union in this round.

The weight of the evidence demonstrates that now is the time for a significant catch-up and a return to competitive RN wages in Ontario. Viewed in its totality, the objective data supports the Union's wage proposal.

The Union's RN wage proposal has three elements:

1) eliminate the non-competitive "Start" and "1 Year" Rates
2) increase rates across the board ("ATB"), and
3) add retention premiums at 14, 21, and 28 years of service.

The Union's proposal supports recruitment by improving early salary progression for entry level RNs. The proposal eliminated the bottom two rates and replaces them with a new "Step 1", resulting in a 7-step wage grid from "Step 1" to "Step 7". Concurrently, the Union proposes ATB increases for 2023 and 2024 as follows:

- 12.0%: April 1, 2023
- 6.0%: April 1, 2024

Lastly, the Union's proposal supports retention by adding Long-Term Service Entitlements in 2.0% increments at 14 years (2.0%), 21 years (4.0%), and 28 years (6.0%) of service.

Combined, the Union's wage proposal best addresses the demonstrated need to attract and retain RNs in the short and medium term.

THE THREE ELEMENTS

1. ELIMINATE NON-COMPETITIVE ENTRY-LEVEL RATES

The 7-Step Grid Addresses the Demonstrated Need to Recruit and Retain RNs

The need to attract and retain nurses in the province is urgent. The OHA has identified staffing shortages as the most pressing issue emerging from the COVID-19 pandemic.

The Union's 7-Step grid reflects what the Union would have achieved in free collective bargaining. As of April 1, 2022, the RN wage grid includes 9 steps, spanning 8 years. The Union's proposal will result in a grid with 7 steps, spanning 6 years. A compressed wage grid is neither a radical nor an unprecedented outcome between these parties. The Hospitals and the Union have a history of making similar grid adjustments over the last 40 years to address recruitment and retention issues.

In the current environment, the Hospitals are facing an unprecedented challenge attracting and retaining RNs. It is an aggressive problem that, according to the OHA, calls for aggressive solutions.

Competitive Entry-Level Wages Support Recruitment

The Union's 7-Step wage grid eliminates the two entry-level steps of the current grid. The Union submits that the elimination of these first two steps is consistent with the demonstrated need to recruit new nurses into the profession and to attract nurses from other jurisdictions.

In the midst of what is now a nurse labour shortage in Ontario, RN wages are the least competitive in the country. This lack of competitiveness is most evident at the entry level. In a recent Toronto Star article, entitled: "*Is this the most wanted worker in Canada? Why provinces are rolling out the red carpet for nurses*", one Ontario nursing student, on the cusp of graduating, observed:

> No one really wants to put themselves in a position where they think that they'll struggle with burnout or anything like that..[a]nd the world of nursing is really great

> in the sense that we can really work anywhere. And a lot of the hospitals and outpatient clinics are really in need.

The article notes that most provinces are offering tens of thousands of dollars to recruit new nurses. In the east, Nova Scotia has committed $10,000 to each nurse in the province as a "thank-you" and an additional $10,000 for a 2-year commitment. In British Columbia, the province has begun implementing mandatory nurse-to-patient ratios to improve working conditions.

At present, Ontario is being outmatched by other provinces in terms of both start rates and incentives. Eliminating the first two entry rates is the first step that must be taken to support recruitment efforts in Ontario.

Both parties understand that eliminating the entry-level steps will help attract new graduates. In the 2004-2006 round of bargaining, the Hospitals proposed to eliminate the first two entry-level rates, with the following rationale:

> The Hospitals are proposing that the start rate and the first year rate be eliminated from the grid, in order to shorten the length of time that it takes a nurse to progress through the grid, and to provide for a more competitive start rate for new nurses coming into the system.
>
> The Hospitals believe that a more competitive start rate may assist in encouraging more young people in Ontario to choose nursing as a career and will encourage Ontario grads to stay in Ontario. These measures are necessary to deal with the expected shortages that will be the result of the expected increase in nurse retirements. At the expiry of the collective agreement, Ontario ranked sixth amongst all of the provinces in terms of start rate; the elimination of the first two steps will improve Ontario's ranking to third.

While Ontario is competing with other provinces for new recruits, it is still offering some of the lowest entry level wages in the country. As the Hospitals' noted in 2004, Ontario ranked sixth amongst the provinces in terms of start rate. As of April 1, 2022, Ontario ranks, at best, seventh amongst all the provinces for entry level wages. Ontario is not even in the ballpark of the top five rates. There is an 8.3% difference between the start rate in Manitoba and Ontario's start rate. The rate in Nova Scotia almost exceeded Ontario's 2022 rate in 2020:

Rank	Province	2022 Start Rate
1	Manitoba	$38.46
2	Alberta	$38.44
3	Saskatchewan	$37.82
4	British Columbia	$37.67
5	New Brunswick	$36.82
6	Nova Scotia	TBD ($35.21 in 2020)
7	Ontario	$35.52
8	PEI	TBD ($34.30 in 2020)
9	Newfoundland and Labrador	$33.64

The abysmal "Start" rate in Ontario is made even worse by the painfully slow progression up the first two steps of the grid. At present, there is only a 17-cent difference between the "Start" rate and the "1 Year" rate. New recruits receive a 0.48% raise after one year of service and a 1.65% raise after two years of service, for a total wage increase over three years of only 2.1%. Removing the first two steps on the grid would end what is currently a three-year micro-progression up the grid:

Step #	Step Title	Rate as of April 1, 2022	Gap b/w Steps	% Wage Adjustment b/w steps
1	Start	$35.52	--	--
2	1 Year	$35.69	1 Year	0.48%
3	2 Years	$36.28	1 Year	1.65%
4	3 Years	$38.07	1 Year	4.9%
5	4 Years	$39.87	1 Year	4.7%
6	5 Years	$42.12	1 Year	5.6%
7	6 Years	$44.39	1 Year	5.4%
8	7 Years	$46.65	1 Year	5.1%
9	8 Years	$50.85	1 Year	9.0%

The 2.1% progression in the first three years means that entry-level nurses, in addition to receiving one of the lowest start rates of any RN in Canada, experience no significant wage progression in their first years on the job. To put this into perspective: a nurse approaching 3 years of clinical experience in Ontario (2022) is still making less than a nurse on day one in Manitoba, Alberta, Saskatchewan, British Columbia, and New Brunswick.

Nurses in Ontario have identified slow wage progression as a reason for leaving the profession. According to one nurse at the ER in Pembroke Regional Hospital:

> "I've already looked into course to take me out of nursing completely," she says.

> "Going somewhere I can move up the ladder easier, make more money, and have more respect."

By removing the first two steps alone, the revised grid would offer meaningful year-to-year wage increases for entry-level nurses. Under the revised grid, an RN will progress up the grid by 4.9% after one year and 4.7% after two years, making the grid progression in Ontario comparable with grid progression in other provinces and incentivizing new recruits to stay within Ontario's hospital system. Eliminating the first two steps of the current wage grid will vastly improve wage progression for entry-level nurses. However, it will take much more to make entry-level wages in Ontario competitive with other provinces. The resulting wage increase at the entry level would only go up by 2.1%. Concurrent ATB wage increases make Ontario a leader, and not a follower, on entry level wages (see discussion on ATB increases, below).

Removal and Adjustment of the Entry-Level Steps have Precedents

The parties have a history of making significant adjustments to entry-level wages in both voluntary agreements and through arbitral awards.

a. 1998-2001 Collective Agreement

In 2000, the parties reached a voluntary agreement covering three years, from April 1, 1998 to March 31, 2001. In that agreement, the parties consented to remove the "Start" rate and move all existing employees up one level of the grid as of ratification (March 31, 2000). In addition to the wage grid compression, employees received an additional 2.5% wage increase the next day (April 1, 2000).

The 2000 voluntary agreement resulted in a 7.7% increase to the "Start" rate, a 12.2% increase to the "1 Year" rate, and a 7.6% increase to the "2 Years" rate. The average rate increase at every other step was 7.7%. By removing the existing "Start" rate, the grid moved from a 10-step grid to a 9-step grid.

b. 2006-2008 Collective Agreement

Six years later, an interest arbitration Board chaired by Arbitrator Albertyn (the "Albertyn Board (2006)") awarded another set of significant adjustments to the entry level rates. Like today, the Albertyn Board (2006) found that the Hospitals were facing a significant recruitment problem and awarded a 9.3% increase to the start rate and a 6.7% increase to the "1 Year" rate. The remaining steps were given 3.0% increases, with the exception of "8 Years", which received 3.25%.

In light of these precedents, the Union's current proposal to eliminate the first two steps of the grid is not a departure from adjustments that have been made in the past to address recruitment concerns.

Eliminating the Entry-Level Rates Promotes Retention

Meaningful wage progress in the first years of employment can improve morale and keep RNs in Hospitals. Currently, the percentage difference between the RN "Start" rate and the "8 Years" rate is 43.2%. Because RN salaries start off so low, and initially progress in such small increments, the climb to the top rate feels slow.

The Union's proposed grid will fix and stabilize the year-to-year wage progress between Step 1 and Step 6 at approximately 5.0% annually. The final step on the wage grid—achieved after six years—results in a 9.0% raise, which incentivizes retention:

Step #	1-April-23	% Wage Adjustment b/w steps
1	$40.63	N/A
2	$42.64	4.9%
3	$44.65	4.7%
4	$47.17	5.6%
5	$49.72	5.4%
6	$52.25	5.1%
7	$56.95	9.0%

2. RAISE RATES ACROSS THE BOARD

After the "Start" to "1 Year" steps are removed, what is left is a 7-step grid that will require concurrent ATB increases to achieve a grid that is competitive with relevant comparator grids:

Classification – Registered Nurse	
Step 1	$36.28
Step 2	$38.07
Step 3	$39.87
Step 4	$42.12
Step 5	$44.39
Step 6	$46.65
Step 7	$50.85

The Union proposes ATB increases of 12% (April 1, 2023) and 6% (April 1, 2024). The resulting grid would appear in the renewed collective agreement as follows:

Classification – Registered Nurse		
	1-Apr-23	**1-Apr-24**
Step 1	**$40.63**	**$43.07**
Step 2	**$42.64**	**$45.20**
Step 3	**$44.65**	**$47.33**
Step 4	**$47.17**	**$50.00**
Step 5	**$49.72**	**$52.70**
Step 6	**$52.25**	**$55.39**
Step 7	**$56.95**	**$60.37**

For the reasons outlined below, the Union submits that its ATB proposals represent what is necessary in the current context. The current "context" is dominated by:

i. A Decade of Declining Real Wages
ii. An Ongoing Staffing Crisis
iii. Non-Competitive Wages

i. A Decade of Decline in Real Wages: Demonstrated Need for "Catch-Up"

For the past 12 years, the real value of RN wages has declined. Given the current recruitment and retention problems, there is a demonstrated need for RN wages to catch up.

The parties have a long history of both voluntary agreements and awarded contracts. However, a decade ago, there was a notable change to the established pattern of ATB increases. From 1998 to 2010, both voluntary agreements and arbitral awards included ATB increases of more that 3.0%. Since 2010, there have been no voluntary agreements. Instead, ATB increases averaging less than 1.50% per year emerged in interest arbitration awards:

Date	% Increases	Voluntary Agreement or Award
April 1, 1998	2.0%	Voluntary Agreement
April 1, 1999	2.0%	Voluntary Agreement
April 1, 2000	2.5% and "Start" eliminated – all employees move up the grid with pay increases averaging of 7.7% at each step (average 3.9% per year ATB over 3 years)	Voluntary Agreement
April 1, 2001	3.0% "8 Years" increased by 4%	Voluntary Agreement
April 1, 2002	3.0% "8 Years" increased by 4%	Voluntary Agreement
April 1, 2003	3.2%	Voluntary Agreement
April 1, 2004	3.0%	Award (Keller)
April 1, 2005	3.0% "25 Years" added as of January 1, 2006 at 2.0% above "8 Years"	Award (Keller)
April 1, 2006	3.0%	Award (Albertyn)
April 1, 2007	Varied (Avg. 5.05%) "Start" increased by 9.3% "1 Year" increased by 6.7% "2-7 Years" increased by 3.0% "8 Years" increased by 3.25% "25 Years" increased by 3.0%	Award (Albertyn)
April 1, 2008	3.25%	Voluntary Agreement
April 1, 2009	3.0%	Voluntary Agreement
April 1, 2010	3.0%	Voluntary Agreement
April 1, 2011	0.0%	Award (Devlin) Public Sector Wage Freeze
April 1, 2012	0.0%	Award (Devlin) Public Sector Wage Freeze
April 1, 2013	2.75%	Award (Devlin)
April 1, 2014	1.4%	Award (Kaplan)
April 1, 2015	1.4%	Award (Kaplan)
April 1, 2016	1.4%	Award (Albertyn)
April 1, 2017	1.4 % (additional 32 cents to "Start" rate)	Award (Albertyn)
April 1, 2018	1.4%	Award (Kaplan)
April 1, 2019	1.75%	Award (Kaplan)
April 1, 2020	1.0% (additional 0.75% per Re-Opener)	Award (Stout) Wage Restraint Legislation
April 1, 2021	1.0% (additional 1.0% per Re-Opener)	Award (Stout) Wage Restraint Legislation
April 1, 2022	1.0%	Award (Gedalof)
	(additional 2.0% per Re-Opener)	Wage Restraint Legislation

As the chart above indicates, from 1998 to 2010, 3.0-3.25% annual wage increases were the standard for nurses, including the standard in voluntary agreements. In fact, the highest increases achieved by Ontario nurses in the last 25 years were through voluntary three-year agreements: average 3.9% (1998-2001), 3.0%, 3.0%, 3.2% (2001-2003), and 3.25%, 3.0%, 3.0% (2008-2010).

During the same 12-year period, there were two awarded contracts: 2004-2005 and 2006-2007. Both the awarded contracts included additional percentage increases above the normative 3.0-3.25% ATB. In 2004, the Keller Board found there was a legitimate recruitment and retention issue and added a "25 Years" step at 2% above the existing "8 Years" step, effective January 1, 2006. In 2007, the Albertyn Board (2006) found that retention and recruitment were still a problem and awarded a 9.3% increase to the "Start" rate and a 6.7% increase to the "1 Year" rate to address the ongoing nursing shortage. The "8 Years" step was increased by 3.25%, to support retention, and the remaining steps advanced by 3.0%.

Crucially, the regular and predicable ATB increases from 1998 to 2010 always outpaced ordinary inflation, which averaged 2.01% annually during the same period. In other words, year to year, nurses saw their real wages improve from 1998 to 2010.

At the time, both parties agreed that increases above the rate of inflation were consistent with the established pattern between the parties. In its 2004 Interest Arbitration Brief, the Employer confirmed that:

> Registered Nurse wages have historically outpaced inflation as report by the CPI no matter what time frame is examined…As is evident from the above, inflation has increased 13.2% from 1998 to 2003, whereas nurses' wages have increased by 20.3% at the start rate and 16.7% at the maximum rate. The CPI for 2005 is projected to increase by 2.1% and the Hospitals are proposing increases that will keep pace with inflation and provide for real gains beyond inflation.

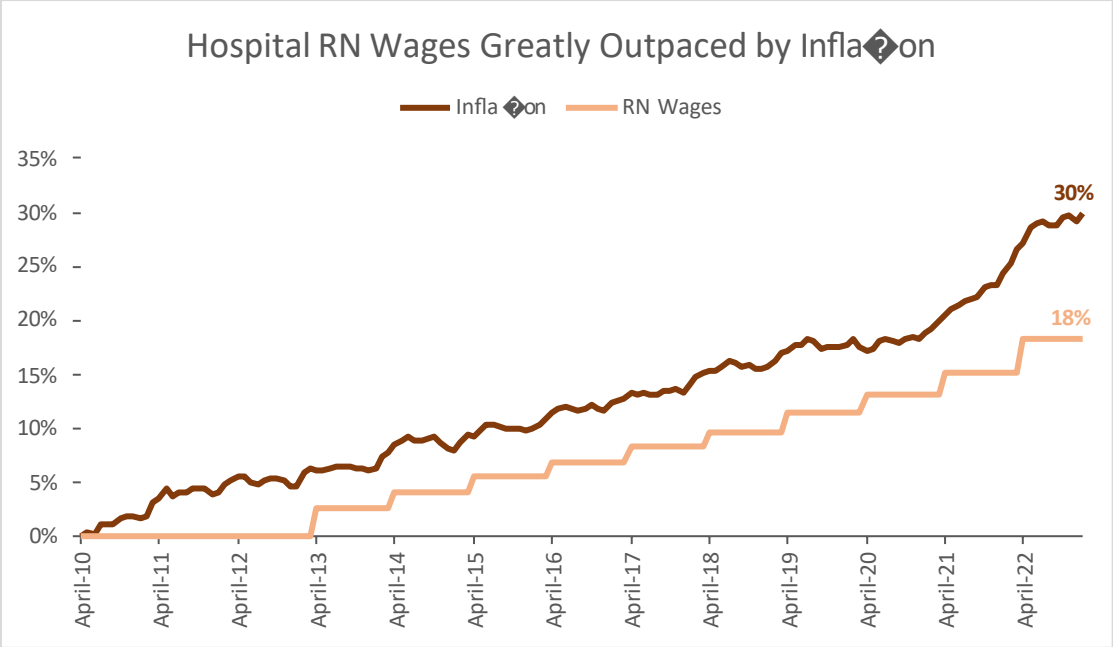
Despite the Employer's acknowledgement that nurse salaries have always kept pace with inflation, the pattern between the parties was significantly disrupted after 2010. In 2011, the Ontario government froze public sector wages and declared no additional funding for hospitals to cover wage increases. Although unionized workers, including nurses, were not directly subject to the freeze, the government declared its intention of seeking two years of zero wage increase through

bargaining. In 2011 and 2012, ATB increases were set by a Board chaired by Arbitrator Devlin at 0.0% and 0.0%.

Following the Devlin Board Award, the parties have never achieved a voluntary agreement. The pattern between the parties was abandoned by multiple interest arbitration boards. In arbitral decisions from 2011 forward, the ATBs awarded resulted in net decreases, not increases, to real wages.

The average ATB annual increase from 2010 to 2023 was 1.21%. The average annual rate of inflation was 2.26% for the same period. The contrast between salary increases and inflation was most stark in 2020-2022 when the average rate of inflation was 6.84% and salary increases were capped at 1.0% by Bill 124. Most recently, the 2020-2022 interest arbitration Board, chaired by Arbitrator Stout, increased the awards for 2020 to 1.75% and for 2021 to 2.0%, for a total increase of 3.75% over 2 years. Inflation increased by 6.84% for the same period. On April 25, 2023, the Gedalof Board released its Bill 124 Re-Opener award. The award increased the ATB on April 1, 2022 from 1.0% to 3.0%. The average rate of inflation in 2022 was 6.66%.

Overall, from 2010 to 2022, inflation increased by 30%, but nurses' wages have only increased by 18%



The conclusion is inescapable that nurses, over the last 12 years, have fallen significantly behind.

The context in which the Union and the Employer entered this round of bargaining is one in which RNs have experienced a decade of significant decline in real wages. Simultaneously, wage rates for RNs in other provinces have outstripped those in Ontario, to the point where Ontario now has the worst RN wages of any province. Nurses working through private sector agencies are being offered double the wage rate of a staff position, plus added perks. There is a demonstrated need to catch up.

ii. *Recruitment and Retention: Addressing the Staffing Crisis through Fair Wages*

Despite repeated assertions by the Employer over the years that nursing shortages were at an end, in the last decade—coinciding with the RN wage decline—Ontario

hospitals have remained precariously staffed in accordance with what the OHA euphemistically refers to as the "efficient staffing model". According to the OHA, its stakeholders, which include the participating hospitals, have observed that:

> For over a decade, Ontario's efficient yet over-stretched hospital system has been striving to keep pace with the growing demands of an aging population with multiple co-morbidities and limited year-over-year financial increases.

The Employer is now experiencing the fallout of ten years of depreciating RN wages, combined with a precarious staffing model, in the form of a critical labour supply shortage.[181] This challenge is heightened by the fact that RNs have other viable job options and are exercising those options by leaving the hospital system. The OHA know this. It has correctly noted that, "[t]he continual need to fill the increased number of vacancies is a challenge…this is occurring within a competitive labour market."

At this point, any claim that low wages are not a contributing factor to the RN labour shortages in Ontario would be disingenuous. In its 2014 Interest Arbitration Brief, the OHA quoted extensively from economist Morley Gunderson's paper for the Ontario Economic Council entitled, "Economic Aspects of Interest Arbitration". The paper—as quoted by the OHA—identifies economic indicators of excessively low wages as follows:

> *A guide can be found in the basic principles of economics, which suggest that arbitrators can use measures of disequilibrium on the quantity side as a proxy for disequilibrium on the wage side. That is, wage rates that are too high, relative to their private-sector counterparts or for the requirements of the jobs, result in excess supplies of workers for those jobs. Conversely, wage rates that are too low result in shortages of workers. Provided any such disequilibrium can be quantified and measured, an arbitrator can use it as a criterion for a settlement.*
>
> *Such disequilibrium quantity measurements can be obtained with relative ease. One measure of supply is the number of applicants relative to the number of jobs. Another is the quit rates (a measure that has the advantage of counting only workers who have been judged qualified to do the relevant jobs). Indirect evidence of disequilibrium also exists. When above-market wages result in an excess supply of labour, job rationing is likely; it may be manifested in discrimination, nepotism, high union or professional dues, and unnecessary job requirements. Signals of excessively low wages include high rates of absenteeism and tardiness and other manifestations of low morale. Any or all of these phenomena can be used by an arbitrator as a signal of disequilibrium and those that are measurable can serve as a criterion for settlement.*

The "measures of disequilibrium" identified by Gunderson such as quit rate, absenteeism, and low morale, are all present in the current labour market. In February 2022, the OHA noted that:

> 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.

Further:

> Bill 124…has been raised as a significant concern impacting health care worker morale and potentially one of several factors leading to health care worker recruitment and retention challenges.

In addition to reports by the OHA's own members, there have been a number of reports in the media over the last year confirming that morale amongst hospital RNs is low and RNs are leaving the Employer's ranks.

In November 2022, an emergency room physician in Perth explained:

> 'We've got governments promoting the idea that people can take off their masks and have a good time. We have now a documented reduction in people getting booster shots for COVID, and we still have hospital capacity that is way beyond safe, and staff morale is low,' he said. 'So it's going to be a coming s---storm in the next couple of months unless we address it.'

The CEO of the Kemptville District Hospital noted, in September 2022, that:

> labour shortages are the result of a combination of staff calling in sick due to COVID-19 and other viruses, staff finally taking vacation that they deferred during the worst of the pandemic, and nurses retiring or leaving the profession for quality-of-life reasons. "Nurses that remain in the system are fatigued … they're burned out from pandemic care. They're not up to taking extra shifts," said Vassallo, noting that his hospital currently has 15 Registered Nurse (RN) positions vacant, representing a 37.5 per cent vacancy rate.

One ICU RN in Toronto, who left her staff position to become an agency nurse, noted that in April 2022 she was feeling burnt out and disrespected. The government's refusal to repeal Bill 124 felt like a "slap in the face." In her own words:

> Morale was low…[i]t felt like we'd worked through this entire pandemic — seeing so many people die, saving as many lives as we possibly could — and at the same time there was no recognition of that.'

Low morale is also a consequence of staff RN's seeing higher wages paid to agency nurses doing the same work. According to the CEO of South Bruce Grey Health Services:

> 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.

All the indicators of excessively low wages identified by Gunderson are present. Higher wages will address precarious staffing by aiding recruitment and retention. This is not a novel suggestion. In the Keller Board Award (2005) and Albertyn Board Award (2006), higher wages were linked to recruitment and retention issues.

The Keller Board (2005):

> After an extensive review of the literature, it is hard for the Board not to acknowledge that first, there is legitimacy to the recruitment/retention issue and two, that no one initiative by itself will adequately address that problem. We acknowledge that nothing we do will be the silver bullet that will provide the solution…
>
> …Although salaries per se was not considered in the literature to be the major reason for migration and although RNs did not rank salary as the number on reason to stay in the profession, there is an established relationship between economic factors such as wages, allowances and benefits on the one hand and nurses job satisfaction and retention on the other (Blegen and Mueller, 1987; Shields and Ward 2001).

Albertyn 2006 Board:

> While there has been a significant increase in the employment of nurses in the
>
> hospitals in Ontario in the period since 1999 and this increase has been predominately in full-time positions, there appear to be some areas of continuing acute shortage. This information, provided by the parties, suggests that what we do in this award should encourage recruitment to nursing in Ontario as a desirable professional choice, and it should assist in retaining nurses in this Province, given the lively competition within Ontario and across Canada for the recruitment of nurses.

…

> To address the need to attract skilled individuals to nursing, and to retain as many of the existing nurses as possible, we award the following amendments to the wage grid in Article 19.01(a)…

The Albertyn Board (2006) went on to award a 9.3% increase to the "Start" rate and a 6.7% increase to the "1 Year" rate.

The Employer also knows that wages are one way to address a staffing crisis. In February 2022, the OHA noted its strong opposition to Bill 124 and its eagerness to address the staffing crisis through compensation:

> OHA was opposed to the compensation restraint measures established under Bill 124…The province's current HHR challenges are the result of a complex history, which also includes the current legislated compensation restraint measures that impact the hospital workforce"
>
> A planned a[nd] deliberate exit from the current period of legislated wage restraint is necessary – this will provide an opportunity to address compensation and other contributors to the current HHR challenges. This includes an unequivocal comment that Bill 124 or other similar wage restraint legislation will not continue beyond the life of the current measures, if they are not repealed immediately"

The OHA has been clear: interference with compensation hurts morale and harms recruitment and retention.[191] As matters currently stand, Bill 124 has been declared unconstitutional by the Ontario Superior Court. The Employer, represented by the OHA, has an opportunity to tackle the nursing crisis by giving nurses wage catch-ups.

A CEO at one of the participating hospitals confirmed that it would rather improve compensation for staff nurses than spend the same money on agency 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.

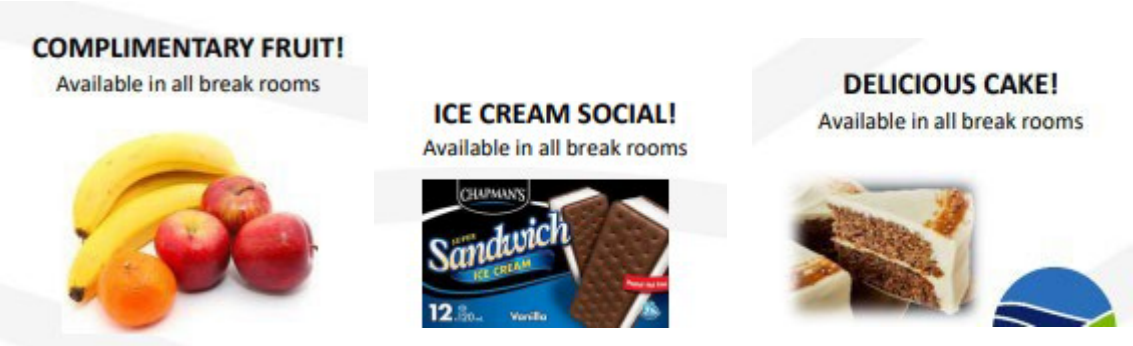
In a community presentation, the hospital claimed it could not pay its nurses more, or offer incentives to recruit nurses, because it was constrained by the collective agreement and Bill 124.

In Toronto, Dr. David Gomez—who has studied how emergency department closures can influence potential access to emergency care in Ontario—says:

> "It's already difficult to recruit young nurses and physicians to work in rural areas and significantly limiting the capacity of hospitals to recruit with additional financial incentives and higher wages, significantly limiting the capacity of increasing wages for nurses, leaves those nurses who are working in these areas in a precarious situation."

As indicated above, the Employer has expressed a desire to pay its staff nurses more. The Employer has also demonstrated that it *can* pay nurses more. It is a case of necessity being the mother of invention, or in this case, the mother of resource allocation. The Employer is paying private agencies up to quadruple the hourly rate of an RN staff position to fill baseline vacancies (as opposed to *ad hoc* absences). The Employer is voluntarily paying RNs overtime rates that are well in excess of the current collective agreement rate. The system is in dire need, and so the system has found a way. As the Employer is well aware, that way is unsustainable in the long-term. The use of agency nurses and excessive overtime is a province-wide problem and financial resources must be re-directed to catch-up wage improvements for staff nurses. This is the sustainable and long-term solution.

The non-wage recruitment and retention "solutions" put forward by the Hospitals are woefully inadequate. Rather than tackle wages, some hospitals have attempted to address the retention problem with "action plans" that include small prize draws, snacks, non-monetary excellence awards, staff mugs, walking groups, a therapy dog, staff BBQs, mini-massage days, mini-manicure days, and long-service celebrations (i.e. cake). South Bruce Grey Community Health informed the community that it was unable to offer higher wages or incentives. However, it wished to show its appreciation for its staff by offering such perks as:



These efforts are completely out of touch with the reality on the ground. The reality is that wages matter. The Hospitals know wages matter. And, until nurses begin to see wages that reward "the critical role they play in society", no amount of cake, therapy dogs, and mini-manicures will keep nurses in hospitals.

So, would hospital RNs walk off the job for higher wages if they could? The evidence suggests that they already are. Whether it be to agencies, other sectors, other provinces, or out the profession entirely, RNs are leaving the hospitals. As noted by Arbitrator Luborsky in *Jarlette Leacock Care Centre and CLAC* (2007):

> We agree with the observations by a number of commentators that employees who are unsatisfied with the terms and conditions of employment and have a practical alternative employment option typically 'vote with their feet'.

As one ICU nurse in Toronto has explained, she and at least two other nurses in the ICU have quit their permanent staff positions for agency work. "She said she now gets paid nearly double what she used to make at UHN, sometimes while literally working the same job — her very first shift as an agency nurse was at her old ICU at Toronto Western." According to an ER nurse in Pembroke: "I think the biggest thing is wages…[b]ecause unfortunately wherever you go you're still going to deal with a respect thing, and values and breaks and being short-staffed."

The objective evidence is that excessively low wages are contributing to the staffing crisis. This evidence supports the Union's position that a significant wage "catch-up" for nurses will replicate what the parties would have agreed to in a free bargaining environment.

iii. Relevant Comparators Show Better Compensation Everywhere Else

The current climate is one in which RNs can see their professional counterparts making better wages virtually everywhere else. Under such conditions, replicating free bargaining requires the substantial adjustment to wages proposed by the Union.

Other Provinces

During the decade of real wage decline and precarious staffing, the salaries of Ontario nurses continued to fall behind the salaries of nurses in other provinces. Currently, Ontario nurses have the lowest salaries in the country. This was not always the case. Prior to 2010, nurses in Ontario were amongst the highest paid nurses in the country. As the Employer noted in its 2005 interest arbitration brief, "Ontario nurse rates continued to increase during [the 80s and 90s] despite the recessionary economic situation in Ontario…Ontario nurses have never had to endure salary rollback no matter how severe the economic conditions."

Since 2010, it has been nothing but rollback. Consequently, the wages of nurses working in Ontario hospitals are amongst the least competitive in Canada.

In Ontario, problems exist at both the bottom and the top of the wage grid. The Union's proposed ATB increases—in combination with the compressed grid adjustments—will align RN salaries in Ontario more closely with RN salaries in other provinces. As illustrated in the charts below, the Union's proposal will move Ontario into highly competitive positions at both the start rate and the top rate. Having competitive rates at both ends of the grid will bring new graduates into the Ontario hospital sector and give them a strong incentive to remain there throughout their careers.

CURRENT RANKING – START RATE

As noted above, Ontario's current start rate is one of the lowest in the country:

Rank	Province	2022 Start Rate
1	Manitoba	$38.46[206]
2	Alberta	$38.44
3	Saskatchewan	$37.82
4	British Columbia	$37.67[207]
5	New Brunswick	$36.82
6	Nova Scotia	TBD ($35.21 in 2020)
7	Ontario	$35.52
8	PEI	TBD ($34.30 in 2020)
9	Newfoundland and Labrador	$33.64

The current start rate in Ontario is nowhere near where it needs to be to solve recruitment problems in the province. According to the OHA, the need to fill vacancies is occurring in a highly competitive labour market. There is no way for

the Employer to compete in this market without a significant boost to entry level wages.

START RATE RANKING FOLLOWING ONA PROPOSAL

The Union's proposal will make Ontario's start rate the most competitive in the country, just slightly above the start rate in British Columbia:

Rank	Province	2023 Start Rate
1	Ontario	$40.63
2	British Columbia	$40.21
3	Manitoba	$39.23
4	Alberta	$39.21
5	Saskatchewan	$38.58
6	New Brunswick	$37.56
7	Nova Scotia	TBD ($35.21 in 2020)
8	PEI	TBD ($34.30 in 2020)
9	Newfoundland and Labrador	TBD ($33.64 in 2022)

CURRENT RANKING - TOP RATE

As a result of the April 2023 Gedalof Board Re-Opener Award, the top rate in Ontario now slightly surpasses the top rate in Alberta, putting Ontario second, relative to all other provinces. However, it still leaves Ontario 13.7% behind the 8-year rate in British Columbia (and 17.0% behind British Columbia's top rate at 30 years of service):

Rank	Province	2022 Top Rate
1	British Columbia	$59.50 (at 9 Years); top rate is $59.50 (at 30 Years)
2	Ontario	$50.85
3	Alberta	$50.45
4	Saskatchewan	$49.09
5	Manitoba	$48.13
6	New Brunswick	$44.77
7	Nova Scotia	TBD ($42.94 in 2020)
8	PEI	TBD ($43.07 in 2020)
9	Newfoundland and Labrador	$41.65

TOP RATE RANKING FOLLOWING UNION PROPOSAL

The Union's wage proposal will narrow the gap between British Columbia and Ontario, but will keep British Columbia in the top spot: 6.3% above Ontario at the comparable 6-year step (assuming Ontario's first 2 steps are eliminated) and 23.4% behind British Columbia's top rate (at 30 years of service):

Rank	Province	2023 Top Rate
1	British Columbia	$60.57 (at 6 Years); top rate is $70.27 (at 30 Years)[211]
2	Ontario	$56.95
3	Alberta	$51.46
4	Saskatchewan	$50.07
5	Manitoba	$49.02
6	New Brunswick	$45.67
7	Nova Scotia	TBD ($42.94 in 2020)
8	PEI	TBD ($43.07 in 2020)
9	Newfoundland and Labrador	TBD ($41.65 in 2022)

While the new top rate proposed by the Union, for 2023, is still below the comparable rate in British Columbia, and well below the hourly rate being offered to agency nurses in Ontario, it offers a meaningful incentive to experienced nurses to remain in (and return to) permanent staff positions. It has the added benefit of attracting experienced nurses to Ontario from other provinces.

Public Sector (Police and Firefighters)

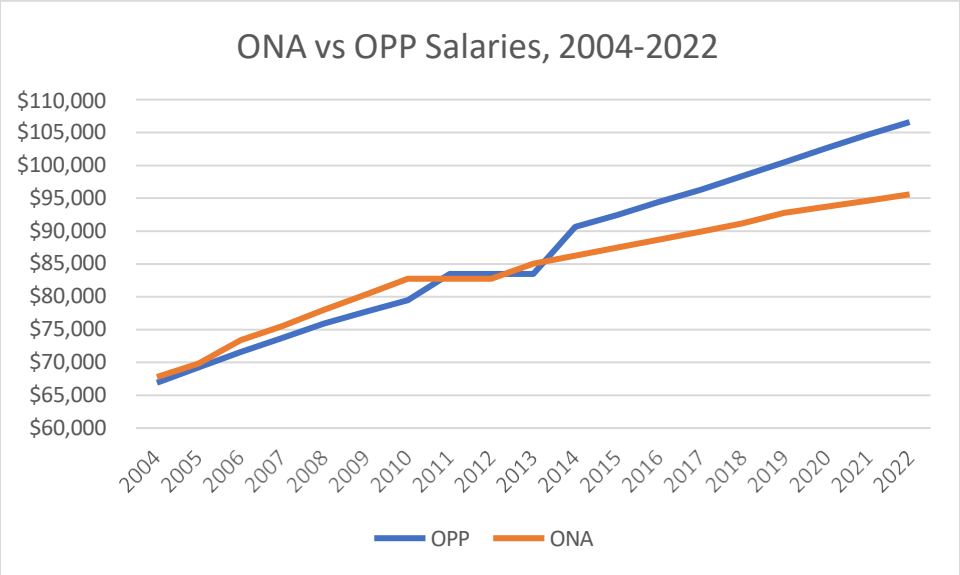
As noted above, at one time, the Employer argued that male-dominated frontline occupations—police and firefighters—were relevant comparators. At the time, the RN wage grid exceeded the Police and Firefighter wage grids. That was in 2005. As the Union has already demonstrated, the real value of nurse wages began to decline in 2010, when annual wage increases started to fall below annual rates of inflation. This was not the case for Firefighters and Police. During the same period (2010-present) police and firefighters saw their salaries steadily increase to the point where, today, compensation for police and firefighters far exceeds compensation for RNs. Given this reversal of fortunes, the Employer now insists that Police and Firefighters are not relevant comparators and seems to have forgotten that they ever were.

So, what has changed since 2010? Very little. Nursing is still a female-led profession and police and firefighting are still male-dominated professions. The only

real change is that nurse salaries have declined while police and firefighter salaries have climbed:

ONA vs Fire Wage Comparison, 2005-2020[213]				
	2005	**2010**	**2015**	**2020**
ONA Hospital (RN)	$69,810	$82,758	$87,438	$93,694
Fire (1st Class)	$65,149	$76,665	$88,121	$97,393
Difference	**$4,661**	**$6,093**	**-$683**	**-$3699**
% Difference	**7%**	**7%**	**-1%**	**-4%**

ONA vs Municipal Police Wage Comparison, 2005-2023[214]					
	2005	**2010**	**2015**	**2020**	**2022**
ONA Hospital (RN)	$69,810	$82,758	$86,229	$93,694	$95,577
Police (1st Constable)	$67,829	$79,953	$92,308	$102,598	$107,125
Difference	**$1,718**	**$2,805**	**-$6,079**	**-$8,904**	**-$11,548**
% Difference	**3%**	**3%**	**-7%**	**-10%**	**-12%**



Recent Voluntary Agreements in the Public Sector

Recent voluntary agreements in the public sector demonstrate that wages are a priority issue for workers across the country.

In a recent voluntary agreement between Ontario Power Generation and the Power Workers' Union, the Employer agreed to 8.25% wage increases over two years (4.75% on April 1, 2022 and 3.50% on April 1, 2023). In addition to these significant ATB increases, the Employer agreed to provide a payment of $5000 to all active Regular and Term employees (half on ratification and half on April 1, 2023).

Most recently, in British Columbia, the BC Nurses' Union and the Health Employers Association of British Columbia (HEABC) ratified a voluntary agreement that included the following wage increases:

- April 1, 2022: an additional $.25 per hour and then 3.24% ATB
- April 1, 2023: 6.75% ATB
- April 1, 2024: 2.0% + up to 1.0% additional Cost of Living Adjustment

By April 1, 2024, RNs in BC will have achieved up to 13% ATB increases. In addition to these ATB increases, the parties also agreed to additional wage increases at 10, 15, 20, 25, and 30 years of service.

These public sector agreements, both in Ontario and in British Columbia, demonstrate that the public sector "pattern" is moving in the direction of significant ATB increases, with meaningful add-ons such as large lump sums and long-service entitlements.

Private Sector (For-Profit Hospital Nurses)

In addition to the recent voluntary public sector agreements demonstrating a pattern of larger ATB increases, there is evidence of similar increases for comparable private sector groups. In *Shouldice Hospital Limited v ONA*, the Employer demonstrated to the satisfaction of the Board that it had no recruitment or retention issues. Nonetheless, the Board awarded increases to RNs of 2.0%, 2.5%, 3.0% from 2020 to 2022. In addition to these increases, the Employer was ordered to make mandatory contributions to the existing pension plan at a rate of 7.0%. The result was an increase in total compensation well above the 3.0% wage rate increase for 2022. For employees not previously contributing to the plan, this would mean a total 10% increase in 2022. This is in addition to the fact that the 2.0% in 2020, and 2.5% in 2021, are above the 1.75% and 2.0% awarded to nurses in the Stout Award and Stout Re-Opener Award, for the same two years.

Private Sector (Agency Nurses)

Agency nurses are relevant private sector wage comparators. Agency nurses are doing the exact same work as publicly employed nurses. Not only are they doing identical work, but there have been situations reported where the same work is being done at the same location by the same person. According to the OHA:

> We are now hearing from many of our members that new, "pop-up" agencies are promising health care workers, primarily nurses, substantive bonuses and higher wages which is disrupting the sector. Some health care workers are purportedly quitting their full-time jobs only to turn around and be hired by agencies and then deployed to work at the very same workplace/positions where they were originally employed. Given the competitive environment to recruit talent, agencies are reportedly paying agency nurses two times their salary and are charging hospitals as high as $1,000 a day for select nurses during high vacancy periods."

The Hospitals understand that low wages are a barrier to recruitment and retention. Nurses are migrating from hospital staff positions to external agencies, where they can earn significantly more. The Hospitals, in turn, look to agencies to fill vacant staff positions at 2x, 3x, and 4x the hourly rate of the staff position. The absurdity of the situation can be illustrated in one example from Quite Health Care, where agency use continues to climb. In August 2022, the Hospital's human resources consultant informed the Union that:

> The Hospital would always prefer to employ its own Registered Nurses as opposed to agency staff, but the reality of today's labor market is that there just are not enough RNs readily available and willing to work in a hospital environment for us to be able to safely eliminate the usage of agency staff at this time.

The point the consultant is trying to make is entirely contradictory because the "agency staff" she refers to are the very RNs she claims are not "readily available" and "willing to work in a hospital environment". Clearly, there are RNs who are available and willing to work in hospitals, but not on the terms and conditions currently being offered by the hospitals.

It has been widely reported that RNs are leaving their staff positions for work with agencies. Agency salaries are objective evidence of the type of monetary offers required to keep nurses in hospitals and to bring them back to hospitals from other sectors. The volume of agency use, outlined in the Union's Introduction, is evidence that there is a supply of nurses to fill the current demand and the way to mobilize that supply is to simply higher wages.

When public sector employees doing identical work to their private sector counterparts experience a significant wage disparity, then wage "catch-up" through

significant ATB increases represents what is fair and reasonable in the circumstances.

The ATB increases proposed by the Union will result in RN hourly wage rates that are still only a fraction of hourly rates being paid to their private sector counterparts. For example, on just one day alone—April 27, 2023—agencies were offering RNs $60.00-$100 per hour to work in various locations across the province, urban, rural, and remote.

Postings for Agency RNs – April 27, 2023

Location	Rate	Agency
Northern Ontario	$85-$100	EZcare Nursing Agency
Vaughan	$70-$95	911 Nurses GTA Staffing Agency
Northern Ontario	$90	Hero Care - ICU
Northern Ontario	$90	Hero Care - OBS
Northern Ontario	$75-$85	Caring Hands 4U Staffing Services
Kingston	$75	Staffy
Ottawa	$75	Affinity Health
Northern Ontario	$75	Hourglass - Community Health
Collingwood	$65-$70	Greenstaff Medical Canada
Toronto	$70	Staffy
Northern Ontario	$70	Curaga - OBS
Northern Ontario	$70	Hourglass - ER
Northern Ontario	$70	Curaga - ICU
Oshawa	$60	Staffy
Uxbridge	$60	Staffy
Hamilton	$60	Staffy
Burlington	$60	Staffy
Guelph	$60	Staffy
Mississauga	$60	Premium Healthcare Providers

Even the bottom of this range ($60.00) is 18% above the current top rate and 69% above the current start rate on the RN wage grid.

In response to the massive disparity between the hourly rates paid to agency nurses and the hourly rates paid to staff nurses, the Hospitals may argue that agencies do not provide the additional benefits and stability of permanent employment and/or that nurses today want the flexibility to work when they choose for a better work-life balance. There are several reasons why these explanations do not hold water.

First, the collective agreement accounts for premiums in lieu of added benefits. That premium is currently 13%. In contrast, the "premium" for agency nurses being paid the lowest agency rate ($60.00/hours) ranges from 18% to 69% above the straight time RN grid rate. In other cases, it is much higher. Rates are being offered to RNs as high as $100.00/hour. This rate represents a nearly 100% raise above the current RN top rate and a 181.5% raise above the current start rate. In addition to this massive premium, agency nurses receive perks and benefits not afforded to long-term staff nurses. These perks include on-site parking, paid transportation, and paid accommodations.

Second, there is evidence that agency nurses do value job stability over precarious employment. For example, at Quinte Health, agency nurses have requested, and are being given, regularly scheduled shifts.

Wage adjustment awards that correct years of declining wages and a massive disparity between public sector and private sector counterparts are not unheard of. In 2000, the Association of Law Officers of the Crown took the position that crown lawyer salaries "should be substantially increased to redress or reduce a significant and growing disparity with their private sector counterparts." The Association in that case was seeking increases of 28.12% and 5.3% over two years. The Board agreed with the position taken by the Association and substantially awarded the Association's proposal. Specifically, the Board noted the following:

- the workers in question played a "critical role…in society", were "indispensable", and carried "huge responsibility";

- the workers in question were expected "to perform at the highest professional standards, to exercise high degrees of diligence, skill, ability and judgement, and…to do so often in emotionally attenuated circumstances";

- the evidence showed that "the workload has also been increasing, involves high stakes and high responsibility";

- there was an absence of any real improvement to wages over the preceding decade accompanied by actual and substantial losses in spending power due to significant increases in the cost of living; and

- private sector salaries—involving identical training and qualifications—were well in excess of those earned by the public workers in question, even when adjusted by the Board's award.

The Board found that these considerations, whether taken as a whole or independently, justified a catch-up award of 7.5% for year one of the agreement and 22.5%, spread out in increments, over the course of year two.

Like the adjustments made in *Association of Law Officers*, the Union's full wage proposal would still leave the salaries of staff RNs well below their private sector counterparts. At $60.00/hour, the lowest agency rate would remain 47.7% above the new start rate and 5.4% above the new top rate.

3. INCENTIVIZE RETENTION AT 14 YEARS, 21 YEARS, AND 28 YEARS OF SERVICE

The Union's proposal to add retention premiums (i.e. Long-Term Service Entitlements) at 14 years (2%), 21 years (4%), and 28 years (6%) of service will address the Hospitals' need to retain experienced nurses. The premiums proposed by the Union in this round (the "2-4-6 premiums") are modest in comparison with the existing premiums in public sector comparator agreements, particularly firefighters and police.

According to the OHA, the retention of senior nurses is a problem that needs to be addressed:

> 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.

The recent Gedalof Board Re-Opener Award eliminated the problematic "25-Years" step on the RN wage grid. While this addressed serious concerns about the origins and negative impact of the 25-Years step, it left RNs who had waited 25 years to reach the top of the prior wage grid with no recognition beyond the 3% general wage increase.

Long-term service entitlements—which recognize commitment and dedication to the employer and to the profession—are standard in many collective agreements, including many of the comparator agreements identified by the Union. For Example, in *North Bay Police Services Board v North Bay Police Association*, Arbitrator Snow outlined the relationship between service allowances and retaining experienced workers:

> The basic salary structure for sworn police officers has been in place throughout Ontario for many years. That structure changed in 2003 when the Toronto Police Service and Toronto Police Association agreed upon an additional retention allowance for experienced officers. As many experienced officers were leaving the Toronto force, the retention allowance was intended as a means of retaining the force's experienced officers. The amount of the retention allowance was 3% after 8 years, 6% after 17 years and 9% after 23 years. The parties implemented the change in two steps with the first step being 3%, 4% and 5% for one year, with 3%, 6% and 9% a year later. At the same time, the parties to the Toronto agreement made several compensating changes elsewhere in their collective agreement to help pay for this new allowance.
>
> This change in salary structure has been adopted by most of the police forces in Ontario and is now the norm**.** The collective agreements covering the vast majority of the police officers in Ontario now either have this new salary structure fully in place, or are in the process of implementing it. The retention allowance has been adopted by police forces which have no problem retaining senior police officers.

Although the retention allowance originated a tool to combat retention problems in Toronto, Arbitrator Snow awarded the retention premiums in North Bay—where there was no retention problem—because the premiums had become ubiquitous in policing contracts.

A few years later, in *Toronto Police Services Board v Toronto Police Association*, Arbitrator Kaplan noted the retention and recruitment rationale behind the Service Pay benefit in the Toronto agreement:

> Extending and increasing pay based on service was, without a doubt, the bargaining priority for the Association in negotiating the 2002-2004 collective agreement. Roger Aveling, the long-service labour relations counsel to the Association and its principal witness, testified about its importance particularly given the serious recruitment and retention problems the force was experiencing. Contributing to the problem, and the

urgent need for a solution, was the large and growing cohort of members eligible, or soon to be eligible, for retirement and the implications of that on maintaining service strength.

The retention allowance in the Toronto Agreement is now the standard in both police and firefighter agreements across the province. The agreements all follow the same pattern of: 3% at 8 years, 6% at 17 years, and 9% at 23 years (the "3-6-9 premiums"). The same "3-6-9 premiums" were most recently awarded by Arbitrator Stout in *Port Colborne (Corporation of the City) v Port Colborne Professional Firefighters' Association*.

Notably, the 3-6-9 premiums are both more generous and achieved much earlier than the Union's 2-4-6 proposal. The 3-6-9 premiums typically start at 8 years and are paid as premiums on all hourly rates, including overtime, vacation, holiday pay etc. Examples of police and firefighter agreements with the 3-6-9 premiums include:

Comparison of ONA LTSE Proposal vs Police/Fire LTSEs		
Collective Agreement	**Long Term Service Entitlement**	**Eligible Hours**
Toronto Police Service and Toronto Police Association (Expiry December 31, 2023)	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, overtime, call-back pay, vacation pay, sick pay, statutory holiday pay, paid lieu time, sick pay gratuity, pension contributions, etc.
Barrie Police Services Board and Barrie Police Association (Expiry December 31, 2023)	3% at 8 years 6% at 17 years 9% at 23 years	Basic wage, pension contributions, overtime, court-time, and vacation pay, and sick payouts.
Regional Municipality of Durham Police Services Board and The Durham Regional Police Association (Expiry December 31, 2024)	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, pension contributions, statutory holiday pay, pregnancy/parental leave entitlements, sick leave pay, WSIB, and secondment
Greater Sudbury Police Services Board and Sudbury Police Association (Expiry December 31, 2024)	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, pension contributions, overtime, sick time, court time, and vacation pay

Guelph Police Services Board and Guelph Police Association (Expiry December 31, 2023)	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, overtime, court time, acting pay, call out, stand by, sick leave, pregnancy/parental leave top up, WSIB top up, annual leave, statutory leave pay and pension contributions
Halton Regional Police Services Board and Halton Regional Police Association (December 31, 2022)	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, Pregnancy/Parental Leave
Hamilton Police Services Board and Hamilton Police Association (Expiry December 31, 2020)	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, overtime, vacation and statutory holiday pay, pension contributions, sick leave pay, etc.
Kingston Police Services Board and Kingston City Police Association (Expiry December 31, 2022)	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, pension contributions
London Police Services Board and London Police Association (Expiry December 31, 2022)	3% at 8 years 6% at 17 years 9% at 23 years	Basic wage, Overtime, Vacation, Statutory Holiday pay, pension contributions, Maternity/Parental Leave, and Sick Leave pay.
Regional Municipality of Niagara Police Services Board and Niagara Region Police Association (Expiry December 31, 2026)	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, overtime, acting pay, emergency and call-back duty pay, stand-by duty pay, sick pay, annual leave and float time and statutory holiday pay, Court pay, pension contributions and special duty pay.
Ottawa Police Services Board and Ottawa Police Association (Expiry December 31, 2024)	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, all entitlements under the collective agreement that are presently calculated on the basis of a member's hourly or regular annual salary.

Waterloo Regional Police Services Board and Waterloo Regional Police Association (Expiry December 31, 2024)	3% of PC1 salary at 8 years 6% of PC1 salary at 16 years 9% of PC1 salary at 23 years	Basic wage, overtime, court-time pay, acting pay, call-out, on-call pay, stand-by duty pay, sick leave, pregnancy and parental supplementary benefit, annual leave and statutory holiday pay, pension contributions, and life insurance benefit pay out.
City of Ottawa and Ottawa Professional Fire Fighters Association (expiry December 31, 2023)	3% at 8 years 6% at 17 years 9% at 23 years	Basic wage, bank time, overtime, vacation, lieu days, WSIB, pregnancy leave, parental leave, sick leave, other paid leaves, stand-by pay, payout of sick leave, pension contributions, life insurance, accidental death, and course of duty death.
City of Hamilton and Hamilton Professional Fire Fighters Association (Expiry December 31, 2022)	3% at 8 years 6% at 17 years 9% at 23 years	Basic wage, overtime, vacation and statutory holiday pay, pension contributions, sick leave pay, etc.
City of Vaughan and Vaughn Professional Fire Fighters Association (Expiry December 31, 2020)	3% of a FF1C salary at 8 years 6% of a FF1C salary at 17 years 9% of a FF1C salary at 23 years	Basic wage, pension contributions, overtime, vacation, statutory holiday pay, sick leave pay, and WSIB benefits, etc.
City of London and London Professional Firefighters Association (Expiry December 31, 2024)	3% of a FF1C salary at 8 years 6% of a FF1C salary at 17 years 9% of a FF1C salary at 23 years	Basic wage, overtime, vacation pay, Statutory Holiday pay, pension contributions, maternity and parental leave top up and sick pay.
City of Brampton and Brampton Professional Fire Fighters Association (Expiry December 31, 2023)	3% at 8 years 6% at 17 years 9% at 23 years	Basic wage, overtime, vacation and statutory holiday pay, pension contribution and sick leave pay and sick leave credits
City of Kitchener and the Kitchener Professional Fire	3% of a FF1C salary at 8 years	Basic wage, overtime, vacation, statutory

Fighters Association (Expiry December 31, 2022)	6% of a FF1C salary at 17 years 9% of a FF1C salary at 23 years	holiday pay, pension contributions, WSIB, and sick pay.
City of Barrie and the Barrie Professional Fire Fighters Association (Expiry December 31, 2023)	3% of a FF1C salary at 8 years 6% of a FF1C salary at 17 years 9% of a FF1C salary at 23 years	Basic wage, overtime, vacation, recognized holidays, pension contributions, WSIB entitlements, and sick leave entitlements (including payout).

Again, the Union's 2-4-6 proposal is modest in comparison with the retention premiums found in these comparator agreements:

ONA Proposal: Participating Hospitals and Ontario Nurses Association (Expiry March 31, 2025)	**2% at 14 years** **4% at 21 years** **6% at 28 years**	**Straight time**

In addition to the Police and Firefighter agreements, Long-Term Service Entitlements are commonly found in other provincial RN agreements. In the recently ratified collective agreement between the BC Nurses Union and HEABC the parties voluntarily agreed—for the first time—to additional wage increases at 10 years, 15 years, 20 years, 25 years, and 30 years of service.[237] These increases, start with a 2.37% increase at 10 years. Additional percentage adjustments at 15, 20, 25, and 30 years result in a total wage increase from 10 years to 30 years of 7.5%. This means that a nurse in British Columbia with 25 years of service will receive $69.02/hour in 2023. By comparison, the Union's 2-4-6 proposal would result in $60.37/hour for a nurse in Ontario with 28 years.

In addition to British Columbia, Long-Term Service Entitlements exist in RN agreements in Alberta, Saskatchewan, and New Brunswick. New Brunswick's agreement provides a 1% premium at 15 years of service and a 5% premium at 25 years of service. Alberta and Saskatchewan both provide a 2% premium at 20 years of service.

The Union's proposal for Long-Term Service entitlements would have a major impact on retention but would come at relatively minor cost to the Employer. The Union's 2-4-6 premium proposal amounts to 1% of total compensation. Currently, 14% of all ONA members have achieved 25 years of service. The Hospitals' need

those nurses to stay within the sector for as long as possible. The demonstrated need to retain senior nurses, and an examination of the relevant comparators, all support awarding the Union's proposal for long-term service entitlements.

CONCLUSION

Now is the time to award nurses wages that are commensurate with their free market value. Grid adjustments and catch-ups are required to reverse the nursing shortage crisis and ensure future sustainability. The combined simplified grid and ATB increases will restore RN wages in Ontario to competitive levels. Importantly, it will also bring nurse wages back on track with relative inflation, which will restore the real value of RN wages.

The Union's proposals are not based on speculation, but on actual evidence of the context in which this Board is being asked to "replicate" free collective bargaining.

The weight of the evidence demonstrates that the Employer is facing a significant recruitment and retainment problem, both acutely and in the medium term. This problem is the culmination of a decade of declining real wages for nurses in Ontario. This decline carries no rationale. The pattern between these parties for decades included normative wage increases above inflation, periodic grid adjustments to address nursing shortages, and a wage grid that slightly exceeded other public sector "hero" professions. This pattern was abandoned for no apparent reason other than to perpetuate an "efficiency" staffing model that could not survive the demands of the COVID-19 pandemic.

The Union's wage proposals re-establish the pattern between these parties. More importantly, awarding the proposals will restore the dignity of hospital nurses in Ontario.

3. STANDARD OVERTIME

ARTICLES 14.01(a)&(b); 14.04: PREMIUM PAYMENT

[STANDARD OVERTIME and PAID HOLIDAY PREMIUM]

UNION PROPOSAL

14.01 (a) (Article 14.01 (a) applies to full-time nurses only)

If a nurse is authorized to work in excess of the hours referred to in Article 13.01 (a) or (c), they shall receive overtime premium of ~~one and one-half (1½)~~ **two (2)** times their regular straight time hourly rate. […]. For purpose of clarity, a nurse who is required to work on their scheduled day off shall receive overtime premium of one and ~~one-half (1½)~~ **two (2)** times their regular straight time hourly rate except on a paid holiday the nurse shall receive ~~two (2)~~ **two and one half (2.5)** times their straight time hourly rate.[…]

(b) (Article 14.01 (b) applies to part-time nurses only.)

If a part-time nurse is authorized to work in excess of the hours referred to in Article 13.01 (a), they shall receive overtime premium of ~~one and one-half (1½)~~ **two (2) times** their regular straight time hourly rate. A part-time nurse (including casual nurses but not including part-time nurses who are filling temporary full-time vacancies) who works in excess of seventy-five (75) hours in a two (2) week period shall receive ~~time and one-half (1½)~~ **two (2) times** their regular straight time hourly rate for all hours worked in excess of seventy-five (75). A part-time nurse who is filling a temporary full-time vacancy shall receive ~~time and one-half (1½)~~ **two (2) times** their regular straight time hourly rate for all hours worked in excess of an average of 37½ hours per week over the full-time nursing schedule determined by the Hospital.[…]

…

14.04 Where a nurse is required to work on a paid holiday or on an overtime tour or on a tour that is paid at the rate of time and one-half (1½) the nurse's regular straight time hourly rate as a result of 14.03 above and the nurse is required to work additional hours following their full tour

on that day (but not including hours on a subsequent regularly scheduled tour for such nurse) such nurse shall receive ~~two (2)~~ **two and one half (2.5)** times their regular straight time hourly rate for such additional hours worked. Where a nurse is called back from standby and works in excess of the hours of a normal shift on their unit, such nurse shall receive ~~two (2)~~ **two and one half (2.5)** times their regular straight time hourly rate for such additional hours worked.

EMPLOYER POSITION

Opposed.

RATIONALE FOR UNION PROPOSAL

Overtime premiums serve two purposes. First, to fairly compensate workers for putting in work hours over and above their standard contractual hours. Second, to discourage employers from relying on overtime work to maintain operations. Reliance on overtime work is a symptom of inadequate staffing. When overtime comes at too high a cost, the employer is motivated to increase its staffing complement to meet operational needs at straight-time rates.

The Union's proposal to increase overtime premiums promotes both these purposes. Increasing regular overtime premiums from 1.5x to 2x will: i) fairly compensate nurses who are contributing extra hours of labour to keep hospitals in Ontario operational, and ii) motivate the Hospitals to find permanent staff solutions to meet their operational needs.

The corresponding increase of overtime premiums in article 14.04, from 2x to 2.5x, will address the stress and burden of working while others receive a paid vacation or working overtime in conjunction with standby and other overtime duties.

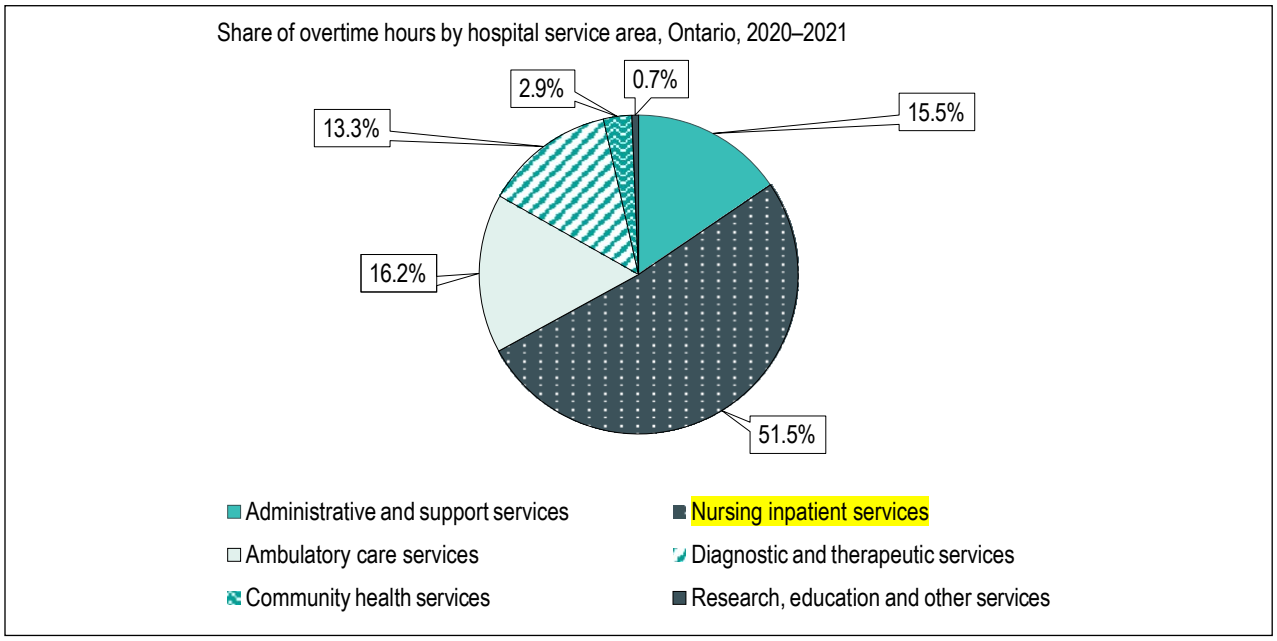
When Overtime is Offered, it must be fairly Compensated

The Union wishes to be clear: the priority for nurses is not more overtime, but better work-life balance. Nurses do not want to work more. Unfortunately, the reality is, they are working more than ever. In the last published report from the

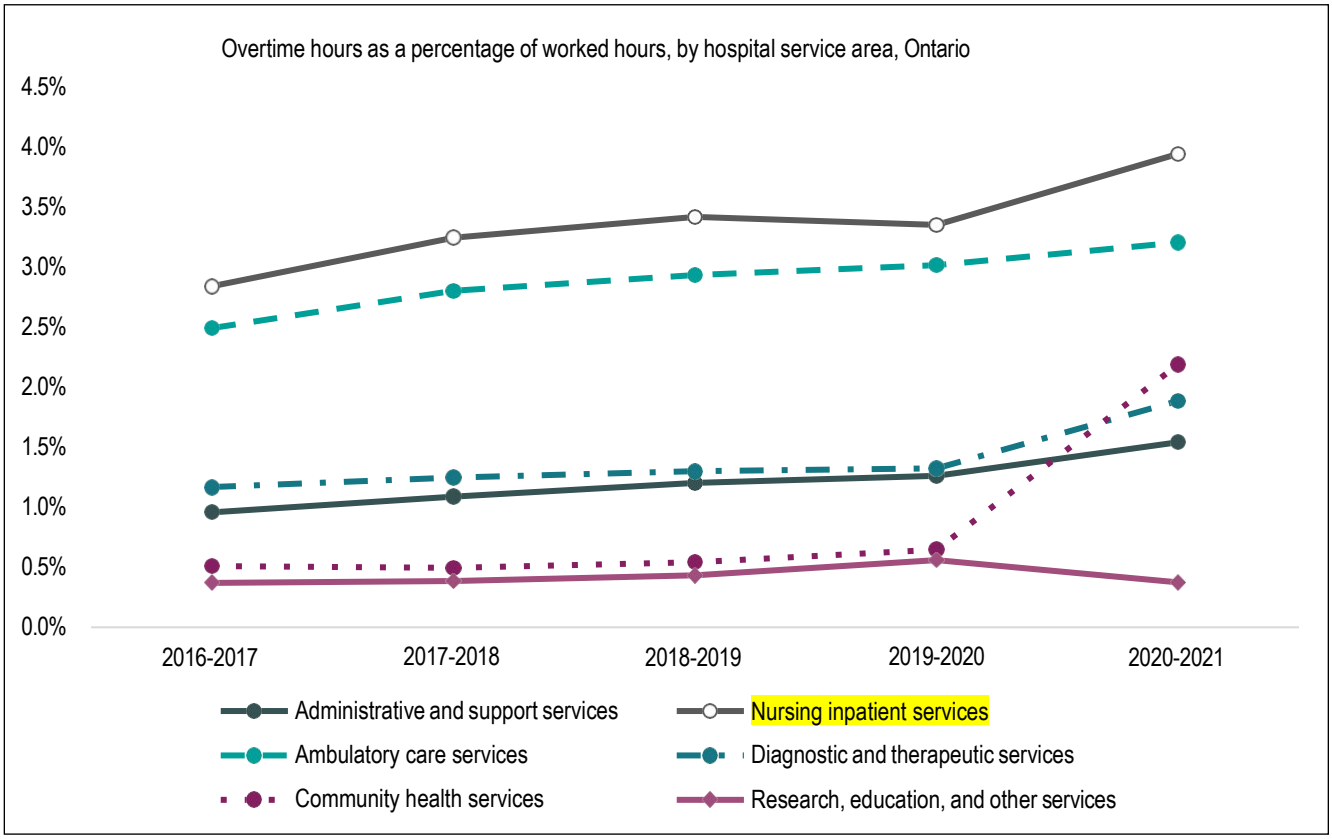
Canadian Institute of Health Information ("CIHI"), which surveyed hospital overtime hours between 2020 and 2021, it found that:

> [H]ealth care workers' overtime rates in hospitals were higher than in previous years. More than 18 million overtime hours were recorded in Canada's hospitals in 2020–2021, up by 15% over the previous year. These overtime hours alone translate to over 9,000 full-time equivalents (FTEs). More than half of the hospital overtime hours in 2020–2021 were for nursing inpatient services, where nursing staff along with a host of other personnel performed 9,771,633 overtime hours (equivalent to 5,011 FTEs).

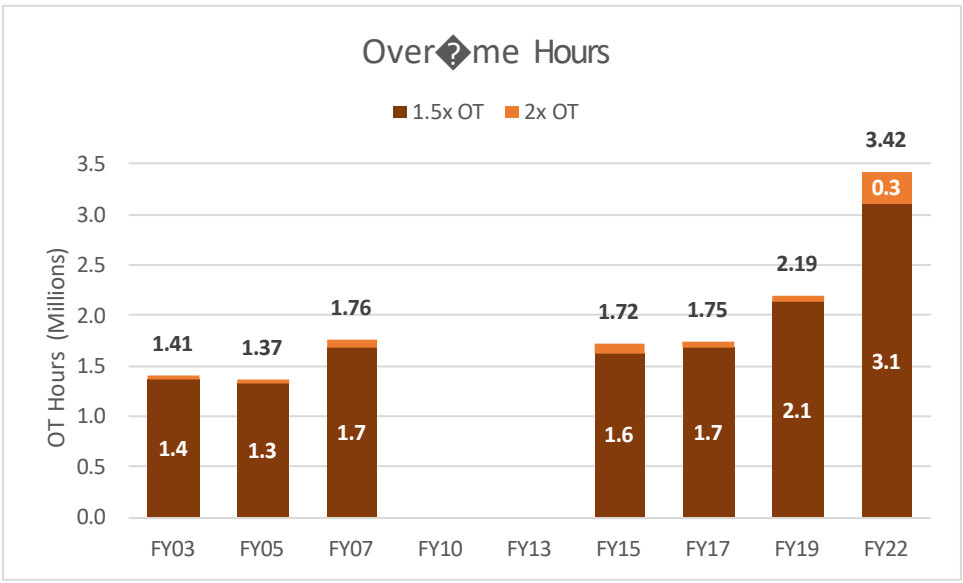
In Ontario, the numbers match the national percentages. Most overtime hours worked in Ontario's hospitals are being worked by nurses:



Prior to the Covid-19 pandemic, nurses were already the greatest overtime contributors in Ontario hospitals. In the first year of the Covid-19 pandemic, that percentage sharply increased:



The rise in overtime hours for ONA nurses, and hospital spending on overtime hours, is nothing short of astonishing. In fiscal year 2016-2017 the Employer recorded 1.75 million hours of overtime. In fiscal year 2018-2019 that number was 2.19 million. For the fiscal year ending in March 2022 that number was 3.42 million hours:



Naturally, an increase in spending on overtime has accompanied the increase in hours. Between fiscal year 2021 and fiscal year 2022, there was a 70% increase in overtime costs reported by the Hospitals, for a total of $277,656,162 spent on overtime in fiscal year 2021-2022.

These levels of overtime work are seriously harmful to employees—it is not an exaggeration to say they are driving nurses out of the profession. In a member survey report, from March 2023, the Canada Federation of Nurses' Union found:

- Poor career satisfaction especially among early career nurses and those in hospitals.
- Intention to leave the profession is high (40%), staffing and workload is extremely important consideration for leaving, retention solutions include days off, scheduling flexibility and lower taxes. Mental health is poor.
- Agency work is of interest to 1 in 3 nurses, especially to early-career and hospital nurses.
- 90% have been asked to work overtime, almost half report being asked a few times a week or every day/shift. A large percent report mandated overtime.

Over the last three years, nurses have put in an unprecedented number of overtime hours to keep hospital departments running. Burnout is a serious concern and resignations are at a record high. Nurses that have chosen to remain in the hospital sector have reached their limits. In September 2022, the CEO of the Kemptville District Hospital ("KDH") noted that:

> Nurses that remain in the system are fatigued … they're burned out from pandemic care. They're not up to taking extra shifts," said Vassallo, noting that his hospital currently has 15 Registered Nurse (RN) positions vacant, representing a 37.5 per cent vacancy rate.

Given the incredible burden and strain that overtime work puts on nurses, if a nurse still chooses to accept overtime, that overtime should be fairly compensated.

The Union's proposal for double-time compensation replicates what the parties would freely agree to because they are already freely agreeing to it. For example, Hamilton Health Sciences ("HHS") started paying its nurses double time from August 2022 to April 2023, to fill critical staff shortages. Meanwhile, on April 26, 2023. London Health Sciences Centre ("LHSC"), announced that it is offering double-time pay for overtime hours. According to the LHSC's corporate nursing

executive, the measure is being implemented as one of a variety of strategies to address recruitment and retention problems.

In addition to HHS and LHSC, other voluntary overtime incentives at the participating hospitals that include double time for overtime:

Hospital	Incentive	Effective Dates
Baycrest Centre	Double time on all Overtime Shifts	January 4 to 31, 2022
Cambridge Memorial Hospital	Double time on all Overtime Shifts	September 2022 to present
Campbellford Memorial Hospital	Double time on Overtime if ER is at risk of closure	January 2023 to present
Collingwood General & Marine Hospital	Double time for certain shifts (unspecified)	June to December 2022
Four Counties Health Services	Double time on all Overtime Shifts	August to October 2022
Health Sciences North	Double time on all Overtime Shifts	September 2022 to February 2023
Headwaters Health Care Centre	Double time for additional shifts for FT and PT over 75hrs	July 15, 2022 to September 5, 2022
Lakeridge Health	Double time for call ins	Ongoing
Mackenzie Health	Double time for all OT on weekends	July 1, 2022 to September 15, 2022
Southlake Regional Health Authority	OT offered as double time on any unit	November 3, 2022 to Feb 6, 2023
Unity Health Toronto	double time for all OT - in MSICU TNICU (St. Mike's) ICU, CCU and ER (St.Joe's)	Update (March 16, 2023) - When the Employer can't fill a shift at 1.5X they offer double time on certain units (ICU's and ED's at both sites), family Birthing, Paediatrics, and Inpatient Mental Health (7M) at St. Joseph's. Inter Professional Resource Team (IRT) at St. Michaels.
Perth Smith Falls Hospital	Shifts extension paid at 2x	As of January 2023
Northumberland Hill Hospital	Double time overtime	To mid-September 2022
Peterborough Regional Health Hospital	Weekend double time tours	Ongoing
Brockville Hospital	Double Overtime	Ongoing
Quinte Health Centre	Double Overtime	Ongoing

Mattawa	Double Time over 75 hrs	September 16, 2022 to February 5, 2023
Geraldton District Hospital	Double Overtime	April 10 to June 4, 2022
North Bay Regional	Only to CCU staff	December 5, 2022 to January 22, 2023
Sensenbrenner	Double Overtime	July 27, 2022 to September 1, 2022
Thunder Bay Regional	Double Overtime	September 9, 2022 to January 2023
Hamilton Health Sciences	Double Overtime	End date in May 2023
Niagara Health Sciences	Double Overtime	Summer 2022
Norfolk General	now 2x for any shift deemed to be 'critical' in needs	
St. Joseph's Hospital (Hamilton	Double Overtime	Stopped March 27, 2023
Bluewater Health	Double Overtime	August 9, 2022 to October 1, 2022
Four Counties Health Services	Double Overtime	August 9, 2022 to October 1, 2022
Hotel Dieu	Double Overtime	November 3, 2022 to January 3, 2023
London Health Sciences Centre	Double Overtime	Ongoing
St. Thomas Elgin General Hospital	Double Overtime	December 5, 2022 to January 16, 2023
Tillsonburg District Memorial Hospital	Double Overtime	December 2022 to April 2023 LOU had been signed; ER requested further extension of LOU until June 2023.

Increasing the standard overtime premium to double time is also consistent with the market value of the shift *vis a vis* its comparators:

RN Collective Agreements in Alberta, British Columbia, Nova Scotia, Saskatchewan, and Manitoba all have double pay overtime provisions. British Columbia and Nova Scotia pay double time when a nurse works overtime hours that pass a minimum threshold. The Alberta, Saskatchewan, and Manitoba agreements have no minimum threshold. The rate paid for all overtime hours is double time.

Agency nurses also provide a relevant market comparator. The cost to the Hospitals of staffing a vacancy with an agency nurse is—at a minimum—two times the cost of paying its most senior nurses double time. Double time is also comparable to the rate the same nurse would receive if she left her permanent staff position and worked the same hours through an agency. This is an option that many nurses are now choosing to exercise.

Higher Premiums Encourage Hospitals to Find Permanent Staffing Solutions

By increasing overtime premiums, the Hospitals are motivated to recruit and retain in-house staff. This, in turn, addresses the internal shortage and relieves the burden placed on existing staff. The Employer has the means to recruit and retain more nurses by offering higher wages. With a greater complement of permanent staff, the Employer will rely less and less on overtime to make up the shortfall. This reduces overall costs. A larger complement of nurses—that collectively enjoy a better work-life balance—are then more likely to accept overtime opportunities when they do arise.

Reliance on overtime is evidence of internal staffing shortages. If the existing complement of nurses at a hospital is too low, the hospital relies on overtime to stay operational.[251] If staff nurses refuse additional overtime work, the hospitals turn to staffing agencies to fill vacancies. The CEO of KDH noted that the hospital was responding to inadequate staffing by "actively recruiting new nurses, working with temporary staffing agencies and evaluating new staffing strategies."

While reliance on overtime is evidence of an internal labour supply problem, it is not evidence of an external labour shortage. For example, at KDH, there is an increasing external supply of nurses being tapped through temporary agencies. The OHA's initial disclosures to the Union indicated that the KDH contracted out 1149 hours to agencies 2021-22. Further disclosures (obtained following this Board's March 17, 2023 disclosure order), revealed that in 2022-23 (up to March 11, 2023) the KDH had contracted out 5043 hours to agencies. In other words, the amount of RN hours the hospital was able to extract from the external labour supply almost quintupled in the span of one year. Those hours come at a price that exceeds the straight time and overtime hourly rates of permanent staff. The 5043 agency hours

came at a cost of $90.00 to $120.00/hour and a total cost of $517,376.70 (included paid transportation totalling $7,440.00).

A higher premium on overtime would discourage the Employer from relying on overtime to maintain operations. Reliance leads to burnout, which leads to agency use. Agency use is far too costly and is currently draining the internal labour supply.[253] The $120.00/hour paid by KDH to a third-party agency is 3.5 to 2.5 times the cost of paying a staff nurse her straight-time rate and is more costly than paying any staff nurse double time for overtime.

Conclusion

The Union's proposal addresses fair compensation for nurses who are willing to work overtime hours and motivates the Employer to find permanent staffing solutions, rather than accept heavy overtime costs. At the current overtime rate, when there are heavy staff shortages, the Employer is not deterred from relying on overtime, and when that fails, agencies, to keep departments operational.

In the lead up to this interest arbitration, several of the participating hospitals offering double time for overtime have notified staff that double time will be phased out, claiming the practice of paying double time is "unsustainable." This claim is a red herring. The truth is that excessive reliance on overtime is unsustainable, not higher overtime rates. Hospitals should be hiring more nurses to fill shifts at straight time. Agency use, which shows no signs of being phased out, is far more "unsustainable" than attracting permanent staff with better straight-time wages and paying committed staff nurses double time for the occasional overtime shift.

The Union's proposal represents fair compensation for the high value of the overtime work nurses provide. The proposal will also motivate the Employer to choose the sustainable solution to the nurse staffing crisis.

For these reasons, the Union's proposal ought to be awarded.

ARTICLE 14.09: PREMIUM PAYMENT

[TIME OFF IN LIEU OF PREMIUM PAY]

UNION PROPOSAL

14.09 Where a full-time nurse has worked and accumulated approved hours for which they are entitled to be paid premium pay (other than hours relating to working on paid holidays) such full-time nurse shall have the option of electing payment at the applicable premium rate or time off equivalent to the applicable premium rate (i.e., where the applicable rate is **two (2) times the hourly rate** ~~time and one-half [1½]~~ then time off shall be at **double (2x) time** ~~and one-half [1½]~~). Where a full-time nurse chooses equivalent time off such time off must be taken within the period set out in the Appendix of Local Provisions or payment in accordance with the former option shall be made.

The application of this clause for part-time nurses will be determined by the local parties.

EMPLOYER POSITION

Opposed.

RATIONALE FOR UNION PROPOSAL

This proposal is a housekeeping measure. The proposed amendment confirms that the "time off in lieu of premium payment" under Article 14.09 mirrors the double time for overtime premium at Article 14.01(a)&(b) of the collective agreement. **See Union's Rationale re Article 14.01(a)&(b) – Standard Overtime**.

4. SHIFT AND RESPONSIBILITY PREMIUMS

ARTICLES 14.10 AND 14.15: PREMIUM PAYMENT

[EVENING, NIGHT AND WEEKEND PREMIUMS]

UNION PROPOSAL

14.10 Effective April 1, 2021, a nurse shall be paid a shift premium of ~~two dollars and twenty-five cents ($2.25)~~ **two dollars and fifty cents ($2.50)** per hour for each hour worked which falls within the hours defined as an evening shift and ~~two dollars~~ **three dollars** and eight- eight cents ($~~2~~**3**.88) for each hour worked which falls within the hours defined as a night shift provided that such hours exceed two (2) hours if worked in conjunction with the day shift. Tour differential will not form part of the nurse's straight time hourly rate. For purposes of this provision, the night shift and the evening shift each consist of 7.5 hours. The defined hours of a night and evening shift shall be a matter for local negotiation.

14.15 A nurse shall be paid a weekend premium of **one and one half (1.5) times their straight time hourly rate** ~~two dollars and eighty cents ($2.80)~~ per hour for each hour worked between 2400 hours Friday and 2400 hours Sunday, or such other 48-hour period as the local parties may agree upon. If a nurse is receiving premium pay under Article 14.03, pursuant to a local scheduling regulation with respect to consecutive weekends worked, the nurse will not receive weekend premium under this provision.

~~Effective April 1, 2022, a nurse shall be paid a weekend premium of three dollars and four cents ($3.04) per hour for each hour worked between 2400 hours Friday and 2400 hours Sunday, or such other 48-hour period as the local parties may agree upon. If a nurse is receiving premium pay under Article 14.03, pursuant to a local scheduling regulation with respect to consecutive weekends worked, the nurse will not receive weekend premium under this provision.~~

EMPLOYER POSITION

- Evening Premium: five cent (5¢) increase in 2023; five cent (5¢) increase in 2024
- Night Premium: twenty-five cent (25¢) increase in 2023; twenty cent (20¢) increase in 2024

- Weekend Premium: Thirty-five cent (35¢) increase in 2023; thirty cent (30¢) increase in 2024

RATIONALE FOR UNION PROPOSAL

The purpose of evening, night, and weekend premiums is to compensate nurses who take on the less desirable shifts. These shifts—falling outside traditional working hours—impact a nurse's ability to maintain a healthy work-life balance. Hospitals must maintain operations 24/7, and shift premiums are crucial in order to recruit and retain nurses into hospitals. These shift premiums must add real value to a nurse's salary to make these shifts desirable. This is particularly so given the acute and systemic staffing shortages the Hospitals are currently facing and continuing impact of high inflation (See Union Rationale re Article 19.01 – Wages).

Accordingly, any premiums awarded must be truly compensatory and not merely symbolic. True compensation replicates what the parties would have agreed to in free bargaining.

The Union seeks the following increases to the Evening and Night Shift Premiums:

- evening shift premium increase by $0.25 effective April 1, 2023, and
- night shift premium increase by $1.00 effective April 1, 2023.

These increases are supported by a demonstrated need to recruit and retain nurses in Ontario and are comparable to RN agreements in other provinces. The Union's proposals provide a much-needed catch-up for Ontario nurses, who not only lag behind their comparators in other provinces but who have seen insufficient premium increases in the last several rounds.

The Union also seeks a Weekend Premium at one and one-half times the straight-time hourly rate. This increase is already being voluntarily offered by some Hospitals in an effort to maintain coverage of these shifts. The fact that this premium is being offered voluntarily reflects the actual market value of a weekend shift. Lastly, a weekend premium at one and one-half times the straight-time rate is significantly less costly to a hospital than filling the shift with agency nurses (See Union Rationale re 14.01(a)&(b) – Standard Overtime).

History of Premium Increases

Historically, ONA has bargained or been awarded increases to shift premiums along with general wage increases. In the last round, Arbitrator Gedalof noted that ONA "has routinely bargained increases to its night and weekend premiums on a periodic

basis." Even in the context of Bill 124, the Union was awarded an increase to the call-back premium in the 2020 round.

Despite this history, evening, night, and weekend shift premiums have stagnated in recent rounds. Together with below-inflation wage increases and more strenuous working conditions, the inadequacy of odd-hour shift premiums has contributed to the current staffing and retention problems among the Hospitals.

Historical ONA Premiums								
Premium	Devlin	Albertyn		Kaplan		Stout		Gedalof
	April 2013	**Sept 2016**	**April 2017**	**April 2018**	**April 2019**	**April 2020**	**April 2021**	**April 2022**
Evening	$2.10	$2.15	$2.25	$2.25	$2.25	$2.25	$2.25	$2.25
Night	$2.50	$2.55	$2.65	$2.65	$2.65	$2.65	$2.88	$2.88
Weekend	$2.65	$2.70	$2.80	$2.80	$2.80	$2.80	$2.80	$3.04

The Hospitals' proposals to increase these shift premiums—although insufficient—are an acknowledgment that the current premiums are plainly not enough to support the current recruitment and retention efforts.

Evening premiums have not increased in over six years. The Union's modest proposal for a $0.25 increase is a gradual, restorative increase that is amply supported by the demonstrated need to attract workers to cover these shifts.

Similarly, the night shift premium has only been increased by $0.22 in the last 6 years. A $1.00 increase represents meaningful compensation for nurses who realign their sleep schedules to maintain the Hospitals' operations through the night.

Finally, the weekend premium has only been increased by $0.24 over the last 6 years. Arbitrator Stout's recent award, allowing an additional $0.10 for the Night and Weekend premiums, is totally divorced from the reality of the Hospitals' retention problems or the sacrifices nurses make to keep Ontario hospitals operational. Within the traditional work week, weekends are supposed to be time for rest, rejuvenation, and spending time with friends and family. A 24-hour healthcare operation needs nurses who are willing to work on weekends. In a competitive labour market, the premium for that work ought to reflect its market value. The alternative is to fill staffing vacancies with agency nurses at double, triple, and quadruple the cost of paying a staff nurse time and a half.

Normative Evening and Night Premiums in Other Provincial RN Agreements

The Union's proposal to increase Evening and Night premiums is also in line with the premiums offered to comparators in other provinces:

Evening/Night Premium Provincial RN Comparison				
Province	**Evening**	**Difference**	**Night**	**Difference**
Ontario	**$2.25**		**$2.88**	
British Columbia	$0.70	$1.55	$3.00	-$0.12
Alberta	$2.75	-$0.50	$5.00	-$2.12
Saskatchewan	$3.75	-$1.50	$3.75	-$0.87
Manitoba	$2.00	$0.25	$3.50	-$0.62
New Brunswick	$2.10	$0.10	$2.60	$0.28
Nova Scotia	N/A	N/A	$2.35	$0.53
Prince Edward Island	N/A	N/A	$3.00	-$0.12
Newfoundland and Labrador	$2.30	-$0.05	$2.30	$0.58

Ontario's evening and night premiums continue to lag behind several key comparators. The Union's proposal would bring Ontario premiums closer to its comparators, but still behind the leading rates in the country.

1.5x Weekend Premiums Are Already Being Offered By Participating Hosptials

The Employer proposes a $0.65 increase to the Weekend Premium over the life of the agreement. This proposed increase is wholly unresponsive to the gravity of the nurse shortages the Hospitals are facing.

The Employer cannot find enough nurses to fill weekend shifts. Nurses that remain in the hospital system are stressed and overworked. Such nurses are understandably reluctant to give up their weekends for wages and premiums that are out of sync with the sacrifices that weekend work demands.

In order to fill weekend shifts, the Hospitals are relying on agency nurses at rates far outside the range of the straight time and premium rates of the positions they are filling.

In order to avoid the more costly alternative, some Hospitals are offering additional incentives for nurses to take on weekend work. These incentives go well beyond the current Weekend Premiums and in some cases outstrip the Union's proposal. The reality is that, at many participating hospitals, nurses are already receiving time and a half for weekend shifts and in some cases more. The Union submits that this

situation is demonstrative of the actual market rate for a nurse working a weekend shift.

Throughout the past year, the following five Hospitals offered time and a half for nurses who worked weekend shifts:

- Headwaters Health Care Centre
- Niagara Health System
- Southlake Regional Health Centre
- Trillium Health Partners
- West Haldimand General Hospital
- Norfolk General Hospital

In addition to the above, Hotel Dieu Grace Healthcare and Sensenbrenner Hospital have offered nurses double time for weekend shifts.

These incentives are a rational, measured response to the systemic staffing and retention crisis in Ontario hospitals. Not only does a 1.5x weekend premium achieve the compensatory purpose of premium rates by offering a meaningful increase to the nurse salaries, but it also allows nurses to benefit from their placement on the pay scale. Tying the weekend premium to a nurse's regular wage rate provides a significant incentive for weekend work and assists in long-term service retention.

The Union submits that, in light of the Hospitals' recruitment and retention problems, the collective bargaining environment, and the significant toll the pandemic and a strained healthcare system has put on nurses, its weekend premium proposal replicates what the parties would have agreed to.

For all of these reasons, the Union's proposals ought to be awarded.

ARTICLE 9.08(a)&(c): PROFESSIONAL DEVELOPMENT

[SUPERVISION AND MENTORSHIP PREMIUMS]

UNION PROPOSAL

9.08 (a) Student Supervision

…

Where a nurse is assigned nursing student supervision duties, the Hospital will pay the nurse a premium of ~~sixty cents ($0.60)~~ **two dollars and fifty cents ($2.50)** per hour for all hours spent supervising nursing students.

9.08 (c) Mentorship

…

The Hospital will pay the nurse for this assigned additional responsibility a premium of ~~sixty cents (60¢)~~ **two dollars and fifty cents ($2.50)** per hour, in addition to their regular salary and applicable premium allowance.

EMPLOYER POSITION

- Student Supervision Premium: forty-five cent (45¢) increase in 2023; forty-five cent (45¢) increase in 2024
- Mentorship Premium: forty-five cent (45¢) increase in 2023; forty-five cent (45¢) increase in 2024

RATIONALE FOR UNION PROPOSAL

The Union's proposal to increase the supervisory and mentorship premiums will support the retention and recruitment of experienced nurses and compensate experienced nurses who are taking on mentorship/supervisory roles help the Employer combat the nurse shortage.

More Opportunities and Better Compensation for Mentors/Supervisors Supports Retention

Unquestionably, the Hospitals are facing a recruitment and retention crisis. In particular, the Employer is struggling to retain senior nurses. According to the OHA:

> 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.

The OHA has identified the expansion of mentorship opportunities for late career nurses as one way to retain them:

> Many late career nurses have expressed a willingness to stay employed at the hospital in roles that offer more flexibility, such as part-time employment, or where they are developing new skills such as in mentorship roles. During the pandemic, hospitals were given additional funding to pay for preceptorship and mentorship roles which were extremely successful in preparing new grads and less experienced nurses with additional skills and competencies. More mentorship and preceptor opportunities, as well as support for clinical placements, are needed for late career nurses to help support retention and morale and prepare new grads with the skills and development needed.

Incentivizing experienced nurses to take on mentorship opportunities has the corollary benefit of aiding recruitment by boosting the morale of new graduates who look to experienced nurses for leadership and guidance.

Compensation for mentorship should reflect the critical part mentorship plays in supporting the Employer's ongoing recruitment and retention efforts.

The increased need for Mentorship/Supervision must be accompanied by increased compensation for Mentorship/Supervision

In order to address ongoing staff shortages, many participating hospitals have relied on hiring "externs" to fill staffing gaps. Externs are clinical learners (including nursing students and internationally trained nurses) who are working towards completing their education. The government released new guidelines, in October 2021, allowing Internationally Educated Nurses to apply for externships. The OHA has identified the hiring of externs as one means of addressing its staffing needs. However, externs can only work under the supervision of skilled and experienced professionals.

According to the OHA:

> Externs are employed as unregulated health professionals working under the supervision of regulated health providers called extern mentor/coordinators.

As the hospitals rely more and more on externs—including internationally educated externs—many experienced nurses are being asked to take on additional duties as supervisors/mentors. Experienced nurses guide new recruits into the hospital system. Given the vital role that experienced nurses are being asked to play in alleviating the staffing crisis, that role must be fairly compensated.

Both parties have proposed increasing the amount of the supervision and mentorship premiums. The Union's proposal is to immediately increase the premiums to $2.50 per hour. The Employer proposes two, 45-cent increases (in 2023 and 2024) to achieve a premium of $1.50 per hour, as of March 31, 2024.

The Employer's proposal offers too little, too late.

The Hospitals' need to retain experienced nurses is immediate. A 45-cent increase to the supervisory and mentorship premiums in 2023 does not signal to experienced nurses that their experience is valued or that the Employer is truly motivated to keep experienced nurses working in Ontario hospitals. By comparison, the Union's proposal shows experienced nurses the respect they deserve. It acknowledges that the Hospitals are seeking to expand the supervisory/mentorship duties of senior nurses and compensates those duties fairly.

For all of these reasons, the Union's proposal ought to be awarded.

ARTICLE 19.04(d): COMPENSATION

[GROUP, UNIT OR TEAM LEADER PREMIUM]

UNION PROPOSAL

19.04 …

(d) Group, Unit or Team Leader

Whenever an employee is assigned additional responsibility to direct, supervise or oversee work of employees within their classification, and/or be assigned overall responsibility for patient care on the unit, ward, or area, for a tour of duty, the employee shall be paid a premium of **five dollars ($5.00)** ~~two dollars ($2.00)~~ per hour in addition to their regular salary and applicable premium allowance.

…

EMPLOYER POSITION

Opposed.

RATIONALE FOR UNION PROPOSAL

The Union's proposal, in combination with the Union's proposal for Article 10.12(c), will deter the Employer from continuing its unrestrained use of temporary agencies and will provide staff nurses with fair compensation for overseeing, assisting, and monitoring the work of agency nurses.

The premium pay under this Article is commensurate with the responsibilities that come with overseeing the work of agency nurses, who have no or limited familiarity with the hospital, the unit, and the patients. The added workload that comes with working along side agency nurses has long been identified but has never been compensated (see Union Rationale re Article 10.12(c) – Work of the Bargaining Unit). The "added stress and workload added to regular staff by the need to provide orientation and monitoring to Agency staff" has led some permanent staff to quit the hospital sector and join agencies.

The Union's proposal also supports the retention of senior, experienced nurses. Over half of the bargaining unit is comprised of members with 8 or more years of experience. This premium payment will not only encourage experienced nurses to remain within the system, it will encourage them to take on leadership position at a time when staffing is strained and morale is low.

The failure to properly remunerate nurses for the additional stress and workload will impact the Employer's ability to retain its most senior and experienced nurses. The Union's proposal supports the retention of senior nurses by fairly compensating senior nurses for the experience they bring to group, unit, and team leadership roles.

For these reasons, the Union's proposal ought to be awarded.

5. AGENCY USE

ARTICLE 10.12(c): WORK OF BARGAINING UNIT/AGENCY NURSES

[AGENCY USE PREMIUMS]

UNION PROPOSAL

10.12 (c) It is agreed that ad hoc usage of agency nurses (RN) will not exceed ~~the lesser of~~ 1.5% of ~~the total bargaining~~ **an individual hospital** unit**'s** hours ~~or the Hospital's actual usage for 2005- 2006 base fiscal year~~. The Hospital will make ongoing best efforts to reduce any use of agency nurses. Any use of agency nurses ~~beyond 1.5% in a fiscal year~~ will result in a payment to the **Local** Union of ~~62 cents~~ **two dollars and fifty cents ($2.50)** per hour of agency use **on a biweekly basis** ~~above 1.5% to be determined annually at the end of each fiscal year~~.

It is understood that all nurses working with agency nurses will be entitled to Group, Unit or Team Leader pay under Article 19.04 (d).

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

EMPLOYER POSITION

Opposed.

RATIONALE FOR UNION PROPOSAL

The Union's proposal supports the underlying objective of Article 10.12(c). The Employer's continued and increasing use of agency nurses is wasteful, unsustainable, and must be discouraged. The current penalty on the Employer for use of agency nurses beyond 1.5% in a fiscal year is clearly insufficient to deter the Employer from keeping agency use to a minimum. In the last three years the use of agency nurses by participating hospitals across the province has ballooned. As the COVID-19 pandemic has subsided, the use of Agency nurses has only escalated (See Union's Introduction re Agency Use).

The cap on agency use was an important outcome of the 2004 decision in *Sunnybrook and Women's College Health Sciences Centre and ONA.* In *Sunnybrook*, Arbitrator Kaplan found that hospitals were contracting out bargaining unit work to agencies, contrary to the terms of the central collective agreement. As a remedy, Arbitrator Kaplan imposed a 2% cap on the use of agency nurses and directed the hospitals to pay the Union 38 cents on any hour the exceeded the 2% cap (to be reported quarterly, but calculated and paid annually).[267] The decision was clear that:

> …it would be inconsistent with this award for any of the Hospitals now, or in the future, to interpret the 2 per cent cap as a licence to increase the use of Agency Nurses either to that level or beyond traditional usage levels. That is not the purpose of this award and its remedy. The purpose of the award and its remedy is to place an outer limit on the permissible use of Agency nurses consistent with the obligations of the Central Collective Agreement but all the while directing the ongoing best efforts of the Hospitals to continue to reduce Agency nurse usage below that cap.

Almost twenty years later, the purpose of the award and the remedy in *Sunnybrook* have yet to be fulfilled.

In 2007, the Albertyn Board formally added language to the collective agreement consistent with the *Sunnybrook* decision, at Article 10.12(c). Ten years later, another Board chaired by Arbitrator Albertyn found that the hospitals should be hiring more part time and casual staff to avoid reliance on agencies and awarded an increase on the penalty payable to the Union (from 38 cents to 62 cents) and lowered the cap on total agency usage from 2% to 1.5%.

Six years later, neither of these adjustments by the Albertyn Board have had their intended effect. In 2020, the Union tabled a proposal before the Stout Board that would have placed further limits on agency use. At that time, the OHA submitted to the Stout Board that the Union's proposal was unnecessary because agency use was "limited" to 38 hospitals. Arbitrator Stout found that agency use was not widespread across the province, but still a significant issue in the Greater Toronto Area ("GTA"). Arbitrator Stout also referred to his 2019 decision in *Humber River Hospital and ONA,* where he allowed the Union's grievance that the Employer was using agency nurses well beyond the "ad hoc" use permitted in the collective agreement. Consequently, the Stout Board awarded a clarity note to be added to Article 10.12(c) as follows:

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

Again, this amendment has had no discernable deterrent effect. The number of participating hospitals using agency nurses in fiscal year 2021-22 increased, conservatively, to 44 hospitals. In 2022-23 the number increased again, to 65 hospitals. Temporary agencies are being used by hospitals in every corner of the province and continue to be used extensively in the GTA.

The Union—per the collective agreement—does NOT consent to the use of agency nurses beyond the *ad hoc* scenarios described in Article 10.12(c), and yet agency use is rampant. Clearly, Article 10.12(c) needs to be recalibrated in a manner that effectively deters agency use going forward. The Union's proposal puts a $2.50 per hour penalty on <u>all</u> hours of agency use. The proposal heightens the immediate effect of the penalty by mandating bi-monthly payments to the affected Local. A penalty of $2.50 per agency hour translates to approximately 2.0% of the average hourly rate that hospitals are paying to temporary agencies. This 2.0% is an appropriate "tax" on agency use that will have a greater deterrent effect than the current fine.

<u>A Premium for Overseeing and Monitoring Agency Nurses must be Assured</u>

The Union's proposal contains another critical amendment. The amendment clarifies that, when agency nurses are used, staff nurses working with the agency nurses must be given <u>Group, Unit or Team Leader pay under Article 19.04(d)</u>. This premium pay reflects the inevitable increase in responsibility that comes with overseeing the work of agency nurses, who have zero or limited familiarity with the hospital, the unit, and the patients.

The added workload that agency nurses create was identified in the *Sunnybrook* decision:

> The issues identified by ONA include dissatisfaction and concern about the skill level of agency staff and their familiarity with hospital equipment, policies and procedures, including infection control, concern about the quality of care provided by agency staff who are not familiar with patients, an assertion that the use of agency nurses often results in inexperienced care, increased medication errors and poor continuity of care, not to mention the added stress and workload added to regular staff by the need to provide orientation and monitoring to Agency staff.

Twenty years later, this scenario remains the same. One Toronto ICU nurse, who left her permanent staff position to join an agency, observed this about her former workplace:

> [A]t times nearly half of the nurses in her ICU were from agencies — and getting paid twice as much. Meanwhile, the agency nurses sometimes added to the workload of staff nurses, who had to show them the ropes or help them access medication storage rooms that require a staff ID.'

The added burden placed on staff nurses, when working alongside agency nurses, is a natural consequence of having to work alongside a contingent parallel workforce. Staff nurses taking on these added duties and responsibilities are entitled to the premium pay that normally accompany them.

In sum, the Union's proposal corrects the deficiencies in the current provision, which is having no deterring effect on agency use. It also confirms that the extra work that comes with overseeing and monitoring agency nurses will be compensated.

For all of these reasons, the Union's proposal ought to be awarded.

ARTICLE 10.16(e): INFORMATION REPORTED TO THE UNION [AGENCY INFORMATION]

UNION PROPOSAL

10.16 (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.

EMPLOYER POSITION

Opposed.

RATIONALE FOR UNION PROPOSAL

The parties have long agreed that the use of agency nurses is not a sustainable solution to staffing shortages. This history, and the rationale for the current restrictions on agency use, are outlined in Article 10.12: Work of the Bargaining Unit / Agency Nurses.

Like the language in 10.12(c), the requirement to provide "satisfactory reporting" has its roots in the 2004 *Sunnybrook* decision. As Arbitrator Kaplan reasoned, the purpose of that award and its remedy was:

> to place an outer limit on the permissible use of Agency nurses consistent with the obligations of the Central Collective Agreement but all the while directing

> the ongoing best efforts of the Hospitals to continue to reduce Agency nurse usage below that cap."

"Satisfactory reporting" is crucial to achieving that goal.

Article 10.16(e) is an ancillary provision, designed to ensure compliance with the restrictions in Article 10.12. Since adopting the restrictions in Article 10.12, the need for clarification on the data required by Article 10.16(e) has emerged.

The current language in Article 10.16(e) is vague, requiring the Hospital to provide "satisfactory reporting respecting the use of agency nurses and the percentage that use represent of total bargaining unit hours worked (RN)". The language does not specify what information constitutes "satisfactory reporting". However, satisfactory reporting imposes real requirements for disclosure. As Arbitrator Stout reasoned in *Humber River*:

> The obligation of satisfactory reporting includes reporting on the on-going efforts being made to reduce "any use of agency nurses". This includes meaningful discussions and the exchange of relevant information and ideas aimed at meeting the obligation of reducing agency use at the Hospital.

As *Humber River* shows, some hospitals have interpreted their obligation in a restrictive fashion, creating the need for unnecessary litigation. Clearly, Arbitrator Stout reasoned, "the reporting requirements in the Collective Agreement are broader than a one page spreadsheet with a dollar amount owing for usage above the given threshold."

Arbitrator Stout ordered the Hospital to provide the following information:

> Effective immediately, the Hospital shall provide the Union with timely quarterly reports, in accordance with Article 10.12 (c). The quarterly reports are to contain information, by unit, of the total bargaining unit hours and total agency nurse (RN) hours. The quarterly reports shall also provide Hospital wide bargaining unit hours and agency (RN) hours.

The Union's proposal would provide much-needed clarity to that requirement that the Employer provide "satisfactory reporting". The Union's proposal explicitly states what information must be provided, quarterly, to the Union. This data is the most basic information necessary for the Union to monitor compliance with Article 10.12 and is not an addition, but a clarification, of the Employer's existing reporting obligations.

Indeed, the Union's proposal simply replicates the language in several local agreements that already clarify the commitment to provide agency data:

Hospital	Agency Reporting Language
Humber River Hospital	Not local language, but 2019 Stout award states: "Effective immediately, the Hospital shall provide the Union with timely quarterly reports, in accordance with Article 10.12 (c). The quarterly reports are to contain information, by unit, of the total bargaining unit hours and total agency nurse (RN) hours. The quarterly reports shall also provide Hospital wide bargaining unit hours and agency (RN) hours."
Lakeridge Health	(a) Agency nurse hours worked per unit; (b) Total agency nurse hours worked hospital-wide; (c) Total bargaining unit hours worked per unit; (d) Total bargaining unit hours worked hospital-wide; (e) Percentage of agency nurse hours worked per unit; and, (f) Percentage of total agency nurse hours worked hospital-wide
Mackenzie Health	(a) Agency nurse hours worked per unit; (b) Total agency nurse hours worked hospital-wide; (c) Total bargaining unit hours worked per unit; (d) Total bargaining unit hours worked hospital-wide; (e) Percentage of agency nurse hours worked per unit; and, (f) Percentage of total agency nurse hours worked hospital-wide.
Unity Health Toronto	(a) Agency nurse hours worked per program; (b) Total agency nurse hours worked hospital-wide; (c) Total bargaining unit hours worked per program; (d) Total bargaining unit hours worked hospital-wide; (e) Percentage of agency nurse hours worked per program; and (f) Percentage of total agency nurse hours worked hospital-wide
William Osler Health System	(a) Agency nurse hours worked per unit; (b) Total Agency nurse hours worked hospital-wide; (c) Total bargaining unit hours worked per unit; (d) Total bargaining unit hours worked hospital-wide;
Women's College Hospital	(a) Agency nurse hours worked per unit; (b) Total agency nurse hours worked hospital-wide; (c) Percentage of agency nurse hours worked per unit; and (d) Percentage of total agency nurse hours worked hospital-wide.

6. PART-TIME NURSES

ARTICLE 19.01(b) & (c): COMPENSATION

[PART TIME PERCENT IN LIEU]

UNION PROPOSAL

19.01 …

(b) The hourly salary rates, inclusive of the percentage in lieu of fringe benefits in effect during the term of this Agreement for all regular and casual part-time nurses shall be those calculated in accordance with the following formula:

Applicable straight time hourly rate + **15%** ~~13%~~.

(c) The hourly salary rates payable to a regular or casual part-time nurse include compensation in lieu of all fringe benefits which are paid to full-time nurses except those specifically provided to part-time nurses in this Agreement. It is understood and agreed that holiday pay is included within the percentage in lieu of fringe benefits. It is further understood and agreed that pension is included within the percentage in lieu of fringe benefits. Notwithstanding the foregoing, all part-time nurses may, on a voluntary basis, enrol in the Hospital's Pension Plan when eligible in accordance with its terms and conditions. For part-time nurses who are members of the Pension Plan, the percentage in lieu of fringe benefits is **eleven percent (11%)** ~~nine percent (9%)~~.

It is understood and agreed that the part-time nurse's hourly rate (or straight time hourly rate) in this Agreement does not include the additional **11%** ~~9%~~ or **15%** ~~13%~~, as applicable, which is paid in lieu of fringe benefits and accordingly the **11%** ~~9%~~ or **15%** ~~13%~~, as applicable, add on payment in lieu of fringe benefits will not be included for the purpose of computing any premium or overtime payments.

EMPLOYER POSITION

Opposed.

RATIONALE FOR UNION PROPOSAL

The Union's proposal supports the recruitment and retainment of part-time nurses by providing a long overdue adjustment to the percentage in lieu of fringe benefits part-time nurses receive. The percentage in lieu is intended to compensate part-time nurses for certain benefits enjoyed by full time nurses such as sick leave, health and

wellness, group life insurance, long-term disability, holiday pay, and pension, if not enrolled. It is not a one-for-one trade-off of wages for benefits. Rather, it is meant to reflect, in the form of additional wages, the proportion of benefits a part-time nurse should have access to in relation to her total hours worked. Although the basket of fringe benefits in the collective agreement has grown from contact to contract, the percentage in lieu of such benefits has never increased alongside it.

Forty years ago, in the first central agreement between the parties, the percentage in lieu of fringe benefits was 14%. In the 1991-93 collective agreement, that percentage was reduced to 13%, but part-time nurses were allowed to opt into the Employer's pension plan in exchange for 9% in lieu. Since these changes were adopted thirty year ago, the percentages in lieu have not changed.

While the percentages in lieu have not changed, the basket of fringe benefits available to full time nurses has increased. For example, over the last forty years there have been normative improvements to health and wellness benefits with each renewed agreement. Examples include:

- In 2001, increases to vision care, dental and orthodontics benefits.
- In 2004, extended vision and dental benefits; addition of massage therapy, physiotherapy, and chiropractic care ($300 per service).
- In 2006, $500 additional for crown and bridgework; additional $500 for orthodontic benefits; extended health care benefits beyond age 65 (up to age 70).
- In 2008, increases to massage therapy, physiotherapy, and chiropractic care, improvements to orthodontics and inclusion of hearing benefits.
- In 2011, increases to dental benefits, vision benefits, massage therapy, physiotherapy, hearing aid benefits, and chiropractic care.
- In 2016, increases to hearing, vision, and dental benefits.
- In 2018, $800 for mental health services.
- In 2020, unlimited mental health coverage, and increases to massage therapy, physiotherapy, and chiropractic care.

The current percentages in lieu no longer reflect the basket of benefits the "in lieu" is meant to offset. Although part-time nurses and full-time nurses share the same hourly wage rates, the real wages of nurses over the last decade have declined (see Union Rationale re Article 19.01 – Wages). This loss in real spending power has amplified the disparity between the percentage in lieu and the current fringe benefits. The Union's proposal represents a reasonable (2%) adjustment to the percentage in lieu that accounts for the larger collection of benefits the "in lieu" payment is intended cover.

Like full-time nurses, part-time nurses have endured stress, fatigue, and burnout stemming from the demands of the COVID-19 pandemic. Full-time nurses now have access to unlimited mental health coverage. A part-time nurse cannot access this crucial benefit without paying the premiums for coverage. An increase to the percentage in lieu would assist part-time nurses in covering that premium or offset

some of the cost of independently seeking unlimited mental health services. This would benefit all parties by keeping nurses healthy and able to work.

An increase in the premium means better wages for part-time nurses. Better wages will help the Employer attract and retain part-time nurses. A 2% adjustment represents a small amount of total compensation, less than 0.5%. However, it will mean real wage improvement for part-time nurses. With a larger complement of part-time nurses, the Employer will rely less on overtime and temporary agencies to fill vacancies, both of which are currently a drain on the system (see Union rationales re Article 14.12 - Notice of Shift Change, and Article 14.01(a)&(b) – Standard Overtime). Without this wage improvement, the Hospitals are competing with temporary agencies for part-time nurses. These agencies are offering alternatives for part-time nurses, with hourly rates that exceed wage rates with 13% in lieu attached to them.

For all of these reasons, the Union's proposal ought to be awarded.

ARTICLE 14.12: PREMIUM PAYMENT

[NOTICE OF SHIFT CHANGE]

UNION PROPOSAL

14.12 (a) ~~(Article 14.12 (a) applies to full-time nurses only)~~

The posting of work schedules shall be as set out in the Appendix of Local Provisions. It shall be the responsibility of the nurse to consult posted work schedules. The Hospital will endeavour to provide as much advance notice as is practicable of a change in the posted schedule. Changes to the posted work schedule shall be brought to the attention of the nurse. Where less than forty-eight (48) hours' notice is given personally to the nurse, time and one-half (1½) of the nurse's regular straight time hourly rate will be paid for all hours worked on the nurse's next shift worked.

Where less than forty-eight (48) hours' notice is given personally to the nurse for the cancellation of a shift that was added to their schedule, time and one-half (1½) the nurse's straight time hourly rate will be paid on the nurse's next shift worked. This shall not include shifts added to their schedule within the same forty-eight (48) hour notice period unless the employer paid such premiums under an existing practice as of March 31, 2004.

Where a nurse is cancelled without the required notice on two (2) or more separate occasions prior to working their next shift(s), premium pay under this provision will be extended to subsequent shifts worked, such that the number of premium paid shifts equal the number of such separate occasions.

Where a shift that attracts premium pay pursuant to this provision is otherwise a premium paid tour, they will be paid two times their straight time hourly rate for all hours worked on that tour.

~~(b) (Article 14.12 (b) applies to part-time nurses only)~~

~~i) The posting of work schedules for regular part-time nurses shall be determined by local negotiations. It shall be the responsibility of the regular part-time nurse to consult posted work schedules. The Hospital will endeavour to provide as much advance notice as is practicable of a change in the posted schedule. Changes to the posted work schedule shall be brought to the attention of the regular part-time nurse.~~

~~ii) Where less than twenty-four (24) hours' notice is given personally to the regular part-time nurse, time and one-half (1½) of the nurse's regular straight time hourly rate will be paid for all hours worked on the nurse's next shift worked.~~

~~Where less than twenty-four (24) hours' notice is given personally to the nurse for the cancellation of a shift that was added to their schedule, time and one-half (1½) the nurse's straight time hourly rate will be paid on the nurse's next shift worked. This shall not include shifts added to their schedule within the same twenty-four (24) hour notice period unless the employer paid such premiums under an existing practice as of March 31, 2004.~~

~~Such changes shall not be considered a lay-off.~~

~~iii) Where a nurse is cancelled without the required notice on two (2) or more separate occasions prior to working their next shift(s), premium pay under this provision will be extended to subsequent shifts worked, such that the number of premium paid shifts shall equal the number of such separate occasions.~~

~~Where a shift attracts premium pay pursuant to this provision is otherwise a premium paid tour, they will be paid two (2) times their straight time hourly rate for all hours worked on that tour.~~

~~iv)~~ **(b)** Where a nurse is called in to work a regular shift less than two (2) hours prior to the commencement of the shift and arrives within one (1) hour of the commencement, then the nurse will be paid for a full tour provided that the nurse works until the normal completion of the tour.

~~v)~~ **(c)** Casual part-time nurses whose work schedule has been pre-scheduled and whose schedule is changed with less than ~~twenty-four (24)~~ **forty-eight (48)** hours' notice then paragraph ~~(b)~~ **(a)** – shall apply to casual part-time nurses.

~~(c)~~ **(d)** Where a hospital is encountering problems around the provision of personal notice to nurses, the parties will endeavour to resolve these concerns at the Hospital-Association Committee.

EMPLOYER POSITION

Opposed.

RATIONALE FOR UNION PROPOSAL

The Union's proposal supports the retention and recruitment of part-time nurses. The proposal extends the notice of shift change that a hospital is required to provide to part-time nurses (regular and casual) from 24 hours' notice to 48 hours' notice. The Hospitals are already contracted to provide 48 hours' notice to full-time nurses. The Union's proposal harmonizes this work-life balance provision between full-time and part-time nurses.

The Hospitals are facing a recruitment and retention problem. Many career nurses are burnt out and leaving the sector or even the profession. Staff shortages, in turn, have exacerbated schedule disruptions. Nursing has become a less attractive career option for young graduates. One of the ways that the Employer could improve work-life balance for existing part-time employees, and make part-time nursing attractive to new recruits, is by providing more stable work schedules. 48 hours of notice—which is currently the standard for full-time nurses—allows part-time nurses to predict and plan their lives outside of work.

Part-time nurses are entitled to have their off-work hours respected in the same way as full-time nurses. This quality-of-life improvement for part-time workers will support the recruitment of additional part time nurses, which will decrease the Employer's reliance on overtime and agency nurses. In 2016, the Albertyn Board noted that the addition of more part-time and casual nurses was one means of reducing the use of temporary agencies:

> As part of its effort to maintain job security for its members, the Union has proposed the elimination of the use of agency nurses. We have been provided with details of the extent of use of agency nurses by participating hospitals. There is a substantial variation. A number of hospitals make no use of agency nurses. A few use agency nurses extensively. The Union asks for a complete prohibition against the use of agency nurses. In our view greater effort should be made by hospitals to avoid the use of agency nurses by bolstering the pool of part-time and casual nurses in the bargaining unit.

In order to encourage the hiring of more part-time and casual nurses, the Albertyn Board lowered the cap of total agency use from 2% to 1.5% and increased the penalty to be paid to the Union for agency hours above the cap, from 38 cents to 62 cents.

Unlike the Albertyn Board award, the current proposal is a no-cost proposition that benefits all parties. The proposal primarily imposes an administrative obligation on the Employer. This administrative obligation benefits the Employer because nurses

that can maintain a better work-life balance are less likely to leave the hospital sector. The Employer should equally compensate all nurses (full-time and part-time) for the interruption of off-work hours within the 48-hour window. However, so long as the Employer provides the requisite notice, the Union's proposal comes at zero added cost to the Employer.

The disruption of a nurse's work schedule significantly impacts her ability to create a healthy work-life balance and avoid burnout. The Employer can provide part-time nurses with 48 hours' notice of a shift change, because it already does so for full-time nurses. The Union is simply seeking harmonization with a comparator group within the same central bargaining unit. Improving the ability of part-time nurses to balance their work life and their personal life will help the Hospitals to recruit and retain more part-time (regular and casual) nurses. This will, in turn, address the Employer's heavy reliance on overtime hours and temporary agencies to fill vacancies.

For all of these reasons, the Union's proposal ought to be awarded.

7. NURSE PRACTITIONERS

ARTICLE 19.01(a): COMPENSATION: NURSE PRACTITIONER GRID

UNION PROPOSAL

***NEW* Nurse Practitioner Grid**

Classification – Nurse Practitioner		
	1-Apr-23	**1-Apr-24**
Step 1	$71.49	$75.78
Step 2	$72.95	$77.33
Step 3	$74.43	$78.90
Step 4	$75.95	$80.51
Step 5	$77.51	$82.16
Step 6	$78.86	$83.59

EMPLOYER POSITION

- No central grid for Nurse Practitioners

RATIONALE FOR UNION PROPOSAL

The Union's proposal for a central Nurse Practitioner ("NP") wage grid is consistent with the principles of harmonization and parity among similar workers doing similar work. A centralized NP grid—much like the central RN grid—offers wage predictability and stability between the participating hospitals, encouraging retention and aiding recruitment. The proposed wages for the central NP grid are uniquely based on internal comparability and are consistent with a demonstrated need for hospitals to attract and retain NPs. The adjusted wage rates proposed by the Union reflect the breadth and scope of an NPs extended practice, qualifications, and responsibilities.

1) Harmonization and Parity

According to the CIHI, as of 2021, Ontario had 3649 NPs. Of those, 37.6% were working in Ontario hospitals. At last count, there were 524 NPs in the bargaining unit working at 78 of the participating hospitals.

Harmonization and In-Classification Wage Parity is the Standard between the Parties

The Union's proposal for a centralized NP grid—a priority proposal advanced in multiple rounds—is based on the basic principle of equal pay for equal work. NPs at the participating hospitals are the same professionals, assigned the same classification, doing the same work, for the same employers (i.e. hospitals). We know that a centralized wage grid for professionals within a single classification is an item these parties can agree to in free bargaining: a centralized wage grid for RNs has been a pillar of the centralized agreement for over forty years. The fact that there has never been an attempt to decentralize the RN grid is evidence that there is nothing antithetical about standardizing NP wages province-wide.

The Union's proposal to create a central NP grid would harmonize the wage rates and step progression of the 524 NPs covered by the collective agreement. At present, there are NP grids with 10 steps, 4 steps, 6 steps, 7 steps, and 8 steps. The "Start" rates range from $53.47 to $66.89, the top rates range from $58.52 to $69.35.

The degree of variance in NP salaries between participating hospitals is clear, and it is extreme. The top rate at some hospitals is well below the start rate at others. For example, an NP in Georgian Bay waits 8 years to earn $60.01/hour. Only two and a half hours away, in Peterborough, an NP receives $66.86/per hour on day one. The same two hospitals pay their RNs identical wages from day one to year 8. Paying RNs identical wages makes sense. Paying a year-one NP in Peterborough 11.4% more than a year-8 NP in Georgian Bay does not.

The start rates for NPs vary considerably, even within common geographical regions. For example, the start rate of an NP at Lakeridge Health, in Oshawa, is 23.23% higher than the start rate for an NP at Mackenzie Health, only 50 minute away, in Richmond Hill.

The Union's proposal is intuitive. Not only are the parties already familiar with bargaining around a central grid, the process of harmonizing wage grids between hospitals is not a foreign concept to the Hospitals. The Union's proposal bears many

similarities to the upward wage harmonization that occurs—both by mutual agreement and arbitral awards—when hospitals in the province amalgamate. One distinction is that the amalgamation procedure typically involves a job matching process, where job descriptions are examined to determine matching classifications. In the case of NPs, a matching process is entirely unnecessary because the employees in question already share one classification across the province. Like RNs, NPs carry the same credentials and are subject to the same professional regulatory body province-wide.

In *CUPE v Scarborough Health Network* [*Scarborough Health*], Arbitrator Gedalof provided detailed reasons why hospital amalgamations typically result in harmonized wages at the highest level. He explained that this preserves previously bargained outcomes between the parties. In *Lakeridge Health v Canadian Union of Public Employees, Local 6364*, Arbitrator Gedalof highlighted other interest arbitration decisions where the same conclusion was reached:

> There is a well-established pattern in the hospital sector of post-merger harmonization of wages to the higher rate. This pattern is reflected in numerous voluntary settlements, and Arbitrators have adopted this approach on the basis of replication (See, e.g., *The Niagara Health System and Service Employees International Union, Local 204*, July 5, 2002 (Kaplan) at p. 2-4, *Participating Hospitals and Canadian Union of Public Employees,* March 4, 2011 (Petryshen), *Trillium Health Partners and CUPE,* December 9, 2015 (Kaplan)).
>
> This well-established sectoral pattern is also consistent with what these parties freely negotiated in the year 2000, when resolving the wage harmonization issues arising from the merger of the Oshawa Whitby, Port Perry, Bowmanville and Uxbridge hospitals that formed Lakeridge Health Care. In all cases, the parties harmonized to the highest rate. In all the circumstances, we are satisfied that it is appropriate to harmonize the outstanding classification to the higher Ajax rate, but without retroactivity.

Similar to an amalgamation, the Union's proposed central grid simply harmonizes the existing NP grids by using the highest start rate and highest top rate as guide posts. These rates exist as a result of previous settlements and awards between the parties.

The Union's Proposal for a Central Grid is consistent with Gradualism

Another compelling reason to fully award the NP grid in this round of bargaining is that an NP grid was already awarded in principle in the 2016-18 round of bargaining. During that round, the Board, chaired by Arbitrator Albertyn, found as follows:

> We are persuaded by the Union that there ought to be a salary grid for the Classification - Nurse Practitioner (NP). From the info provided by the parties in their briefs it is apparent that there is a wide discrepancy both in the number of steps of NPs' salaries, and in the salaries paid to them.

Despite this finding, Arbitrator Albertyn opted to leave much of the deeply inequitable wage structure intact and referred the issue of a central grid back to the parties:

> A committee is to be struck between the Hospitals and the Union to make recommendations to the parties on an integrated Classification Grid for NPs that will form part of the central agreement, having regard to the range of rates applicable across the participating hospitals, for use in future bargaining. The parties are directed to agree to a letter giving effect to this Committee. If they cannot agree to the letter, we remain seized.

Respectfully, this order reanimated the stalemate that the parties were in prior to advancing the matter to interest arbitration. The subsequent meetings between the parties to discuss the central wage grid recommendations were wholly unsuccessful, as the Employer continued to object to the notion of a central wage grid. Any similar order would be equally fruitless. In *Scarborough Health*, the Board rejected the Employer's proposals to set up a parallel process outside of interest arbitration to resolve the wage harmonization issue—saying it would effectively require the Union to forfeit its right to have its collective agreement determined by a board of arbitration.

Because the NP grid was not resolved by the Albertyn Board award, the proposal was raised again (2018) and again (2021) in subsequent rounds. In 2018, the Kaplan Board declined to award the proposal. The reason for the denial was not addressed in the Board's decision. In 2021, the Gedalof Board likewise declined to award the proposal, but noted that the proposed item was moot given the limitations imposed by Bill 124:

> For NPs, extended class nurses with an expanded scope of practice, the Association proposes to introduce a single standardized 6-step wage grid with a top rate at 5 years. Currently, the wage grid for NPs varies from one hospital to another, with a variety of wage rates and steps. The Association further proposes that RNs and NPs be placed on these grids so that they receive a salary increase.
>
> …

> We are similarly precluded from awarding enhanced placement on the salary grid for NPs, which would also represent an incremental increase in compensation within the meaning of Bill 124.

It has now been seven years since the Albertyn Board awarded the NP grid in principle. Resolving the item in this round is consistent with the principle of gradualism in collective bargaining. The proposal is not a breakthrough item. Rather, the Union's proposal seeks to finalize this matter in a prudent manner. The outcome proposed by the Union is preferable to maintaining the widely varying wage rates between the same professionals, doing the same work, in the same sector.

ONA's Proposal for a Central Grid is consistent with the Recommendations of other Nursing Groups

The harmonization of NP wages is not simply an ONA concern. While ONA has been raising its central grid proposal in bargaining for years, other nursing bodies have also advocated for harmonized wages to support the recruitment and retention of NPs in Ontario.

In 2018, the Canadian Federation of Nurses' Unions ("CFNU") released a report examining the untapped potential of NPs in Canada's health care system. The CFNU noted that compensation for NPs varied widely in different health care settings. The report included recommendations for remuneration, including:

> Harmoniz[ing] NPs' salaries across all health care settings within each province/territory to substantially bridge the wage gap that currently exists. In determining what constitutes appropriate compensation, account for NPs' formal education and experience, their scope of practice, professional responsibilities, as well as their accountability as autonomous health care providers.

In 2021, the Registered Nurses' Association of Ontario ("RNAO") released a report by its Nurse Practitioner Task Force entitled "Vision for Tomorrow". In that report, the task force made eight recommendations to the provincial government, which included harmonization of NP compensation across all sectors and settings. Specifically, the task force noted:

> Retention and recruitment of NPs is essential for their successful integration and utilization within the health system. In order for the system to reap the benefits of existing NPs and to grow the number of NPs, it must be able to attract and retain them through fair, harmonized compensation across the system.

Lastly, the Nurse Practitioners' Association of Ontario ("NPAO") included the harmonization of NP compensation across all sectors as part of its 2021 Ontario Budget Requests. In its presentation, the NPAO recommended that the compensation scales of NPs be aligned across all healthcare sectors. The NPAO offered the following justification:

> For almost a decade, Nurse Practitioners wages were frozen. Finally, with the announcement of the Primary Care Recruitment and Retention Funding in the 2016 and 2017 Provincial Budgets, improvements were made to compensation for NPs in funded primary care models. However, this does not address compensation for NPs employed in other healthcare sectors, such as hospitals and LTC. Most NPs working outside of the organizations covered by the recruitment and retention funding continue to make well below the minimum suggested salary rate identified in the "Developing a Provincial Compensation Structure for Primary Care Organizations – 2012 Report" produced by the Hay Group. Nurse Practitioners work across the healthcare system in a wide variety of settings. In this current compensation model, compensation equalization does not exist, resulting in NPs with similar responsibilities not getting equal pay for the same work. For this reason, the NPAO recommends a targeted investment to equalize Nurse Practitioner compensation across ALL sectors.

In sum, the harmonization of NP wages by way of a central grid has been a refrain echoed by professional groups across the province and at the national level. A central wage grid for NPs is a workable proposal because a central wage grid has worked for RNs for over forty years. The proposal is also workable because it copies the harmonization process adopted during hospital amalgamations. A decision by this Board awarding a central grid is not a breakthrough, but the next logical step following the Albertyn Board's decision, in 2017, that there ought to be a salary grid for the NP classification.

2) Wage Adjustment

The central NP grid proposed by the Union is an amalgam of existing NP wage grids among the participating hospitals. The Union's proposal takes the highest existing start rate and the highest existing top rate to create a six-step grid, with the highest rate achieved after five years. The NP grid would then be adjusted by 10% (avg) in 2023, and 6% (ATB) in 2024, mirroring the 2024 ATB proposal for RNs. The 2023 adjustments are an average of 10% (as opposed to ATB of 12%) in order to construct a reasonable span between the start rate and top rate. The Union's adjustment widens the gap between the start rate and the top rate on the new grid from 3.6% (pre-adjustment) to 10.3% (post-adjustment). This allows for reasonable progressions up the grid of approximately 2% each year.

Classification – Nurse Practitioner				
STEP	**1-Apr-22**	**1-Apr-23 12% (avg)**	**1-Apr-24 6% ATB**	**% Progression between new grid Steps**
1	$66.89 (highest existing start)	$71.49 (6.8%)	$75.78	--
2	N/A	$72.95	$77.33	2.0%
3	N/A	$74.43	$78.90	2.0%
4	N/A	$75.95	$80.51	2.0%
5	N/A	$77.51	$82.16	2.1%
6	$69.35 (highest existing top rate)	$78.86 (13.7%)	$83.59	1.7%

The new NP start rate is approximately 26% above the new top rate for RNs proposed by the Union. This wage differential recognizes that NPs have a higher level of training and a greater scope of practice than RNs. NPs provide a bridge between medicine and nursing with the authority to diagnose, prescribe medication, perform procedures, and order and interpret diagnostic tests. The NP scope of practice includes the ability to admit, treat, and discharge patients from hospitals. As the CFNU noted in 2018:

> Currently, widely varying total compensation (including salaries, pensions and benefits) for NPs exist between different health care settings and across the country. The analysis of unionized salaries shows that the gap between RN maximum and NP minimum salaries is insufficient to attract and retain NPs.

At present, there is only a 5.2% gap between the lowest start rate for NPs and the RN top rate. The Union's proposed NP grid addresses long-standing inequities between bargaining unit NPs and achieves a gap between RN and NP wages that will enhance the recruitment and retention of NPs.

There is a demonstrated need to recruit and retain nurse practitioners

The OHA's Fall 2022 "Health Human Resources Workforce Survey" included vacancy rates for combined RN and RN-Specialty, which includes NPs. That survey found that

between March 31, 2018 and October 2022, the vacancy rate for RN and RN-Speciality had tripled (from 4.90% to 14,78%). The turnover rate (i.e. that rate of resignations, retirements, and involuntary separations) had doubled (from 7.52% to 14.81%). While retirements and involuntary separations had increased, their rates remained relatively stable. The same was not true for resignations. Between March 31, 2018 and September 30, 2022, the resignation rate more than doubled, from 4.98% to 10.93%.

Further evidence of a need to recruit and retain NPs can be found in the extraordinary measures taken by the government of Ontario to attract and retain NPs. The Community Commitment Program for Nurses ("CCPN") allows eligible hospitals to provide $25,000 to Nurse Practitioners who have not been employed in Ontario for the last six months and who make a two-year commitment to full-time work with the hospital. Hospitals are only eligible if they can demonstrate that they were unable to fill the position internally. The participating hospitals are utilizing the program to bring in NPs. For example:

> *Thunder Bay hospitals use $25K incentive to attract nurses*, dated January 25, 2023: Thunder Bay's hospitals are taking advantage of a provincial government program to try to fill job openings for registered nurses, registered practical nurses and nurse practitioners…Last fall the two city hospitals [St. Joseph's Care Group and Thunder Bay Regional Health Sciences Centre] reported they had 195 openings for RNs, RPNs and nurse practitioners between them.

Similar to the CCPN, the Ontario government has offered the Temporary Retention Incentive for Nurses Program ("Retention Incentive") to Nurse Practitioners who are already practicing and employed within the system. The Retention Incentive provides two payments, of $2500 each, to eligible NPs.

These measures by the government are short-term solutions to a long-term problem. As indicated in its name, the Retention Incentive is temporary. These recruitment and retention incentives do not result in any permanent wage increases for NPs.

As noted in the OHA "Practical Solutions" report, the hospitals are facing health human resource issues across multiple health care professions. The system requires forward thinking and long-term solutions: what the OHA describes as the need to find "bold solutions and aggressive strategies." Recruiting more NPs into hospitals would fill gaps in medical care and alleviate the pressure on the system to recruit more physicians, which is a more costly endeavour. The Canadian Federation of Nurses' Unions describes Nurse Practitioners as "untapped potential" for a reason. Multiple studies have found that:

> Nurse Practitioners (NPs) help to improve timely access to individualized, high-quality, cost-effective care, resulting in shorter wait times, reduced costs, prevented (re)admissions and better interprofessional collaboration.
>
> Integrating NPs has been shown to improve patient and system outcomes and contribute to high-quality chronic disease management, helping to improve the health status of individuals on several measures. In fact, research indicates that health outcomes are as good as, or better than, comparators.

Harmonized wages for NPs, at a level that is commiserate with their skills, ability, and training, will offer a solution to recruitment and retention issues in the immediate term, and alleviate overall costs to the system in the long term.

Internal Comparators Offer a Reasonable Starting Point for Wage Adjustment

The best comparator for an NP is another NP. Even better: an NP working for the same employer (hospital) as another NP. Uniquely, NPs governed by the central agreement provide their own comparators. As noted above, the Union's central grid proposal is derived from the pre-existing rates among the participating hospitals. They represent the outcomes of both free collective bargaining and arbitral awards. Similar to an amalgamation, they provide a starting point by way of upward harmonization. In *Scarborough Health*, the employer argued against this approach, noting that:

> [T]he rates at each site reflect historical trade-offs in bargaining and local priorities, a balance that would be undermined by harmonization to the highest rate."

The Board did not share this concern. Rather, the Board cited a long line of cases favouring upward harmonization and noting that this upward harmonization prevents ongoing and administratively burdensome red circling, in which employees would continue to work—in some cases side-by-side—at different rates.

In this case, as noted above, the current "start" rates range from $53.47 to $66.89, the top rates range from $58.52 to $69.35. These rates are distributed across grids spanning different lengths. The upward harmonization proposed by the Union would begin at Step 1 with the existing the highest "start" rate of $66.89 and end with the existing highest top rate at $69.35.

External Comparators Support Significant Wage Adjustments

Following the adjustment of the start rate and end rate to match internal comparators, the Union's proposal then adjusts the start and end rates by 6.8% and 13.7% to allow for a reasonable progression of 2% per annum up the grid.

While the 6.8% and 13.7% wage adjustments proposed by the Union, first and foremost, result in a reasonable annual progression between steps, the 6.8% and 13.7% adjustments are also consistent with the annual salary for NPs recommended by the Korn Ferry Hay Group ("KFHG"). In 2012, the NPAO and others commissioned the KFHG to analyze the salaries and responsibilities of professionals across the health sector and make specific compensation recommendations for NPs.

In its analysis, the KFHG recommended a pay scale for NPs based on its established comparator, in this case, clinical psychologists. In 2012, the KFGH recommendation was for a maximum annual salary of $135,915, based upon 1950 hours annually ($69.70/hour). In 2017, the NPAO requested an updated review. At that point, the KFGH suggested a maximum annual salary of $147,712 ($75.75/hour) and a minimum salary of $108,488 annually ($55.63/hour). These numbers, adjusted for their 2023 value, result in a max rate of $90.23/hour and minimum rate of $66.27/hour. The recommended maximum, adjusted for inflation, is well above the to top rate in the Union's proposal for both 2023 and 2024. The recommended minimum rate is nearly identical the Union's proposal for the entry level rate in 2023.

Based on disclosures provided by the OHA, the Union's NP central grid proposal would come at a minimal cost to the Employer: roughly 0.21% of total compensation. A modest proposal with a major impact.

Conclusion

For all of the above reasons, the Union submits that its proposal for a central NP wage grid should be awarded. Resolving the gross disparity in wages among the same workers, of the same profession, of the same classification, in the same sector, will replicate what the Union and Employer would have agreed to in free bargaining.

Harmonization and same-classification wage parity is the standard that has been set by these parties. The RN wage grid has been a pillar of the central agreement for over forty years. Like the RN grid, the establishment of a central NP grid will improve the efficiency of labour relations and demonstrate equity between identically classified employees, with identical classifications, doing identical work.

The Union's proposal represents the culmination of a gradual progression towards a centralized grid for NPs. In 2017, the Albertyn Board awarded a central grid in principle, finding that an NP central grid ought to exist. However, the Board created a parallel process in order to move towards the establishment of a central grid. That process proved unsuccessful, and the proposal has been raised again and again in subsequent rounds. In tandem with the Union's efforts to carry this item forward in each round, other nurse advocacy groups—the RNAO, NPAO, and CNFU—have all issued reports that recommend harmonizing NP wages across all sectors.

The central grid proposed by the Union includes wage adjustments that are consistent with the need to recruit and retain NPs in the short, medium, and long-term. The starting point for these adjustments is the highest start rate and highest end rate

that already exist within the participating hospitals. Added to this are wage rate adjustments that allow for a six-step grid with uniform progression from one step to the next (2%) and a total 10.3% wage differential from the bottom to the top of the grid. The adjustments are also equal to or less than the wage rates recommended as a result of the KFHG analysis.

The Union submits that its proposal for a central NP grid be awarded and that the Board remained seized with respect to the implementation of the new grid.

ARTICLE 19.05(b): COMPENSATION

NEW [RN EXPERIENCE OF NURSE PRACTITIONERS]

UNION PROPOSAL

19.05 **(a)** Claim for related clinical experience, if any, shall be made in writing by the nurse at the time of hiring on the application for employment form or otherwise. Once established consistent with this provision, credit for related experience will be retroactive to the nurse's date of hire. The nurse shall co-operate with the Hospital by providing verification of previous experience so that their related clinical experience may be determined and evaluated during their probationary period. Having established the related clinical experience, the Hospital will credit a new nurse with one (1) annual service increment for each year of experience (for part-time nurses, experience will be calculated pursuant to the formula set out in Article 16.03) up to the maximum of the salary grid.

If a period of more than two (2) years has elapsed since the nurse has occupied a full-time or a part-time nursing position, then the number of increments to be paid, if any, shall be at the discretion of the Hospital. The Hospital will give due consideration to an internationally educated nurse's experience where the process for registration with the College of Nurses of Ontario has prevented them from occupying a nursing position for a period of more than two (2) years. For full-time nurses, the Hospital shall give effect to part-time nursing experience, and for part-time nurses the hospital shall give effect to full-time nursing experience.

NOTE: For greater clarity, related nursing experience includes related nursing experience out of province and out of country.

(b) It is understood and agreed that RN experience shall be applicable in determining placement on the grid for Nurse Practitioners (NPs).

EMPLOYER POSITION

Opposed.

RATIONALE FOR UNION PROPOSAL

Article 19.05 provides one-to-one credit for related clinical experience to RNs. The value of article 19.05 for recruitment is obvious: RNs can join a hospital without

losing years of experience. The value to the Hospital is also clear: the Hospital gets the most experienced nurses, who can provide the best care to patients.

The same logic applies, even more forcefully, to Nurse Practitioners. NPs are highly qualified—and highly experienced—medical professionals. Before becoming NPs, they must work for at least two years as an RN, though, on average, they have worked 17 years as an RN and as an RN in the Extended Class for six years. They must study for a further two years to obtain a graduate diploma.

NPs bring high value to the hospital setting. They have a broad scope of practice. They are competent to diagnose conditions and prescribe medications, including controlled substances. They can perform comprehensive assessments, refer patients to specialists, and develop treatment plans. They can provide medical assistance in dying.

NPs bring significant experience as RNs to their work. This experience makes them better NPs, who can provide better care, more efficiently, taking pressure off both RNs and MDs. The value of prior work experience is a core reason why such experience is universally recognized by placement on the wage grid. Yet, when NPs join a hospital's workforce, they are treated as though they have no prior relevant experience.

Failing to recognize prior RN experience hurts the recruitment and retention of NPs. Currently, there is only a 5% different between the top of the RN wage grid and the lowest first step on the NP wage grid. This is a serious barrier to recruitment. It also provides little incentive for RNs already employed withing the hospital sector to update their credentials. Former RNs, now NPs, should not have their prior experience erased when they have created a benefit for themselves—and the Hospitals—by expanding their credentials.

There is a demonstrated need to address this issue. In 2007, Arbitrator Burkett found that the existing collective agreement language did not allow the Employer to take into account RN experience when placing RNs on the NP grid because it would create an inequality between internal and external hires. This has created an obvious barrier to recruitment that some NP employers are already taking steps to correct. Hotel Dieu Grace Healthcare, has already voluntarily agreed to recognize RN experience of currently employed NPs and new NP hires/transfers. The Letter of Understanding finalizing this agreement notes that "ONA and the Hospital have a common desire to enhance the ability to successfully recruit and retain Nurse Practitioners at Hotel Dieu Healthcare." The Union's proposal would extend the same entitlement to all NPs covered by the collective agreement.

In addition to Hotel Dieu, several long-term care homes that employ NPs, represented by ONA, recognize the RN experience of NPs. These include the IOOF Home, a large long-term care home in Barrie, the Rainycrest Long Term Care Home, and the District of Kenora Home for the Aged. For example, at Rainycrest, a Letter of Understanding (LOU) between the Employer and ONA, signed in April 2022, states:

> Effective date of ratification, recent related experience will be recognized on the basis of one (1) annual increment for each one (1) year of service up to the maximum of the wage grid. Related experience shall include both Registered Nurse and Nurse Practitioner experience.

The LOUs between ONA and Hotel Dieu, and ONA and Rainycrest, are examples of voluntary agreements that rationally recognize the value of the prior RN experience of NPs.

The Union's proposal ought to be awarded by the Board.

LETTER OF UNDERSTANDING

NEW [LOU RE NURSE PRACTITIONERS]

UNION PROPOSAL

***NEW* Letter of Understanding re Nurse Practitioners**

The parties agree that addressing issues related to clinical and non-clinical responsibilities will optimize the Nurse Practitioner workforce, improve quality patient care and outcomes, and foster quality work environments.

To that end, the local parties will collaborate to establish guidelines and parameters whereby Nurse Practitioners will devote 80% of their time to clinical responsibilities and approximately 20% to non-clinical responsibilities. These non-clinical responsibilities may include but are not limited to administrative duties, research, education, leadership, policy and procedure development, vacation catch up and education material development.

Additionally, the local parties will collaborate to establish guidelines and parameters where preceptorship stipends are received directly from universities. For clarity, this funding is in payment for administrative and/or other duties related to a preceptorship that occurs outside of paid clinical time.

EMPLOYER POSITION

Opposed.

RATIONALE FOR UNION PROPOSAL

The Union's proposal envisions a collaborative framework for ensuring that Nurse Practitioners receive allotted time to focus on non-clinical responsibilities. This proposal is supported by a demonstrated need to recruit, support, and retain NPs within the hospital sector.

The Hospitals are facing an acute shortage of direct care providers, increased wait times, and access issues. NPs can and must play a vital role in filling these gaps in the healthcare system. Non-clinical hours for NPs are necessary for NPs to maintain professional credentials and optimal standards of patient care.

NPs, also known as Registered Nurses in the extended class, are RNs who have met additional education, experience, and exam requirements set by the College of Nurses of Ontario. To become an NP, a nurse must have a minimum of 5 years of

clinical experience and then complete a minimum of 2 years of university. They are authorized to diagnose, order, and interpret diagnostic tests, and prescribe medication and other treatment.

NPs serve an increasingly critical function in the healthcare system, particularly in underserved communities that struggle for access to physicians. They are the fastest growing nursing category in Canada and provide vital expertise as clinicians, leaders, educators, and researchers. In Ontario, the number of NPs per 100,000 population has increased every year since 2017 from 21.4 to 26 in 2021.

Yet, the role of NPs is frequently misunderstood. In 2018, the Canadian Federation of Nursing Unions ("CFNU") conducted a Canada-wide study of NPs which found that a general lack of understanding of the NP role by hospital and health care leaders contributes to job dissatisfaction and suboptimal utilization of the NPs to meet the health care needs of Canadians.

The CFNU study further identified that, to maintain specialist knowledge and competence, "it is essential that NPs be given the support, protected time, and resources" to do so. It found that 47% of NPs reported dissatisfaction with the opportunities for professional development, and the amount of paperwork and time required to complete it. These ranked among the top five most important factors for improved recruitment and retention.

The CFNU Study also observed that NP-specific language in collective agreements related to professional development varies greatly by province, an observation that is borne out in recent RN agreements across the country.

Nonetheless, some provinces have shown a willingness among hospital employers to adapt to the particular needs and capacities of NPs. For instance, Nova Scotia's Central RN agreement includes detailed provisions concerning NPs, including a "collaborative scheduling process" to allow NPs to meet operational requirements.[333] Saskatchewan's Central RN agreement provides an additional 8 hours of professional development leave for NPs—double what it offers to other RNs. While these efforts are laudable, there is still ample room for Ontario to be a leader in facilitating NP integration into the healthcare system.

Moreover, as Ontario continues to spearhead the development of Ontario Health Teams ("OHT"), a new model for integrating various health services within local communities, NPs can have an increased role in facilitating care. For this reason, the Nurse Practitioners' Association of Ontario has called for standardized guidelines around the time commitment and compensation of OHT planning work for NPs.

NPs require discrete, allotted, and paid time to attend to their non-clinical responsibilities. The Union's NP members report that their clinical responsibilities often overwhelm their time for administrative tasks, research, and professional development. The result leaves NPs with insufficient time to harness the key capacities of their role. While this is an urgent concern for the Union, it ought to be a concern for the Hospitals as well.

The Union's proposed LOU seeks to remedy barriers to the successful integration of NPs at a local level. While the lack of dedicated non-clinical time remains a systemic, province-wide issue, the solution will vary between each workplace and depend upon the unique role NPs play hospital to hospital. For this reason, the Union is not seeking to impose onerous, substantive requirements on NPs hours or time, but only a collaborative framework whereby NPs receive the necessary time they need for non-clinical tasks.

The LOU also seeks to create a local-by-local framework for how stipends are received from Universities for NPs' professional development. Again, both parties and the healthcare system benefit from allowing NPs to gain access to opportunities for professional development in their communities.

For all of these reasons, the Union's proposal ought to be awarded.

8. HEALTH AND WELLNESS

ARTICLE 6.05(f): OCCUPATIONAL HEALTH & SAFETY

NEW [SALARY CONTINUATION DURING QUARANTINE ETC.]

UNION PROPOSAL

6.05 ***NEW***

(f) Employees who are absent from work due to exposure to a communicable disease, required to quarantine or self-isolate, or otherwise prevented by law or any order, directive, or employer policy from attending the workplace shall be entitled to salary continuation. The Hospital will notify the Union of the names of these employees within one (1) day.

EMPLOYER POSITION

Opposed.

RATIONALE FOR UNION PROPOSAL

Employees who are required to stay home and self-isolate should be paid during their absence. This proposal is justified by demonstrated need, replication, and basic fairness.

This is a priority item for the Union, as it was in the previous round of bargaining. In that round, Arbitrator Gedalof found that he was precluded from awarding it due to Bill 124.

Demonstrated need

The COVID-19 pandemic has clearly, and compellingly, demonstrated the need for this provision. Quite obviously, working in a hospital presents an inherent risk of exposure to communicable diseases. To mitigate that risk and/or comply with the law, hospitals may order nurses exposed to communicable diseases to stay home. Unsurprisingly, high numbers of nurses have been ordered to remain home throughout the pandemic due to exposure to COVID-19.

The Union argued forcefully in multiple cases that self-isolation due to COVID-19 exposure is, and ought to be, covered under the sick leave provisions of the Collective Agreement. Arbitrators rejected that interpretation and held that the current

language in the Collective Agreement does not include paid leave for employees who are required to self-isolate due to exposure to a communicable disease, such as COVID-19.

Notably, in at least two of those decisions, the arbitrators remarked that the parties were "free" to bargain amendments to the Collective Agreement to cover these circumstances. However, bargaining in this sector is not as "free" as these awards suggest. The workers in this bargaining unit cannot withdraw their labour and strike to obtain this benefit and, instead, only have recourse to arbitration in accordance with *HLDAA*. Therefore, this arbitration represents the only avenue by which the Union can secure this necessary amendment to the Collective Agreement.

Replication

In the long-term care sector, several arbitrators have addressed a similar gap in collective agreements and recently awarded language to ensure that absences due to self-isolation are paid. The arbitrators awarded language allowing employees to use existing entitlements to vacation, sick days, or in-lieu entitlements for any lost days of work. In one award, Arbitrator Trachuk found that the union had made out a case for awarding this new language, both based on replication and demonstrated need.

The trend in the broader sector is to expand entitlements to paid leave to cover circumstances in which employees are required to stay home and self-isolate. This Board should follow that trend and award the Union's proposal.

Indeed, this proposal replicates what the parties would voluntarily agree to because several of them have already agreed to it in the context of the Covid-19 pandemic. Multiple participating hospitals voluntarily implemented paid leave for employees who were required to self-isolate, including Sunnybrook Health Sciences Centre, Southlake Regional Health Centre, Orillia Soldiers' Memorial Hospital, and the Champlain Health Regional Hospitals (Almonte General Hospital, Fairview Manor, Lanark County Paramedic Services and the Carleton Place & District Memorial Hospital).

Fairness and public interest

Simply put, it is unfair to ask nurses to bear the financial costs of reducing the spread of illness in the workplace. Nurses show up for work despite the risk of exposure to communicable diseases. They are limited in their ability to protect themselves from these exposures and have no control over the measures adopted by the Hospitals to address outbreaks of communicable diseases. It is patently unfair to place nurses at

risk of exposure, and then deprive them of their pay when they must remain home after an exposure.

This proposal also serves the interests of the Employer and the public interest. If nurses are paid during self-isolation, they are more likely to self-report exposures without fear of financial penalty and thereby reduce the risk of spreading disease in the workplace. Therefore, this proposal will help protect the Hospitals, employees, and patients in the event of any future outbreak or pandemic.

Finally, given that most COVID-19 public health orders have now expired, this proposal entails minimal costs to the Hospitals at this time.

For all of these reasons, the Union's proposal ought to be awarded.

ARTICLE 16.01 & 16.06: VACATIONS

NEW [8-WEEK ENTITLEMENT]

UNION PROPOSAL

[FULL TIME]

16.01 All employees shall receive vacations with pay based on length of full-time continuous service as follows:

~~(f)~~**(g)** **Employees who have completed thirty (30) years or more of full-time continuous service (as of the date for determining vacation entitlement in the individual hospital) shall be entitled to an annual vacation of eight (8) weeks with eight (8) weeks' pay (300 hours' pay for employees whose regular hours of work are other than the standard workday), provided the employee works or receives paid leave for a total of at least 1525 hours in the vacation year.**

~~(g)~~**(h)** If an employee works or receives paid leave for less than 1525 hours in the vacation year, they will receive vacation pay based on a percentage of their gross salary for work performed on the following basis:

3-week entitlement – 6%
4-week entitlement – 8%
5-week entitlement – 10%
6-week entitlement – 12%
7-week entitlement – 14%
8-week entitlement – 16%

NOTE: Employees who presently enjoy better vacation benefits shall continue to receive such better benefits while employed by the Hospital.

…

[PART TIME]

16.06 All regular part-time employees shall be entitled to vacation pay based upon the applicable percentage provided in accordance with the vacation entitlement of full-time employees, of their gross earnings in the preceding year. If an employee works or receives paid leave for less than 1100 hours in the vacation year, they will receive vacation pay based on a percentage of their gross salary for work performed on the following basis:

3-week entitlement – 6%
4-week entitlement – 8%
5-week entitlement – 10%
6-week entitlement – 12%
7-week entitlement – 14%
8-week entitlement – 16%

EMPLOYER POSITION

Opposed.

RATIONALE FOR UNION PROPOSAL

Vacation is a crucial aspect of modern working life. It allows employees to recharge and return to work refreshed and ready to perform their jobs. While vacation is a significant benefit at all points in a nurse's career, given the high workload and stress involved in the role, it is especially vital in the latter stages of their career.

Vacation entitlements have not improved for over a decade, since Arbitrator Devlin's award in 2011. That award lowered the service thresholds for five- and seven-week entitlements to 11 and 25 years of service, respectively. In the last round, Arbitrator Gedalof noted that Bill 124 precluded consideration of the Union's vacation proposal for long-service nurses. No such constraint exists in the current round.

Accordingly, the Union once again proposes an additional week of vacation for nurses who have completed thirty years or more of service. This proposal is supported by a demonstrated need to retain experienced nurses. The proposal is also in keeping with the principles of gradualism and comparability. Moreover, although it represents a modest percentage of total compensation, that small cost is more than justified by the significant impact on the retention of senior nurses.

Nurses are burnt out. While exhaustion and burnout are concerns in any profession, the need to address nurse burnout in the hospital sector is urgent. Nurses need relief from hospital understaffing, unsustainable workloads, and increasingly long hours. This is particularly the case as they enter the latter stages of their career and require additional flexibility in their working lives.

The Hospitals are struggling to retain experienced nurses, who cite exhaustion and heavy workload as reasons for leaving the profession.

In its 2022 report, *Practical Solutions to Maximize Health Human Resources,* the OHA acknowledged 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.

Despite this burnout, late career nurses report "a willingness to stay employed at the hospital in roles that offer more flexibility, such as part-time employment…"

A modest increase in vacation entitlement for nurses with 30 years of experience would allow late career nurses more flexibility in their work schedules akin to part-time employment. It would also provide much needed additional relief for experienced nurses from the stressful realities of nursing in the current climate. This stress-release value would have a considerable impact on retention and allow the hospitals to continue benefiting from valuable, experienced senior nurses.

An additional week of vacation at 30 years of service would also have a relatively insignificant impact on total compensation. Only 14.4% of ONA members are at or above 25 years of service. Given this narrow demographic, the estimated cost of this additional benefit is only $5,978,658 or 0.1% of total compensation.

The Union's proposal is far from an outlier in the sector.

Central RN agreements across the country contain vacation entitlements for late career RNs, well in excess of what the Union is proposing.

In Alberta and Manitoba, RNs receive six weeks of vacation at 20 years, and an additional week of vacation for each subsequent fifth anniversary of service. While Alberta RNs top out at 11 weeks at 45 years of service,[347] Manitoba contains no maximum vacation for late career RNs:

> In recognition of length of service, each nurse shall receive an additional five (5) days of vacation on completion of twenty (20) years of continuous service, and on each subsequent fifth (5th) anniversary of employment (i.e. 25th, 30th, 35th, 40th, etcetera).

Similarly, in British Columbia, RNs start at four weeks of vacation at one year of service and can receive up to 43 workdays of vacation (roughly 8.6 weeks) after 27 years of continuous service.

Considering the above, the Union's proposal represents a modest improvement in vacation entitlement that would address a shared interest in retaining long-service

nurses. It represents a small amount of total compensation and represents a gradual adjustment towards the comparable, yet superior entitlements, in other provinces.

For all of these reasons, the Union's proposal ought to be awarded.

ARTICLE 17.01(c): HEALTH AND WELFARE BENEFITS [HEALTHCARE SPENDING ACCOUNT]

UNION PROPOSAL

17.01 The Hospital agrees, during the term of the Collective Agreement, to contribute towards the premium coverage of participating eligible nurses in the active employ of the Hospital under the insurance plans set out below subject to their respective terms and conditions including any enrolment requirements:

…

(c) The Hospital agrees to contribute 75% of the billed premiums towards coverage of eligible nurses in the active employ of the Hospital under the Liberty Health Extended Health Care Benefits Plan (which is comparable to the existing Blue Cross Extended Health Care Benefits Plan) or comparable coverage with another carrier providing for $22.50 (single) and $35.00 (family) deductible, providing the balance of monthly premiums are paid by the nurses through payroll deductions. In addition to the standard benefits, coverage will include hearing aids [maximum $700/person every thirty-six (36) months]; vision care maximum $450 every 24 months with ability to use coverage for laser surgery); and Drug Formulary 3.

In addition to the above vision care shall include one eye exam per insured person every 24 months.

Extended Health Care benefits includes **an annually renewed Health Care Spending Account of $1000**. Chiropractic, massage therapy and physiotherapy coverage (maximum of $400/insured person annually for chiropractic, massage therapy and physiotherapy for each service). Superior benefits are to be maintained in those hospitals where payment for one or more of these services is covered.

EMPLOYER POSITION

Health Care Spending Account: one hundred ($100) dollars

RATIONALE FOR UNION PROPOSAL

The Union proposes a Health Care Spending Account of $1,000 to promote health and wellness. This proposal is supported by demonstrated need and is in line with the normative increases to health and welfare benefits awarded in past rounds between these parties.

In the 2021 award between these parties, Arbitrator Gedalof highlighted his inability under Bill 124 to award nurses "(e)ven highly normative and modest improvements to health and welfare benefits—commonly awarded by past boards of interest arbitration between these parties." Bill 124 is no longer a barrier in this round.

The purpose of a Health Care Spending Account is to promote employee well-being by providing coverage for wellness expenses not covered under the existing healthcare plan or through OHIP. Crucially, for this benefit to have value in promoting employee well-being, it must be capable of covering actual expenses.

Both parties agree on the introduction of a Healthcare Spending Account. However, the Hospitals' proposal of $100 is so low, it renders the proposed account virtually meaningless. A $100 per year account would barely cover a single appointment or expense. This amount is grossly out of touch with the cost-of-living and the increasing costs of health and wellness expenses. For example, an annual gym membership at Canada's most popular fitness centre costs more than eight times the employer's proposed account.

RNs are the backbone of the province's healthcare system and continue to work long hours to keep the Ontario's hospital network operational. The Union's proposal of $1,000 is a reasonable amount that can still make a meaningful impact on nurses' health and wellness.

ARTICLE 12.01: SICK LEAVE AND LONG-TERM DISABILITY [LTD COVERAGE TO AGE 80]

UNION PROPOSAL

12.01 …

The Hospital will pay 75% of the billed premium towards coverage of eligible employees **up to the age of 80** under the long-term disability portion of the Plan (HOODIP or an equivalent plan). The employee will pay the balance of the billed premium through payroll deduction. For the purpose of transfer to the short-term portion of the disability program, employees on the payroll as of the effective date of the transfer with three (3) months or more of service shall be deemed to have three (3) months of service. For the purpose of transfer to the long-term portion of the disability program, employees on the active payroll as of the effective date of the transfer with one (1) year or more of service shall be deemed to have one (1) year of service.

EMPLOYER POSITION

Opposed.

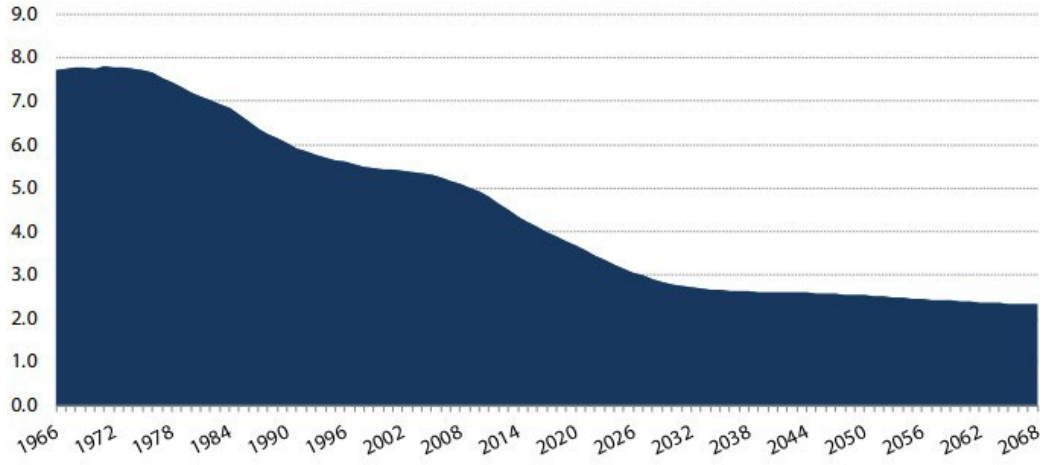
RATIONALE FOR UNION PROPOSAL

Under the current long-term disability ("LTD") plan, benefits terminate at age 65. While maintain LTD benefits for employees past the age of 65 is not a normative benefit, it is necessary to promote retention in the face of a rapidly aging workforce. This proposal will address the Hospitals' ongoing challenges retaining experienced RNs.

Canada's workforce has never been older.

According to Statistics Canada census data, the ratio between what is traditionally considered "working age" (15-64) and the over-65 demographic has been steadily declining, a trend expected to continue into the near and distant future:

Figure 3: Ratio of Working Age Population (Ages 15 to 64 years) to Those 65+, 1966-2068



Note: values from 2022 onwards are based on Statistics Canada's M1 population projection.
Sources: Statistics Canada, Tables 17-10-0005-01 and 17-10-0057-01.

Employers in every sector need to remove barriers to the workforce participation of older workers. Likewise, all employers must move beyond stereotypes about the costs and benefits of retaining older workers. University of Toronto Labour Economist, Morley Gunderson, identifies the loss of long-term disability and other benefits at age 65 as a key barrier to retention.

Hospitals are struggling to retain experienced RNs. In contrast to the overwhelming demographic trend across the country, the number of RNs working past their 60th birthday is declining. According to CIHI data, the percentage of RNs in Ontario over the age of 60 has declined each year since 2017:

Year	Total RNs	Age <30 (%)	Age 30-59(5)	60+(5)
2017	101,912	13.5	69.3	17.2
2018	102,396	14.2	69.4	16.4
2019	103,877	14.9	69.2	15.8
2020	104,976	15.3	69.4	15.3
2021	106,595	15.6	69.6	14.8

A gradual increase in LTD eligibility would improve retention and respond to the needs of a strained healthcare system.

This proposal would also address the collective agreement's compliance with the *Charter.* In 2018, the Human Rights Tribunal of Ontario held that it was contrary to the *Charter* for the *Human Rights Code* to exclude discrimination claims concerning a denial of benefits for employees over the age of 65*.*

Similarly, in *Rayonier v Unifor, Locals 256 and 89,* Arbitrator Knopf held that the restricting LTD to workers under the age of 65 "does amount to *prima facie* discrimination, contrary to s. 15 of the *Charter.*" While she found such restrictions may be justified under s. 1 by offering other benefits, both the Hospitals and the Union have a shared responsibility to ensure that their agreements remain compliant with the *Charter.*

Allowing LTD to terminate at 65, in the absence of actuarial evidence, uncritically relies on stereotypes about older workers and contributes to the trend of experienced nurses leaving the workforce. The Union's proposal should therefore be awarded.