In the matter of an interest arbitration pursuant to the
Hospital Labour Disputes Arbitration Act, R.S.O. 1990 c. H. 14, as amended ("HLDAA");

B E T W E E N:

THE PARTICIPATING HOSPITALS
(as represented by the Ontario Hospital Association ("OHA"))

("the Participating Hospitals" or "the Hospitals")

and

ONTARIO NURSES' ASSOCIATION

("the Union" or "ONA")

AWARD

Board of Arbitration:
Sheri Price, Chair
Philip Abbink, Union Nominee
Brett Christen, Hospitals Nominee

On behalf of the Union:
Wassim Garzouzi, Counsel
Julia Williams, Counsel
Adam Gregory, Counsel
Erin Ariss, Provincial President, ONA
Alan Warrington, Interim First Vice-President/Vice President, Region 5
Andrea Kay, Chief Executive Officer
Matthew Stout, Chief Operating Officer
David Cheslock, Regional Manager, Contract Administration/Negotiations Lead
Marilynn Dee, Manager, Negotiations
Patricia Carr, Manager, Negotiations/Organizing
Jason Dupras, Full-Time Region 1 Representative, ONA20
Tracey Devuono, Part-Time Region 1 Representative, ONA46
Kelly Robert, Full-Time Region 2 Representative, ONA3
Kelly Gagnon, Part-Time Region 2 Representative, ONA84
Devin Stephanian, Full-Time Region 3 Representative, ONA95
Jane Penciner, Part-Time Region 3 Representative, ONA6
Heather Bache, Full-Time Region 4 Representative, ONA70
Marianne Fletcher, Part-Time Region 4 Representative, ONA71

Jasen Richards, Full-Time Region 5 Representative, ONA100
Jo-Dee Brown, Part-Time Region 5 Representative, ONA8
Kieran Maxwell, Manager, Anti Racism and Anti Oppression
Ryan FitzGerald, Member Benefits Specialist
Dave Campanella, Economist, Labour Market Research, Collective Agreement Analysis
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On behalf of the Participating Hospitals:
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Dara Marcoccia, Royal Victoria Regional Health Care
Dean Osmond, Sioux Lookout Meno Ya Win Health Centre
Paulette Clannon, St. Joseph's Healthcare Hamilton
Danielle Sanagan, Trillium Health Partners
Robin Ross, Unity Health
Mandy Madill, University Health Network
Dawn Morrisette, West Nipissing General Hospital

Hearings were held in Toronto on April 2, 3, 14, and 17, 2025
Executive sessions held on May 29, June 3, 12, and 16, 2025

INTRODUCTION

[1] This interest arbitration board ("the Board") was appointed by the parties pursuant to the *Hospital Labour Disputes Arbitration Act* ("*HLDAA*") and the parties' January 13, 2025 Memorandum of Conditions for Joint Bargaining to settle the provincial terms of the renewal collective agreements between ONA and 127 Participating Hospitals (represented by the Ontario Hospital Association (the "OHA")). The previous collective agreements between the Union and

the Participating Hospitals expired on March 31, 2025. This is the 21st round of provincial bargaining between these parties.

[2] The collective agreements between the Union and each of the Participating Hospitals are comprised of provincial terms (previously referred to as "central terms"), which apply to all of the Participating Hospitals, and "local" terms, which are bargained between the Union and individual Hospitals at the local level. This award settles the provincial terms of the collective agreements between the Union and the Participating Hospitals, which cover approximately 62,000 nurses, nurse-practitioners and allied healthcare professionals in 71,000 full-time and part-time positions who provide healthcare to Ontarians in the 127 Participating Hospitals. The Participating Hospitals are located throughout Ontario and range in size from small rural general hospitals, with fewer than 10 nurses, to large tertiary care teaching hospitals, with more than 3,000 nurses, as well as hospitals specializing in certain aspects of patient care, such as rehabilitation and mental health.

[3] Notice to bargain was given on January 2, 2025 and the parties subsequently met to bargain for several days in January 2025, followed by two days of mediation later that same month. The parties were able to resolve a few minor issues. However, numerous issues remain in dispute, which were submitted to the Board for determination.

A BRIEF SUMMARY OF THE PARTIES' SUBMISSIONS

[4] The parties provided the Board with extensive written briefs with respect to the outstanding issues in dispute, which were supplemented by four days of oral evidence and argument and the post-hearing submission of numerous documents and bargaining outcomes. Although the Board has carefully considered the entire record in determining this matter, we provide only a brief overview of the parties' positions, sufficient to explain the reasons for our decision.

The Union's Proposals

[5] The Union says that its focus during the current round of bargaining is on nurses' health and safety, job security and wages. Although the Union put numerous proposals before the

Board, it focussed its oral submissions on four items: Registered Nurse-to-Patient ratios; protecting the work of the bargaining unit; the elimination of unpaid Transfer of Accountability (TOA); and, of course, wages.

Nurse-to-Patient Ratios

[6] The first item identified by the Union as a priority is its proposal for a new provision requiring the Hospitals to maintain specific minimum Registered Nurse-to-Patient ratios ("NPR") in 18 different units and/or sub-units of the Hospitals "24 hours per day, 365 days of the year," failing which the Hospitals would be required to put all non-urgent patient care "on hold." For example, the Union proposes that all Participating Hospitals be required to adhere to a 1:4 NPR in Adult Medical Surgical units, a 1:2 NPR in Step-Down units, a 1:1 NPR in Critical Care/Intensive Care units, and so on. The proposal, if granted, would also establish a requirement for every unit to have a Charge RN with no patient assignments.

[7] The Union submits that, at present, there is a wide divergence in how Ontario hospitals staff the same types of units with RNs. For example, while some Adult Medical Surgical units (one of the largest and most ubiquitous units among the Participating Hospitals) are meeting or close to meeting the Union's proposed ratio of at least one RN for every four patients (1:4), the Union says that several others require RNs to care for three to six times as many patients (and one Participating Hospital assigns one RN to care for 69 patients). The Union says that its proposal will ensure that RN staffing levels across the Participating Hospitals are coherently linked to the protection of nurse health and safety and the required level of patient care. The Union further submits that its proposed ratios are practical and feasible, as evidenced by the fact that 13 of them are currently being met by at least one Hospital in the province, and 22 Hospitals are already staffing between one and four of their units to the proposed ratios.

[8] In support of its NPR proposal, the Union relies on the expert evidence of Dr. Linda Aiken, a professor at the University of Pennsylvania who founded the Center for Health Outcomes and Policy Research. Dr. Aiken was not consulted on ONA's proposal, but she was qualified as an expert on Nurse-to-Patient ratios generally, including their outcomes on nurses and patients. Dr. Aiken testified that nurses have one of the highest burnout rates of any profession. She explained that burnout is caused by the stress that arises when a nurse does not have control over the resources that she needs to meet her employer's expectations or her own personal expectations for a job well done. Although many things, such as missing resources or operational failures,

contribute to the stress that causes burnout, Dr. Aiken testified that inadequate staffing has been identified as a major factor. Indeed, she testified that the top reason that nurses leave the nursing profession is job dissatisfaction and burnout, linked to insufficient staffing. Drawing on the experience of other jurisdictions, such as California and Oregon in the United States and three Australian states, Dr. Aiken testified that the implementation of minimum nurse-to-patient ratios (NPR) has proven to be an effective way to reduce burnout, improve job satisfaction, decrease intent to leave the workplace and enhance nurse safety by reducing incidents of emotional and physical abuse (by patients and/or families). Apart from the impact on nurses, Dr. Aiken testified that the implementation of minimum NPR has been shown to have a positive impact on patient outcomes by reducing the length of hospital stays, the number of hospital readmissions and even patient mortality. The Union submits that Dr. Aiken's uncontradicted evidence on the above points confirms the hazardous nature of nursing and convincingly establishes the implementation of minimum NPR as an effective means to address this serious problem.

[9] The Union submits that freely negotiated outcomes in other provinces demonstrate a clear trend in favour of minimum staffing ratios, which should inform the Board's replication exercise in this case. The Union points out that BC has already adopted minimum NPR in its Hospitals and says that Manitoba is not far behind (the latter's commitment being evidenced by the establishment in 2024 of a joint union-employer subcommittee to make recommendations to the Minister of Health on appropriate NPRs, having regard to the overall skills mix of staff providing patient care on a unit, the complexity of care, acuity of care, nurse expertise, multi-disciplinary team supports, safety and physical layout.) Alberta nurses have also obtained a commitment from their employer to provide safe staffing for all patients, residents and clients and to undertake a new evidence-based safe staffing review. The Nova Scotia Health Authority agreed to establish a working group on nurse staffing, as well. In addition, the Union submits that the Board should consider that safety-driven minimum staffing levels are not uncommon in the male-dominated police and fire sectors. There is no reason, the Union submits, that such a measure should not be extended to protect the health and safety of nurses who are overwhelmingly women.

Work of the Bargaining Unit

[10] The Union also puts forward a proposal to prevent the Participating Hospitals from assigning work normally performed by employees in ONA's bargaining unit to employees outside that bargaining unit. The Union notes that art. 10.12(a) of the collective agreement permits the

Hospitals to assign work normally performed by RNs to employees outside ONA's bargaining unit if the duties and responsibilities assigned are appropriate to the position to which they are being assigned, and the assignment is consistent with "quality patient care." This, the Union says, allows the Participating Hospitals to assign work that is normally performed by RNs to RPNs in bargaining units represented by other bargaining agents. The Union maintains that this constitutes an existential threat and says that its proposal is necessary in order to prevent the erosion of ONA's bargaining unit and to protect RNs' job security. The Union points out that the collective agreements of other unions who bargain centrally with the Participating Hospitals do not contain the permissive language found in the ONA collective agreement. On the contrary, CUPE, SEIU and Unifor all have provisions in their collective agreements that restrict the Participating Hospitals from assigning duties normally performed by bargaining unit employees to employees not covered by the collective agreement, except for the purposes of instruction or experimentation or in emergencies. According to ONA, this means that once work performed by RNs is assigned to RPNs in another bargaining unit (subject to the conditions in art. 10.12), it can never be reassigned to RNs represented by ONA. The Union submits that this asymmetry is completely untenable and needs to be rectified in the current round.

[11] The Union points out that, since 2015, the proportion of total nursing hours worked by RNs in the ONA bargaining unit has decreased from 80 percent to approximately 70 percent. In addition, the Union presented evidence of several occasions on which a Participating Hospital has notified the Union of its intention to change models of care to assign work previously done by RNs to RPNs or a mix of RNs and RPNs.

Transfer of Accountability (TOA)

[12] The Union also brings forward a proposal to eliminate what the Union says is outdated language in the collective agreement requiring RNs to provide the Hospitals with unpaid labour when transferring accountability for patient care from one nurse to another at shift change ("Transfer of Accountability," "TOA," or "reporting"). Currently, if TOA takes up to 15 minutes beyond the scheduled hours of the nurse's daily tour, the nurse is not paid for this critical aspect of her duties. The Union proposes to amend art. 13.01(a) so as to require the Participating Hospitals to pay nurses overtime for any TOA that falls outside the scheduled hours of their normal daily tour (whether regular or extended tours). The Union's specific proposal is set out below:

> **13.01** (a) The normal daily tour shall be seven and one-half (7½) consecutive hours in any twenty-four (24) hour period exclusive of an unpaid one- half (½) hour meal period**, it being understood that at the change of tour there will normally be additional time required for reporting which shall be considered to be part of the normal daily tour, for a period of up to fifteen (15) minutes duration. Should the reporting time extend beyond fifteen (15) minutes, however, the entire period shall be considered overtime for the purposes of payment under Article 14.**

[13] The Union explains that TOA, a professional responsibility for all regulated health professionals, entails the review and conveyance of relevant patient information from one nurse to another to ensure continuity of care and patient safety. The Union submits that the importance of TOA is underscored in some of the Participating Hospitals' own policies. For example, one Participating Hospital characterizes TOA as "complex and high-risk moments for patient safety." Another Hospital notes that inadequate TOA is one of the most common factors contributing to adverse events in Hospitals, such as the wrong treatment being administered, delays in medical diagnosis, and life-threatening adverse events, not to mention client complaints and increased healthcare expenditures associated with longer hospital stays and litigation. The Participating Hospitals' own policies, the Union says, make it clear that not only is TOA work, it is vitally important work. Yet, its performance by Ontario's nurses has been undervalued and underpaid. The Union suggests that this is because of gendered stereotypes, which undervalue the work of women, especially in caring professions like nursing, where 91 percent of employees are women.

[14] Although the language in art. 13.01(a) was awarded by the O'Shea board in 1981, the Union suggests that the expectation that nurses would be unpaid for TOA originated in a 1975 rights arbitration award, *Central Hospital Corp. and Ontario Nurses' Association, Local 107*, (1975) 10 L.A.C. (2d) 412 (Weatherill, Walsh, Churchill-Smith). The issue in that case was whether the grievor was entitled to overtime pay in respect of several occasions when she "worked beyond her standard working hours" due to having to stay and complete end-of-shift report and/or drug counts. The relevant collective agreement language provided that overtime would be paid for "authorized work performed by a nurse in excess of her normal daily hours of work." In denying the grievance, the Weatherill board found that staying beyond the conclusion of her scheduled hours to give end-of-shift report was part of a nurse's "routine," which was not and did not need to be "authorized" within the meaning of the overtime provision. The Weatherill board also found that reporting time was part of (and not "in excess of") normal daily hours, even if the time spent

reporting extended beyond standard working hours specified in the collective agreement. The board wrote, at para. 17:

> …the persons covered by this collective agreement are professional nurses, paid a monthly salary, and accustomed, as a matter of long-standing routine, to carry out the end-of-shift report and drug count even although (*sic*) it might involve remaining on duty after the hours of the normal tour.

[15] The Union points to a number of recent awards in which the above-noted reasoning has been rejected by arbitrators. In *Corporation of The City of Kingston v. Canadian Union of Public Employees, Local 109*, 2018 CanLII 26065 (ON LA) ("*Kingston*"), Arbitrator Misra dissociated herself from the conclusion in *Central Hospital Corp.*, above, writing, at para. 56:

> To the extent that decision stands for the proposition that if nurses are meeting their professional responsibilities and that work takes them beyond the end of their shift, that they do not have to be paid for such time, with all due respect, I do not agree with Arbitrator Weatherill's view in that regard.

[16] In *Markham Stouffville Hospital v. Canadian Union of Public Employees, Local 3651*, 2021 CanLII 9807 (ON LA), at p. 18, Arbitrator Burkett similarly found the 1975 *Central Hospital Corp.* case to have been "wrongly decided" and rejected the suggestion that reporting time was a voluntary professional activity for which RPNs were not entitled to be paid. Likewise, in *Rosewood Senior Living/Erie Glen v. UFCW, Local 175*, 2021 CanLII 58425 (ON LA), Arbitrator Jesin followed Arbitrator Misra's approach in *Kingston*, above, to conclude that the employer was required to pay nurses for reporting time.

[17] In addition to the above, the Union relies on Arbitrator Goodfellow's interest arbitration award in *Victoria Village Inc. v. Canadian Union of Public Employees, Local 4660*, 2020 CanLII 55857 (ON LA), wherein he awarded a collective agreement provision stating that, "The normal work day may also include up to 15 additional minutes of reporting time … but it is understood that reporting time is time worked and shall be compensated." The bargaining unit in that case was comprised of RPNs and PSWs working at a long-term care home.

[18] The Union submits that its proposal for nurses to be paid for TOA rests primarily on the simple uncontroversial premise that workers should be paid for their work. However, the Union also argues that its proposal should be awarded because art. 13.01(a) violates the *Employment Standards Act*, S.O. 2000, c. 41 ("*ESA*"). Specifically, the Union points out that s. 15(1) of the

ESA requires an employer to record, for each employee in its employ, "the number of hours the employee worked in each day and week." Insofar as art. 13.01(a) of the collective agreement allows Participating Hospitals not to track how much "additional time" nurses spend "reporting" at the change of tour, the Union says that it is contrary to a mandatory provision of the *ESA*.

[19] The Union further submits that its TOA proposal is justified based on relevant comparators. The Union points out that none of the Participating Hospitals' central agreements with other bargaining agents whose bargaining units contain regulated health professionals – CUPE, SEIU, OPSEU, PIPSC or PARO – contains a provision requiring TOA to be done on an unpaid basis. Moreover, nursing agreements in British Columbia, Alberta, Saskatchewan, Manitoba and Nova Scotia all provide that TOA be done on paid time. The Union highlights that BC used to have similar language to that found in the ONA agreement. However, that changed in 2019 when the BC Nurses' Union and the provincial employer entered into a voluntary settlement providing that TOA would be paid (at straight time). Although there are a couple of Atlantic provinces in which it is "customary" for nurses to arrive early or stay late for TOA (New Brunswick and Newfoundland), the Union submits that Ontario is the only jurisdiction aside from PEI where the collective agreement explicitly states that TOA will be unpaid. This is unfair, illegal and must be fixed, the Union says.

Wages

[20] Unsurprisingly, wage increases were also identified by the Union as a top priority. In this round of bargaining, the Union seeks a general wage increase of 6% in 2025 and a further 6% in 2026. The Union explains that it seeks those particular increases because that is what would be required to propel Ontario RNs ahead of nurses working in Alberta (given the wage increases in the collective agreement reached by the United Nurses of Alberta (UNA) and Alberta Health Services (AHS) in April of this year) and to keep Ontario nurses at the top of the Canadian market, where they belong. The Union submits that ONA nurses were at or near the top of the nursing market in Canada until 2007, when a mediated settlement in Alberta "catapulted" that province's nurses to the highest wage rate in the country. The Union says that it then spent years advocating for Ontario's RNs to return to their "top of market" position, which they finally resumed following the last central award by Arbitrator Kaplan. The Union maintains that its "top of market" status is fully justified given that Ontario is the most populous province in Canada but has the lowest number of nurses per capita. The Union points to other Ontario professionals who are the highest

paid in Canada, such as teachers and physicians, and says that there is no justification for Ontario's nurses to be treated any differently.

[21] The Union advances another argument in favour of finding nurses in Alberta to be the appropriate comparator for this bargaining unit: replication of free collective bargaining. The Union notes that, unlike Ontario, nurses in both Alberta and British Columbia have the right to strike, subject to negotiating an essential services agreement with the employer to maintain the minimum staffing required to protect public health and safety during a strike. The task of an interest arbitration board under *HLDAA* is to replicate what nurses who provide essential public services would achieve in a free collective bargaining environment. The Union says that there can be no better evidence of this than what nurses in another Canadian province who do have the right to strike have achieved. According to the Union, the fact that UNA and AHS ratified their collective agreement in April 2025, while facing the same tariff threats as Ontario, is also a complete answer to the Hospitals' argument that the current climate of economic uncertainty favours lower wage increases.

[22] In the alternative, the Union says that the Board should look to police and fire comparators as other essential services, which, like nursing, are dangerous frontline occupations. Among other bargaining outcomes, the Union points to three voluntary police settlements: the Ontario Provincial Police, which negotiated with the Ontario government to obtain 2.75% increases in 2025 and 2026 as part of a four-year agreement (2023-2026); the Toronto Police, which obtained increases of 4.45% and 3.11% in 2025 and 2026 (also as part of a longer agreement); and the York Region Police, which obtained increases of 6.81% and 3.5% for 2025 and 2026, as part of a five-year collective agreement covering the years 2025 to 2029. The Union also points to a recent settlement between Hydro One and the Power Workers' Union, wherein increases of 4.5% and 3.5% for 2025 and 2026 were agreed to as part of a 2025 to 2028 agreement.

[23] The Union also urges the Board to take recruitment and retention into account when determining wage increases. Although the RN vacancy rate in the Participating Hospitals has decreased since the last round to approximately 5.65% in March 2025, the Union submits that it is still significantly higher than other industries. The Union submits that this, together with high resignation rates and high continuing agency nurse usage, shows that the nurse staffing crisis is far from resolved. The Union submits that the Board ought to continue the work begun last round by increasing wages to improve recruitment and retention. The Union also points out that RNs

have never regained the purchasing power they had in 2010 and submits that this Board can and should rectify that by awarding the wage increases proposed by the Union.

Other Proposals

[24] Also under the heading of "wages," the Union proposes the introduction of new long-term service entitlements, which would provide employees with percentage increases upon attaining 15, 20, 25, 30, 35 and 40 years of service; an increase in the "percentage in lieu" for part-time RNs; and new harmonized wage grids for Nurse-Practitioners and the very small group of RPNs (less than 100) who fall within ONA's bargaining unit. In addition, the Union put forward numerous other proposals seeking substantial improvements to overtime and shift premiums; missed meal breaks; pregnancy and parental leave; WSIB top-up; domestic, sexual and intimate partner violence leave; holiday pay; vacation; and benefits, among other things. In terms of non-monetary items, the Union proposes that the seniority provisions of the collective agreement be amended, so as to require the Hospitals to post vacancies and new positions within 30 days (there is currently no time constraint) and to restrict the Hospitals' ability to create time-limited temporary positions.

Participating Hospitals' Response

[25] By way of overview, the Participating Hospitals say that the Union has put 37 monetary proposals before the Board which, combined, would represent a $2.53 billion or 32.85% increase in total compensation over the two years of the renewal collective agreement. The Participating Hospitals describe these costs as "astronomical" and say that the Union's proposals are completely unrealistic. Rather than engaging in focused bargaining, the Participating Hospitals say that the Union has really just put forward a "wish list," which is completely unfeasible in the current climate of economic uncertainty and funding constraints. On this latter point, the Participating Hospitals emphasize that they are already facing a $705 million deficit from 2024 and are expecting a $2.5 billion shortfall in 2025 before any increases associated with the current round of bargaining are taken into account. The Participating Hospitals submit that their fiscal reality is absolutely relevant to what the Participating Hospitals could and would agree to at the bargaining table and is something that must be considered by the Board if it is to replicate free collective bargaining.

Nurse-to-Patient Ratios (NPR)

[26] The Participating Hospitals are strenuously opposed to the Union's NPR proposal.

[27] At the outset, the Participating Hospitals submit that the Union's description of existing nurse-to-patient ratios at the Hospitals is not accurate because the Union has excluded from its calculations any regulated health professionals who are involved in patient care, other than RNs. For example, the Hospitals say that the Union's assertion that there is one nurse for 69 patients at one particular Hospital is not accurate; when RPNs and other employees are factored in, the nurse-to-patient (as opposed to RN-to patient) ratio at that Hospital's Adult Medical Surgical unit is actually 1:5 or 1:6. Leaving that aside, the Participating Hospitals say that the Union's proposal that "one size fits all" NPR be implemented at all of the Participating Hospitals ignores the realities of patient care delivery in Ontario, where staffing levels are determined based on clinical expertise and using scheduling tools that account for patient acuity and level of complexity. The Hospitals emphasize that, since interest arbitration boards are not clinical experts, they are in no position to override the clinical judgment of hospital leaders, including Chief Nursing Executives, who have the expertise to determine staffing levels and who are accountable for the decisions they make.

[28] The Participating Hospitals also take great issue with the fact that the Union proposes RN-only staffing ratios that exclude RPNs in other bargaining units. The Hospitals submit that ONA's protectionist approach is completely at odds with the Hospitals' current practice of relying on multidisciplinary teams, which include RPNs and other regulated health professionals, to provide quality patient care in a timely manner. The Hospitals say that they rely on RPNs to manage stable patients and support care activities in order to allow RNs to focus on the more complex clinical interventions that they are uniquely qualified to perform. The Union's proposal to sideline RPNs (which, the Participating Hospitals say, is precisely what would happen if it had to adhere to an RN-only staffing model) would reduce system capacity and leave Ontario ill-equipped to respond to an increasing demand for services, due to rapid population growth and an aging population. The Hospitals say that they would never freely agree to include fixed RN-to-patient ratios in the collective agreement because it would significantly impair their fundamental management right to determine the number and type of employees required to do the work and to deploy them as effectively and efficiently as possible.

[29] Even more alarming, from the Participating Hospitals' perspective, is the Union's proposal that all non-urgent patient care be cancelled whenever the Hospitals are unable to meet the proposed staffing ratios. Such cancellations, the Hospitals say, would waste resources (such as physician availability and available beds) and worsen patient backlogs. The Participating Hospitals say that, if granted, the Union's proposal would erect an artificial barrier to non-urgent but nonetheless essential patient care, not based on clinical judgment or patient safety, but due to an inability to meet arbitrary staffing ratios. Contrary to the Union's suggestion that enshrining NPR in the collective agreement would enhance patient care, the Hospitals say that it would end up reducing capacity and harming patients.

[30] The Hospitals further submit that the Union's RN-only NPR proposal should be rejected because it bears no resemblance to the staffing ratio models in any other jurisdiction. On cross-examination, Dr. Aiken acknowledged that the jurisdictions in which NPR have been implemented have used not just RNs, but multiple nursing classifications to meet them, including the equivalent of Ontario's RPNs. The Hospitals also emphasize that, in all other jurisdictions where minimum NPR have been implemented, they have been implemented by governments as a public policy choice either through legislation or direct negotiations with nurses' unions. The Hospitals say that the policy choices made by governments are not collective bargaining outcomes to be replicated by an interest arbitration board. The Participating Hospitals also dispute the suggestion that nurse staffing models in other Canadian jurisdictions are comparable to the proposal under consideration here. For example, the safe staffing model recently adopted in Alberta is very similar to the process that ONA already has under art. 8 of the collective agreement.

[31] The Hospitals also question the feasibility of awarding minimum staffing ratios where, as here, the government has not committed to provide the funding that would be necessary to implement them. The Participating Hospitals note that when the BC government reached an agreement directly with the BC Nurses' Union to adopt NPR, it allocated $1.2 billion to support the initiative. The Participating Hospitals estimate that it would cost more than twice that amount to implement the Union's proposed ratios throughout Ontario.

[32] The Participating Hospitals further submit that, from a practical standpoint, the Union's proposed NPR may not even be achievable, which is another reason the Union's proposal should be dismissed. The Hospitals note that, in BC, implementation of the NPR negotiated by the government and the BC Nurses' Union had to be postponed because there were not enough nurses to hire to meet existing needs, even before factoring in the additional nurses that would

be needed to meet the ratios. The Participating Hospitals submit that, although there has been a major improvement in the recruitment and retention of RNs in Ontario hospitals since the last round of bargaining, it would not be realistic to expect them to be able to expand the RN workforce to the extent needed to meet the proposed ratios.

Work of the Bargaining Unit

[33] Turning to the Union's "work of the bargaining unit" proposal, the Participating Hospitals submit that the Union is seeking to "calcify" current RN roles, regardless of regulatory changes that allow work to be done by others or the need to provide quality patient care. The Participating Hospitals explain that the scopes of practice of NPs, RNs, and RPNs (as well as certain other regulated health professionals) have been expanded in recent years in order to increase access to patient care. According to the Participating Hospitals, this public policy shift is a response to the increasing demand for healthcare, linked to a growing and aging population. If they are to preserve their ability to deliver quality patient care in the current environment, the Participating Hospitals say that they must be able to maximize the limited resources they have available, by ensuring all regulated health professionals, including RNs and RPNs, are working to their full scope of practice. The Union's protectionist "work of the bargaining unit" proposal flies in the face of that objective, by prioritizing the Union's own jurisdictional concerns over patient needs. It could also lead to litigation between unions over work jurisdiction. Again, the Participating Hospitals say that this is not something they would ever agree to in free collective bargaining. In addition, they say that the Union's assertions of a large-scale replacement of RNs by RPNs is simply not supported by the data. The fact is that there are more RNs working more hours in Ontario hospitals today than ever before. Finally, the Participating Hospitals point out that, although the language proposed by the Union is found in the CUPE, SEIU and Unifor collective agreements, it is not found in the OPSEU collective agreement, which covers many regulated health professionals and occupations requiring specialized training, and which the Hospitals submit is the most relevant comparator.

Transfer of Accountability (TOA)

[34] The Participating Hospitals are also opposed to the Union's proposal to amend art. 13.01(a) so as to require time spent reporting at the change of tour (TOA) to be paid.

[35] The Participating Hospitals agree with the Union that it is important to view the language in art. 13.01 in its historical context but disagree that Arbitrator Weatherill's 1975 rights arbitration award had anything to do with it. The Participating Hospitals note that, going into the 1980 round of central bargaining, the daily and weekly hours of work for nurses varied across the Participating Hospitals with about half working 7.5-hour daily shifts and half working 7.75-hour daily shifts, all for the same monthly salary. At arbitration, the Union brought forward a proposal to standardize 7.5-hour daily shifts, whereas the Participating Hospitals sought to make 7.75 hour shifts the standard. At the same time, the Participating Hospitals "confirm[ed] their willingness to continue provisions at those hospitals already providing a 37.5-hour work week on the understanding that there is a reporting time at the change of tour which does not attract overtime payment providing the period does not exceed 15 minutes." Ultimately, the O'Shea board awarded the Union's proposal for a normal daily tour of 7.5 hours but included language in art. 13.01 stating that additional time required for reporting at the change of tour would be "considered to be part of the normal daily tour, for a period of up to fifteen minutes duration." Although no reasons for that choice were given in the award, the Participating Hospitals say that the O'Shea board clearly intended to incorporate reporting time in the normal daily tour as a trade-off for awarding the shorter normal daily tour sought by the Union. The Participating Hospitals submit that this bargain has been in place for 45 years and there is no need to change it now.

[36] The Hospitals agree that TOA is a crucial component of the care transition process, which nurses must perform pursuant to the CNO Code of Conduct. However, the importance of the work is no reason to award the Union's proposal. The simple fact of the matter, according to the Participating Hospitals, is that up to 15 minutes of reporting time has always been and continues to be part of the nurse's scheduled shift, which is factored into the wages she is paid for that shift.

[37] The Participating Hospitals also characterize the Union's TOA proposal as a prohibitively expensive breakthrough for which there is no demonstrated need. Specifically, the Hospitals submit that paying all employees in ONA's bargaining unit for an additional 15 minutes of TOA for each tour they work at overtime rates, as the Union proposes, would increase total compensation by more than 2.6% in the first year of the contract, not to mention the compounded impact in subsequent years. Even if TOA were paid at straight time, the Participating Hospitals say that it would still be too costly, particularly given concerns about the economy in general and the impact of tariffs on the Ontario government's revenues and its ability to increase funding to the Hospitals.

[38] As for the rights arbitration awards relied upon by the Union regarding RPNs' entitlement to be paid for TOA, the Participating Hospitals say that they are not relevant. The Participating Hospitals point out that those awards were made under other collective agreements which do not contain a provision similar to 13.01(a) and submit that they cannot be relied upon to demonstrate a need to change the language in this collective agreement.

Wages

[39] Turning to wages, the Participating Hospitals reject the Union's proposal as inconsistent with the current collective bargaining landscape, the Hospitals' fiscal realities and the economy. Leaving aside the Union's other monetary proposals, the Union's wage proposal would add more than $1 billion in costs over the course of the two-year collective agreement. The Participating Hospitals submit that this is completely unrealistic.

[40] In stark contrast to the Union's position, the Participating Hospitals have proposed a general wage increase of 2.15% in the first year of the agreement and 1.5% in the second year. The Hospitals acknowledge that they were offering higher wage increases when the parties were at the bargaining table earlier this year (2.65% and 2%). However, by March 2025, the Hospitals had revised their proposal downwards. This, the Hospitals say, was driven not only by concern about tariffs and uncertainty about the economy, but by the changing collective bargaining landscape.

[41] The Participating Hospitals recognize that, in April 2024, Hospital employees represented by CUPE and SEIU were awarded a general wage increase of 3% for 2025: *The Participating Hospitals v OCHU/CUPE*, 2024 CanLII 33105 (Kaplan) and *The Participating Hospitals v SEIU*, 2024 CanLII 33108 (Kaplan). However, they submit that the wage trend for 2025 has been decreasing as economic conditions have worsened. For example, in September 2024, employees represented by PARO received a lower wage increase (2.65%) than the 3.0% which the Kaplan board had awarded CUPE and SEIU five months earlier. Outcomes from the Ontario broader public sector provide more evidence of this same trend. For example, the Participating Hospitals draw our attention to a voluntary settlement reached in June 2025 between the WSIB and the Ontario Compensation Employees Union (OCEU) following a six-week strike. That freely bargained agreement provided for wage increases of 2.75% for 2025 and 2.25% for 2026, which were the same increases achieved by OPSEU and the LCBO, also following a strike in the summer of 2024. The Participating Hospitals also draw our attention to a recent voluntary

settlement covering employees in the Ontario Public Service (OPS) represented by AMAPCEO, which reinforced the pattern with these same 2.75% and 2.25% increases for 2025 and 2026. The Participating Hospitals submit that there is a history of general alignment between Ontario central hospital outcomes and those achieved by other major Ontario broader public sector groups. These outcomes, the Hospitals submit, provide the Board with more guidance with respect to replication than irrelevant outcomes from the municipal (police and fire) or private sector advanced by ONA.

[42] The Participating Hospitals also reject the Union's argument that wage rates for Ontario's nurses should be determined based on what is happening in another province, such as Alberta, which, among other things, has a very different economy than Ontario. If one were to look to other provinces, notwithstanding that they have not been relevant comparators, the Participating Hospitals suggest that it would make more sense to look at the neighbouring provinces of Quebec and Manitoba (both of which have lower end rates than Ontario), which, by virtue of their geographic proximity, would be more likely to draw nurses away from Ontario than the Western provinces. In actuality, however, the data shows that the number of RNs educated in Ontario who migrate to other provinces is minimal. Indeed, the only Canadian province with higher RN retention rates than Ontario is Quebec, where language is likely a factor. The Participating Hospitals say that the Union has argued in every round of bargaining that nurses in other provinces are appropriate comparators for nurses in Ontario. However, this has never been accepted by arbitrators, nor is it reflected in the parties' own bargaining history. In this regard, the Participating Hospitals highlight that, in February 2008, the parties entered into a three-year voluntary settlement in full knowledge of the fact that it provided for lower end-rates than those that had been negotiated in Alberta for the same years.

[43] The Participating Hospitals also dispute that wage increases are warranted to address recruitment and retention. The Participating Hospitals note that the RN vacancy levels have been steadily and significantly decreasing since their peak in 2023, notwithstanding that 6,000 new RN positions have been added over the course of the most recent collective agreement. The Hospitals submit that these and other indicators, such as a reduction in turnover and retirement rates, show that the Participating Hospitals are already well-positioned to recruit and retain nurses.

[44] By way of reply, the Union utterly rejects the Hospitals' proposal for 2.15% and 1.5% increases in 2025 and 2026. Without wavering from its primary position that 6% increases are warranted in each year, the Union points to evidence that at least two public hospitals in Ontario whose RNs are not unionized unilaterally increased nurses' wages by 3% in 2025. There is no universe, the Union submits, in which ONA would not achieve at least the same wage increase that non-unionized hospital nurses in Ontario receive. Given its historical and rightful place in the Canada-wide nursing wage hierarchy, the Union maintains that free collective bargaining would produce considerably more.

The Hospitals' Proposals

[45] The Participating Hospitals also bring forward a small number of proposals of their own, seeking what they describe as modest and incremental improvements to the collective agreement.

Overtime on Scheduled Day Off (14.01)

[46] The Participating Hospitals propose to amend art. 14.01 to delete a clarity note that specifies that a nurse who works on her scheduled day off is entitled to overtime. The Hospitals submit that the effect of this amendment, if granted, would be to limit the overtime premium to circumstances where a nurse has worked more than her regular full-time hours. The Participating Hospitals say that this proposal is not put forward to achieve cost savings, but rather as a matter of fairness. Specifically, the Participating Hospitals say that it is not fair that two nurses working the exact same schedule would be compensated differently if one of those nurses, as a result of having her schedule changed by the Hospital, happens to work on a day that she was originally scheduled to be off.

Call-back (art. 14.06)

[47] The Hospitals also propose to delete the reference in art. 14.06 to a nurse who "has completed their regularly scheduled tour and left the hospital and is called in to work outside their regularly scheduled working hours," thereby limiting eligibility for the call-back premium to those nurses who are on standby. The Hospitals also propose to amend art. 14.06 to make the call-

back premium unavailable to any nurse who "elects to work additional unscheduled hours made available by the Hospital."

Professional Responsibility (art. 8.01)

[48] Art 8.01 of the collective agreement describes a process that nurses can use to raise concerns about their workload in the context of their professional responsibilities. The provision currently encourages nurses to raise any issues that negatively impact their workload or patient care, including but not limited to four enumerated factors (gaps in continuity of care, balance of staff mix, access to contingency staff, and appropriate number of nursing staff). Among other things, the Participating Hospitals propose to delete those enumerated factors and add several bullet points describing what the art. 8.01 process is not intended to do (i.e. undermine management's right under the collective agreement to assign work to different types of health care professionals, impact on nurses' professional responsibilities to the CNO, substitute for the grievance and arbitration procedure, etc.).

Time-Limited Temporary Positions (art. 10.07(e))

[49] The Participating Hospitals also propose to extend their ability to create time-limited temporary positions, so that they can take greater advantage of funding that is available to provide nursing coverage during peak periods and/or to trial new approaches to care delivery. Currently, art. 10.07(e) allows Hospitals to post temporary vacancies that are expected to last between 60 days and six months. The Participating Hospitals seek to extend the maximum term for time-limited temporary vacancies from six months to one year and to allow that term to be extended for a further year on agreement of the parties.

Partnership Arrangements (art. 10.12)

[50] The Participating Hospitals propose to add a new provision to the collective agreement that would allow them to establish partnership arrangements with other health care organizations and to assign Hospital nurses to work at such organizations for a limited time, with the assigned nurses' terms and conditions of employment subject to "agreement of the parties." The Participating Hospitals also propose that nurses from other employers be permitted to work at the

Participating Hospitals, while remaining employees of the "sending employer" and subject to the terms and conditions of employment with that employer.

Lay-off and Recall (art. 10.07(a)(iv) and 10.09(b)(iii)(H)

[51] The Participating Hospitals also propose to amend the layoff and recall provisions by deleting the provision in art. 10.07(a)(iv), which requires vacant positions to be posted prior to offering them to employees who have been laid off and who are subject to recall.

[52] The Union opposes all of the Hospitals' proposals on the basis that they are concessions, which would be inappropriate to award in the current bargaining climate. The Union also submits that there is no demonstrated need for any of the Participating Hospitals' proposals.

ANALYSIS AND DECISION

[53] Section 9(1) of *HLDAA* establishes the duty of a board of arbitration. It is to, "examine into and decide on matters that are in dispute and any other matters that appear to the board necessary to be decided in order to conclude a collective agreement between the parties." In conducting this exercise, s. 9(1.1) requires the board to "take into account all factors it considers relevant, including the following criteria":

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.

[54] Giving effect to this duty, boards of arbitration have established the following well-known principles: comparability, demonstrated need, total compensation, gradualism, and, of course,

replication. Of these, replication is perhaps the most important, as the fundamental task of an interest arbitration board is to attempt to replicate the collective agreement that the parties themselves would have achieved, if they had been able to engage in collective bargaining that included the right to strike and lockout to break an impasse.

[55] The principle of comparability is closely related to replication, the presumption being that, where industry norms can be identified, parties would be unlikely to have deviated too far from what their similarly situated peers have agreed to: *Ontario Nurses' Association v. Strathroy Middlesex General Hospital*, 2012 CanLII 14936 (Goodfellow) at p. 8. The parties' own history can also provide guidance as to the bargain that the parties themselves would have struck if left to their own devices.

[56] "Demonstrated need" refers to the existence of a real and significant practical problem, which needs to be rectified by amending the collective agreement. This is relevant to replication because interest arbitrators recognize that, in a free collective bargaining environment, a party would not resort to economic sanctions to try to compel the other side to fix a minor or merely hypothetical problem.

[57] The principle of total compensation reflects the bargaining reality that no party settles a collective agreement looking at monetary issues in isolation. Rather, parties reach agreement based upon the totality of the package: *65 Participating Hospitals and CUPE,* 1981 CarswellOnt 3551 (Weiler, Dinsdale, Tirrell) at para. 46.

[58] Taking the foregoing criteria into account and applying these principles in the case at hand leads us to the conclusions set out below.

Nurse-to-Patient Ratios (NPR)

[59] We are not persuaded that the Union has established a demonstrated need for its proposal to embed specific RN-to-Patient ratios in the collective agreement. The Union appears to have drawn its proposed NPR from what some of the Participating Hospitals are currently doing in some of their units. For example, as evidence that its proposed ratios are practical and feasible, the Union points out that two (of the 127) Participating Hospitals are already meeting the 1:4 ratio it seeks in their Adult Medical Surgical units (although only one of those two meets that ratio on both days and nights, which is what the Union proposes). However, there is no evidence on which

the Board could conclude that the 1:4 ratio in Adult Medical Surgical units or any of the other specific NPRs proposed by the Union are necessary in order to protect nurses' health and safety and/or to retain nurses in the Hospitals, as the Union also argues. In assessing demonstrated need, the Board needs to be satisfied not only that an underlying problem exists, but also that the proposal that has been put forward is needed to solve it. Leaving aside whether the Union's evidence is sufficient to establish that any of the staffing levels that have been set by the Participating Hospitals are inadequate, as well as the Hospitals' concerns about whether an interest arbitration board is ever suited to make decisions of a clinical nature, we find that the Union has failed to demonstrate a need for its proposed provision. The fact that most of the ratios proposed by the Union can be found in at least one (out of 127) of the Participating Hospitals is also not evidence that there is a need for the Union's proposal to substantially limit the Participating Hospitals' ability to determine appropriate staffing levels to meet both patient needs and nurses' health and safety.

[60] The fact that there are already mechanisms in place by which concerns about appropriate staffing levels and nurses' health and safety may be addressed is further reason to find that there is no demonstrated need for the Union's proposal. Article 8 of the collective agreement enshrines a process by which an employee can raise concerns about her workload and how it impacts her ability to fulfill professional responsibilities. During the current round of bargaining, the parties have also renewed a Letter of Understanding that was awarded by Arbitrator Gedalof in 2021, requiring the local parties to meet annually to discuss the optimal complement of RNs based on patient care needs. This is a mandatory obligation that was intended to address the very concern put before us. We heard no evidence as to how that process has played out – what efforts have been made therein and what the response has been.

[61] The principle of comparability also does not weigh in favour of the Union's proposal. As the Participating Hospitals point out, the Union's proposal differs markedly from the minimum nurse staffing models implemented in other jurisdictions. Unlike ONA's proposal to use RNs exclusively to meet minimum NPR, all of the other jurisdictions in Australia and the US that have implemented nurse staffing ratios have used RNs and other nursing classifications, such as the equivalent of Ontario's RPNs, to meet them. Staffing ratios in those other jurisdictions were also more flexibly applied than the rigid, uniform approach that is proposed here, for example, by allowing for averaging across units, waivers, and variances, etc. However, the most striking difference between the proposal before us and the staffing models adopted in other jurisdictions

is ONA's proposal to cancel non-urgent care when ratios are not met. The Union says that Dr. Aiken's evidence establishes that NPR improve patient outcomes, but it is important to bear in mind that the models she studied did not mandate the cancellation of patient care as an enforcement mechanism. The Union's proposal does contain that mechanism and we agree with the Participating Hospitals that it could jeopardize patient care. As such, we are not persuaded that this proposal is something that would either be bargained to impasse by the Union or accepted by the Hospitals in a free collective bargaining environment. We are also not persuaded by the Union's alternative submission, in reply, that it would be appropriate to order the Union's proposed ratios and remit the enforcement mechanism to the parties.

Work of the Bargaining Unit

[62] We also decline to award the Union's "work of the bargaining unit" proposal. The Union contends that the assignment of RN work to RPNs represented by another bargaining agent will erode its bargaining unit. However, the evidence does not bear that out. Although the proportion of nursing hours worked by RPNs, relative to RNs, has increased somewhat over recent years, ONA members continue to perform approximately 70 percent of total nursing hours in the Hospitals and the size of ONA's bargaining unit has been consistently expanding. Over the course of the most recent collective agreement alone, the number of RN positions at the Participating Hospitals has increased by almost ten percent.

[63] In his 2021 award settling the central terms of the 2021 to 2023 collective agreement between these same parties, Arbitrator Gedalof described a similar Union proposal, which would have restricted the assignment of RN work to other healthcare workers such as RPNs, as "an extraordinary breakthrough that is unlikely to be replicated in free collective bargaining, and for which there is no overwhelming demonstrated need": *Participating Hospitals v. Ontario Nurses Association*, 2021 CanLII 88531 (Gedalof) at para. 46. In our view, that continues to be the case. Like determining the number of RNs needed in any given unit on any given shift, establishing the mix of RNs and other health care professionals needed to best perform the work is a fundamental management right that would not be readily surrendered. It would require substantial evidence of demonstrated need, which is simply not before the Board.

Transfer of Accountability

[64] The Union's proposal requiring the Participating Hospitals to pay employees for the time spent reporting after the conclusion of their shift (commonly referred to as "Transfer of Accountability" or "TOA") is granted, not on an overtime basis, nor on a straight time basis, but at the rate of pay applicable to the shift that has just been worked.

[65] In our view, the Participating Hospitals' position that reporting time should continue to be unpaid is untenable. We say "unpaid" because we cannot accept the Hospitals' suggestion that nurses are paid for TOA as part of the compensation they receive for the regular daily tour or extended tour. The Participating Hospitals' assertion that TOA is paid is clearly inaccurate when one considers that two nurses who work a regular daily tour of 7.5 hours will receive the same wages, even if one nurse is required to stay for up to 15 minutes beyond the end of her shift to transfer accountability for her patients and the other is not (because she works in an area of the Hospital, such as an outpatient clinic or an OR, which does not operate 24/7 and which therefore does not necessarily have an oncoming shift to whom to transfer accountability). Both nurses would be paid for 7.5 hours, even though the nurse who has to do TOA is required to work beyond the end of her 7.5-hour shift. In our view, this clearly demonstrates that the additional time nurses spend doing TOA (for up to 15 minutes) is not compensated at present.

[66] The more normative a provision is, the more likely it is to be granted by an interest arbitration board. It is difficult to think of a stronger norm than that an employee is entitled to be paid for the time spent working. This basic premise weighs heavily in favour of granting the Union's proposal.

[67] As for the Participating Hospitals' argument regarding the O'Shea board's decision in 1981, we do not find it persuasive. As noted above, the Participating Hospitals urge us to find that in 1981 the O'Shea board instituted unpaid TOA as a trade-off for making 7.5-hour daily tours the standard as opposed to the 7.75-hour daily tours sought by the Participating Hospitals. However, since the language in art. 13.01 was awarded without reasons, we cannot know that that is what the board intended. In any event, assuming without finding that the Participating Hospitals are correct about the O'Shea board's thinking, we do not see that as a sufficient reason for preserving the status quo. The fact of the matter is that nurses are paid an hourly rate for their scheduled hours of work, but not for up to 15 minutes, after their shift has ended, engaged in the exceedingly important work of transferring accountability for their patients to the oncoming shift. As the rights

arbitration cases demonstrate, this is a patently unfair practice, which flies in the face of prevailing norms in society at large.

[68] The principle of comparability also provides a strong basis for awarding the Union's proposal. The authorities before the Board confirm that RPNs are entitled to be paid for TOA under the terms of the central agreement between the Participating Hospitals and CUPE. As for other Hospital employees who transfer authority for patients, such as regulated health professionals under the OPSEU or SEIU collective agreements, the Union submits and the Participating Hospitals do not dispute that there is no provision equivalent to the one in art. 13.01(a) requiring reporting time to be unpaid. We see no reason why other Hospital employees who engage in TOA as part of their professional responsibilities should be paid for that work, but RNs should not. Nor are we persuaded that, in a free collective bargaining environment, the Hospitals would resort to economic sanctions to try to maintain this distinction. On the contrary, application of the comparability and replication principles leads us to conclude that ONA should be placed on the same footing as the Hospitals' other employees as regards TOA.

[69] That said, and as noted above, we are not granting the Union's proposal that any time spent reporting that extends beyond the nurse's scheduled hours of work be automatically compensated at overtime rates. Rather, we are amending the collective agreement so that nurses will be paid for up to 15 minutes of reporting time beyond the end of their scheduled shift at the same rate as the shift they have just worked and in respect of which they are reporting. If the amount of time required for reporting exceeds 15 minutes, the collective agreement provision that already states that nurses are entitled to overtime for the entire period will continue to apply.

[70] Further, by way of clarity, in awarding the Union's proposed provision, as amended, it is the Board's intention to eliminate unpaid reporting time; it is not our intention that other collective agreement entitlements, particularly those based on hours worked, be impacted. Thus, although time required for reporting that extends beyond the nurse's scheduled shift will now be paid, such time is not to be counted in determining whether overtime thresholds in the collective agreement have been met or to determine whether a nurse has been "called back" within 24 hours of the end of her regularly scheduled shift (art. 14.06). Rather than attempt to provide an exhaustive list, we simply offer these as illustrations of what this aspect of our award is not intended to do. We remit to the parties the implementation of this aspect of our award, leaving it to them to make any consequential amendments to the collective agreement required to give effect to the stated intent. We remain seized to resolve any disputes.

[71] Finally, in order to give the parties adequate time to implement this aspect of our award, and bearing in mind that reporting time has apparently not been recorded by the Participating Hospitals to date, we are delaying the implementation of our amendment to art. 13.01 for a period of 60 days from the date of our award.

Wages

[72] This brings us to wages. There is a wide gulf between the parties' respective positions with respect to the wage increases that should be awarded in each year of the contract and the comparators to whom we should be looking in order to replicate, as closely as possible, what these parties would likely have done in a fully free collective bargaining environment. As noted above, the Union maintains that the Board's primary goal in resolving this dispute should be to ensure that the top rate for RNs in Ontario is the highest rate in Canada. This, the Union says, translates into a need for six percent (6%) increases in 2025 and 2026, in order to place it slightly higher than RNs in Alberta who currently occupy the top spot. The Hospitals oppose the suggestion that the Alberta nurses are an appropriate comparator. According to the Participating Hospitals, it is well established that the appropriate comparators are other employees in the Ontario hospital sector. However, the Participating Hospitals do not urge us to replicate the 3.0% increase awarded to the Hospital service units represented by CUPE and SEIU for 2025 or even the 2.65% increase awarded to PARO. Based on a worsening economic outlook since those increases were awarded, the Participating Hospitals ask us to award less than what its other employees will receive: 2.15% for 2025. As for 2026, the Participating Hospitals propose that we award a general wage increase of 1.5%.

[73] It is true that, over the years, there have been a couple of references in the parties' interest arbitration awards to nurses in other provinces. However, we cannot agree with the Union that that is the governing pattern in Ontario central hospital settlements and awards. Nor can we draw from the Kaplan board's 2023 award an intention to ensure Ontario nurses are "top of market" in Canada. The factors that motivated Arbitrator Kaplan to make significant and meaningful wage adjustments in that award were said to be high inflation and an extremely serious recruitment and retention problem. There is nothing to suggest that the board's 2023 award was based on what nurses were earning in other provinces, even when extraordinary circumstances led it to look

beyond traditional healthcare comparators: *The Participating Hospitals v. ONA*, 2023 CanLII 65431 (Kaplan, Christen, Abbink) at p. 28.

[74] Like the central board in the 2018 round of bargaining, we find that, absent exceptional circumstances, other central hospital professionals are the most relevant comparators for this bargaining unit: see *The Participating Hospitals v. ONA,* 2018 CanLII 69947 (Kaplan, O'Byrne, Hughes) at p. 4.

[75] Looking to the central hospital comparators, we recognize that the CUPE and SEIU bargaining units are not comprised exclusively of healthcare professionals, like this unit is, and that ONA has not consistently followed the bargaining outcomes achieved by those parties: *The Participating Hospitals v. Ontario Nurses' Association*, 2014 CanLII 20914 (Kaplan, Kay, McIntyre) at p. 3. However, in the context of the current round of bargaining, taking all of the relevant factors into account, for 2025, we find it appropriate to award ONA the same general wage increase that was awarded to those parties: 3.0%.

[76] In coming to this conclusion, we reject the Participating Hospitals' suggestion that, in the context of fully free collective bargaining, ONA would not have been able to achieve the same wage increases for 2025 as were obtained by these other Hospital employees. Even if there is now a greater degree of uncertainty about Ontario's economic prospects than existed at the time of the CUPE and SEIU awards, we find it highly implausible that, in a free collective bargaining environment, ONA would not have been able to achieve at least the same level of wage increases that had been achieved by their Hospital counterparts. In our view, the economic clouds to which the Participating Hospitals point would not have yielded such an exceptional result (*cf. Participating Hospitals and OPSEU*, unreported, November 4, 2009 (Gray)).

[77] In the same vein, we find it appropriate to award a general wage increase of 2.25% for 2026. In coming to this conclusion, we reject the Participating Hospitals' suggestion that its proposed increase of 1.5% accurately reflects what ONA would have achieved in a free collective bargaining environment. As noted above, unions in the Ontario broader public sector recently attained a 2.25% increase after exercising their right to strike. In our view, there is no reason to believe that nurses delivering critical health care in Ontario's public hospitals would have achieved anything less than LCBO, WSIB and OPS employees (even taking into consideration the fact that

those other employees obtained a slightly lower increase for 2025 (2.75%) than we are awarding here).

[78] At the same time, in the context of the present round of bargaining, we are of the view that the principle of total compensation militates against more than the same 3.0% and 2.25% increases noted above. In particular, although we regard our award on TOA as a necessary and important improvement, we recognize that it comes at a substantial cost to the Participating Hospitals, which, along with the additional improvements to which we will come shortly, limits what other gains might be achieved in a two-year agreement. We note that, by awarding wage increases that exceed anticipated inflation in respect of the two-year period in question and that are also slightly higher than those obtained by other public sector employees, we have also considered (still present, if reduced) recruitment and retention issues, in balance with all of the other relevant factors.

[79] Two further points must be made.

[80] First, we disagree with the Participating Hospitals' suggestion that the result in *Ontario Teaching Hospitals v. Professional Association of Residents of Ontario*, 2024 CanLII 90530 (Gedalof), reflects a general trend towards lower 2025 wage rates due to worsening economic conditions. There is nothing in the award to suggest that. On the contrary, at para. 4, Arbitrator Gedalof indicated that the general wage increase of 2.65% in 2025 reflected the parties' acknowledgement that a portion of the monies that would otherwise have been available for wages should be used to improve call stipends and to make certain benefit improvements.

[81] Second, we disagree with the Union's submission, in the alternative, that 2025 and 2026 outcomes in the police sector should have any impact here. Even if we were to find them to be a relevant comparator, we note that those outcomes appear to represent a significant effort at catch-up, having regard to the effects of inflation under prior contracts. Although a true apples-to-apples comparison is difficult, it appears to us that by the end of this contract, ONA will have done as well or better than the police in terms of catching up to post-pandemic inflation when the significant grid adjustments and general wage increases made in the 2023 Kaplan award and the effects of the 2022 Gedalof reopener award are taken into account.

Nurse-Practitioner (NP) Wage Grid

[82] We are also persuaded that the Union's proposal for a harmonized Nurse-Practitioner wage grid needs to be addressed. As the Union points out, the Albertyn board essentially awarded this in principle in 2016, although it appears not to have been realized because the parties were unable to agree on what a harmonized provincial wage grid would look like, when the matter was remitted to them: *Participating Hospitals v Ontario Nurses' Association*, 2016 CanLII 59375 (Albertyn, O'Byrne, McIntrye), at para. 38.

[83] Comprising approximately 1% of the ONA bargaining unit, there are currently 917 NPs employed by 68 Participating Hospitals throughout the province at widely disparate wage rates, with the top rate at some Participating Hospitals below the start rate at others.

[84] The Union proposed retroactively moving all NPs to a three-year harmonized grid with a top rate somewhat above the top rate that is currently being paid by any of the Participating Hospitals. We decline to award that proposal. In our view, given the degree to which NP wage rates vary at present, the implementation of a harmonized NP wage grid realistically needs to be done in an incremental fashion, which builds on the previous award of the Albertyn board in 2016.

[85] At the vast majority of Participating Hospitals, NPs reach the top rate in eight years or less. However, there are two or three outliers with nine-year or 25-year grids. Effective the date of the award, we are directing that any Participating Hospital that has a wage grid with more than nine steps (i.e. 8-year grid plus a start rate) revise its grid to ensure that it takes no more than 8 years for an NP to reach the top of the grid (end rate).

[86] Effective April 1, 2025, we award all NPs the GWI of 3.0%. However, if that results in an hourly rate that is lower than the minimum hourly rate based on their years of service, which is set out in the chart below, then, effective the date of the award, the applicable minimum hourly rate will apply. (The minimum hourly rates in the chart below are the averages of the wage rates currently being paid by those Participating Hospitals that employ NPs, plus the 2025 GWI.)

[87] Effective April 1, 2026, all NPs will be entitled to the GWI of 2.25%.

[88] For clarity, for this round of bargaining, the NP wage rates will not be adjusted in accordance with Article 19.01(d). (See *Participating Hospitals v Ontario Nurses' Association*, 2016 CanLII 85901 (Albertyn, O'Byrne, McIntyre) at para. 8)

Other Proposals

[89] In addition, we are persuaded that it is appropriate to increase the supplemental top-up for nurses on pregnancy and parental leave from 84% to 93%, which is the percentage top-up available to many other unionized employees in the Hospitals and the Ontario broader public sector. We also find some modest improvements to dental benefits to be in order, given that these were last improved between 14 and 22 years ago (depending on the particular benefit).

[90] We also award the Union's proposal to amend art. 11.15 regarding support for employees who are experiencing domestic, sexual or intimate partner violence, albeit in the modified form set out below, as well as the Union's proposal to amend art. 10.07(a) so as to require the Hospitals to post vacancies within a set timeframe (although we are ordering that this be done within 60 calendar days, rather than the 30-day timeframe proposed by the Union.)

[91] Finally, we are ordering an adjustment to RPN wages at one of the Participating Hospitals.

[92] Otherwise, we decline to award any of the Union's many other proposals on the basis that what we have awarded exhausts total compensation for the current round of bargaining. In the circumstances, it is not necessary for us to address the parties' many arguments for and against such proposals.

[93] Turning to the Hospitals' proposals, we are awarding their proposal to amend the term for specific time-limited temporary positions in art. 10.07(e) from six months to one year. However, we decline to award the Hospitals' other proposals because we are not persuaded that there is a demonstrated need for them.

[94] We are also not persuaded that there is a demonstrated need to award the Hospitals' only monetary proposal: the proposal to amend the call-back provision of the collective agreement (art. 14.06). It is not clear to us that the mere fact that there has been an increase in call-back hours and/or call-back grievances since the last round of bargaining means that the call-back

provision is being misinterpreted or misapplied. The Participating Hospitals also suggest that rights arbitrators could find that entitlement to the call-back premium depends on the time a shift is accepted, which could lead nurses to delay accepting shifts and incentivize the very thing (short-notice scheduling) that the provision was designed to avoid. However, this is not in keeping with recent awards on the issue, such as *Ontario Nurses' Association v. Kingston Health Sciences Centre,* 2023 CanLII 35729 (Trachuk).

Award

[95] In the result, we hereby order that the renewal collective agreement will consist of the terms of the previous collective agreement, as amended by the items agreed to by the parties and the following items. Any proposal not specifically addressed by this award is deemed to be dismissed.

Term

Pursuant to HLDAA, the term of the collective agreement will be from April 1, 2025 to March 31, 2027

Wages

April 1, 2025 – 3.0% GWI
April 1, 2026 – 2.25% GWI

Transfer of Accountability

- Effective 60 days from the date of the award:

13.01 (a) The normal daily tour shall be seven and one-half (7½) consecutive hours in any twenty-four (24) hour period exclusive of an unpaid one half (½) hour meal period, it being understood that at the change of tour there **may** ~~will normally~~ be additional time required for reporting. ~~which shall be considered to be part of the normal daily tour, for a period of up to fifteen (15) minutes duration.~~ **Any time spent reporting beyond the end of the normal daily tour for a period of up to fifteen (15) minutes duration will be paid at the same rate as the tour that has just been worked.** Should the reporting time extend beyond fifteen (15) minutes,

however, the entire period shall be considered overtime for the purposes of payment under Article 14.

Nurse-Practitioner Wage Grid

- Effective April 1, 2025, all NPs to receive the GWI of 3.0%

- Effective the date of the award, all Participating Hospitals to revise their wage grids, if necessary, to ensure that it takes no more than 8 years to reach the top of the grid (i.e. maximum of 9 steps with the start rate).

- Effective the date of the award, any NPs whose hourly rate, after the 3.0% GWI, is lower than the minimum hourly rate for their years of service set out in the chart below, will move to the applicable minimum hourly rate

	Minimum Hourly Rates for NPs (effective date of award)
Start	$63.66
Year 1	$66.19
Year 2	$68.08
Year 3	$69.57
Year 4	$71.38
Year 5	$72.31
Year 6	$72.95
Year 7	$73.50
Year 8	$74.46

- Effective April 1, 2026, all NPs will be entitled to the GWI of 2.25%

RPN Wages

- Effective April 1, 2025, new RPN wage grid at Smooth Rock Falls Hospital as follows:

	April 1, 2025
Start	$38.11

1 year	$38.62
2 year	$39.14

- Article 19.01(d) will then be applied, effective April 1, 2025, and as usual on April 1, 2026.

Job Posting

Amend art. 10.07(a) as follows:

10.07(a)

i) Where a permanent full-time vacancy occurs in a classification within the bargaining unit or a new full-time position within the bargaining unit is established by the Hospital, such vacancy shall be posted **within sixty (60) consecutive calendar days,** for a period of seven (7) consecutive calendar days. Nurses in this bargaining unit and nurses in another ONA bargaining unit at the Hospital, if any, may make written application for such vacancy within the seven (7) day period referred to herein. Subsequent vacancies created by the filling of a posted vacancy are to be posted for seven (7) consecutive calendar days. Where a vacancy under this provision has remained unfilled for a period of six (6) months from the date of the initial posting, and the employer still requires the position to be filled, it will be reposted as noted above.

ii) Where a permanent regular part-time vacancy occurs in a classification within the bargaining unit or a new regular part-time position within the bargaining unit is established by the Hospital, such vacancy shall be posted **within sixty (60) consecutive calendar days,** for a period of seven (7) consecutive calendar days. Nurses in this bargaining unit and nurses in another ONA bargaining unit at the Hospital, if any, may make written application for such vacancy within the seven (7) day period referred to herein. Subsequent vacancies created by the filling of a posted vacancy are to be posted for seven (7) consecutive calendar days. Where a vacancy under this provision has remained unfilled for a period of six (6) months from the date of the initial posting, and the employer still requires the position to be filled, it will be reposted as noted above.

Specific Time-Limited Temporary Positions

Amend art. 10.07(e) as follows:

10.07(e) Specific time-limited temporary positions which are expected to exceed a term of sixty (60) calendar days but no greater than ~~**six (6) months**~~ **one (1) year** will be posted in accordance with Article 10.07 (a). This term may be extended a further ~~**six (6) months**~~ **one (1) year** by mutual agreement of the local parties. Where a nurse is transferred under this Article, their vacated position shall be posted in accordance with Article 10.07 (a).

Upon completion of such temporary position, the nurse will be reinstated to their former position.

Should such position continue beyond the expected term, it shall be considered to be a permanent bargaining unit position and posted as such at that time.

Domestic, Sexual or Intimate Partner Violence Leave (Article 11.15)

Amend art. 11. 15 as follows:

11.15 Domestic or Sexual Violence Leave will be granted in accordance with the Employment Standards Act.

The parties recognize that domestic violence, which may include intimate partner violence or sexual violence, is a serious issue that can manifest in various ways, including but not limited to, disruptive phone calls, harassing emails, threats, inappropriate visits, violent confrontations, violent offences between current and/or former partners, regardless of cohabitation. Hospitals who are aware of, or who ought reasonably to be aware of, domestic violence that would likely expose a nurse to physical injury in the workplace must take every precaution reasonable in the circumstances to protect the nurse (OHSA section 32.0.4).

Where a nurse has advised that they are suffering from or in fear of domestic violence, or the Hospital is aware or ought reasonably to be aware, they will be offered supports and services that may include but are not limited to, work accommodations to schedules or duties, safety planning, training, referrals and protections, risk assessment, and/or health care benefits, support in reporting to law enforcement and/or regulated colleges, and leaves (including job protected leaves as per the Employment Standards Act, 2000); and other supports, as appropriate.

Pregnancy and Parental Leave

Effective the date of the award:

- Increase the percentage in art. 11.07 and art. 11.08 to 93%

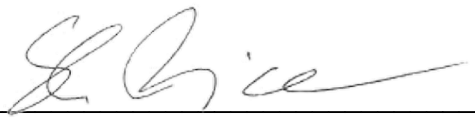
Benefits

Effective the date of the award:

- Dental:
  - Increase coverage for crowns, bridgework, implants and repairs to $2500
  - Increase coverage for orthodontics to $2500

[96] We remain seized in accordance with s. 9(2) of HLDAA.

Dated at Toronto this 3rd day of September, 2025.



Sheri Price, Chair

"I dissent in part (see attached)."

Philip Abbink, Union Nominee

"I dissent in part (see attached)."

Brett Christen, Hospital Nominee

DISSENT

I respectfully dissent from the Award of the Chair dated September 3, 2025 (the "Award") and the reasons therein.

Background

The Award settles the central terms of the collective agreement covering a two-year period from April 1, 2025 to March 31, 2027.

The previous central award between these parties was also settled by interest arbitration, by a panel Chaired by William Kaplan (the "Kaplan Award"; *ONA and Participating Hospitals*, unreported award of Arbitrator Kaplan dated July 20, 2023).

The Kaplan Award was preceded by a "re-opener" award Chaired by Arbitrator Gedalof (the "Gedalof Award"; *ONA and Participating Hospitals*, unreported award of Arbitrator Gedalof dated April 25, 2023) which was a supplemental award to an award dated September 9, 2021 (the "Initial Gedalof Award"). The Gedalof Award addresses compensation issues not addressed in the Initial Gedalof Award which was issued when the *Protecting Sustainable Public Sector for Future Generations Act*, 2019 ("Bill 124") was in effect.

The Initial Gedalof Award contained a typical reopener clause which allowed for monetary issues to be re-visited in the event that Bill 124 was determined to be unconstitutional. After the Initial Gedalof Award was issued, the Ontario Superior Court declared Bill 124 to be unconstitutional and of no force or effect. (For completeness, it should be noted that the Gedalof Award followed a "re-opener" and initial award of panels Chaired by Arbitrator Stout; the "Stout Awards"; *ONA and Participating Hospitals*, unreported award of Arbitrator Stout dated April 1, 2023 and *ONA and Participating Hospitals*, unreported award of Arbitrator Stout dated June 8, 2020).

The outcomes in the Kaplan Award and the Gedalof Award were primarily motivated by two factors: inflation, and recruitment and retention. The inflation rate in Ontario during the period of these awards was 6.8% (2022), 3.8% (2023) and 2.4% (2024). Vacancy rates in the ONA bargaining unit during the same period reached a high of 14.78% in 2022, a high of 15.46% in 2023 and a high of 8.76% in 2024.

In the Gedalof Award, Arbitrator Gedalof awarded a 3% general wage increase for 2022 and also replaced the RN wage grid's 8-year rate with the grid's (higher) 25-year rate. This amendment to the RN grid resulted in an additional wage increase for all RN's with 8 to 24 years' service (a significant percentage of the bargaining unit).

In the Kaplan Award, Arbitrator Kaplan awarded general wage increases of 3.5% for 2023 and 3.0% for 2024 in recognition of what he described as "extraordinary circumstances" in the economy. In addition, Arbitrator Kaplan amended the RN wage grid providing additional increases at each of the 9 steps of the grid (while at the same time, it should be fairly noted, amending the collective agreement's layoff and severance provisions as requested by the Participating Hospitals). As a result of the GWIs and grid adjustments granted in the Gedalof Award and the Kaplan Award, the wage increases received by RN's during these three years exceeded Ontario inflation.

The evidence before this Board was very different from that which was before Arbitrators Gedalof and Kaplan. RN vacancy rates have dramatically declined from the 15.46% high in March 2023 to 5.65% in March 2025. Contrary to the suggestion of the Chair, RN vacancy rates are within historical norms and only slightly above the average RN vacancy rate of 4.92% in existence in the three years preceding the pandemic (2017-2020). In 2025, Ontario inflation is averaging less than

2% and projected inflation for 2026 is about the same. In short, no "extraordinary circumstances" are in existence.

In the case of the Kaplan Award, it should be noted that Arbitrator Kaplan considered two wage settlements in the public sector/broader public sector reached between the conclusion of the hearing before Board and the release of the award (see comments of Arbitrator Kaplan at pp.26 - 27 of the Kaplan award). Arbitrator Kaplan felt that it was appropriate to consider those recent settlements given the "extraordinary circumstances" in the economy:

> Summarily stated, in extraordinary circumstances it is entirely appropriate to look at settlements from sectors not normally considered. Having done so, we find that the best evidence of free collective bargaining is the recent OPG and PWU settlement – authorized by Ontario's Treasury Board – and the also recent settlements between the Government of Canada and PSAC covering 155,000 core public servants and employees of the Canada Revenue Agency (ratified by both parties in June 2023). For whatever reason, including possibly happenstance, in terms of the numbers, these settlements – again freely negotiated in strike/lockout regimes – are identical.
>
> In OPG and PWU, wage increases of 4.75% and 3.5% were agreed upon for 2022 and 2023, along with signing bonuses of $2,500 in each year, not to mention other significant compensation improvements. In the federal government PSAC settlement, the parties agreed on the exact same percentage general wage increases for 2022 and 2023, along with a $2,500 signing bonus, and some other (more modest) compensation improvements. These two settlements are extremely instructive and have informed our view of how to best replicate free collective bargaining in this round. These settlements are among the best evidence available of free collective bargaining in a high and sustained inflation environment.

Arbitrator Kaplan awarded a 3.5% increase for 2023 matching the GWI for that year in the two settlements he considered. In giving weight to those settlements, Arbitrator Kaplan noted, at p. 28, "We conclude that these voluntarily negotiated outcomes covering so many employees in the quasi-public and public sector are the best guide for setting compensation in the current circumstances".

In Ontario, interest arbitrators in the hospital sector have historically looked to other hospital employees in Ontario as comparators in accordance with the fourth HLDAA criteria. Stability in the use of these known comparators has served the hospital sector well by providing at least some measure of predictability to the parties when bargaining. A sustained departure from this long-standing approach would lead to unpredictability of outcome, increased interest arbitration costs as a result of even fewer voluntary settlements, the imposition of "whipsawing" awards on the hospitals and even more "cherry-picking" of any provident settlement or award in any sector by unions.

In "extraordinary circumstances", such as those before Arbitrator Kaplan, arbitrators have, on very rare occasions, considered non-hospital comparators. Arbitrator Kaplan only departed from the traditional hospital comparators used in Ontario in the hospital sector because of the "high and sustained inflation environment" in existence during the years he was considering. Subject to my comments below, I therefore strongly agree with Arbitrator Price's decision to confirm the predominant importance of Ontario hospital comparators in Ontario hospital interest arbitrations.

In this proceeding ONA repeatedly submitted to the Board that it should follow an approach similar to that taken by Arbitrator Kaplan in the Kaplan Award suggesting that the best comparators for determining an appropriate wage settlement in this proceeding were recent voluntary collective bargaining settlements, especially any such settlements concluded where a right to strike existed. ONA urged the Board to follow a recent settlement involving nurses in another province with the right to strike and settlements involving police and firefighters. Nurses in other provinces and police and firefighters in Ontario have not been recognized by Ontario interest arbitrators, for a variety of valid reasons, as a comparator for Ontario nurses. I therefore completely agree with

Arbitrator Price's decision not to follow those settlements in determining the wage increases she awarded.

In any event, the most relevant settlements where a right to strike exists are not those identified by ONA but rather two recent voluntary settlements in the Ontario public sector.

The first between OPSEU and the WSIB followed a six-week strike involving approximately 3600 bargaining unit employees. The agreed upon GWI was 2.75% for 2025 and 2.25% for 2026.

The second voluntary settlement involved the Ontario Government and AMAPCEO, the bargaining agent representing approximately 14,000 employees in a broad range of administrative, technical, and professional roles. Again, the agreed upon GWI was 2.75% for 2025 and 2.25% for 2026.

By coincidence or otherwise, the GWI of 2.75% for 2025 and 2.25% for 2026 in these two settlements exactly mirror another voluntary settlement (again following a strike) concluded between the Ontario government and OPSEU in July of 2024 in respect of approximately 8000 LCBO employees, where the parties agreed to 2.75% for 2025 and 2.25% for 2026. It should also be noted that the 2.75% GWI for 2025 in these three voluntary settlements exceeds the 2025 increase of 2.65% increase awarded by Arbitrator Gedalof for the Professional Association of Residents of Ontario ("PARO") and the Ontario Teaching Hospitals in September of 2024 (PARO represents medical residents in Ontario Hospitals).

These four recent settlements involving Ontario employees in the public and broader public sector (and therefore the same funder as the hospitals) establish a recent, clear and consistent precedent for GWI's in 2025 and 2026 of no more than 2.75% and 2.25% or, together, 5% over the two years.

The GWI's awarded by the Chair of 3% in 2025 and 2.25% in 2026 (or 5.25% over the two years) exceed this norm and are unjustified on any basis as discussed in detail below.

The Award

In my respectful view the Chair's Award is excessive and does not follow recognized principles of interest arbitration as they have traditionally been applied in the hospital sector or the *HLDAA* criteria. Although I have concerns with several aspects of the Award, in this dissent I will focus upon three aspects of the Award: (1) the Chair's unjustified amendment to Article 13.01 of the Collective Agreement relating to transfer of accountability ("TOA"); (2) the non-normative general wage increase ("GWI") awarded, and (3) the Chair's award of only one hospital proposal.

Before outlining my concerns with respect to these issues, I would first note my strong agreement with the Chair's dismissal of the Union's proposals relating to nurse-patient ratios ("NPR") and the Union's proposal regarding work of the bargaining unit.

In the case of the NPR proposal, in addition to the reasons listed by the Chair, I would note that employers do not voluntarily agree to minimum staffing guarantees on any basis let alone on a department-by-department basis. As noted herein, Arbitrator Kaplan in part rationalized the greatly increased ability of hospitals to reassign nurses across hospital units as being in exchange for the adjustments to the wage grid he made. This increased flexibility directly enhanced the hospitals' ability to improve patient care in the dynamic hospital environment by increasing the ability of hospitals to reassign nurses to the departments where they are most needed in the hospital. There is no theory of replication which would justify the granting of a proposal such as the Union's NPR

proposal which would effectively eliminate the ability of the hospitals to utilize the increased flexibility in nurse assignments they had just gained at substantial cost under the Kaplan Award.

With respect to the union's work of the bargaining unit proposal, in addition to the reasons listed by the Chair, I would suggest that the type of antiquated work protection clause proposed by the Union would not ever be agreed to by hospitals in free collective bargaining. The focus of hospitals is properly upon enhancing patient care by assembling the team of health care providers who can most effectively and efficiently provide quality patient care. Hospitals' time and money should not be wasted upon managing needless union jurisdictional disputes. Rather, where work of the bargaining unit clauses exist in other hospital collective agreements, they should be removed to provide the hospitals an enhanced ability to focus upon providing patient care based upon best practices and ever evolving scopes of practice rather than irrelevant considerations such as union jurisdiction claims.

i) <u>Article 13.01 --- TOA</u>

The language of Article 13.01(a) was awarded by an interest arbitration board chaired by Arbitrator O'Shea in 1980 in an arbitration which standardized terms of the central portion of the collective agreement. One issue that needed to be addressed by Arbitrator O'Shea was the standardization of the hours of work for RN's. At that time some RN's worked shifts which were 7.5 hours in length while other RN's worked shifts which were 7.75 hours in length. The RN's received the same monthly salary regardless of whether they worked 7.5 or 7.75 hours per day. Arbitrator O'Shea set the standard shift length at 7.5 hours. In doing so, he did not reduce the wages of the RN's who worked shifts of 7.75 hours with the result that these RN's continued to receive the same pay for 1.25 hours less of work each week.

Transfer of accountability is a professional responsibility of RNs in charge of a patient's care which requires a RN to provide relevant information regarding the patient at the end of their shift to the RN on the next shift who is assuming responsibility for the patient's care. Not all RN's perform transfer of accountability as some RNs work in areas (e.g. clinics in the hospital and the OR) that do not provide continuous patient care. Where transfer of accountability occurs and cannot be completed during the RN's shift, the time spent by the RN will often vary greatly but usually takes the RN ending her shift less than fifteen minutes.

In standardizing the shift length at 7.5 hours, Arbitrator O'Shea also addressed the issue of transfer of accountability and awarded the language of Article 13.01(a). That language has remained in the collective agreement for 45 years.

Arbitrator O'Shea appears to have taken a common sense approach to the issues relating to standardizing the shift length at 7.5 hours (with no reduction in pay for any RN) and the varying nature of the transfer of accountability obligation, and directed that any transfer of accountability of less than 15 minutes would be deemed to form part of the RN's normal shift but that TOA of greater than 15 minutes would entitle the nurse to overtime. At the same time, the weekly pay of the RNs who had previously worked 7.75 hour shifts was maintained despite the fact that following the O'Shea Award they would work .25 of an hour (or 15 minutes) less each day. Given this outcome, it seems quite clear that the TOA language in dispute was "bought and paid for" by the Participating Hospitals in 1980.

Regardless of the circumstances in which the TOA language was awarded by Arbitrator O'Shea, however, Article 13.01(a) has formed part of the Central Collective Agreement for the last 45 years and is a provision upon which the Participating Hospitals have negotiated local scheduling

provisions. During those 45 years, participating hospitals have established local schedules of work based upon the existence of Article 13.01(a). As a result, hospital schedules currently often provide for contiguous rather than overlapping RN shifts. If the hospitals are unable to amend these shifts so that TOA must occur after the departing RN's scheduled shift, the Chair's Award will increase costs for those hospitals.

The award of this item is unjustified in my view. The Award reverses the status quo between the parties which has been in effect for the last 45 years and undeniably constitutes the award of a massive breakthrough item.

From the material before the Board, the Union has never before proposed an amendment to article 13.01(a) and has certainly never taken the proposal to interest arbitration. Although the union says Article 13.01(a) is unfair and/or contrary to the Employment Standards Act, there is no evidence that it has ever filed a grievance challenging the validity of Article 13.01(a), let alone obtained an arbitration decision confirming its assertions. Rather, it relies upon rights decisions involving RPN TOA under different collective agreements. Those collective agreements, which were established at a time when the duties and responsibilities of what are now known as RPNs were very different than today, do not contain a provision akin to article 13.01(a). Rather, they are silent as to whether transfer of accountability forms part of the nurse's compensation for their normal shift. The rights decisions decided under these collective agreements are wholly distinguishable on that basis.

I would also note that a collective agreement can take precedence over the Employment Standards Act where it provides a greater entitlement to an employee with respect to an employment standard (ss.5(2) of the ESA). Here, the collective agreement's hours of work provision provide for paid breaks of a minimum of one-half hour. I would also note that a failure to record time worked under

the ESA does not mean that the time must be assumed to have been unpaid. In any event, the normal shift worked by a nurse is undoubtedly recorded by the hospitals and, under Article 13.01, TOA is "considered to be part of" that shift.

If the Union wants a change to a valued collective agreement provision that has been in effect for 45 years, it should negotiate it. Interest Arbitrators have long noted that breakthroughs should not readily be awarded at arbitration. For example, the changes to the job security language achieved by the participating hospitals in the Kaplan Award had been persistently prioritized by the hospitals over two decades and were fully supported by evidence of demonstrated need. There is no doubt that the Chair's Award in respect of Article 13.01(a) is a massive breakthrough for the Union disrupting what has been the status quo in hospitals for over four decades. The Chair's amendment to Article 13.01(a) will cause disruption throughout the Province as hospitals seek to amend work schedules to ensure that TOA can be performed during a nurse's scheduled tour where possible and should not have been awarded.

(ii) Wages

The Chair awarded a GWI of 3% in 2025 and 2.25% in 2026. Given the significant wage increases achieved by the union under the Kaplan Award and the Gedalof Award, current and projected inflation, current levels of provincial funding for hospitals, and the trend to lower wage settlements for 2025 and 2026 made clear by the recent settlements involving the hospitals' funder referenced above, the Chair's Award is excessive.

The Chair based her decision to award a 3% wage increase for 2025 upon the central awards of panels chaired by Arbitrator Kaplan for CUPE and SEIU issued on April 18, 2024; the "CUPE

Award" and the "SEIU Award" (*The Participating Hospitals* v. *OCHU/CUPE*, 2024 CanLII 33105 (ON LA) and *The Participating Hospitals v. SEIU,* 2024 CanLII 33108 (ON LA)).

While I agree with the Chair's decision to focus upon Ontario hospital employees as the appropriate (and traditional) comparator, I believe that the Chair erred by failing to consider the CUPE Award and the SEIU Award as a whole.

As noted in my dissent to those awards, Arbitrator Kaplan balanced the GWI's granted to the unions by awarding key hospital proposals to establish Weekend Workers, to provide an enhanced Nurse Graduate Guarantee Program, and to limit the circumstances in which hospitals were required to provide early retirement allowances. As such, the CUPE Award and the SEIU Award followed the approach of Arbitrator Kaplan in the Kaplan Award (see Arbitrator Kaplan's comments under the heading "Overall Approach" commencing at p.29) wherein the gains made by ONA in that award were balanced by the award of several key employer proposals including those providing greater flexibility to the hospitals in the reassignment of nurses and those limiting the circumstances in which early retirement allowances and severance pay are required to be paid by hospitals.

In stark contrast to the approach of Arbitrator Kaplan in these three central awards, the Chair does nothing to balance the non-normative wage increases granted in this Award. Rather, and as noted above, the award of the amendment to Article 13.01(a) (TOA) is a major breakthrough which the Union has achieved without giving anything in return. Further, the GWI's awarded greatly exceed actual and projected inflation for 2025 and 2026, are unsupported by recent settlement trends, and are unsupported by other hospital outcomes when considered as a whole.

To the extent that the Chair factored the award of the TOA amendment into the wages increases granted in the Award (which is not at all apparent to me), I would suggest that the cost to the hospitals of the TOA amendment, the disruption to the status quo, and the difficult and time-consuming process many hospitals may face to amend existing shift schedules to manage the additional costs associated with this amendment, were not sufficiently recognized by the Chair.

For these reasons, I find the Chair's reasons for her decision to award 3% in 2025 and 2.25% in 2026 unpersuasive and unsupported by the HLDAA criteria, hospital comparators, and the trend to lower wage settlements as reflected in the most recent and relevant Ontario settlements.

(iii) The Award of Only One Hospital Proposal

Although the Hospitals made several modest and reasonable proposals, only one hospital proposal (the amendment to Article 10.07(e)) was awarded by the Chair. In contrast, and leaving aside the TOA amendment which should not have been awarded on any basis, the Chair also addressed several other amendments sought by the Union including improvements to dental benefits, increasing the pregnancy and parental top up from 84% to 93%, and the long-standing variance in NP wages across the hospitals.

An amendment to reduce variance in NP wages across the hospitals has been pursued by ONA for many years. In my view, the Chair's Award would have been significantly more balanced had she awarded additional hospital proposals in exchange for the changes to NP wage rates granted and the other union items awarded. In particular, I would have granted, at a minimum, the hospitals'

proposal clarifying the circumstances in which call back pay arises and the hospitals' proposal giving laid off employees priority to posted vacancies.

Dated September 3, 2025

Brett Christen
Nominee of the Participating Hospitals

ONA & Participating Hospitals

Dissent of Union Nominee

I must dissent from the Chair's award. Nurses remain overworked and underpaid. They and their work remain undervalued and unsafe. Serious health and safety issues have not been acknowledged or addressed in this award. I completely disagree with the Chair's decision to dismiss ONA's proposals on health and safety, work of the bargaining unit, and wages.

Paid Work:

No other employee is expected to work for free. The Participating Hospitals have received a windfall of free labour for fifty years. Correcting that injustice and paying Registered Nurses ("RNs") what they are entitled to, as of right, is not, in my view, a trade-off. It is simply what the law and social norms require. For that reason, the Chair's decision to recognize all work as "paid work" should not be considered as part of total compensation. I also disagree with the decision not to order that time spent performing transfer of accountability ("TOA") be compensated at overtime rates as is the case with other healthcare professionals in the Participating Hospitals, despite the fact that TOA occurs beyond the normal daily tour.

Health and Safety:

Section 9(1) HLDAA requires the Board to, "decide on matters that are in dispute and any other matters that appear to the board necessary to be decided in order to conclude a collective agreement between the parties." The Board is obligated to address concerns for which there is demonstrated need. ONA's core concern in this round was the health and safety of RNs in Ontario hospitals. ONA established that nursing is a dangerous job. There was clear demonstrated need. This decision, however, fails to address the health and safety crisis faced by RNs on the front lines of acute care hospitals.

ONA presented the Board with considerable evidence of the dangers faced by nurses. Since the hearing, we received evidence of three more violent incidents. There was evidence from one RN who continues to suffer from physical and psychological injuries. Hospital RNs in Ontario do not have the right to strike. Interest arbitration is the only legal avenue available to address their working conditions. Failing to award critical health and safety proposals, while also rejecting WSIB top-up (a benefit which is available to other dangerous professions) leaves RNs openly vulnerable to the same serious dangers as ever.

In my view, the expert evidence, which was not substantively challenged by the Participating Hospitals, showed that nursing is a dangerous profession, and that establishing minimum staffing levels in the form of nurse-to-patient ratios improves health and safety and is one of the best means to address those issues. That cannot be reasonably disputed. The Chair points to the current provisions of the collective

agreement as avenues to address these issues, but despite those provisions dire health and safety concerns persist. The Board also heard evidence about various other approaches to ensure safe staffing in other jurisdictions, which would have been reasonable alternatives to awarding the specific ratios and other elements of ONA's proposal.

This sends a message to Ontario RNs that they are on their own. At the very least, this Board ought to have awarded provisions similar to those found in other provinces so that these parties can move towards determining the correct minimum staffing levels.

Work of the Bargaining Unit:

The requirement for demonstrated need is diminished when a proposal is an industry norm, which is acknowledged by the Chair. The presumption is that demonstrated need has already been established, which is why the provision is standard. Yet, the Chair reasons that there is insufficient demonstrated need for ONA's proposal protecting bargaining unit work. The Chair does so, despite the fact that other central agreements in place at the Participating Hospitals which cover regulated health care professionals contain provisions similar to what ONA proposed. In these circumstances, there was no requirement for evidence of demonstrated need. The fact that those provisions were awarded or agreed with other unions who bargain centrally with the Hospitals is crystal clear evidence of what the parties would have bargained. The Participating Hospitals say they would never agree to this, but it is the bargain in place between the Participating Hospitals and other unions representing regulated health care professionals.

Relevant Comparators:

The Participating Hospitals noted that Ontario hospitals are the "most efficient in Canada." The efficiencies lauded by the Participating Hospitals is a result of overworked and underpaid RNs. These "efficiencies" are achieved on the backs of ONA members. Even putting that aside, if the Participating Hospitals benchmark their performance against the acute care hospitals in other provinces, there is no reason why the terms and conditions of the employees in those hospitals are not the most relevant comparators.

HLDAA requires, "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." Virtually all the RNs employed in acute care hospitals in Ontario are covered by this agreement. If we are to seek comparators based on the work performed, RNs working in other acute care hospitals are clearly the closest equivalent. They are found in other Canadian provinces, particularly where they have the right to strike.

Replication requires discerning what the parties would have done if they had the right to strike and lock out. Looking primarily at other regulated health professionals in Ontario not only distorts the nature of RN work, but is circular, since none of those groups have the right to strike and lock out either. The most realistic comparators are RNs in acute care hospitals with the right to strike, which can be found in Alberta and B.C. The

evidence before this Board was that the award in the last round placed the wages for ONA RNs at the top of market in the country. It is devastating that this award fails to maintain that trend.

Wages:

Hospital RNs work in dangerous frontline essential services. Within Ontario, we can find other employees working in those conditions. In my view, a principled application of replication and comparators requires consideration of RNs working in acute care hospitals in Canada with the right to strike, and other frontline employees working in dangerous essential services in Ontario.

Instead, the Chair relies on the awards for CUPE and SEIU in ordering a 3% increase for 2025. I do not accept that result. Historically, including in the previous round, while the general wage increases for these groups have been similar, they have not been identical. In addition, those groups are not comprised exclusively of healthcare professionals but include various service classifications which are not facing the same vacancy rates or the same serious health and safety issues. This does not diminish the contributions of those other employees, but they do not perform the same kind of work in the same context. The Chair acknowledges these considerations yet awards the same increase. Even assuming that they are relevant, the increases awarded for those groups is the bare minimum that would apply to ONA members.

Similarly, the Chair references the broader public sector in awarding 2.25% in the second year. Those bargaining units include retail workers and office workers. Some of those, such as LCBO workers, work in industries which are facing existential threats from the government's move to permit alcohol sales in grocery and convenience stores. They are losing their market share and revenues. Office workers are also routinely asking to work from home – a thing that RNs could never do. If the results of bargaining in those non-essential and non-hazardous sectors following a work stoppage is relevant and persuasive, then it must be the case that outcomes where hospital RNs have the right to strike are even more persuasive, since they are at least doing the same kind of work. The evidence before this Board was that there were around 5,000 vacancies, a factor that is given insufficient weight by the Chair.

All these considerations should have resulted in higher increases to compensation. In addition, the evidence before this Board was that ONA's wages continue to lag inflation since 2010, and that this award does not result in a complete catch-up. In real dollars, hospital RNs in Ontario earn less today than they did fifteen years ago, to say nothing of the increased health and safety risks, and lean staffing models which leave RNs more exposed than ever.

Inferior and inadequate outcomes such as this Board's award are precisely why the last voluntary agreement between these parties was in 2010. Unfortunately, the Participating Hospitals have no incentive to come to an agreement with ONA at the bargaining table when they can achieve such "efficiencies" at interest arbitration.

I would have awarded ONA's proposal on work of the bargaining unit, significantly higher wage increases, and at the very least an enforceable process to establish safe staffing levels. Instead, nurses remain unsafe, overworked, and underpaid.

Philip Abbink

September 3, 2025