

IN THE MATTER OF AN ARBITRATION

BETWEEN:

Participating Hospitals,

Employers,

- and -

Ontario Public Service Employees Union,

Union

BEFORE: Michael Bendel, Chair
Douglas K. Gray, Employer Nominee
J. Cameron Nelson, Union Nominee

APPEARANCES: For the Union:

Michèle Dawson Haber, Research Officer

For the Employers:

Malcolm Winter, Counsel

Hearing held in Toronto, Ontario, on March 7, 21 & 25; April 1 & 10; and May 7 & 22, 2003.

ARBITRAL AWARD

I

This board was established to deal with a dispute between six hospitals and the union on the terms of new collective agreements for para-medical employees, pursuant to the Hospital Labour Disputes Arbitration Act, R.S.O. 1990, c. H. 14, as amended. After the board was established, the union and the Ontario Hospital Association ("OHA"), which is representing the hospitals, agreed to expand the scope of this arbitration so as to include a further 34 hospitals.

The employees in the bargaining units occupy a wide range of classifications. Traditionally, they have been grouped for bargaining purposes into three broad categories: Registered Technologist ("R.T."), employees above R.T., and employees below R.T. The employees above R.T. include various health-care professionals, including Physiotherapists, Social Workers, Pharmacists and Dietitians, but not Doctors or Nurses. The employees below R.T. are primarily Laboratory Technicians.

II

Two themes ran prominently through the presentations of both parties, while each party also had issues of its own.

Firstly, these negotiations are "central" negotiations. Arbitration boards have recognized on numerous occasions that the central negotiations in the health-care sector should set the pattern to be followed by non-participating bargaining units. However, only 40 of the 71 hospitals where the union holds

bargaining rights, employing 51% of its members in the sector, are participating in these negotiations. In addition, some 30% of the participating hospitals are exceeding the central rates of pay or other conditions of employment. (The union has made several complaints to the OLRB about hospitals negotiating directly with employees it represents.) Many of the non-participating hospitals also have superior wages and conditions of employment. On the other hand, some participating hospitals are paying below the centrally negotiated rates of pay. How to ensure the continuing viability of these central negotiations and to prevent the process from fragmenting was one of the major themes in the parties' submissions.

The other prominent theme was the appropriate response to recruitment and retention problems experienced by the hospitals. The parties agreed that serious recruitment and retention problems exist in several classifications throughout the province and that qualified employees in several classifications are in short supply. As a result of the large number of vacancies, existing staff are often stretched to unreasonable limits. In the case of many occupations, the hospitals are in competition for qualified staff with other hospitals, with the private sector and even with employers in the United States. Both parties made thoughtful presentations on the causes of these problems and on possible solutions.

On the employer side, the board's attention was also drawn to the inadequate funding of hospitals. The hospitals cautioned that an award that was too costly could force them to reduce staff, which would exacerbate the workload and overtime complaints of the union.

III

On the question of pay, the union proposal is as follows:

1. The establishment of a standard wage grid to include all the employees in these units, effective April 1, 2002.
2. Wage parity for R.T.'s and Registered Nurses.
3. Economic increases (a) on October 1, 2002, of 3% to all steps except the maximum, which would receive 4%, and (b) on April 1, 2003, of 3.2% to all steps.
4. Effective April 1, 2002, special adjustments for the following classifications: Lab Technician/Assistant (+9%), Pharmacy Tech/Assistant (+9%), Kinesiologist (+12%), Biomedical Technologist (parity with R.T.), Echocardiographer (parity with R.T.), Autopsy Master (parity with R.T.), Dietitian (parity with Senior Physiotherapist and Occupational Therapist) and Bachelor of Social Work (parity with Senior Physiotherapist and Occupational Therapist), and the establishment of a new classification of Chiropodist (at the same rate as Senior Physiotherapist and Occupational Therapist).

Although the union proposes the same economic increases for all classifications, placement on the grid would generate substantially different increases among the various classifications. The placement of R.T.'s on the new grid, in such a way as to ensure parity with Registered Nurses, would lead to an increase of 14.9% for R.T.'s, while other classifications would receive increases of between 2% and 35% on movement to the new grid. In addition, the union, while proposing standard economic increases for the whole unit, has proposed special adjustments for certain classifications.

The hospitals propose the following pay adjustments:

1. Effective April 1, 2002, R.T. and above would receive an increase of 3%, except that the maximum step would be increased by 4%, and the bottom step in the R.T. range would be deleted.
2. Effective April 1, 2002, below R.T. would receive an increase of 2.5%.
3. Effective April 1, 2003, R.T. and above would receive an increase of 3.2%.
4. Effective April 1, 2003, below R.T. would receive an increase of 3%.
5. Effective April 1, 2003, the maximum rate for Physiotherapists, Occupational Therapists, Pharmacists, Perfusionists, Ultrasound Technologists, MRI Technologists and Registered Respiratory Care Practitioners would be increased by a further 3%.

IV

Although both parties made extensive arguments on rates of pay, we wish to comment specifically on just two of them.

First is the union's proposal for parity between R.T.'s and Registered Nurses.

This has been an objective of the union's for several years, although voluntary settlements have been arrived at that are at odds with that objective. The notion of tying R.T. rates to those of R.N.'s was endorsed by the arbitration board chaired by arbitrator Verity in the 1982 arbitration, but rejected by the board chaired by arbitrator Devlin in the 1993 arbitration. The Verity board, however, ordered what it referred to as "comparability" only at the starting rates.

In this arbitration, the union, in addition to arguing that there was an historical basis for parity, presented a consultants' report, which it had commissioned, comparing the work of R.T.'s and R.N.'s in terms of education, judgment, responsibility, etc. The report concluded that the jobs were of comparable value.

As the board observed at the hearing, it has difficulty concluding that what the Verity board ordered was really parity for R.T.'s and R.N.'s. The most significant rate of pay for comparison purposes has always been held to be the maximum rate that employees can attain. In our view, to align hiring rates, as the Verity board did, is not to order parity, even though the board did express approval for what it called "comparability" between R.T.'s and R.N.'s.

As for the consultants' report, we respectfully question the value of such a study in the present context. In an arbitration like this, it must be borne in mind that there exist different markets for each occupation. R.T.'s and R.N.'s, however similar their work and the demand for their services might be, are not interchangeable and are not part of the same market. The focus for an arbitration board, it seems to us, must be on the market value of employees' work. We should also observe that if a study such as the one presented by the union were to be conducted on the work of any two occupations in the same broad category within this bargaining unit (e.g., Occupational Therapists and Audiologists), we would anticipate the conclusion would be that their work was comparable. Moreover, a simple finding that two jobs are comparable, although paid differently, does not indicate which rate is the more appropriate.

We wish to comment, next, on the union's proposal for a standard wage grid.

The union has noted that there is a lack of logic and symmetry in the present wage scales. There is no standard length to the scales. There is no standard value of an increment, even within scales. There is overlap between different scales. The union, on the basis of internal equity, proposes a new grid, with 40 levels, onto which all bargaining unit employees would be placed, with six steps at each level, and a standard 3% difference between each level.

The hospitals, in opposing this proposal, point out that the cost of moving to the new grid would be substantial and that the union's proposals would create inequities of their own. They also question the need for any such exercise and the appropriateness of an arbitration board embarking on it.

For at least three reasons, we are not persuaded that there is a proper basis for endorsing the union's proposed grid.

In the first place, we question the premise of the union's proposal. As we understand it, this bargaining unit contains employees of disparate occupations who have joined together for the purpose of engaging in collective bargaining. There is no scope for any employee to move from one occupation to another within the bargaining unit, except if the employee went back to school to obtain further qualifications. In these circumstances, with the somewhat limited community of interest among employees, we do not regard the union's "internal equity" argument as being particularly compelling.

Secondly, like the employer, we are concerned at the cost of moving to a new grid. The monetary benefits to employees on the move would be unequal and somewhat arbitrary. We feel that this is not a wise use of available dollars.

Thirdly, even if we were to agree with the union's plan in its entirety, the union has not provided us with contract language to implement this new approach. It has, rather, given us examples of how it would work and stated certain principles that should be followed. We do not believe that this would be an adequate basis for putting this grid into effect.

V

Both parties have relied on extensive data and arguments in support of their proposals. While we have considered all of them, there are two elements that appear to us to be of particular note.

Firstly, the union reached a voluntary settlement in December 2002 with Scarborough Hospital. Although applying to just one bargaining unit, this settlement is, in our view, good evidence of what is an acceptable voluntary settlement for para-medical employees at the present time. The agreement contained increases of 9%, effective April 1, 2002, and 4.25%, effective April 1, 2003, for R.T. and above, as well as the elimination of the first two steps in each of these pay scales. For classifications below R.T., wages were increased by 3.5% each year. The agreement also provided for improved vacations for employees below R.T. and various other changes.

Secondly, a board of arbitration chaired by arbitrator Goodfellow issued a unanimous award on June 3, 2003, in a dispute between the union and The Ottawa Hospital. Although this award was complicated by reason of being the first since the amalgamation of four Ottawa-area hospitals and although it expired on the eve of the effective date of our award, it is a significant award since it applies to some 1,550 para-medical employees and is unanimous. It provides, among other things, for economic increases of 5%

effective April 1, 2000, and 5% effective April 1, 2001, which puts Ottawa-area wages some 5% ahead of "central" rates as of March 30, 2002.

VI

Having regard to all the above considerations, our award is as follows:

WAGES

- (a) For R.T. and above, all rates shall be increased by 7%, effective April 1, 2002, and by a further 6.6%, effective April 1, 2003;
- (b) The lowest step shall be eliminated for R.T. and above, effective April 1, 2003;
- (c) Effective April 1, 2003, the maximum rate for Physiotherapists, Occupational Therapists, Pharmacists, Perfusionists, Ultrasound Technologists, MRI Technologists and Registered Respiratory Care Practitioners shall be increased by a further 3%.
- (d) For below R.T., all rates shall be increased by 3.5%, effective April 1, 2002, and by a further 3.5%, effective April 1, 2003.
- (e) Retroactive payments will be made as soon as possible.

CREDIT FOR RECENT RELATED EXPERIENCE (ARTICLE 25.02)

This provision shall be amended to provide that prior experience be credited at the rate of one increment on the salary scale for every one year of recent, related, full-time experience. The previous

limitation that any such credit cannot bring an employee higher than two steps below the maximum shall be deleted.

As regards current employees, we have decided that they should be paid at the step to which they would have been entitled if the above amendment had been in effect when they were hired. However, no such employee shall be entitled to any retroactive payment as a result of this change.

LAYOFF AND RECALL (ARTICLE 11.03 and 11.04)

The agreement shall be amended by adding the following:

An employee who has the right to displace another employee shall have the right to the same training period as would typically be accorded to a new employee. Such training period may commence prior to the anticipated layoff.

VACATION (ARTICLE 19)

The agreement shall be amended as follows, effective the first of the month following the month in which this award is issued:

- (a) Employees below R.T. will receive the same vacation benefits as other bargaining unit employees; and
- (b) Employees will receive six weeks vacation after 23 years of service.

SHIFTS AND WEEKEND PREMIUMS (ARTICLE 17)

Effective the date of this award, shift premiums shall be increased to the following amounts:

Evening shift - \$1.10

Night shift - \$1.35

Weekend shift - \$1.45

BENEFITS FOR EARLY RETIREES

The following new provision shall be added:

The Hospital will provide to all employees who retire on or after the date of this award and have not yet reached age 65 and who are in receipt of the Hospital's pension plan benefits, semi-private, extended health care and dental benefits on the same basis as is provided to active employees, as long as the retiree pays the Employer the full amount of the monthly premiums in advance.

ALL OTHER PROPOSALS

All of the parties' proposals not referred to above are rejected.

The board wishes to thank the parties for their excellent presentations.

DATED at Thornhill, Ontario, this 29th day of August 2003.

Michael Bendel,
Chair

~~I concur/dissent~~
Addendum attached

Douglas K. Gray,
Employer Nominee

~~I concur/dissent~~
Addendum attached

J. Cameron Nelson,
Union Nominee

ADDENDUM OF THE EMPLOYER NOMINEE

I have concurred with this award, thus making it unanimous. Having done so, I should make it clear that there are some elements of the award with which I am uncomfortable, and, if they were to stand alone, I would not agree with them. I have subscribed my name to the award, however, because I believe the Chair, assisted by the other board members, has tried very hard to craft a balanced award. In this respect, the award replicates something close to what is usually achieved in collective bargaining: an agreement in which neither party achieves everything it wants but is, in the overall result, fair.

I am particularly uncomfortable with the award on wages. It considerably exceeds what would be a normative award in the hospital industry. However, I think it can be justified as a special case arising out of unique market factors affecting this particular bargaining unit (and specifically some employee groups within this bargaining unit) at this time. Absent special circumstances, a normative award would be appropriate. For that reason, albeit with considerable reluctance, I am prepared to agree with the amounts awarded.

Douglas K. Gray,
Employer Nominee

ADDENDUM OF THE UNION NOMINEE

I concur in the substantive orders set out in Part VI of the award. I do so because, in general, it represents a reasonable and balanced approach to what was a highly contentious, difficult and relatively unique situation. In doing so I believe that the award comes close to replicating what the results of a freely bargained agreement would have looked like in all the circumstances.

As a result some worthy and well reasoned proposals were not included in the award and in a number of areas both parties will no doubt be dissatisfied with the result. The award, however, must be looked at in its totality and as a complete package. Looked at that way I believe it reasonable and support it.

What I cannot support is the award's analysis of the parity between Registered Technologists and Registered Nurses issue and the rejection by the Chair of the principle of parity between the two classifications. In particular I strongly disagree with the Chair's conclusion, that RT's and RN's "however similar their work and the demand for their services might be, are not interchangeable and are not part of the same market."

With the exception of periods where the coincidence of wage restraint legislation with contract expiry dates led to short term differences, wage comparability existed between Registered Technologists and Registered Nurses from 1973 until the 1991 Devlin award failed to match the 29.3% increases achieved by ONA in that year. The basis for this comparability was set out in the Pyle award and founded in an Employer sponsored job evaluation study that found essential comparability between the general staff nurse and the registered technologist insofar as wage rate classifications were concerned.

The Devlin award did not dispute the job evaluation comparability. The rationale advanced by Arbitrator Devlin for failing to match the ONA settlement in spite of the long history of comparability was simply that the reason for the ONA settlement was the existence of an acute shortage of nurses at the time where there was no such acute shortage of Registered Technologists. Consequently Arbitrator Devlin awarded OPSEU 17.4% at the maximum rate creating a 12% gap that had grown to a \$ 4.08/hour or 14.9% difference by 2001.

In this arbitration the Union presented compelling evidence of a growing and acute shortage of registered technologists throughout the Province and introduced evidence from a consultant's study commissioned by it which once again found essential comparability between the RN and RT classifications.

Given that the only reason parity was lost was the fact that there was no serious shortage of RTs in the province it stands to reason that when such a shortage is, in fact, demonstrated parity ought to be reestablished. If the work is similar, as it is, and if both groups are integral parts of our health care teams, as they are, and if the demand for their services outstrips the supply, as it does, parity ought to be the result.

I believe that the case for parity has been made out and that parity ought to be re-established.

This award does not do that.

It does, however, represent a significant step in that direction. It more than eliminates the gap completely at the start rate and reduces the gap from 14.9% to 8.1% at the top rate. In the context of a two-year agreement it is a reasonable start.

I concur with the award of the Chair if not wholly with his reasons therefore.

J. Cameron Nelson,
Union Nominee