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Résumé de l'article

Tant au niveau fédéral que celui des provinces, le Canada a connu une croissance explosive de la négociation collective dans le secteur public depuis deux décennies. On trouve une plus grande diversité dans les négociations et les conventions collectives dans le secteur public que dans le secteur prive. De même, il y a beaucoup de malaises tant dans les procédures que dans les résultats des négociations. De là, il est évident que nous ne possédons que deux cas de contrôle des salaires en temps de paix. Les deux se sont produits dans la dernière décennie et l'un et l'autre découlaient pour une large part de la réaction du gouvernement face aux conventions collectives et aux décisions arbitrales dans le secteur public. L'article analyse l'évolution de la négociation chez une portion importante du secteur public dans la plus grande province du Canada. On y étudie la croissance et la répartition de l'emploi dans les hôpitaux ontariens. On y explique aussi la législation en vigueur dans le secteur. L'article poursuit en montrant comment les employeurs et les syndicats s'arrangent pour négocier, comte tenu de la législation, de la politique de la Commission des relations du travail et d'autres forces qui sont à l'œuvre. On a également considéré le champ de la négociation collective et son développement au point de vue chronologique. Finalement, l'article discute des attitudes des parties par rapport au système actuel.

L'auteur conclut que, après une expérience de deux décennies de l'utilisation du présent régime, il y aurait lieu de réviser et de réévaluer l'ensemble du processus.

Collective Bargaining in Ontario Public Hospitals

Arthur Kruger

This paper outlines and evaluates some of the more important developments that have taken place in the past three decades in Ontario public hospital labour relations.

It is now almost forty years since the first local union was certified in an Ontario public hospital[1]. Almost twenty years ago, Ontario made arbitration compulsory for resolving interest disputes in this sector. This has been a period of rapid change in hospitals, particularly in union organization and collective bargaining. The purpose of this article is to outline and evaluate some of the more important developments that have taken place in the past three decades.

Although Ontario public hospitals are funded largely by the Province, they operate as autonomous entities, each governed by its own governing board. These boards, however, are constrained to operate within the provisions of various statutes applicable to hospitals[2] and within the revenue they can generate from government grants and other sources.

The cost of medical care and the importance we attach to it in our society have made it inevitable that governments would play a significant role in this sector. Initially this role was limited to the statutory regulations required to ensure both a minimum standard of quality and that all regions of the Province were serviced by hospitals.

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•• I wish to thank the Canada Department of Labour for a research grant that assisted me in carrying out my research and the Centre for Industrial Relations at the University of Toronto for administering the grant. I am also indebted to an unknown reader who reviewed the paper and made many helpful suggestions that were incorporated prior to publication.

1 The focus here will be on the public hospitals. I will not deal with the psychiatric hospitals operated directly by the Province under the Ministry of Health or with nursing or chronic-care homes operated either for profit or by charitable organizations.

2 In particular they are subject to the *Public Hospitals Act* which regulates the standard of care, the *Ontario Labour Relations Act* and the *Hospital Disputes Arbitration Act*. The latter two statutes govern union-management relations in this sector, and will be discussed at greater length later in this article.

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In the immediate post-war period, private hospital insurance coverage became quite extensive. While initially it was purchased by individuals, it gradually came to be a common fringe benefit provided in whole or in part by employers. The demand grew for government-sponsored health insurance after such plans were developed in the United Kingdom and in the Province of Saskatchewan. On January 1, 1959, Ontario replaced private hospital insurance with its own system of insurance covering the entire population of the province. This was followed by universal medical insurance which extended the government plan to cover physicians' services and other related areas.

HOSPITAL EMPLOYEES IN ONTARIO

In Table 1 you will find statistics showing important changes in the size and distribution of employment in this sector.

From Table 1, the significant growth of employment in public hospital in Ontario is apparent. The importance of part-time staff is immediately obvious from this Table.

Hospital employment between 1960 and 1979 grew at an average annual rate of 3.7%. In the same period private sector employment grew by only 2.8% and public sector employment by 3.5%.

The importance of the hospital sector as a source of employment becomes apparent when we compare this sector to some leading Ontario private sector industries in Table 2.

The hospitals are remarkable for the mix of skills they employ. What strikes the observer immediately is the array of different professional groups, each with its own unique formal training programme. These groups depend on one another and on the non-professional staff for success in carrying out their functions. All of the employees, other than physicians, are salaried. Indeed, a significant number of the physicians are salaried as well. Furthermore, those physicians on a fee for service basis now negotiate with the government concerning their fees, so that their situation bears some similarity to that of unionized employees paid on a piece-rate system.

The unique training of each professional group means that these employees have short progression ladders with virtually no movement among these occupations. Thus, for example, a technician cannot readily become a nurse or pharmacist or dietician by on-the-job experience. One may rise by promotion to one of the managerial positions in one's own professional area, but there are usually few steps up this narrow ladder.

Table 1

Ontario Public Hospitals
Selected Employment Data for Selected Years

Employment	1963	1970	1976	1977-78	1978-79	1979-80	1980-81
No. of full-time employees	67,100	92,664	93,367	94,549	93,101	92,876	94,073
No. of part-time employees	10,192	16,463	23,334	25,821	26,425	28,115	30,916
No. of full-time nurses	—	42,706	39,971	39,881	39,300	39,174	39,453
No. of part-time nurses	—	8,959	12,800	14,020	14,559	15,717	16,775
No. of full-time diagnostic and therapeutic employees	—	11,704	18,084	18,526	18,720	19,250	19,764
No. of part-time diagnostic and therapeutic employees	—	1,716	3,147	3,803	3,910	4,354	4,965
No. of full-time administrative and support employees	—	28,342	30,586	30,819	30,073	29,647	29,749
No. of part-time administrative and support employees	—	5,389	7,327	7,919	7,890	8,464	9,106

Source: Ontario Department of Health: *Hospital Statistics.*

1. The calendar year is used prior to 1977. Thereafter the fiscal year is used.
2. Not all of the sub-groups of employees are included here. Accordingly, the totals exceed the sum of the sub-groups listed below.

Table 2

Employment in Ontario: Hospitals; Motor Vehicles Manufacturing and Parts; Iron and Steel Mills; Pulp and Paper Mill — 1971 and 1981

Sector	*1971*	*1981*
Hospitals	127,210	150,650
Motor Vehicle Manufacturing and Motor Vehicle Parts & Accessories	80,200	95,955
Iron & Steel Mills	41,630	51,975
Pulp & Paper Mills	24,185	25,315

Source: Statistics Canada: *1981 Census, Population: Labour Force, Industry Trends.*

Most of the professionals have skills that are marketable only in the medical sector, and for many of them, only in hospitals. The non-professionals, on the other hand, can find comparable work in a variety of industries.

Many of the occupations in a hospital are staffed predominantly by women. Thus of the 127,000 employees in 1971 in Ontario hospitals 99,000 (almost 80%) were females. In 1981, of the 150,000 employees, 121,000 (about 80%) were females[3]. The employment of women has been accompanied by the use of a significant and growing number of part-time employees in many hospitals as is apparent from Table 1. Also, many of the married women are bound to the local labour market by family ties.

On the other hand, many of the professionals, men and single women in particular, are mobile nationally or even internationally.

It is possible in this sector to deal with imbalances between supply and demand for any particular kind of skilled labour by adjusting quantity rather than salaries. Thus, when shortages occur, the Province will conduct an aggressive campaign to recruit immigrants with the required skills or will increase the capacity of local training facilities. Similarly, surpluses of a given profession can be handled by increasing the barriers against would-be immigrants or by reducing the intake of students in training programmes.

Earlier we mentioned the specific formal training programmes for professionals employed in hospitals. It is worth noting some of the changes in

3 See Statistics Canada, *1981 Census and Population: Labour Force — Industry Trends.*

these programmes in recent years. Neither the medical profession nor the government is eager to see the number of licenced physicians rise significantly. Barriers are placed in the way of immigrants seeking to practice here. Medical schools have been instructed to hold the line on new admissions. Recently, restrictions on the number of interns to be funded has imposed yet another pressure to hold down supply.

While some nurses have been trained in university programmes that continue in existence, until 1976 most nurses were trained in hospitals. In that year the hospital programmes were transferred to the colleges of applied arts and technology (CAATs). Since then, the CAATs have become the major source of supply for nurses in Ontario. The shift to the CAATs removed a supply of cheap student labour from the hospitals. It also altered the character of the training programme somewhat, with more emphasis on classroom instruction and less on learning on the job. It brought nursing students into close contact with other CAAT students rather than with hospital personnel during the period of training.

The CAATs have also developed programmes to train medical secretaries and medical librarians.

LEGISLATION GOVERNING COLLECTIVE BARGAINING IN HOSPITALS

Public hospital have always been considered to be private sector employers, subject to the provisions of the *Ontario Labour Relations Act.*

This Act is administered by the Ontario Labour Relations Board (OLRB). It provides for the certification by the Board of a union that can show that it enjoys the support of a majority of those in a bargaining unit. It is the Board that determines the appropriate bargaining unit, although the Act imposes certain limits on the Board's discretion in this matter. Thus, for example, the bargaining unit must be limited to employees of a single employer. It may not include managerial employees. Security guards cannot be in a unit with other employees. In spite of these and other restrictions, the Board retains considerable latitude to decide the number of bargaining units to designate for a given employer.

Once a bargaining unit has been created by the Board and a union has been certified, the employer is required to bargain «in good faith» with that union with a view to concluding a collective agreement covering all employees in the bargaining unit. The employer may no longer bargain with individual employees.

An employer may voluntarily recognize a union as representing the majority of a given group of his employees. That union need not be certified but it acquires rights comparable to those of a certified union[4].

What is most significant for our purposes is the way in which the Act and the Board have determined the nature of bargaining units in this sector. Since the Act limits a bargaining unit to employees of a single employer, organization must take place at each hospital separately.

Furthermore, the Board has seen fit to divide employees within a hospital into a number of distinct bargaining units. Separate units within a hospital are common for nurses, technologists and technicians, service employees, clerical workers, paramedical employees, operating engineers and security guards[5]. The OLRB seems to feel that professional groups in hospitals should retain their separate identities as they move to unionization and is reluctant to merge them in multi-professional groupings. In those few cases where a single union bargains for all these employees in a given hospital, that union was voluntarily recognized by the employer and was not certified by the Board.

Under the *Ontario Labour Relations Act*, a union may strike in an attempt to obtain its objectives when negotiating a new agreement[6]. This soon became the subject of controversy in public hospitals. Nurses and other professional employees were reluctant to organize unions because they did not want to engage in work stoppages that could harm patients. As we shall soon note, once the right to strike was actually exercised, the Province also became concerned about the impact of hospital strikes on the health and safety of the public.

A Select Committee of the Ontario Legislature met in 1957-58 to consider changes in the *Ontario Labour Relations Act*. Briefs were received from numerous bodies including some submissions from those involved in the hospital sector.

The Registered Nurses' Association of Ontario asked to be excluded from the Act and to be covered by a special act applicable only to nurses. The proposed legislation would have outlawed strikes and lockouts and

4 This brief summary omits many important features of the Act and focuses only on those matters of concern for purposes of this study.

5 Sometimes technologists and technicians are further divided, with separate units for each of these two groups. In some cases, clerical employees are included in the service group. Recently the Board has ended its practice of establishing separate units for operating engineers and has included them in the service units.

6 An employer has the comparable right to lock out his employees. However, this is rarely exercised and would not likely appeal to hospitals given the adverse public reaction to such a step.

would have provided for compulsory arbitration of unresolved disputes. It also would have prevented the inclusion of nurses in the same bargaining unit with other hospital employees.

At that time, the Building Service Employees International Union, which had organized non-professional (services) workers in a number of hospitals, also favoured compulsory arbitration of hospital disputes. However, the Ontario Federation of Labour and other unions opposed compulsory arbitration in hospitals.

In its brief, the Ontario Hospital Association (OHA), speaking on behalf of its member hospitals, wanted to outlaw strikes in hospitals but opposed compulsory arbitration. The unstated conclusion of their position was that hospital boards should retain final control over the determination of wages and working conditions.

The Committee reported in July 1958. Among its recommendations was a proposal that hospital work stoppages be outlawed and that compulsory arbitration be employed for resolving disputes. At that time, the Province chose not to implement this proposal.

In August 1960, Ontario experienced its first hospital strike, when operating engineers at three Windsor hospitals walked out. The stoppage lasted only seventy-two hours and did not cause significant disruption of service to patients.

Late in 1963, service employees at the Trenton Memorial Hospital struck. That dispute lasted three months. It raised public concern over the potential risk to patients resulting from hospital disputes.

Soon after that strike began, the Province established a Royal Commission to look into this matter. The Commission's report opposed automatic compulsory arbitration in hospital disputes. However, it recommended legislation that would have given the Cabinet the discretion to prevent or to end work stoppages by imposing compulsory arbitration in cases where either adequate patient care was threatened by stoppage or where one of the parties had not bargained in good faith and the other had requested arbitration.

The Province rejected this advice, and in 1965 it enacted the *Hospital Labour Disputes Arbitration Act* (HLDAA). While this sector remained subject to the *Ontario Labour Relations Act* for such matters as certification of unions, the new legislation outlawed work stoppages in hospitals and provided for compulsory arbitration of all unresolved disputes in public hospitals.

This brought the public hospitals into line with the way in which disputes were resolved in the Ontario Civil Service, including the psychiatric hospitals. However, one major difference should be noted. Whereas all organized civil servants were in a single union, the Civil Service Association of Ontario (CSAO)[7], hospital workers continue to be divided into a number of separate bargaining units organized by a variety of unions.

Some of the unions active in organizing public hospital employees were dissatisfied with the HLDAA and threatened illegal strikes to achieve their objectives. The Canadian Union of Public Employees (CUPE) was the most vocal critic of the new law. It sought the repeal of the HLDAA. It also demanded direct access to the Province across the bargaining table rather than negotiate with individual hospitals or groups of hospitals. Because the Province held the purse strings, CUPE wanted to confront the government directly in bargaining.

In response to criticism of the HLDAA, the Province in 1974 set up the Johnston Commission to examine collective bargaining in public hospitals. That body reported in November 1974. Among its proposals for change were the following:

1) that all employees eligible for organization be grouped in three separate units covering service workers, nurses, and paramedical personnel;

2) that while more than one union might be active in organizing a given group (e.g. service workers), the various unions collaborate in a council of unions to bargain on behalf of that group on a province-wide basis on «central» issues;

3) the hospitals also were to establish a central agency to bargain for all hospitals on «central issues»;

4) that province-wide bargaining on «central issues» be undertaken voluntarily by the parties. However, in the event they failed to do so, the Province should impose it on them. Such bargaining, although conducted centrally, would allow for regional differences in labour market conditions.

5) central issues would include such items as salaries and important fringe benefits. Although the bargaining would be central, there could and should be regional variations in these terms of employment.

6) local bargaining between a given hospital and its employees would continue in order to resolve such local issues as shifts schedules, travel allowances and so on;

7 The CSAO later changed its name to the Ontario Public Service Employees Union (OPSEU)

7) that a uniform province-wide job classification system be established for all hospital employees. Such a system should provide for a number of bench-mark positions that could readily be linked for salary purposes to comparable jobs outside of the hospitals within each region of the Province. The parties and arbitrators would be able to use these bench-mark classifications to guide them in fixing wages and salaries in line with prevailing market rates in each region;

8) that HLDAA be changed so that strikes and lockouts would be permitted except where either patients were endangered or there was evidence of lack of good faith in bargaining.

In examining hospital wages and salaries, the Commission found that compulsory arbitration had reduced somewhat the large gap between what hospitals paid and what prevailed in the private sector for comparable work, but that hospitals continued to lag significantly behind other employers.

None of the Johnston Committee's recommendations was accepted by the government. However, the Province did encourage the OHA to organize itself for central bargaining and agreed to fund the cost of doing this. Other than that, the Johnston Report has remained a dead letter although periodically it is referred to by unions seeking certain changes. The Province had decided that work stoppages in hospitals would be intolerable.

While HLDAA was amended in 1979 to include nursing homes and certain facilities serving hospitals[8] under its provisions, it continued to rely on arbitration rather than work stoppages to resolve disputes over the terms of collective agreements.

The Ontario approach to dispute resolution in public hospitals is in stark contrast with the system in such provinces as Québec and British Columbia where work stoppages are not illegal and arbitration is not automatically employed to resolve interest disputes. Also, in a number of other provinces, central bargaining is either required by law or has become the common practice. For example, in Québec central bargaining is the regular practice. In Ontario, only by mutual agreement is central bargaining possible and, as we shall see later, the parties have moved cautiously in this area.

8 For example, in some communities a group of hospitals would jointly operate a laundry to serve them. The revision brought such a facility under the HLDAA.

THE MANAGEMENT OF PUBLIC HOSPITALS

Each of the public hospitals in Ontario is incorporated as an autonomous entity with its own board of directors. These boards are charged with the responsibility of ensuring that the hospitals provide a level of patient care that equals or exceeds the standard required by legislation and that they do so without incurring significant financial deficits.

Since about 85% of the operating revenue of these hospitals is derived from government grants, the Province has very good reason to be concerned about hospital operating costs. We have already noted that labour costs constitute 75% — 80% of total costs in hospitals. Any programme of cost control is doomed unless it involves measures to curb labour cost.

The Province has used a variety of methods to hold down costs. Initially, hospital budgets had to be approved on a line-by-line basis by the Ontario Hospital Services Commission (OHSC), established in 1959 to administer the public hospital insurance plan and to allocate grants to the hospitals. This system of control was abandoned in 1969 when the Province decided to allow hospitals greater flexibility through a system of global budgeting. Hospitals were told annually what increases they might expect in their provincial grants and they were ordered to contain costs within the revenue available to them. The hospitals, in bargaining with their unions, would take the position that this tied their hands and that the cost of wages and benefits was more or less set by the size of the grant increase. The unions in turn responded by saying that if the Province was going to dictate the position of management at each hospital, then the Province rather than the individual hospitals should appear at the bargaining table to negotiate with the unions. The Province refused, insisting on the autonomy of each hospital in dealing with its employees.

This position of the Province has not always been maintained. On some occasions, global budgets were adjusted upward after negotiations or arbitration awards raised wages and salaries beyond what the hospitals could meet from the original level of funding. On one occasion, in 1974, some of the unions did succeed in dragging the Province into direct negotiations. In 1975 and again in 1982, the Province undertook a programme of temporary wage controls which included this sector. The 1975 controls left collective bargaining and arbitration intact but agreements and arbitration awards were subject to review and «rollbacks». The more recent controls were more rigid and all but eliminated both bargaining and interest arbitration for the period of control.

On several occasions the Province has intervened or threatened to intervene to reduce the number of active treatment beds in Ontario. These plans involved closing some hospitals entirely and reducing the size of others. The result would be to cut employment in hospitals. To no one's surprise, the hospitals and their unions have united to fight such moves and they have enjoyed reasonable success in mobilizing public support against such plans.

In addition to the individual hospitals and the Province, the Ontario Hospital Association (OHA) has become an important participant on the management side of the bargaining table. The OHA was founded in 1924 to serve as the body representing public hospitals in Ontario in dealing with the Government and the public at large. All public hospitals in the Province belong to the OHA which also includes as members the psychiatric hospitals, some nursing homes and others.

Once unions became prevalent in this sector, the view soon developed that it would be desirable for the unionized hospitals to coordinate their bargaining strategies. This was true for a number of reasons. First, each of the unions acted to coordinate its bargaining through the extensive involvement by its central office and its control over the locals. If the hospitals did not develop cooperative arrangements, then the unions would whipsaw and leapfrog to the detriment of all the hospitals. Furthermore, the hospitals were inexperienced in bargaining. They required expert assistance which only the very large hospitals could afford on their own, but which could be available to all of them if they acted jointly.

Finally, if the hospitals were not to be crushed between the pressure on one side to pay higher wages and salaries and, on the other side, to maintain costs within the level set by grant increases from the Ministry, they needed a strong body to bargain on their behalf with both the unions and the Ministry of Health, and also to mobilize public support behind the hospitals. The OHA was the obvious body to assume these responsibilities.

In 1966 the OHA was instrumental in establishing the Hospital Personnel Relations Bureau (HPRB). This organization was independent of the OHA and had its own governing board. While membership was voluntary, almost all the hospitals that were involved in collective bargaining belonged to the HPRB. Member hospitals received from that organization the information that was useful both in bargaining and in formulating their briefs for interest arbitration boards.

Earlier we noted that in 1974 the unions managed to force the Province to intervene directly to grant significant increases in wages and salaries in hospitals. This experience jolted the hospitals and raised their concern

about further encroachments on their autonomy. Within the OHA, support grew for greater activity by that body to head off the pressure to bypass the hospitals in collective bargaining by having the Province confront the unions directly at the bargaining table.

The OHA in 1974 established an Employee Relations Policy Committee (ERPC) and assigned this body the task of guiding individual hospitals in their negotiations with unions. This new Committee included representatives of both the OHA and the HPRB. An official from the Ministry of Health attended its meeting as an observer.

The Employee Relations Policy Committee created three subcommittees with overlapping membership to coordinate bargaining with unions representing nurses, service employees and paramedical personnel. Later these three committees were merged in a single Sub-Committee on Bargaining. Since the OHA expected that each of the unions would continue to negotiate separately from the others, six negotiating teams were established to deal with the six largest unions in this sector[9]. Each of these teams reported to the appropriate sub-committee on bargaining.

In 1976, the OHA decided to abolish the HPRB and to replace it with a new body, the Hospital Employee Relations Service (HERS). Unlike the HPRB, which was formally separate from the OHA, HERS was to be directly under the control of the OHA. The new body absorbed most of the staff formerly employed at the HPRB and added additional staff. Its functions are broader than those of the organization it displaced.

In addition to providing data and technical support for bargaining, it advises the OHA and member hospitals on bargaining policy and also trains hospital managers in industrial relations. HERS, from the outset, has had a staff or advisory function with no line responsibilities either for the actual conduct of negotiations or the formulation of long run labour relations strategy. Those functions are performed by other committees of the OHA that use information made available to them by HERS.

These changes encountered considerable resistance from some of the hospitals which were understandably concerned about the loss of autonomy to the OHA in the crucial area of employee relations. In addition to their concern over autonomy as a matter of principal, there were other considerations which led them to resist centralization. Hospitals differed from one another in many ways that they felt could not be accommodated by central bargaining. They operated in widely separated labour markets with dif-

9 The six teams were to oversee bargaining with ONA (representing most of the organized nurses), OPSEU (the largest union of paramedical employees), and four other unions representing most of the non-professional (service) employees.

ferent wage structures. They differed in size, varying from under twenty beds to one thousand beds, and in organization in ways that they felt called for local differences in job descriptions, work rules and even wage rates. Finally hospital administrators feared they would lose valued contacts with their own employees if bargaining were conducted centrally.

The hospitals conceded control over bargaining to the OHA with great reluctance and agreed to the changes only because they recognized that there were other forces at work eroding their autonomy in any case. A union would negotiate an agreement or secure gains at arbitration at one hospital which it then took to all other hospitals and arbitration boards as the least that the union would accept. In other words, most hospitals found themselves locked into patterns of settlements made elsewhere over which they had had no influence. Only the pattern setting hospitals in any given round of negotiations had any effective autonomy. There was a strong case for bargaining on a regional or even province-wide basis where all hospitals could have a voice in determining the position taken at the bargaining table and before arbitration boards.

At the same time, the hospitals were concerned about further encroachments in their autonomy from the Ministry of Health. If they could show that they were organized to withstand union pressure effectively, they would be in a better position to prevent Ministry involvement. Also if bargaining were more centralized and all hospitals faced similar wage and salary changes, either through common agreements or industry-wide arbitration awards, then they were more likely to succeed in forcing the Province to foot the bill. Finally, after the 1974 experience, the hospitals were concerned that if they did not form a united front and bargain centrally, the unions might again do «an end run» around them and compel the Ministry to enter into direct negotiations with them, leaving the hospitals out of the process.

UNIONS IN PUBLIC HOSPITALS — AN OVERVIEW

The earliest recorded collective agreement in an Ontario Hospital was concluded in May 1945 between the Toronto General Hospital and the Building Service Employees International Union representing most of the non-professional workers employed there[10]. We know that there were also certified unions at the Women's College Hospital and the Wellesley Hospital at that time, but they had not as yet succeeded in concluding agreements.

10 In the near future I intend to conduct a more intensive study of the growth of unions in this sector.

Tables 3 and 4 show the development of union organization in public hospitals in Ontario over the past twenty years.

Table 3

Number of Contracts in Effect in Ontario Hospital 1963-1970

*Date**	
1963	128
1964	135
1965	148
1966	160
1967	178
1968	207
1969	221
1970	243

* The number of contracts in effect on August 1 of each year.

Source: Ontario Department of Labour, *The Impact of the Ontario Hospital Labour Disputes Arbitration Act, 1965: A Statistical Analysis.*

What it obvious from Tables 3 and 4 is that once HLDAA was enacted, unions grew rapidly. The rate of growth varied among groups with operating engineers organizing earlier than nurses or technicians.

As late as 1971 the only professionals with collective agreements were 4,531 nurses under 27 contracts. The only exceptions occurred were in a few cases where a union made up predominantly of non-professionals had been voluntarily recognized by a hospital as the representation of all of its non-managerial employees. Nurses, technicians, technologists, pharmacists, dieticians and therapists were slow to organize in spite of their growing dissatisfaction with their salaries and working conditions. There were a number of reasons for this. They belonged to professional associations which included both managers and rank and file employees. They had strong loyalties to their professions and did not want to divide supervisors from non-supervisors. They were most reluctant to join unions dominated by blue collar workers who would not appreciate their professional needs and concerns. Furthermore, they were concerned that if they joined a union they would be drawn into strikes. Professional codes of behaviour placed great emphasis on the care and well-being of patients and, even if not explicit in so stating, considered strikes to be unprofessional behaviour. If organization of these groups was to occur, it awaited the development of unions and legislation that were responsive to these professional concerns.

Table 4

Number of Agreements by Union in Ontario Hospitals 1967, 1971, 1974, 1979 and 1983*

UNION	*No. of Agreements & in Parenthesis for 1967, 1971 & 1974, the number of employees covered.*				
	1967	*1971*	*1974*	*1979*	*1983*
AAHPO	—	—	—	7	10
CLAC[a]	—	—	—	—	1
CUOE	22(143)	25(194)	28(216)	36	41
CUGE[b]	—	2(1043)	2(1064)	—	—
CUPE	36(8045)	50(12348)	69(15756)	140	106
EA[c]		3(952)	1(198)	3	3
IBEW	—	—	1(112)	1	1
IUOE	47(325)	61(615)	55(1032)	38	31
ONA	2(165)	27(4531)	44(7969)	140	267
OPEIU	3(273)	7(271)	8(55)	12	9
OPSEU	—	1(22)	25(922)	61	76
SEIU	47(8899)	60(12468)	70(12329)	129	138
SEF[d]	—	3(1027)	1(75)	—	—
UPGWA	—	—	2(34)	3	2
FNDesS[e]	4(1031)	—	—	—	—
USWA	1(131)	1(12)	1(25)	1	1
Total # of agreements	162	240	307	564	686
Total # of workers covered	(18,894)	(33,483)	(49,317)		(75,500)

**Note:* The 1967, 1971 and 1974 figures are only for union certified for full-time staff whereas the figures for 1979 and 1983 cover locals of part-time workers as well as full-time workers. However, there were few locals of part-time employees in the early years and this discrepancy is not significant.

Sources: For 1967, Ontario Department of Labour, *Collective Agreement Provisions in Ontario Hospitals.*

For 1971 and 1974 — Ontario Department of Labour, Research Branch, *Negotiated Wages and Working Conditions in Ontario Hospitals.*

For 1979 — B.D. Carmichael, *Collective Bargaining in Ontario Public Hospitals* — (unpublished thesis, Graduate Department of Community Health, University of Toronto, 1980) page 259.

For 1983 — Ontario Hospital Association, Hospital Employee Relations Services.

[a] CLAC: Christian Labour Association of Canada
[b] CUGE: Canadian Union of General Employees
[c] EA: Independant Employees Association
[d] SEF: Service Employees Federation
[e] FNDesS: Fédération nationale des services

Editor's note: Explanation on the other abbreviations are to be found in the text.

Earlier we noted that that Ontario Labour Relations Board, in designating bargaining units in hospitals, favoured craft over industrial unions. This policy made it possible for various professional groups to form new homogeneous unions for each of the professions and, thereby, greatly facilitated the organization of these groups in hospitals. The enactment of the HLDAA removed the concern over strikes and made professionals more receptive to the idea of collective bargaining. Finally, arbitration awards usually included a provision for compulsory payment of union dues. This gave the new unions the financial resources to carry out further organization.

From Table 3 and 4, it is clear that unionization of professionals in hospitals grew rapidly during the 1970s, once these groups had the opportunity to respond to the enactment of the HLDAA in 1965. Members of Allied Association of Health Professionals of Ontario (AAHPO) and Ontario Nurses Association (ONA) are all professionals as are most OPSEU members and even some locals of CUPE and SEIU.

While there are numerous exceptions, there would appear to be six distinct occupational groups for purposes of union certification. These are nurses, technicians and technologists, other paramedical professionals, clerical, stationary engineers, and other service workers[11].

There are at least ten unions active in this sector. The most significant ones are the Service Employees International Union (SEIU), the Canadian Union of Public Employees (CUPE), the Ontario Public Service Employees Union (OPSEU), the International Union of Operating Engineers (IUOE), and the Canadian Union of Operating Engineers (CUOE). In addition there are locals affiliated with the Office and Professional Employees International Union (OPEIU), the Allied Association of Health Professionals of Ontario (AAHPO), the United Plant Guard Workers Association (UPGWA), the International Brotherhood of Electrical Workers (IBEW), and the United Steelworkers of America (USWA). There are also some independent unaffiliated employee associations.

Some hospitals have as many as six separate bargaining units. At the other extreme, Riverdale Hospital in Toronto has a single affiliate of CUPE that represent everyone from nurses and technicians to service and clerical staff. Riverdale, however, is atypical.

11 Where security guards are organized, they are a further distinct unit. Some common exceptions occur where clerical workers are part of the larger service group, or stationery engineers are in the service group, or where technicians are in a unit separate from technologists or where technicians and technologists are part of the service unit.

The pattern of multiple bargaining units in each public hospital is in marked contrast to the situation in the psychiatric hospitals where one union (OPSEU) represents all of the eligible employees in all of these hospitals.

At present in Ontario, over 60% of eligible employees in public hospitals are organized and bargain collectively. About 80% of all public hospitals in the province have at least one bargaining unit. Almost all of the unorganized hospitals are quite small[12]. This is an extraordinarily high level of unionization when compared with the private service or manufacturing sectors. Another way of illustrating the success of hospital unions in Ontario is to contrast this situation with that in the United States where only 24% of hospital employees are organized. What makes this record even more remarkable is the relatively late start in organization, particularly of the professional employees.

THE STATE OF COLLECTIVE BARGAINING[13]

Although it is less than twenty years since the *Hospital Labour Disputes Arbitration Act* (HLDAA) was proclaimed, there is considerable dissatisfaction with the way in which bargaining is conducted in hospitals in Ontario. Some of the unions remain hostile to compulsory arbitration. They point to other provinces where strikes are permitted and seek to secure the same right for themselves in Ontario. All unions in the hospital sector are agreed that they would prefer to bargain on a province-wide basis but that each union would conduct its own negotiations. So far there is no enthusiasm for central bargaining on a multi-union basis.

The hospitals have mixed feelings concerning the operation of the current system. They remain opposed to strikes in this sector and reluctantly accept arbitration as the lesser evil. They complain about the failure of agreements to recognize significant differences among hospitals in a system that has become centralized either through pattern settlements and arbitration awards or through formal central negotiations conducted by the OHA.

The larger hospitals feel they could conduct their own negotiations effectively without OHA controls. Smaller hospitals resent what they see as domination of OHA by the large hospitals.

12 The only large non-union hospital in Ontario is the Hospital for Sick Children in Toronto and there is now an application for certification by at least one union at this Hospital pending before the Ontario Labour Relations Board.

13 This topic will be explored at greater length in a futre study on the patterns of bargaining over the past two decades.

The hospital administrators increasingly feel caught in a bind between inadequate funding on the one hand and costly arbitration awards on the other. They feel that the Province has saddled them with binding arbitration without any commitment to fund the resulting awards.

The Province also is unhappy with the system it has created. Although the government has for the most part managed to remain aloof from the formal process of bargaining, it cannot ignore completely the results of the process. When wages and salaries rise, hospitals can be pushed to take cost-cutting measures up to a point. When patient care deteriorates as a result of these actions, the fear of adverse public reaction compels the government to fund more of the higher costs than it would like to pay. Sizeable government outlays are decided by arbitrators over whom the government has little control. Twice within the past decade Ontario has participated enthusiastically in wage and salary controls. On the first occasion the regulations covered both the public and private sectors. The more recent controls were limited to public sector employees, including hospital workers. It is worth noting that these two events are the only instances of peace time wage controls in the history of this nation.

The pattern that appears to have emerged is to permit the public sector negotiators and arbitrators to do what they consider to be correct, but for the government periodically to intervene to call a temporary halt to these arrangements, substituting government dictated salary and fringe benefit changes for the period of controls.

Arbitrators are also unhappy with the current system. A sizeable and increasing number of arbitrators have refused to chair boards involved in resolving interest disputes in hospitals. While low fees set for this task by government regulation account in part for this, at least equally significant is the fact that many arbitrators feel ill at ease in playing this role. It is one thing to interpret an agreement freely arrived at by the parties involved through negotiation. Arbitrators feel quite comfortable doing this. It is another matter to decide on the terms to be incorporated in an agreement because the parties are unable to resolve this matter. Arbitrators are uncomfortable in making such important decisions with little to guide them.

Recent changes requiring arbitrators to consider ability to pay as one of the criteria for their awards has generated further unrest among both unions and some arbitrators who feel that the process now will be unduly controlled by government policy on the funding of hospitals.

While no one appears to be content with the existing arrangement, there has been no real effort to find a more generally acceptable alternative. The Johnston Commission was the last body to examine the system and its

recommendations were never enacted. It is regrettable that the Province did not take advantage of the temporary freeze under its «six and five» programme of controls to initiate a fresh review of the situation. While Royal Commissions or Task Forces are often devices for avoiding problems rather than solving them, a full scale inquiry into hospital bargaining would produce at least a greater awareness of the strength and weaknesses of the present system and might even generate significant proposals for reform.

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La négociation collective dans les hôpitaux publics en Ontario

Tant au niveau fédéral que celui des provinces, le Canada a connu une croissance explosive de la négociation collective dans le secteur public depuis deux décennies. On trouve une plus grande diversité dans les négociations et les conventions collectives dans le secteur public que dans le secteur privé. De même, il y a beaucoup de malaises tant dans les procédures que dans les résultats des négociations. De là, il est évident que nous ne possédons que deux cas de contrôle des salaires en temps de paix. Les deux se sont produits dans la dernière décennie et l'un et l'autre découlaient pour une large part de la réaction du gouvernement face aux conventions collectives et aux décisions arbitrales dans le secteur public.

L'article analyse l'évolution de la négociation chez une portion importante du secteur public dans la plus grande province du Canada. On y étudie la croissance et la répartition de l'emploi dans les hôpitaux ontariens. On y explique aussi la législation en vigueur dans le secteur. L'article poursuit en montrant comment les employeurs et les syndicats s'arrangent pour négocier, comte tenu de la législation, de la politique de la Commission des relations du travail et d'autres forces qui sont à l'oeuvre. On a également considéré le champ de la négociation collective et son développement au point de vue chronologique. Finalement, l'article discute des attitudes des parties par rapport au système actuel.

L'auteur conclut que, après une expérience de deux décennies de l'utilisation du présent régime, il y aurait lieu de réviser et de réévaluer l'ensemble du processus.