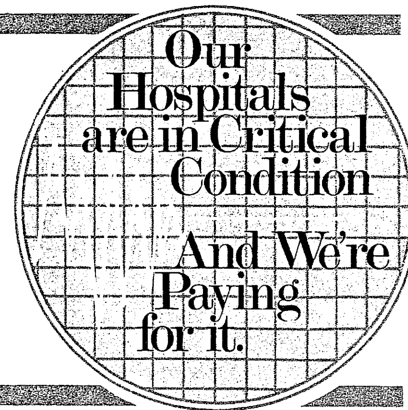
December, 1980 (pre-strike).

CUPE

The Facts



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Ontario's Hospital Workers

Subsidizing the province's hospitals.

Ontario's hospital workers are being forced to subsidize the operations of the province's hospitals with their wages. Their vacation package is the worst in the country. And they can't freely negotiate a contract.

Here are The Facts:

All the people of Ontario are paying for the deteriorating condition of Ontario's hospitals. Taxpayers are paying more for less service. Patients are forced to suffer with less patient care. And hospital workers are paying through their wages and working conditions.

Ontario's hospital employees work as RNA's, housekeeping staff, dietary personnel, laundry workers, orderlies, clericals, maintenance people, tradesmen and much more. They're paying for the critical condition of Ontario's hospitals — in a lot of ways.

Pay-cheques

They pay through their pay-cheques. In the past four years prices have risen 43 per cent. Meanwhile their wages have increased only 23 per cent. They've lost 20 per cent in real buying power. They're actually earning, on the average, $122 a month less than they were in 1976 — and for a lot more work. Take Ontario's RNA's for example: they earn $7.03 an hour. But if they did exactly the same kind of work in Quebec they'd earn $1.82 an hour more. If they worked in B.C. they'd earn $9.26 an hour — 30 per cent more.

It isn't fair. The hospital workers work hard. They care for the patients. And they have families to feed and clothe. They're being forced to subsidize Ontario's hospitals with their wages.

Fringe benefits

They also pay with substandard fringe benefits. Their vacation package, for instance, is the worst in the country. In B.C., Quebec and Newfoundland hospital workers get four weeks of vacation after one year of service. Before Ontario workers can get four weeks of vacation they have to work at the hospital 12 years.

Workloading

They're also paying through the extra workload being placed on them. Government budget restrictions have hit Ontario's hospitals so hard that most of them are doing the work of one and a half people. And that shows in the amount of sick time they need.

But the hospital workers are not the only ones hurt by the extra workloading — the patients end up suffering too. They're not given the time to care for the patients properly. The patients are not getting the service they need and deserve.

Arbitration

And then, to top it all off, the hospital workers can't freely negotiate a contract. Their bargaining rights are determined by the Ontario Hospital Labour Disputes Arbitration Act. Which means their contracts are imposed on them through compulsory arbitration. When they argue for workloading committees to study deteriorating patient care, when they ask for decent wages and working conditions, the hospitals simply say "no". And then a contract is imposed on them. They're the only major group of hospital workers in Canada who can't freely negotiate a contract. It's economic slavery.

Ontario's hospital workers are being forced to pay for government budget cuts with lower pay and substandard working conditions. They're being forced to watch as patient care deteriorates. It hurts. And it has to end.

Contract negotiations

How arbitration imposes contracts.

Ontario's hospital workers are not allowed to freely negotiate a contract. The Ontario Labour Disputes Arbitration Act says that hospital contracts will be imposed by compulsory arbitration. And that has serious effects for Ontario hospital workers.

Here are The Facts:

Arbitration has often been looked at as an "easy answer" for avoiding conflict situations in essential services. The theory is that workers will have no need to withdraw their services since the arbitrator will assure them of a fair settlement, based on "impartiality" and on "objective criteria". While it sounds all right in theory, it rarely, if ever, provides acceptable results on a long-term basis.

In 1965, the Ontario Government withdrew the right of Ontario hospital workers to withdraw their labour. Ontario is now one of only two provinces — the other being Prince Edward Island — which has enacted compulsory arbitration legislation. In all other provinces, hospital workers have the right to freely negotiate a contract and strike if necessary.

Arbitration doesn't work

Compulsory arbitration doesn't work because it literally destroys meaningful collective bargaining. There is no pressure on the employer (the Ontario Hospital Association) to negotiate, since it knows that it will not have to face a withdrawal of services if it does not seriously bargain. There is the additional important factor that the O.H.A. does not want to accept the responsibility of granting a decent wage settlement and probably incurring the wrath of the paymaster, The Ministry of Health. Far better, it says, to let the arbitrator decide and then present the bill to the Ministry as a fait accompli.

Problems with arbitration

As for the arbitration process itself, there are many areas which cause problems. First, it is very difficult to obtain an arbitrator who is acceptable to the Union. The arbitrator is usually appointed by the Minister of Labour, because the employer and the union almost never agree on a mutually acceptable person. Arbitrators who have handed down relatively good awards in the past rarely get appointed since they are on the employer's "black-list".

Breakthroughs not allowed

Secondly, arbitrators are reluctant to innovate, or to award "breakthroughs". They tend only to follow established patterns, which means that hospital workers will forever lag behind their counterparts in other areas. For example, arbitrators only began to award dental plans when they had already been established for years in sectors where free collective bargaining exists. Also, despite the fact that COLA clauses are now very common in collective agreements, arbitrators virtually never award them.

Simple issues only

Thirdly, the arbitration process is not really able to deal with complex bargaining issues. Reclassifications is a good example. Arbitrators are very reluctant to re-classify or make adjustments in the wage scale unless the evidence is so overwhelming that they cannot fail to be convinced. Such overwhelming evidence is rarely found in these disputes.

Fourthly, the arbitrator has no real way of assessing the priorities of the union and the employee. For example, the union might have a Long Term Disability Plan as its priority, but the arbitrator won't award it because it would be a "breakthrough". On the other hand, he might provide increases in other benefit plans which, although justified in terms of precedents, are of far less importance to the union than the LTD. All the benefits of the ability to trade-off in negotiations are lost once the arbitration stage is reached.

Ripple effect

Finally, we have to remember that the CUPE Ontario hospitals bargaining group is one of the largest, if not the largest, bargaining groups in the entire province. Whatever is awarded to such a large group cannot fail to cause a "ripple effect" across other industries. Because of this, there is bound to be a reluctance on the part of an arbitrator to award the kind of catch-up settlement that is both justified and needed for Ontario hospital workers.

Losing to inflation

CUPE Ontario hospital workers have had their last two collective agreements determined by arbitration. These two awards provided a combined total wage increase of 17.1 per cent over a 30-month period (April 1, 1978 — September 28, 1980). During those same 30 months, the Consumer Price Index increased by 26.1 per cent.

Health Care Cutbacks

Patient services are deteriorating.

The Ontario government has been seriously underfunding the province's hospitals. This policy has resulted in cutbacks in patient care services, a decline in full-time staff, and extra workloading for hospital employees.

Here are The Facts:

Hospital patients are facing serious problems due to the cutbacks in hospital services which have occurred during the past few years. These problems have been documented over and over again in the media and have certainly been put forward with considerable force both by the O.H.A. and by individual hospitals.

For example, Mr. Ross Hahn, President of the O.H.A., was recently quoted as saying:

> ''I cannot accept that hospitals should be expected to meet the needs of their communities for their services when funding levels are obviously inadequate . . . You just can't wring any more out of the system . . . Services will have to be cut. Up to now, savings have come from increased efficiency, but now it will come from cutting services.''

While it is probably true that ''you can't wring any more out of the system'', Mr. Hahn is incorrect when he says that savings have come only from ''increased efficiency'' and, not yet at least, from cutting services. To say that services have not been cut is to stick one's head firmly in the sand. How can services not have been cut when in hospital after hospital, emergency patients are lined up on beds in the corridor awaiting admission? How can services not have been cut when nursing staff often simply cannot cope with the patient load they are carrying?

More work

By ''increased efficiency'', Mr. Hahn means that employees are now doing 50 per cent and even more work now than what they were assigned before. While this sounds like a wonderful improvement in productivity, it is not. Although employees are indeed providing ''more work'' in the same amount of time, the quality of the product is simply not the same. Because there is too much to do in too little time, the ''care'' is rapidly disappearing from our ''health care'' system.

Cutback methods

The Ministry of Health appears to be pursuing a continuing policy of seriously underfunding the hospitals of this province. The 1979-80 budgets were to increase by only 4.5 per cent, despite the fact that the inflation rate was around 9 per cent. The 1980-81 allowable increases are in the range of 7.8 per cent, despite the current inflation rate of 11 per cent. As a result of these absurd policies, Ontario hospitals have been literally desperate to find ways to cut costs. Unfortunately, many of the ways that they have adopted have caused considerable problems both for patients and staff. A few of the problem areas are outlined below:

Bed closures

Many if not most hospitals have been forced to cut their number of beds in order to conform to the Ministry's arbitrary guideline of 4 beds per 1,000 population. As a result, the number of ''corridor admissions'' has increased dramatically. Waiting lists for elective surgery grow longer and longer. More seriously, it appears that there is considerable evidence to suggest that bed closures may have been responsible for or contributed to a number of deaths. The media has reported incidents at Windsor Metropolitan Hospital, two Hamilton hospitals, Toronto Sunnybrook, Scarborough Centenary, and Toronto Humber Memorial to this effect. Queensway General Hospital has reported that patients admitted through emergency sometimes line corridors for up to two days before being admitted.

Use of consultants

It appears that the Ministry of Health has put considerable pressure on individual hospitals to engage ''consultants'' to assist them with their cost-cutting programmes. Indeed, last year hospitals were informed that their appeals for additional financing would only be heard if they agreed to engage such consultants.

A large number (at least 10) hospitals have engaged the services of an American firm, Naus-Newlyn. This firm, which is charging fees of $250,000 to $500,000, has created havoc wherever it has gone. Naus-Newlyn has had little if any experience in Canadian hospitals and has shown itself to be totally unrealistic in its suggestions for staff reductions and other cost-cutting measures.

Stratford General

For example, at Stratford General, Naus-Newlyn recommended that the Radiology department be reduced from six technicians a day to four in the morning and three in the afternoon. To show the absurdity of the recommendation, the Head of Radiology, Dr. James Wickwire, immediately began a trial reduction. Total chaos resulted. The Kitchener-Waterloo Record reported: ''Wickwire told the board he had talked to four other

chiefs in hospitals where the consultants have also made studies and the message is the same: inferior quality of care and poor morale."

Consultant fees

Unlike reputable Canadian consultants, Naus-Newlyn's fees are not based upon the number of personnel involved and the time they spend on the study. Rather, they are based upon a percentage of the costs which they guarantee to save the hospital. For example, at Stratford General, Naus-Newlyn guaranteed that the hospital would save at least twice their fee, and that if it didn't the fee would be adjusted.

This "contingency fee" approach is entirely destructive. It is a built-in incentive for these consultants to advise hospitals to cut corners on staffing, equipment and supplies, to shift to part-time and non-union employment, and to speed up work. Already there have been strenuous protests from the workers at Sarnia General, Woodstock General and Stratford General regarding staff cuts and deterioration in the quality of care as a result of Naus-Newlyn's recommendations.

It is nothing short of disgusting that the Ministry is encouraging hospitals to spend millions of public dollars on a foreign company which is cutting a trail of acrimony across the province.

Staff reductions

Most hospitals have reduced their complement of full-time staff. There have been numerous layoffs (eg. Windsor, Campbellford, Sudbury, Brockville, Stratford, Kingston, Hamilton, Sarnia, Woodstock), but even far more cuts via attrition. Workers who quit or retire are often not replaced, or are replaced with only a part-time employee. CUPE bargaining units, as will be documented later, have shrunk substantially in most hospitals over the past five years. The staff reductions have obviously meant more "speed-up" for the remaining employees, as there was simply no fat to be cut away. The effects on the quality of care have been obvious.

Replacement of full-time staff

While the number of full-time CUPE members in hospitals has decreased, the number of part-timers has increased — although not by an equivalent number. Several hospitals now have more part-time than full-time employees.

The reasons for using more part-timers are easy to understand. In the first place, staff cuts do not look so dramatic if a part-timer is hired to replace a full-timer, rather than leaving the job vacant. Secondly, it costs the hospitals less to employ part-timers. In many hospitals, the part-time employees are not organized, and are therefore paid only whatever minimum the market demands. Even in hospitals where they are organized, part-timers usually earn less than full-timers, and receive only a portion of the fringe benefits.

Staff morale

The increased use of part-timers is causing serious problems with staff morale. Employees feel, and rightly so, that at any time the hospital could decide to eliminate their position and replace them with part-time staff. It is also not beneficial to good patient care. A proliferation of part-timers who work only a few shifts a week is not conducive to the proper continuity which is essential in nursing care. Most part-timers do not have the same degree of commitment to the work as do full-timers. It also is a problem for longer-stay patients who have a difficult time adapting to an ever-changing array of part-time staff who are responsible for their care.

Use of volunteers

Volunteers have always had, and always will have, an important role in our hospitals. In the past they have performed valuable services in many areas, particularly such areas as helping patients with errands, conversing with and entertaining patients, and running auxiliary gift and tuck shops. However, the role of the volunteer has expanded dramatically, and dangerously, in the past few years. All signs point to an ever-increasing scope of volunteers' "duties" in the future.

Volunteers as workers

Volunteers are no longer providing "extras" or "added touches" to the hospitals — they are *working* for the hospital as unpaid labour. Volunteers are admitting patients, portering them, feeding them, cleaning the hospital — you name it, they're doing it.

Several hospitals have recently taken out advertisements desperately appealing for volunteer help. The Administrator of the West Nipissing General Hospital in Sturgeon Falls told The North Bay Nugget on October 8, 1980 that:

> "It is imperative that a program of voluntary help be inaugurated at the hospital. Help is needed at meal times and throughout the day."
>
> "He suggested also that the volunteer program could involve wheeling patients to the door of the hospital upon discharge, in addition to other routine tasks inside the hospital."
>
> "It is a matter of survival of the hospital", said Mr. Belanger.

A matter of survival of the hospital! What a sad commentary on the state of hospital funding in this province!

This increased use of volunteers is of course causing serious morale problems. Not only does it further destroy the employee's already marginal sense of job security, it also makes him feel that his job is of little value if the hospital is willing to turn over similar work to untrained housewives and students.

Does it make sense to delegate a substantial amount of real hospital work to a group that is untrained, uncommitted, not subject to direction or discipline, and perhaps not easily integrated with the rest of the

workforce? If the answer is "yes", then we may very well soon see the first "all-volunteer" hospital.

Fund-raising activities

Not only have the operating budgets of hospitals been restricted, the Ministry has also cut capital grants as part of a new province-wide policy. Health Ministry Spokesman Douglas Enright was quoted in the Globe & Mail on December 13, 1979 as saying:

> "All of the hospitals in the province are going to the public for funding. There simply are no funds available for capital costs."

Despite protests from a number of hospital administrators who view capital expenditures as a responsibility of the Ministry, not the public, the Government well has apparently dried up. Hospitals are now forced to engage in all sorts of public fund-raising activities, including the establishment of foundations, to expand and renovate facilities. In our view, this is a wrong and dangerous policy. It will exacerbate problems of "rich" versus "poor" hospitals, will result in excessive unnecessary and duplicated equipment and facilities in some cases, and will require a considerable portion of the hospitals' limited human and financial resources to be devoted to such fund-raising.

It seem ironic that this Government is prepared to hand out hundreds of millions of dollars to corporate welfare to multinationals like Ford and Chrysler, yet has no funds for the improvement of hospitals.

Corporate domination

Further, hospitals are already dominated to a substantial degree by corporations through representatives on their Boards of Directors. Reliance on corporations for substantial funding will only increase that domination and will cause hospitals to become even more remote from the average taxpayer that they are designed to serve.

These are just a few of the ways the hospitals have been using to deal with the crisis in financing they have been forced into by the Ministry of Health. All have had and are continuing to have negative consequences for the patients and the employees.

Staffing and workload

As we said earlier, the problems faced by patients as a result of cutbacks have received considerable attention by the media. Unfortunately, far less attention has been devoted to the effects on the workers. Other than the unions and the New Democractic Party, nobody seems to have taken the time to have consulted them — despite the fact that they are the closest to the patients and are probably the best judges of deteriorating care that we have.

Full-time staff reduced

There is no doubt whatsoever that the vast majority of hospitals have reduced their full-time staff complements and have substantially increased the workload of the remaining employees. CUPE members are constantly telling us that they are now "officially one-and-one-half people" or that they are now doing the same amount of work formally shared by two. Even if some exaggeration is involved, the evidence of overwork and its negative effects is too substantial to be anything less than a cause for the most serious concern.

Total decline

The staff reductions are clearly seen by examining the relative reported size of CUPE bargaining units in 1980 as compared to 1975. Such a study reveals that out of 60 CUPE hospital bargaining units which reported in both 1975 and 1980, only 15 reported increased full-time membership, 2 reported no change, and 43 indicated a decline in the number of employees. The total decline was 1,123 employees (13,003 vs. 14,176).

The decreases were in some cases quite small, but in many hospitals they were substantial enough to cause grave concern. Of the 43 which had reduced numbers, the average decline was 14 per cent over the 1975 figures. Some hospitals had as much as 40 per cent fewer full-time staff than they had in 1975.

Some of the reduction in full-time staff has been offset to a very limited degree by more part-timers, but even so the overall picture remains substantially the same. Burlington experienced a decline of 30 full-time staff since 1975, with an increase of only 5 in the part-time complement.

Expanded services

The decline in membership becomes even more staggering when we take into account the rather obvious fact that many of these hospitals expanded their services and, in some cases, their physical plants in the last five years. For example, the Ottawa Civic Hospital has expanded its services to a considerable degree, including the opening of a large new cardiac unit, yet the size of the CUPE bargaining unit is the same as it was in 1975.

Therefore, we believe that the membership loss we have quoted above actually underestimates the overall effect on hospital staffing.

Even if these reported figures are not precise in all cases, they do constitute prima facie evidence of the seriousness of the staff reductions which have been forced upon Ontario hospitals over the past five years.

Increased workloads

Because of the increased workloads, CUPE members are suffering extra stress, as well as more sickness and injury. The stress and the frustration, combined with the traditionally low wage levels in the hospital industry, have combined to produce a very angry and militant work force.

Workloading committees

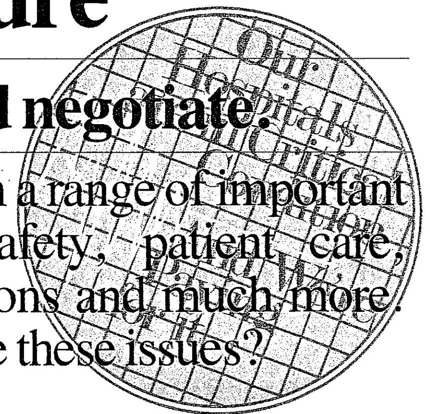
The conditions we have been describing have led to one of the principal union demands in this round of collective bargaining — that is, that there should be "Workload Committees" set up in every hospital to investigate claims of excessive workload and to recommend appropriate action where necessary. Such committees already exist in Quebec hospitals, and a similar form has been established

in collective agreements covering Registered Nurses here in Ontario.

Unfortunately, despite the obvious problems, the O.H.A. refuses to even consider our proposal on "Workload Committees". It is surely a sorry state of affairs when our health-care institutions show so little concern for the well-being of their own employees, or for the problems in quality of patient care which inevitably result from excessive workload.

Bargaining Structure

The committees that represent and negotiate.



Hospital workers in Ontario are actively involved in a range of important issues. They're concerned with health and safety, patient care, provincial legislation, wages and working conditions and much more.

How have they organized themselves to face these issues?

Here are The Facts:

Almost 20,000 hospital workers in Ontario are CUPE members. They work together in many ways through their union to improve their working lives, the lives of their families and the level of care for patients.

Co-ordinating Committee

CUPE's Ontario Health Care Workers Co-ordinating Committee is charged with representing health care workers in the province — hospital, nursing home and old age home employees. The committee, which is chaired by Catherine McQuarrie, conducts wage and policy conferences, runs schools, fights for improved legislation for health care workers, provides a communication link between local hospital unions and represents health care workers at the provincial level.

Bargaining

Before each round of bargaining, the committee organizes special conferences at which representatives of CUPE hospital locals work out bargaining demands for that set of negotiations. Throughout the year, the committee organizes special conferences on selected topics of importance to health care workers. Members of the committee — which is part of CUPE's Ontario Division — are elected at large from across the province.

Another committee is responsible for negotiating our contract. One member from each of the seven regions in Ontario is elected to sit at the central bargaining table and negotiate a new contract. Bill Brown, a CUPE National Representative and the full-time Health Care Co-ordinator for Ontario, sits on the committee to help in bargaining.

Central negotiations

CUPE hospital locals in the province decide for themselves if they want to join centralized bargaining. The management of the hospitals also have the right to join or not join central bargaining. That means some CUPE hospital locals, who would like to join central bargaining, can't do so because their management refuses to be involved.

Sixty-five hospitals with 66 CUPE locals are involved in the 1980-81 round of central bargaining.

Before each set of negotiations hospital representatives and local unions agree on the list of items that will be bargained centrally. They also decide what issues will be left as "local" issues to be bargained at the local level.

Wages

Our Hospitals are in Critical Condition

Using inflation to cut pay-cheques.

Hospital budget restrictions have not just forced heavier workloads on to Ontario's hospital workers. The cutbacks have also eroded the living standards of the hospital workers and their families.

Here are The Facts:

Much of the blame for the low position of hospital wage rates can be attributed to three major factors. First, the traditional, but no longer valid, view of hospital employment as "charitable work", employing many who would otherwise be unemployable. Secondly, the horrendous experience of Ontario hospital workers under the Anti-Inflation Board. Thirdly, the fact that hospital workers in Ontario are forced to submit to compulsory arbitration.

Budget restrictions

However, in the last two or three years, the additional negative factor of draconian budgetary restrictions has added to our difficulties. Hospitals faced with 11 per cent inflation and 7.8 per cent budget increases understandably prove to be very intransigent bargainers.

Wage erosion

CUPE hospital workers have suffered from "wage erosion" to an unprecedented degree over the past four years. The combination of poor wage settlements, caused by the A.I.B. and arbitration awards, and the continuing outrageous rate of inflation has produced a tremendous decline in purchasing power for the average hospital worker. This can be best illustrated by means of the following table:

Increase in Average Monthly Hospital Wage Rate vs Increase in Consumer Price Index 1976-1980

Year	*Wage Increase*	*Price Increase*	*Difference*
Sept. 1976-Sept. 1977	5.0%	8.4%	–3.4%
Sept. 1977-Sept. 1978	4.0%	8.6%	–4.6%
Sept. 1978-Sept. 1979	6.0%	9.6%	–3.6%
Sept. 1979-Sept. 1980	6.2%	10.7%	–4.5%

In total compounded terms, over the last four years prices have risen 43 per cent, while wages have increased by only 23 per cent. This is a 20 per cent cut in the real income, or purchasing power, of the average worker. There are few, if any, bargaining groups in Ontario which have fared so badly over that period of time.

When we deflate the present monthly rate by the increase in the Consumer Price Index, we find that in real terms the average hospital worker is actually earning $122 less per month than he was in 1976.

Hospital workers hit harder

To some extent most workers in Ontario have suffered in recent years from the effects of wage controls and inflation. But hospital workers have been hit far harder than the average. For example, while the average hospital wage in Ontario has increased by only 22.9 per cent over the past four years, the average weekly industrial wage (as published by Statistics Canada) has increased by 34.4 per cent. Another Statistics Canada measure, the "average hourly earnings in manufacturing" has increased by 37.8 per cent.

Clearly the gap between the hospital worker and the industrial worker in this province has widened dramatically.

Other hospital workers

Not only are hospital workers falling behind other Ontario wage-earners, they are also paid substantially less than their counterparts in the other large provinces, paritcularly B.C. and Quebec. For example, Registered Nursing Assistants in CUPE hospitals in Ontario currently earn a maximum of $7.03 per hour. In B.C., the same classification now earns $9.26 per hour, and will be earning an even $10.00 by next August. In Quebec, RNA's make $8.85 per hour, with an increase to $9.71 next July, *plus* additional COLA payments.

Hospital work undervalued

Hospital work is still, unfortunately, vastly undervalued in this province. For example, a Registered Nursing Assistant in a Toronto hospital makes less than a basic labourer employed by the City of Toronto or any of the Boroughs. The Municipal labour rate is presently $7.92 per hour — 89 cents more than the RNA rate. Surely no rational argument can support a situation whereby unskilled labourers earn more than well-trained, registered nursing personnel who are responsible for the care and well-being of the sick and injured. And the City

of Toronto labour rate is not an isolated "high" example. Most labour rates in private industry are at least that high.

Lower wages

Other provinces do not place so little relative value on their hospital workers. As mentioned above, B.C. RNA's earn $9.26 per hour. Labourers working for the City of Vancouver are paid $7.98. Quebec RNA's earn $8.85. Labourers in Montreal make $7.51. Saskatchewan RNA's earn $7.87. Regina labourers are paid $7.53. New Brunswick RNA's receive $6.76. Labourers in Moncton earn $6.26.

The "Catch-Up" campaign (which was undertaken by eleven CUPE hospital locals in early 1974) produced an eleventh-hour settlement which provided wage increases of $1.50 per hour over 2 years — close to 50 per cent on the average rate. While we were very pleased with the settlement at the time, virtually all the gains that were made in the year 1974 have evaporated as a result of the last three rounds of bargaining. For example, one of our goals in 1974 was to bring the hospital cleaner rate up to the level of the Caretaker at the Toronto Board of Education. Despite a narrowing of the gap in 1974 and 1975, the differential between the two rates is now up to 98 cents per hour, or 15 per cent.

OHA's offer

The O.H.A.'s final offer to us remains at 65 cents per hour in each year of a two-year collective agreement. In percentage terms, this amounts to 9.8 per cent in the first year, and 8.9 per cent in the second year. The current rate of inflation is 10.9 per cent, and predictions are for an even higher rate in 1981. Therefore, the O.H.A. is proposing that hospital workers, who have already suffered a 20 per cent cut in real income over the past four years, should suffer additional losses of at least three — four per cent over the coming years.

Workers said no

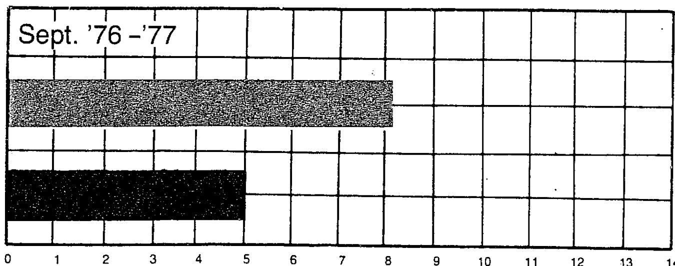
CUPE hospital workers have said no to further real wage cuts in the strongest terms. The 65 cents per hour package was rejected by 91 per cent of the membership in a secret ballot held on the hospital premises. This is one of the most overwhelming rejection votes in the history of CUPE. It is a clear expression of the level of dissatisfaction and frustration which exists among the hospital workers today.

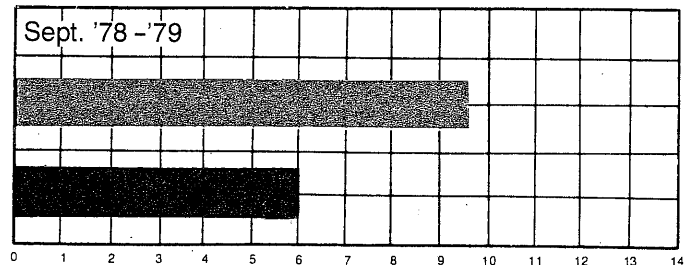
Funding the hospitals

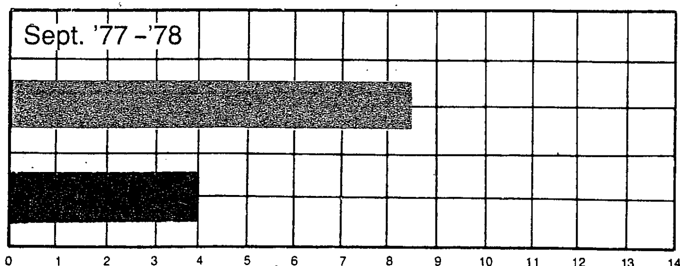
The Ontario government appears to be finally beginning to listen to what the hospitals and their employees have been trying to tell them for the last two years. Although the ridiculous budgetary limits were continued this year, most hospitals appear to be receiving additional funds through successful appeals. While this is no substitute for reasonable initial budgeting, it does indicate that the Government does have the funds available to distribute when it finds it necessary or politically expedient to do so.

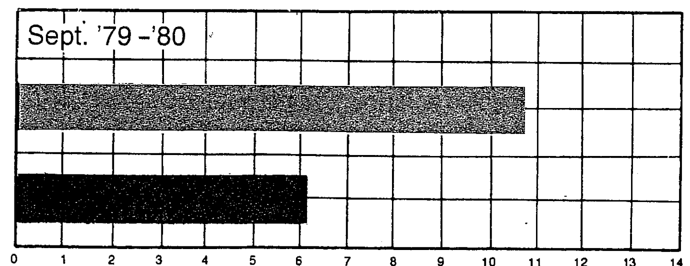
Subsidizing Ontario Hospitals

% Wage Increase ■ % Cost of Living Increase ▒



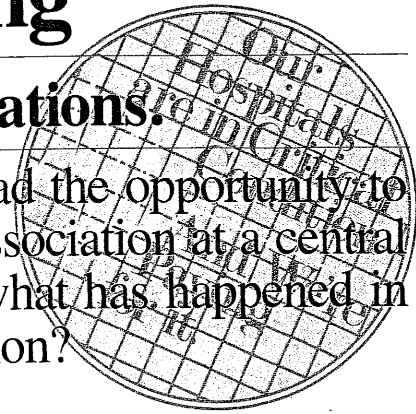






Central Bargaining

A history of centralized negotiations.



Since 1975 CUPE Ontario hospital locals have had the opportunity to bargain major issues with the Ontario Hospital Association at a central bargaining table. How did this come about and what has happened in central bargaining since its inception?

Here are The Facts:

In late 1973, CUPE Toronto hospital locals determined that they would no longer be satisfied with poverty level wage rates, and embarked on the now-famous "Catch-up Campaign". For the first time in CUPE's experience, eleven Toronto hospital locals banded together to conduct negotiations on a joint basis.

The theme of the campaign was "catch-up" — specifically, the demand was that the hospital "cleaner" rate be brought up to the level of the Toronto Board of Education caretakers. At the time, the caretakers were earning $4.14, while the cleaners averaged about $3.00 per hour.

Catch-up campaign

After a six-month campaign, a settlement was reached only hours before the May 1st strike deadline. The wage increase for most employees was to be a total of $1.50 per hour, staged over the life of a two-year agreement expiring December 31, 1975. The cleaner rate in each hospital was to be bench-marked at $4.50 per hour. In hospitals where the cleaner rate was less than or exceeded $3.00 in 1973, the increase was to be the amount necessary to bring the cleaner rate to the $4.50 benchmark. For example, if it took $1.65 to bring the cleaner rate to $4.50, then *all* the employees of that hospital received the $1.65. Similarly, if it took only $1.30 to bring the cleaner rate to $4.50, then *all* employees in that hospital received $1.30.

While the settlement initially only applied to the eleven Toronto locals, it quickly spread to all CUPE hospitals in Ontario (although there were brief but serious struggles against "chiselling" in some areas).

Province-wide bargaining

When the collective agreements were once again about to expire in 1975, it was determined that the time was ripe to enter into Province-wide bargaining. The Johnston Commission had recommended the implementation of broader-based bargaining in late 1974, and by 1975 the Ontario Hospital Association was prepared to agree, although it insisted on restricting "Central Bargaining" to a limited number of items (basically the monetary package).

The first round of Central Bargaining, begun in early 1976, covered 59 participating hospitals and local unions. After several months of negotiations, culminating in 19 straight days of non-stop bargaining at the Royal York Hotel, a settlement was reached and signed on July 3, 1976. The settlement provided for changes to Standby Allowance, Vacation Entitlement, Paid Holidays, Bereavement Leave, Jury Duty, Maternity Leave, Overtime, Callback, Rest Periods, Shift Premium, Reporting Pay, OHIP, Group Life Insurance and Wage Rates. It also provided for the introduction of an Extended Health Care Plan based on a 50 per cent employer contribution.

The wage settlement was to provide for a total of $185.00 per month over a 27-month agreement, expiring March 31, 1978. In addition, RNA and Orderly maximum rates were to all be adjusted to a $970 standard by January 1, 1977.

Anti-Inflation Board

Unfortunately, this settlement was subject to review by the Anti-Inflation Board. The A.I.B. subsequently ordered a roll-back, and the parties once again met to determine how best to implement a settlement to comply with the A.I.B. regulations. A "Revised Memorandum" was signed in January, 1977. The Revised Memorandum provided for a total wage increase of $142 over the 27 month period — $43 per month less than was originally negotiated. This roll-back, along with the following year's "guidelines" arbitration award, are blows from which the hospital workers have not yet begun to recover.

When the next set of negotiations was due to begin in early 1978, the Union made a serious attempt to convince the O.H.A. to negotiate a complete province-wide "Master Agreement". In this endeavour, we had the full support of the members and staff of SEIU Local 220 in 14 southwestern Ontario hospitals. For a brief time, CUPE and Local 220 combined forces in an "Ontario Council of Hospital Unions".

Master Agreement

The O.H.A. of course balked at the idea of a Master Agreement, although they did admit that one would probably "evolve" eventually. They were willing, however, to broaden somewhat the scope of items covered by Central Bargaining.

The 1978 round of Central Bargaining covered 55 participating hospitals and local unions. Since participation was entirely voluntary, hospitals and locals could opt in or out as they so wished. In most cases of "non-participating" hospitals, it was the desire of the hospital, not the local union, to stay out of Central Bargaining.

Because of the long debate over the question of a Master Agreement, negotiations did not actually commence until June, 1978. Because the hospitals would not go beyond the A.I.B. guidelines, negotiations bogged down after a few days. In the meantime, the SEIU Arbitration Award, which had provided a wage increase of 5.85 per cent, was rolled back to 4 per cent by the A.I.B.

Tentative Agreement

Because of this roll-back, and the acceptance of it by the SEIU membership, the CUPE Central Bargaining Committee felt it had nowhere to go. As a result, a Memorandum of Agreement was signed on September 22, 1978, incorporating the 4 per cent A.I.B. guideline figure.

However, on October 11, the union membership voted by a margin of 80% to reject the Memorandum. As a result, the Union began proceedings for the taking of strike votes across the province. The Hospitals then sought intervention by the Labour Relations Board in the form of a cease and desist order. During the Board's hearing, the Minister of Labour personally intervened, and the parties reached agreement to further the dispute to arbitration at the earliest possible time.

Arbitrated settlement

The Arbitration Board met on November 30, and within weeks issued its award. The Board, chaired by Mr. Kevin Burkett, ruled that on virtually every item the Memorandum would be awarded as originally signed. Thus the wage increase for the April 1, 1978 — March 31, 1979 calendar year was 4 per cent across the board. For most classifications, this was less than the $600 per year minimum allowed by the A.I.B. Regulations.

Shortly after the award was issued, it was time to re-enter negotiations. The third round of Central Bargaining, which was to cover the period beginning April 1, 1979, comprised 54 participating hospitals — the lowest number yet. Because of the near-fiasco of the previous year, and because of the hardship being wrought upon the workers by the 4 per cent increase, the Bargaining Committee determined that this round of negotiations would not be allowed to drag on.

Shortly after negotiations began in March, the 43 SEIU Hospitals — bargaining group reached an agreement. The settlement was for two years, and provided only 70¢ per hour in three stages. The Hospitals immediately insisted that CUPE also accept this inferior settlement. The Bargaining Committee categorically refused, and the dispute proceeded to arbitration on July 18 and 19.

Brown Award

The Arbitration Board, chaired by Mr. Howard D. Brown, handed down its Award on September 28, 1979. Because the parties had not previously settled the term of the agreement, the Hospital Labour Disputes Arbitration Act required the term to be one year from the date of the award — that is, September 28, 1980. The agreement was, therefore, to cover an 18-month period.

The Board's award, though falling short of real justice, provided a victory to CUPE in many ways. First and foremost, it provided for wage increases substantially in excess of those agreed to by SEIU. The Award, which was for a total of 12.5% over 18 months, generated 71¢ per hour over 18 months on the average rate, while the SEIU settlement was 70¢ per hour over 24 months. In addition, the Board awarded a reduction in the hours of work to 37½ per week, plus important clauses on Contracting Out and Work of the Bargaining Unit, as well as many more provisions.

No doubt as a result of the success of the 1979 round of Central Bargaining, all local unions except one decided that they would be willing to participate in the 1980 round. Several more hospitals also reassessed their position, resulting in a total of 65 hospitals and 66 local unions participating in 1980 — the highest total ever.

Current negotiations

Central Negotiations began again in July, 1980 and continued on a "week on — week off" basis for the whole summer. On September 26, a tentative Agreement was reached, providing a wage settlement of 65¢ per hour in each year of a two-year agreement. The other major item in the settlement was the mandatory introduction in all participating hospitals of the Hospitals of Ontario Disability Income Plan (HOODIP) — a short-term — long-term income replacement program.

The membership of the participating locals voted on October 27, 1980, and rejected the proposed memorandum by a total of 91%. As a result of this massive rejection vote, the Central Bargaining Committee met with the O.H.A. on November 14. The O.H.A. said they found no basis for any possible settlement, and broke off negotiations. The O.H.A. then began the arbitration process by naming their nominee to the Arbitration Board.

Regional Structure

CUPE hospital local unions.

CUPE Ontario Hospital Locals are divided into seven provincial regions. Each region holds its own meetings and elects a representative to the central bargaining committee.

Region 1 Guelph, Stratford, Owen Sound, Seaforth, Windsor, Leamington and Area.
Region 2 Fort Erie, Port Colborne, St. Catharines, Hamilton, Milton, Burlington, Hamilton, Georgetown and Area.
Region 3 Metropolitan Toronto Area.
Region 4 Ajax, Bowmanville, Cobourg, Lindsay, Oshawa, Peterborough, Port Hope, Port Perry and Area.
Region 5 Brockville, Kingston, Ottawa, Renfrew, Hawkesbury, Pembroke, Smiths Falls, Alexandria, Arnprior, Cornwall and Area.
Region 6 Chapleau, Espanola, Mattawa, Parry Sound, Sturgeon Falls, Sudbury, Haileybury, North Bay, Cochrane and Area.
Region 7 Kenora, Thunder Bay, Red Lake, Fort Frances and Area.

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CUPE Hospitals in Central Bargaining

Local	Participating Hospitals	No. of employees
Region 1		
57	Guelph General Hospital	177
1033	Guelph, St. Joseph's Hospital	214
48	Owen Sound General & Marine Hospital	275
424	Stratford General Hospital	245
Region 2		
1065	Burlington, Joseph Brant Memorial Hospital	334
1531	Fort Erie, Douglas Memorial Hospital	74
839	Hamilton, Chedoke/McMaster Hospital	326
794	Hamilton Civic Hospitals	1290
786	Hamilton, St. Joseph's Hospital	685
778	Hamilton, St. Peter's Hospital	311
815	Milton District Hospital	30
1532	Port Colborne General Hospital	118
1097	St. Catharines, Hotel Dieu Hospital	249
1742	St. Catharines, The Shaver Hospital for Chest Diseases.	78
Region 3		
1474	Toronto, The Doctors Hospital	157
929	Toronto, The Salvation Army Grace General Hospital.	45
2008	Toronto, Hillcrest Hospital	48
1080	Toronto, Humber Memorial Hospital	275
1692	Toronto, North York General Hospital	327
1590	Toronto, Providence Hospital	310
1156	Toronto, Queen Elizabeth Hospital	339
79	Toronto, The Riverdale Hospital	630
790	Toronto, St. John's Convalescent Hospital	98
1144	Toronto, St. Joseph's Health Centre	414
1487	Toronto, Scarborough General Hospital	438
1744	Toronto Western Hospital	646
2001	Toronto General Hospital	736
1106	Toronto, Queensway General Hospital	176
Region 4		
906	Ajax & Pickering General Hospital	175
137	Bowmanville, Memorial Hospital	75
2247	Campbellford Memorial Hospital	68
1784	Cobourg District General Hospital	90
1909	Lindsay, Ross Memorial Hospital	254
45	Oshawa General Hospital	645
19	Peterborough Civic Hospital	249
243	Peterborough, St. Joseph's General Hospital	138
1653	Port Hope & District Hospital	71
1926	Port Perry, Community Memorial Hospital	34
Region 5		
2027	Alexandria, Glengarry Memorial Hospital	70
252	Brockville General Hospital	90
1967	Hawkesbury District General Hospital	76
29	Kingston, Ongwanada Hospital	71
576	Ottawa Civic Hospital	1332
1657	Ottawa, Elisabeth Bruyere Health Centre	515
1657	Ottawa Health Sciences Centre General Hospital	11
870	Ottawa, The Perley Hospital	160
942	Ottawa, Royal Ottawa Hospital	145
883	Ottawa, The Salvation Army Grace General Hospital	195
1548	Renfrew Victoria Hospital	123
2119	Smiths Falls Community Hospital	180

Local	Participating Hospitals	No. of employees
Region 6		
238	Cochrane, Lady Minto Hospital	104
1332	Espanola General Hospital	22
904	Haileybury (now New Liskeard) Temiskaming Hospitals	154
1465	Mattawa General Hospital	34
139	North Bay Civic Hospital	241
1473	Parry Sound, St. Joseph's Hospital	61
1101	Sturgeon Falls, West Nipissing General	117
161	Sudbury, Laurentian Hospital	360
1023	Sudbury Algoma Sanatorium	80
1023	Sudbury General Hospital	316
1182	Sudbury Memorial Hospital	162

Local	Participating Hospitals	No. of employees
Region 7		
795	Fort Frances, La Verendrye Hospital	115
822	Kenora, Lake of the Woods District Hospital	107
1781	Kenora, Lake of the Woods District Hospital	79
1758	Red Lake Margaret Cochenour Hospital	75
1409	Thunder Bay, McKellar Gen. Hospital	121

Fact Sheet

Bargaining restrictions:

Hospital bargaining in Ontario is regulated by the Hospital Labour Disputes Arbitration Act. The Act says that if contract negotiations are not successfully concluded at the bargaining table then the dispute will be decided by compulsory arbitration. According to the Act the arbitration board is to consist of a management nominee, a union nominee and a chairman chosen by the nominees. If either party does not appoint a representative to the Board the government may do so.

Bargaining Structure:

Hospitals and CUPE hospital local unions choose whether or not to join central bargaining. If a hospital chooses not to enter central bargaining then the local is excluded also. At the start of negotiations the hospitals and local unions involved decide what items will be bargained centrally and what items will be left to be negotiated locally.

Number of employees:

CUPE employees involved in central bargaining: 16,000.

Number of CUPE hospital locals:

Locals in central bargaining: 66.

Hospitals:

Hospitals in central bargaining: 65.

Types of jobs:

Clerical employees, laundry workers, dietary aides, technicians, tradesmen, orderlies, porters, Registered Nursing Assistants, ambulance drivers and other support staff.

Average wage:

$6.64 an hour.

Work week:

37½ hours per week.

CUPE:

CUPE is Canada's largest trade union with over 250,000 members across the country. It is the major union for hospital workers in the country. President: Grace Hartman. Secretary-treasurer: Kealey Cummings.

The articles for this issue of The Facts were prepared by Randy Sykes, a Senior Officer in CUPE's Research Department.