1. There are three areas I would like to cover. First, I want to explain why CUPE hospital workers were so disappointed with their pay and working conditions *before* the strike by reviewing some of the bargaining history. Secondly, we will see how those experiences contributed to their lack of faith in the compulsory arbitration system as a means to resolve negotiations. Thirdly, we will review the problems hospital workers had with their bargaining processes and structures within CUPE.

2. Since I only came on staff at CUPE in 1986, I am relying on historical documents in addition to Jerry White's book, *Hospital Strike*. In large part much of my information is found in a Research Department publication written in December 1980. This publication was issued after the proposed memorandum of settlement had been rejected by 91% of the membership in October of 1980, but before the strike commenced in late January 1981 (*CUPE Facts*).

3. Another very important source of information is a report of a task force put together *after* the strike to review the CUPE hospital bargaining structure in Ontario. This task force was called the *Ontario Hospital Bargaining Review Committee*, and part of its work was to tour the province to consult local union leaders and activists, and to make recommendations regarding a more effective and democratic bargaining structure for health care workers.

Enactment of HLDAA

4. I take as my starting point the year 1965 when the right to strike was taken away from hospital workers, and then zoom straight on to 1974 when coordinated bargaining first took place.

5. Bur first, just a comment on the legislation itself. The Hospital Labour Disputes Arbitration Act (or *HLDAA*) was far more draconian than the approach that had been recommended by a government appointed Royal Commission. This Commission was appointed after service employees at the Trenton Memorial Hospital went on strike for three months in 1963 and was charged with examining the feasibility of using compulsory arbitration instead of the strike mechanism for resolving bargaining disputes in the hospital sector.

6. This Commission, the Bennett Commission, recommended that compulsory arbitration should only be applied when **patient care was adversely affected or seriously threatened**, and not automatically, but at the discretion of the Cabinet. However, the government of the day ignored the recommendations of its own Commission, and passed HLDAA which applies automatically where the parties are unable to settle, and applies to all members of the bargaining unit, whether they perform essential services or not.

7. To say this was overkill is an understatement (John Deverall, Toronto Star Labour reporter 1982 academic paper, 5% of service bargaining units like CUPE hospital bargaining units can be considered truly essential, quoting Paul Weiler).

1974 Catch-Up Campaign

8. By the 1970s, wages paid to CUPE members in Ontario hospitals were notoriously low, especially in comparison to other public sector workers represented by CUPE. For example, the average hourly wage paid to CUPE cleaning staff in Toronto area hospitals in 1974 was $3.00 while the hourly rate of pay for the Toronto Board of Education CUPE caretakers was $4.14.

9. In response to this, in 1974, a group of Toronto locals banded to together to bargain jointly and pursued a *Catch-Up* campaign. Previous to this, bargaining had always been conducted on a hospital by hospital basis. The objective of the campaign was to catch up to school board rates of pay, using the hospital cleaner and schoolboard caretaker as tie points.

10. After 6 months of this campaign, and on the eve of an illegal strike when the government had to get involved, a settlement was reached, and most CUPE members won a $1.50 hour wage increase, which for many classifications represented a 50% wage increase. This settlement spread to other CUPE hospital bargaining units across the province.

11. But by 1980, most of these gains had been eroded to an unprecedented degree owing to poor settlements and arbitration awards, made worse by government wage controls, and extremely high rates of inflation.

Bargaining outcomes between 1975 and the 1980 round of bargaining

12. There were three rounds of central bargaining between 1975 and 1980, and by all accounts, the outcomes of the first two were very demoralizing.

13. The very first-time hospital province-wide bargaining took place was in 1975. CUPE locals and 59 hospitals agreed to bargain centrally on a limited number of issues, mostly monetary in nature. After several months of negotiations, a settlement was reached on a number of issues and included a general wage increase and special wage adjustments to the RNA and Orderly classifications.

14. Unfortunately, this took place in the era of government enacted wage and price controls, and a government-appointed Anti-Inflation Board ordered a roll-back on the wage settlement *to 30% less* than what was originally negotiated - leaving the wage increases well below the rate of inflation.

15. The next round of bargaining involved 57 hospitals and local unions. By now, hospitals refused to bargain anything beyond the AIB guidelines so bargaining was unproductive. In the meantime, an SEIU arbitration award which had provided a wage increase of 5.8% was rolled back by the AIB to 4%. At this point the CUPE central bargaining committee, feeling it had nowhere else to go, signed a memorandum of settlement agreeing to the 4%.

16. This settlement was roundly rejected by the membership by a margin of 80% in October of 1978. The union starting mobilizing and taking strike votes across the province. At the request of the Ontario Hospital Association, the Labour Board issued a Cease and Desist order, the

Minister of Labour personally intervened and the parties eventually agreed to submit to arbitration. The arbitration board (chaired by Kevin Burkett), awarded *virtually every item* that was in the original failed memorandum, including the 4% wage increase, which was 4.6% less than the rate of inflation at the time.

17. A third round of bargaining also resulted in arbitration, the OHA insisted on patterning off an earlier, inferior SEIU settlement and the dispute went to arbitration in the summer of 1979. This time, the award was better, it provided for wage increases in excess of those agreed to by SEIU, plus new language on contracting-out and work of the bargaining unit, as well as many other provisions, including a standardized work week.

18. Despite this better award, as the parties headed into negotiations in 1980, hospital workers were very unhappy about their wages and working conditions. CUPE hospital workers' wage rates in the four years ending September 1980 only rose by 23% when prices had risen 43% over the same period. This represented a 20% cut in real income for the average CUPE hospital employee.

19. In the meantime, severe government funding cutbacks to hospitals meant beds being closed, increased hallway medicine, staff reductions, not just by attrition, but by actual layoffs in places like Windsor, Campbellford, Sudbury, Brockville, Stratford, Kingston, Hamilton and Sarnia. The remaining workers were subject to "speed up", full-time positions were replaced by part-time positions, volunteers were being allowed to do all kinds of bargaining unit work.

20. Because of increased workloads, CUPE members were suffering extra stress, as well as more sickness and injury. These factors combined with lower real wages, produced an angry and militant workforce. There were other important factors, including the fact that women represented about ¾ of the workforce. In his book, and in the interview you will see later today, Jerry White elaborates on this theme.

What hospital workers thought of the compulsory arbitration system/1979 resolution

21. As a result of these and earlier experiences, CUPE members in the hospital sector were completely disillusioned with the compulsory arbitration system. Apart from wage awards below the rate of inflation, Issues raised in the *Facts* publication included:

- The fact there is no pressure on the part of employers (i.e. the OHA) to meaningfully negotiate, since they don't have to face a withdrawal of services if they don't seriously bargain. They also don't want to bite the hand that feeds them, better let an arbitrator make the decision.

- Difficulties in obtaining arbitrators who were acceptable to the union.

- The reluctance of arbitrators to innovate, or award breakthrough provisions.

- The realization that arbitration processes are not capable of dealing with complex bargaining issues, or have any real way of assessing the priorities of the union, especially where those priorities would involve breakthrough provisions.

22. For example, one of the principal Union demands in the 1980 round of bargaining was for workload committees to be set up in every hospital to investigate claims of excessive workload and to recommend appropriate actions where necessary.

23. The OHA refused to even consider this proposal, and as it turns out, the arbitrator appointed after the 1981 strike, Paul Weiler, also declined to make an award on this issue, mainly because he said it would have been a "breakthrough" provision.

24. This lack of faith in the arbitration system was at the heart of efforts by hospital delegates a year earlier, at the 1979 National Convention to have a resolution passed defending free collective bargaining.

    The resolution that got passed committed that "CUPE will mobilize all its strength and resources to retain the right to strike, and where it exists, to *fight against all present restrictions on the full right to strike* – which of course would include the compulsory arbitration system in the Ontario hospital sector.

25. I am going to leave to others the events leading up to the strike, the experience of the strike itself, and the reprisals that followed, but I thought you would be interested in learning about the task force created *after* the strike that examined bargaining structures and relationships, and toured the province to consult with hospital leaders and activists. This process, and the report that followed, provided the basis for the founding of OCHU in 1982.

The Ontario Hospital Bargaining Review Committee

26. After the strike, two review committees were struck. One blamed everything on personality clashes and was dubbed the 'Whitewash Commission'. The other arose as senior staff in the National Office approached the National President to set up a CUPE equivalent of a Royal Commission to investigate the strike and make recommendations to correct the situation facing hospital workers. The creation of this committee also coincided with a motion adopted in May 1981 at a Health Care Workers' Coordinating Committee conference in Windsor.

27. The senior staff who approached Grace Hartman ironically included National Office staff who had been accused by the Regional Director, and the Hospital Coordinator, of stirring things up, of interfering in the bargaining, of wanting a strike all along. The four senior staff were the Research Director, Gil Levine, Lofty McMillan, the head of the Organizing Department, Fred Tabachnick who was the Public Relations Director, and Randy Sykes also from the Research Department.

28. The Hospital Bargaining Review Committee had seven elected members from the seven regions which had been created in 1974. At their first meeting in September 1981, Grace Hartman asked the committee if it would be willing to work with the 4 staff persons in the task of investigating the hospital bargaining situation in Ontario. The Committee agreed, and the staff so appointed attended subsequent meetings of the committee. The committee decided to attach its chairperson to the tour of the province. That chairperson was Paul Barry who later became the first president of OCHU.

29. The major conclusion of this committee was that once central bargaining had become a reality in 1975, the union never adapted its structure to suit the new situation.

- While seven regions had been created, the union remained without a central, provincial decision-making body. Decision-making power rested with the regions, with each region having an equal vote on matters, despite some regions having up to 10 times the membership as other regions.

- Another problem with this federation of 7 regions was that regions often made decisions which bound their central bargaining committee representatives without having heard from other regions, elected leaders or staff.

- Also, the regions did not necessarily receive the same information on which to base their decisions, and communication between regions was poor. Local unions complained that hospital workers got more information from the *Globe and Mail* and *Toronto Star* than they did from their own union.

- There was no central forum with authority for bringing locals together, instead there were ad hoc mini-conferences, presidents' meetings, HCWCC conferences, but none of those had any constitutional authority. In the words of the Review Committee *"Their decisions are not binding and can apparently be altered or ignored by locals, regions, bargaining committee members, staff, etc. without consequence*".

- While the central bargaining committee could make certain decisions when constituted, there was no permanent decision-making authority existing between collective agreements.

30. There was clear consensus amongst the locals that the present structure was not working and that changes had to be made right away to stem growing alienation and hostility towards CUPE. The locals felt that the absence of a viable membership-based decision-making structure resulted in the Coordinator having too many responsibilities which could and should be the responsibility of the local leaders and their elected Council.

    And I quote from the Report:

    "The experience of the last round of bargaining up to an including the strike showed that the membership had largely lost effective control over the decision-making

process. Structures and policies must be developed to ensure that democratic control is firmly vested with the membership and its elected leaders, not with the staff."

31. The Review Committee met with 48 hospital locals representing over 80% of the membership. The bargaining structure the Review Committee proposed would put to rest any confusion about who would be in charge of bargaining for hospital workers in Ontario.

32. Affiliated local unions would have direct, delegate input into the Council, which then would elect its Executive and Bargaining Committee. Representation would be by population at Council meetings.

33. The proposed Council was received favourably by all locals and was greeted enthusiastically by the majority. Most local unions indicated they would be prepared to financially support a proper funding scheme for the Council.

34. The Report was published in February 1982, and led to the founding of the Ontario Council of Hospital Unions in April that year – a remarkable achievement in such a short time-frame.

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