PUBLIC INTEREST DISPUTES AND COMPULSORY ARBITRATION: A CASE STUDY OF HOSPITALS IN ONTARIO

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I. INTRODUCTION

Mounting criticism [1] has developed in recent years over disregard of the public interest in labour disputes. Much of this criticism has been directed towards industries or services which are generally regarded as essential. And most of these essential services fall within the public as opposed to the private sector. In a number of jurisdictions, [2] legislatures have met the concern about work stoppages in essential industries by prohibiting the right to strike or lock-out. Compulsory arbitration has usually been substituted as the dispute settlement mechanism of last resort.

Some persons [3] have called for the application of compulsory arbitration to a wider range of essential services as the appropriate technique for the protection of the public interest. Moreover, many of these proponents of compulsory arbitration view it as the logical determinant of "fair" employment conditions and one which would be acceptable to the parties to the dispute if it were only tried. Others [4] have questioned whether compulsory arbitration, where it does exist, really serves the public interest very effectively, if at all. These critics have suggested that it only directs labour or management frustration into other equally damaging channels such as arbi-

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The authors of this article were the chairman of the three man commission and the secretary respectively of the Ontario Hospital Inquiry Commission (1974). The views expressed herein are those of the authors alone and should not be attributed to the Commission.

[1] For the best brief collection of the spectrum of views, see INDUSTRIAL RELATIONS CENTRE, QUEEN'S UNIVERSITY, LABOUR RELATIONS LAW 19-31 (1974), and authorities cited therein.

[2] For a current appraisal, see Collective Bargaining in the Public Service, University of Toronto Industrial Relations Centre, Conference Proceedings (April, 1975) (to be published shortly). For an in-depth study, see H. ARTHURS, LABOUR DISPUTES IN ESSENTIAL INDUSTRIES, STUDY NO. 8, TASK FORCE ON LABOUR RELATIONS (1968). See also, ONTARIO MINISTRY OF LABOUR, REPORT OF THE HOSPITAL INQUIRY COMMISSION 57-59 (1974).

[3] *Supra* note 1.

[4] *Id.*

trary managerial powers, labour inefficiency, high personnel turnover or low morale. They also suggest that it only bottles up labour frustration which ultimately explodes in threats to violate the strike/lock-out prohibition or can only be contained again at an unduly high settlement price.

Commentators who have examined compulsory arbitration machinery where it is in place have varied in their appraisals of it, across a spectrum.[5] That spectrum may be marked at one end by the claim that the crudest compulsory arbitration will work if reinforced by rigid law and order sanction. It is marked at the other end by the claim that compulsory arbitration should be carefully designed and engineered as a complex sensitive set of machinery finely attuned to the peculiarities of the industry it serves, highly dependent on the intimate participation of the parties to collective bargaining and supported by a range of agencies and submechanisms if it is to work. This article will analyze one case study of compulsory arbitration machinery in an industry which is usually regarded as essential, namely, public hospitals in Ontario. The purpose of the article is to demonstrate, as a basic minimum from this case study, that no easy generalizations can be made about compulsory arbitration in public interest disputes and that a compulsory arbitration regime must be carefully tailored according to the structure of collective bargaining which underlies it.

In February, 1974, the Minister of Labour appointed the Hospital Inquiry Commission, the first industrial inquiry commission under the Ontario Labour Relations Act.[6] It was intended that the Commission examine the system of bargaining and dispute settlement in Ontario's public hospitals as it operated under the Hospital Labour Disputes Arbitration Act (HLDA).[7] This legislation prohibits strikes and lock-outs and instead requires binding arbitration of interest disputes. This article examines some of the implications of the report of the Commission.[8] After a brief profile of the public hospital industry in Ontario, this article considers first the problems with which the Commission was expected to deal. It then discusses a number of the Commission's major recommendations designed to deal with the problems. Finally it makes some concluding observations about interest arbitration in the public service.

II. PROFILE OF INDUSTRY

The number of persons in the hospital industry is substantial. Ministry of Health records indicate 234 public hospitals in Ontario as of December, 1973, employing approximately 94,000 full-time and 20,000 part-time personnel. The main categories of full and part-time personnel are:

[5] *Supra* note 1, at 19-31, 108-09; H. ARTHURS, COLLECTIVE BARGAINING BY PUBLIC EMPLOYEES IN CANADA: FIVE MODELS (1971).

[6] ONT. REV. STAT. c. 232 (1970), *as amended.*

[7] ONT. REV. STAT. c. 208 (1970), *as amended.*

[8] REPORT OF THE HOSPITAL INQUIRY COMMISSION, *supra* note 2.

Graduate Nurses	30,000
Nursing Assistants/Orderlies	14,500
Other Nursing Personnel	10,500
General Services	24,000
Paramedical Services	12,500
Administration	8,500
Unallocated Personnel	14,000
Total	114,000 [9]

The pattern of union organization of these employees is disparate. Service employees are organized almost exclusively by either of two major unions well established in other industries. These are the Service Employees International Union (SEIU) and the Canadian Union of Public Employees (CUPE) (approximately 30,000 combined membership). By contrast, more than half the professional nurses are organized with the Ontario Nurses Association which operates only in the hospital industry, and, with approximately 16,000 members is virtually the sole bargaining agent for nurses.

Paramedical employees have scarcely felt the force of union organization to this point. Approximately 2,500 paramedical employees (mainly laboratory and x-ray technicians) are organized principally by the Civil Service Association of Ontario, but in some number by CUPE and SEIU. Finally, two traditional craft unions have established themselves in organizing operating engineers. The relatively few operating engineers in Ontario hospitals are either included in service units or are organized in craft units by the International Union of Operating Engineers or the Canadian Union of Operating Engineers.

The employer side of the bargaining relationship is equally confusing, but for different reasons. While the individual hospital is a legally autonomous entity, two employer organizations, the Ontario Hospital Association (OHA) and the Hospital Personnel Relations Bureau (HPRB), with voluntary membership, each play a role in hospital labour relations. The OHA makes representations to the Ministry of Health on budget issues and distributes detailed information on wages and fringe benefits. The HPRB provides specialized labour relations services, including industrial relations data, consultation and contract negotiation services to hospital managements. As the bulk of hospital budgets are financed by moneys appropriated by the Legislature, the Ministry of Health plays a central though, in actual collective bargaining, passive role in hospital labour relations. From this varied picture of union and employer organization one of the basic difficulties appears, viz. who are the appropriate parties to collective bargaining. However the problems before the Commission were more pervasive than that.

III. The Problems

The Commission was set up because of mounting dissatisfaction with

[9] *Id.* at 11. These are Ministry of Health statistics.

the dispute settlement process under the HLDA Act, particularly with the operation of compulsory arbitration. The Act resulted from the *Report of the Royal Commission on Compulsory Arbitration in Disputes Affecting Hospitals and Their Employees*, [10] which in turn was called into being following the first strike in an Ontario public hospital. That report recommended that compulsory arbitration in a hospital dispute be invoked at the discretion of the Lieutenant Governor-in-Council and that strikes and lock-outs be prohibited only where: (1) patient care is adversely affected or seriously threatened, or (2) one party is convicted of bargaining in bad faith. Instead of following these restrained proposals, the HLDA Act abolished completely the rights to strike or lock-out and provided for compulsory arbitration of disputes that could not be resolved through collective bargaining.

Thus the task of the Commission was in one sense to review the nine years of operation of the HLDA Act, legislation which differed in some principal way from the recommendations of the report which spawned it. More specifically, the Commission was given four-pronged terms of reference:

1. To report on the nature of compensation practices contrasting hospital employees with employees in comparable non-hospital jobs;
2. To recommend appropriate criteria for determining hospital employees' compensation;
3. To determine the feasibility of collective bargaining on other than an individual hospital basis; and
4. To consider the desirability of a pay research centre.

It should be noted that the Commission was not invited to review the nature and scope of the Act. In particular, its terms of reference were not designed to permit it to consider whether the right to strike or lock-out should be returned in any way to the hospital industry.

In its review, the Commission identified a number of fundamental problems associated with the dispute settlement process under the HLDA Act. The Commission observed, in both the bargaining and arbitration elements of the process, interrelated defects which contributed to the gradual demise of the system.

A fundamental weakness of the HLDA Act is that it does not provide arbitrators with criteria on which to base awards. As a result, arbitrators themselves have been free to develop their own criteria or even to use no criteria. Many arbitrators have employed the criteria given most weight in the first hospital award. [11] That award attached greatest weight to wages paid and wage trends in comparable hospitals and to trends in average wages in the locality of the hospital in question. While the comparable hospitals' criterion may have been appropriate for early arbitrations under the HLDA

[10] (1964).

[11] *Re* Building Service Employees, Local 204, 16 Lab. Arb. Cas. 1 (1965).

Act, its rationality quickly evaporated. As subsequent arbitrators observed [12] after a time, arbitration decisions themselves became a major factor determining the kinds of settlements which were "freely negotiated" in comparable hospitals. In this way, a vicious circle developed whereby arbitration awards were justified by negotiated settlements which were themselves strongly influenced by arbitration awards.

Perhaps contrary to expectations, the weight attached by many arbitrators to the comparable hospital and local trends criteria did not produce a consistency to compensate at least in part for the sterility of awards. Consistency did not occur because (a) when arbitrators made reference to those criteria, they did not attach equal weight to each item, and (b) a significant number of arbitrators used criteria quite different from those in the original award. For example, in some cases, abstract appeals to justice or other wages paid in comparable occupations were given weight, while in other awards, Ministry of Health budgetary ceilings or "guidelines" were accorded considerable weight by arbitrators. The weight attached by many arbitrators to Ministry of Health budgetary ceilings has been a particularly contentious issue. Unions have argued that predetermined ceilings are in conflict with the principle of good faith bargaining, especially if such ceilings are low. Combined with the "comparable hospitals" criterion, the budgetary ceilings criterion produced an era of hospital wage settlements that failed to narrow the gap between the compensation of hospital employees and that of many "comparable" workers outside the hospital industry. Further, the settlements were of insufficient magnitude to raise the lowest paid hospital workers above generally accepted poverty line earnings. A number of years of such settlements produced a growing climate of bad faith in the bargaining process and an increasing number of cases went to arbitration.

While a number of arbitrators broke free from the vicious circle of awards, this merely had the effect of encouraging unions to resort to arbitration in the hope of obtaining a "pattern breaking" award. Moreover, the incentive for the hospitals to go to arbitration was always present where stringent budget ceilings were in effect. Some hospital administrators took the view that an approach to the Ministry of Health for funds in excess of their allocation to meet higher wages would be received more favourably if such higher wages were the result of an arbitral award rather than a freely negotiated settlement.

Resort to arbitration was further encouraged by the mediatory posture of many boards of arbitration. To a large extent the absence of clear legislated criteria and the effective dependence of arbitrators on evidence submitted by the parties underlay the mediatory nature of the arbitration process. Emphasis was put on finding a middle ground rather than on producing an award consistent with firm and clearly understood criteria. The fact that some 234 individual public hospitals enjoyed legal autonomy together

[12] *E.g.*, *Re* Building Service Employees, Local 204, 20 Lab. Arb. Cas. 31 (1969).

with the fragmentation of bargaining units on the employee side provided additional explanation for the number of disputes going to arbitration.

Some believe that the success of a system of dispute settlement that has ultimate resort to arbitration can be judged by the extent to which resort to arbitration is avoided. The fact that the combination of the forces outlined above caused 39 of 153 public hospital contracts, or one quarter of the total in 1970, to be settled by arbitration suggests a weakness in the dispute settlements process. [13]

The glut of hospital arbitrations itself produced second order problems in the system. An excessive burden was placed on the capacity of the relatively few mutually acceptable arbitration board chairmen and on the most popular sidesmen. The resulting delays were a source of irritation to both sides and further served to reduce acceptance of the system.

The pressure of discontent on the union side built up. A number of unions saw their numbers as underpaid relative to persons in comparable occupations and sought large "catch-up" increases during negotiations in the early part of 1974. When the CUPE locals of thirteen Toronto hospitals failed to reach a settlement in conciliation, the normal stage of compulsory arbitration was boycotted and an illegal strike threatened for early May, 1974. Last-minute intervention by the Cabinet of the Government of Ontario averted a strike and boosted the base male rate (porter/cleaner) by 50 per cent over two years from approximately three dollars an hour to four and one half dollars an hour. Settlement by such means clearly bypassed the normal channels of dispute settlement and effectively rendered impotent the established dispute settlement process under the HLDA Act.

The problems within the HLDA Act dispute settlement process have been portrayed above as a vicious circle of defects inherent in both the process of bargaining and of arbitration. Weaknesses in the structure and climate of public hospital bargaining exerted sufficient pressure on the arbitration process that it produced in that process flaws which themselves aggravated the climate of bargaining. Conversely, serious defects inherent in the arbitration process were instrumental in creating frictions which greatly impaired the ability of the parties to resolve their differences without resort to arbitration.

The task of the Commission was to recommend appropriate measures to free the parties from the containment of this vicious circle. By necessity, these were recommendations aimed at improving the functioning of both the bargaining and the arbitration processes. Naturally, the close interdependence of the two processes implies that improvements in bargaining will strengthen the arbitration process and vice versa.

IV. Commission's Recommendations

The Commission's recommendations fall under three main headings:

[13] From a Ministry of Labour internal research paper supplied to the Commission.

A. The establishment and proper functioning of a system of dispute settlement based on legislated criteria;

B. The evolution of a more rational and orderly bargaining structure; and

C. The mechanics of streamlining the arbitration process.

A. *Criteria*

The Commission recommended that the following criteria for arbitration be embodied in the HLDA Act: the need to ascertain and preserve appropriate relationships in the conditions of employment (a) as between occupations within public hospitals and (b) as compared to similar occupations outside public hospitals with due regard for the labour market areas.

Essentially, the recommendations postulate a two-step process for settling appropriate levels of public hospital compensation. The first step is to establish benchmark hospital occupations as regards levels of skill, duties and responsibility. The range of compensation paid to such comparable external occupations in the appropriate labour market can then serve as a basis for negotiations between the parties. While it is unlikely that negotiated hospital rates would deviate greatly from the community norm, there would be a measure of uncertainty making for a measure of flexibility and unpredictability desirable in a collective bargaining context.

Application of the principle of relating remuneration in hospital occupations to that of comparable external occupations presupposes the availability of data on salary scales and other conditions of employment that are sufficiently detailed and refined to provide a practical basis of comparison. Accordingly, the Commission recommended establishment of a resource centre to provide the bargaining and arbitration processes with current data on compensation paid to hospital and non-hospital occupations verified by the centre as comparable with respect to levels of skill, duties and responsibility. By means of its own pilot research project, the Commission established that wage data for matched jobs outside hospitals was readily available in urban centres for these hospital occupations: cleaner (heavy duty), switch-board operator, stationary engineer, and electrician (qualified journeyman).

The proposed second step in the hospital wage settlement process required that the compensation to be paid to the many occupations other than the benchmarks be based on a comprehensive and dependable job evaluation system having complete objectivity and acceptability. The proposed system would be financed by the Government of Ontario, but would be undertaken by an independent firm of consultants with substantial input from hospital, labour and management experts. In particular, a seven person committee composed of three union representatives, three management representatives and an independent chairman would serve as the supervisory agency for the job evaluation studies and as an appellate tribunal for difficulties in applying the studies to particular jobs. In addition to rationalizing wage differentials

between occupations, establishments and regions, the proposed job evaluation systems would serve to eliminate many instances of unequal pay for equal work that apparently still occur in public hospitals, particularly as between jobs traditionally performed by females and those traditionally performed by males.

The omission of any further criteria in the settlement of hospital compensation is of some significance. For example, the Commission specifically denies the relevance of Government budgetary guidelines or ceilings to an arbitrator's award. Furthermore, the Commission rejects the option of including a "basket clause" criterion in the legislation, on the grounds that the potential benefits arising from greater latitude available to arbitration would be outweighed by the danger of such flexibility degenerating into a succession of inconsistent awards of the type that have become an undesirable ingredient of the present regime.

The anticipated improvement in rationality and consistency of arbitral awards promises to further improve the arbitration process by discouraging the resort to arbitration. Greater consistency in awards should enable the parties themselves to predict more accurately the probable outcome of arbitration and thereby improve the chances of a negotiated settlement. Greater rationality should eliminate much of the animosity of the type recently generated by irrational awards and reduce the friction that can undermine good faith bargaining.

A further recommendation of the Commission aims at greater rationality in arbitral awards. It has proposed that the HLDA Act specifically free arbitrators from their traditional dependence on the evidence submitted by the disputants. Rather, it would permit arbitrators to use whatever available information they consider relevant to the issue. The intention is to make it easier for arbitrators to make informed awards based on the rational application of the proposed criteria rather than an award that seeks to find some middle ground between the extreme and often unreasonable positions adopted by the disputing parties. It is expected that the pay research centre will be of considerable assistance to arbitrators in this task. This recommendation purports to ensure that the tribunal functions as an arbitration board rather than as a mediation device.

The commission anticipated that, if the parties became aware that arbitration awards were consistently based on the informed application of rational criteria, they would be less willing to go to arbitration with an unreasonable and extreme position designed to obtain a "mediated" settlement somewhere between the positions adopted by the disputing parties. Under the proposed system, such a party would risk obtaining an arbitration award even less favourable to it than a settlement that could have been made during negotiations.

B. *Structure of Bargaining*

The Commission's recommended changes in the structure of bargaining

were aimed at recognizing the realities of broader union groupings that had established themselves in the past few years and at evolving a more orderly process of negotiations. One set of proposals was designed to prevent undue fragmentation of hospital bargaining units while another sought to encourage the evolution of province-wide bargaining for the proposed bargaining unit categories. Thus, it was recommended that:

(a) Hospital employees be grouped into three categories for the purpose of bargaining: service, professional nursing and paramedical; and

(b) Bargaining for all three categories should ultimately take place on a province-wide basis. The Commission concluded that it was essential for individual hospitals to be represented at negotiations by an accredited employers' association.

A number of advantages were anticipated from the recommended broader scope of bargaining. First, the absence of hospital by hospital negotiations would encourage the parties, as well as arbitrators, to turn away from the traditional "comparable hospitals" criterion to the recommended "external comparisons" criterion in settlement of public hospital compensation. Consolidation of negotiations would improve the quality of bargaining by making it possible for all parties to be represented by the most able negotiators. This is not always the case at present as individual hospitals and local unions often do their own negotiating.

The reduced number of negotiations resulting from implementation of the Commission's recommendations would make it practicable to put into effect the further recommendation that the Ministry of Health be present as an observor at negotiations. Without greater centralization of bargaining, Ministry of Health presence at negotiations would be expensive and altogether rather impractical. As the Commission considered Ministry of Health presence at the bargaining table essential to good faith bargaining, it is important to have a structure of bargaining that facilitates such presence.

The reduced number of negotiations that would accompany broader-based bargaining would also reduce the number of arbitration boards required. Consequently, it is likely that all arbitrations could be handled by a few highly-qualified and experienced arbitrators. This would do much to free the system from the large number of inconsistent and delayed awards that have contributed significantly to the climate of bad faith in public hospital negotiations of recent years. On the union side, there was almost universal support for more centralized bargaining. Only the method and timing were in dispute. Thus the major price to be paid was the loss of freedom for individual hospitals in centralized bargaining. The judgment of the Commission was that, on balance, there were more compelling arguments to support centralized bargaining as set out above and that there were several realities which would be ignored in opting for the opposite course. First, a considerable amount of individual hospital freedom had disappeared through the current bargaining practices. For example, the nurses union

had obtained agreement from employees for the next round of bargaining to be province-wide. In addition, the two major service unions had bargained regionally for one award and applied this award almost uniformly region by region across the province. Thus to call for a return to individual hospital bargaining might be similar to Canute's order to the sea. Second, at least through budgetary restraints the image of the individual hospital as employer and paymaster, and therefore bargainer, had become considerably blurred. Some mechanism had to be found which identified the Ministry of Health as a participant in pay discussion, if not as paymaster.

The Commission stressed that the move to province-wide bargaining should be orderly and consistent with recognized trends. Further, the Commission urged the parties themselves to work together with assistance from the Ministry of Labour to achieve an evolutionary phasing-in of centralized bargaining. This co-operation is fundamental to the success of these proposals and has been clearly lacking in recent public hospital bargaining. Conflict and lack of communication have been present not only between labour and management but within the two camps. The Commission hoped that its proposals would provide the various parties with the opportunity to make constructive input into reshaping their inter-relationships.

C. *Arbitration Mechanism*

In recommending measures to streamline the arbitration mechanism, the Commission anticipated secondary benefits in the form of an improved bargaining climate resulting from a reduction in the frictions presently inherent in the arbitration process.

In order to reduce delays inherent in the existing system, the Commission recommended that a rigorous time schedule be placed on the parties to bargaining, conciliators and arbitrators. The recommended schedule would permit the parties to expect an arbitration award not later than two months after the expiry date of their contract.

To achieve greater consistency in awards, the Commission recommended replacement of ad hoc arbitration boards by a permanent arbitration tribunal. By means of such a tribunal, a body of expertise could be built up more easily than under an ad hoc system. To ensure that the rationale of awards is understood by the parties, the Commission recommended that all awards contain detailed reasons for the decision.

Recognizing the importance of attracting high calibre persons to form the permanent tribunal, the Commission acknowledged the importance of making remuneration commensurate with what such individuals could earn in alternative endeavours.

In summary, the Commission's recommendations were designed to improve the structure of bargaining and the form of arbitration. The Commission was fully aware, however, that true progress would only occur with the return of a spirit of mutual co-operation between the parties to bargaining

and a reappraisal by Government of the conflict between ability to pay arguments and the removal of the right to strike and lock-out.

V. Concluding Reflections

The HLDA Act in some respects represented the worst of both worlds in public dispute resolution legislation. It abolished the right to strike and lock-out altogether and so left no direct means to resolve intractable disputes. It provided, as a surrogate, compulsory arbitration but without guiding criteria or a formal structure to help it work. From this general proposition, several particular concluding reflections may be asserted.

First, in retrospect, it may have been unfortunate that the pre-HLDA Act recommendations for limited strike, lock-out sanctions were not accepted. These would have provided some means to relieve pressure and establish wage and fringe benefit benchmarks without risking fundamental damage to health care in the province through hospital closedowns. This omission exacerbated the consequences of what appears to be a second omission in the HLDA Act. It was an error to establish compulsory arbitration and leave it to arbitrators to cut their own criteria from whole cloth with no guiding pattern. The result was the frequent use of a comparable hospital criterion which gradually bore less and less relation to the real market, causing dismaying inconsistency in awards, or unreasoned awards which gave little future guidance to the parties. Third, the HLDA Act and regulations thereunder left the mechanics of compulsory arbitration to work in a rather haphazard manner with insufficient attention to timeliness and expertise of compulsory arbitration boards, minimizing occasions for their use and consistency in their awards.

These deficiencies created pressure for broader union organization to build up power, and once that power existed, its use to threaten the strike prohibition in the HLDA Act.

The Commission's recommendations were designed to remedy these deficiencies. However, the process of restoring compulsory arbitration and making it acceptable is now more difficult once it has been used and found wanting and subsequently defied successfully. The rather dismal performance of the compulsory arbitration mechanism in Ontario's public hospitals makes it difficult to resist the temptation to condemn all compulsory arbitration as unworkable. The Commission rejected this pessimistic generalization in favour of the view that compulsory arbitration can be made to work provided it is not seen by the parties as a substitute for good faith bargaining and provided it is adjusted to the circumstances of the particular industry and to the particular parties for a given time and is supported by a number of carefully conceived and executed submechanisms to help it function.