In the Matter of an Adjudication Concerning
Market Supplemented Wage Rates
In the following classifications:

- **Emergency Medical Technician**
- **Emergency Medical Technician - Advanced**

Between:

Health Sciences Association of Saskatchewan

-and-

Saskatchewan Association of Health Organizations

Before:	**Beth Bilson, Adjudicator**	
Appearances:	**For HSAS:**	**Jennifer Bowes** **Kevin Glass** **Renee Honoway** **Braden White**
	For SAHO:	**Ian Billett** **Gloria Wall**
Date of Hearing:	**June 8, 2015**	

Decision of Adjudicator

The Health Sciences Association of Saskatchewan (HSAS) and the Saskatchewan Association of Health Organizations (SAHO) are parties to the collective agreement which governs the terms and conditions of employment of a number of classifications of employees in the health care sector. Appended to the collective agreement are two Letters of Understanding outlining a process for considering and implementing market supplemented wage rates for these classifications. My authority and function as an adjudicator is set out in those Letters of Understanding.

As I have noted in a number of these decisions, the terms of the Letters of Understanding make it clear that the market supplement program is limited in scope, and does not purport to address all of the staffing and budgetary issues that may create stresses on employers and employees in the health care sector. Letter of Understanding #12 begins with the following paragraph:

> The SAHO Market Supplement Program is designed to address specific pay related skill shortages by use of a market supplement to attract and/or retain qualified Employees where workplace initiatives have been unsuccessful in addressing recruitment and retention challenges. A market supplement will be implemented only when it is necessary to enhance the ability of Employers to retain and/or recruit Employees with the required skills to deliver appropriate health services.

Letter of Understanding #13 specifies the criteria I may consider in deciding whether a market supplement is appropriate, or the amount of the market supplemented wage rate. These are limited to service delivery impacts; turnover rates; vacancy rate analysis; recruitment issue analysis; and salary market conditions.

I have also noted in the past that the environment in which determinations must be made about market supplements is not static. I understand my role to be to assess whether a market supplement, or a particular level of market supplement, may act as an inducement to employees to take or remain in positions in the Saskatchewan health care system. This will depend on current market conditions and trends; it will also depend on developments that are taking place in the health care system itself, such as collective bargaining or changes in policy. Since the determination of market supplemented wage rates occurs according to a series of steps set out in the Letters of Understanding between the parties, there may in some cases be a lag between the request for consideration of a market supplement and the ultimate determination at adjudication, and this must also be taken into account.

In this case, I have been asked to consider whether a market supplement is warranted for the classifications of Emergency Medical Technician (EMT) and Emergency Medical Technician – Advanced (EMT-A). Though these classifications have separate wage scales, they are both part of a continuum of employees hired to provide emergency response in the health regions, and I will deal with them together.

HSAS requested a consideration of whether a market supplement should be added to the wage rates for EMTs and EMT-As in May 2014. The report of the Market Supplement Review Committee (MSRC) was finally issued in September 2014; the MSRC concluded that no market supplement was warranted for these classifications at that time. In January 2015, HSAS advised SAHO that it would be referring this decision to adjudication.

Ms. Bowes referred me to the MSRC report, and argued that the report was flawed because the MSRC had failed to take into account a number of realities relevant to these classifications. She argued that the summary of the information submitted to SAHO by employers did not support the conclusion that there were not service delivery impacts attributable to recruitment and retention issues, or show that employers did not think a market supplement would assist in resolving staffing issues. She pointed out that four of seven rural health regions responding to SAHO had indicated that they thought a market supplement should be considered.

She noted that the statistics on which the MSRC based its conclusions included only permanent full-time and permanent part-time positions, and did not take account of the fact that many of the health regions, particularly in rural areas have moved to a staffing model based primarily on casual positions. She referred me to a number of media stories from rural areas alluding to the difficulties the health regions there were having in maintaining sufficient staffing levels to provide adequate service. One practice described in stories related to the Cypress and Heartland health regions was "staging," a term used to refer to a system of locating ambulance vehicles equidistant from towns so that the wait time for each town will be equal; this practice has been adopted even where there is ambulance equipment available in both centres because there are not sufficient employees to staff the ambulances all the time. Another document presented by Ms. Bowes purported to show that ambulance service was eliminated altogether at certain times in one health region because of the difficulty finding staff.

In the case of the Heartland Health Region, the stabilization of the Emergency Medical Service (EMS) had been selected as one of the priority areas for planning in the region for 2014-15. A special intensive planning session with a number of stakeholders was held in March 2015 to discuss ways to improve the EMS, and one of the outcomes was a commitment to "ensure a baseline staffing model is in place."

Ms. Bowes said that the difficulties staffing the EMS in the rural health regions created significant pressures on staff. She presented some information from HSAS members indicating that they worked extensive overtime hours.

With respect to other factors relevant to my decision – vacancy and turnover rates, and efforts to recruit and retain employees – Ms. Bowes argued that the analysis of the MSRC on these points is skewed because the churning of casual staff, the difficulties recruiting and retaining them, and the efforts made by employers to hire and retain them, are all ignored in the report. Though the largely urban regions of Regina Qu'Appelle and Saskatoon are less reliant on casual staff, even Saskatoon reported to SAHO that retention of casual staff was a challenge.

Finally, she said that the wage levels for the EMTs and EMT-As are the lowest in the comparator provinces in western Canada.

Mr. Billett noted that there are significant changes on the horizon for the EMSs. There will be a change in educational qualifications, and a redefinition of the scope of practice for various grades of EMTs.

He also pointed out that the parties have been engaged in collective bargaining since 2013, and that the possible impact of a new collective agreement on the wage levels for job classifications represented by HSAS is difficult to predict.

He reminded me of the limits placed on my mandate by the LOUs. As I have said often in these decisions, the market supplement program was clearly not meant to address every issue concerning

staffing, working conditions or service delivery about which the health regions and HSAS members may disagree. Employers may decide, for example, to cut back on the number of positions in a classification; this may have the consequence of increasing the workload for employees who continue to work in that classification, but this does not in itself lead to the conclusion that a market supplement is warranted. The market supplement program is aimed at recruitment and retention issues, and is based on the premise that a market supplement may help to ease skills shortages in particular areas.

Mr. Billett argued that employers are entitled to choose the model of service delivery that will achieve the best balance, in their view, between their resources and the service needs they face. In this case, the choice of employers to rely heavily on casual employees is not in itself at issue in a market supplement adjudication.

Mr. Billett said that the MSRC did not link service delivery or the difficulties in finding casual staff to wage levels. There was nothing in the report or in the information from employers provided to the MSRC to indicate that wages have been a factor in staffing challenges or in the choice of service delivery models. He acknowledged that there are challenges associated with the operation of EMSs in health regions serving large geographical areas with widely dispersed populations, but the MSRC correctly did not assume that these challenges could be addressed through adding a market supplement to the wages of these employees. He said that the information from employers used by the MSRC showed that employers do not have significant difficulty engaging or retaining the full-time and part-time employees who are the basis of the report, and that this explains why they did not describe significant efforts to recruit.

In response, Ms. Bowes argued that the ease of recruitment to full-time positions is really irrelevant in a situation where there are almost no full-time positions in many of the health regions. Mr. Glass raised the question of the relevance of the experience in the urban health regions, since many EMTs in the Saskatoon area are represented by the union representing firefighters.

I have certainly commented in many of my decisions on the need to isolate the criteria agreed on by the parties as relevant to the award of market supplements from staffing decisions or the effects of those staffing decisions on working conditions.

Looked at from one point of view, what is primarily at issue here is a mode of service delivery and a staffing choice made by a number of regions; they have elected to rely heavily on casual employees to deliver their EMS. Though some employers alluded to the challenges of recruiting and retaining casual staff in their submissions to SAHO, and though some of the material placed before me confirmed that some health regions – particularly in rural areas – have had difficulty laying these challenges to rest, the issues surrounding the "casualization" of the EMSs did not figure in the analysis by the MSRC or affect its conclusion that there is no basis for awarding a market supplement in these classifications at this time.

There are presumably many classifications where the number of casual employees is insignificant enough that there use can be regarded as a simply staffing choice by the employer, and where there deployment is unlikely to have a major impact on service delivery or on the overall ability of employers to maintain adequate staff levels. In this case, however, it was common ground in the arguments of both parties that the use of casual staff has become a predominant element in the delivery of EMT services. Indeed, the information placed before me indicates that casual positions are being defined as "permanent" in some health regions.

Since, in a number of health regions, casual employees are now the backbone of service delivery, I have to agree with HSAS that the analysis of the MSRC is incomplete. Casual employees, like full-time and part-time employees, represented by HSAS, and the difficulties recruiting and retaining them therefore seem relevant to the consideration of whether a market supplement should be awarded. Though concerns about casual employees may be an insignificant factor in relation to many classifications, that is clearly not the case here. Mr. Billett acknowledged that the "churning" of casual staff is a reality faced by a number of health regions; in the information related to the Cypress and Heartland health regions, it is clear that the employers tie that "churning" to difficulties in maintaining adequate levels of service, whatever other factors may also influence service delivery in sparsely-populated areas.

I agree that my mandate does not reach issues like the level of standby pay available to EMTs when they are on call, or to the bleak prospect created by the "staging" process of spending time sitting on the edge of the landfill between Shaunavon and Eastend. On the other hand, though it is unfortunate that I do not have the benefit of observations from the MSRC on this issue, I think I am entitled to take into account the evidence of recruitment and retention difficulties in relation to the casual employees in this instance.

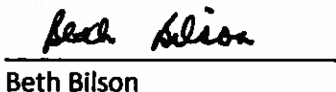
I have in the past commented on the desirability of letting the effects of collective bargaining take effect before determining that a market supplement is necessary, particularly where economic increases have recently been put in place. In this case, however, the parties have as yet been unsuccessful in settling the terms of a new collective agreement. The parties clearly intended to separate the consideration of market supplements from the negotiation of a general collective agreement, or they would have included market supplement rates in the agreement itself rather than setting up a process that occurs outside the framework established by other provisions of the agreement.

Through the LOUs, the parties have identified market supplements as a lever that may ease pressures faced by employers on recruitment and retention of the specialized classifications represented by HSAS, though it can never be guaranteed that a market supplement will eliminate the problem. Most challenges tied to service delivery and staffing have multiple origins, and a market supplemented wage rate is only one instrument.

I have concluded that there is evidence here that recruitment and retention issues, particularly related to casual staff, are having an impact on service delivery. There is also evidence of high turnover ("churning"), vacancy rates, and efforts at recruitment and retention, although these have not been described or quantified very fully since they were ignored in the MSRC process.

I have thus determined that a market supplement is warranted for the EMT and EMT-A classifications.

DATED at Saskatoon, Saskatchewan the 21st day of June, 2015.



Beth Bilson