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

• Respiratory Therapist

Between:

Health Sciences Association of Saskatchewan

-and-

Saskatchewan Association of Health Organizations

Before: **Beth Bilson, Adjudicator**

Appearances:

For HSAS: **Kate Robinson**
Karen Kinar

For SAHO: **Dale Hallson**
Ian Billett
Gloria Wall

Date of Hearing: **January 17, 2013**

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 whose term began on April 1, 2009, 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.

In this instance I am being asked to review the decision of a Market Supplement Review Committee (MSRC) issued on May 27, 2012. In this decision the MSRC determined that an additional market supplement should not be added to the wages of the Respiratory Therapist classification.

As Mr. Hallson pointed out in his submission to me, the purpose of the market supplement program is clearly summarized in the opening paragraph of Letter of Understanding #13:

> 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.

By this wording, the parties indicated their agreement that the program should focus on the contribution made by wage levels to difficulties in recruiting and retaining skilled employees in the Saskatchewan health care system. Other factors that might make working in Saskatchewan health regions more or less attractive – such as workloads, equipment, location, staff relationships, community amenities and so on – were by implication excluded from consideration under the program. I have pointed out in earlier decisions that the Letters of Understanding do not give me authority to address any employee dissatisfaction in relation to those criteria. The parties to the collective agreement have elected to ask me to consider what conclusions about "pay related skill shortages" may be drawn from information about five factors – service delivery impacts. vacancy rate analysis, turnover rates, recruitment issue analysis and salary market conditions.

Although, as noted, I have stated on a number of occasions that employee concerns about such things as the numbers of budgeted positions, or the implications of those numbers for employee workloads, cannot be addressed through this process, the factors chosen by the parties for consideration in relation to the award of market supplements demonstrate the difficulty of isolating the effect of increased wage rates from other aspects of the terms and conditions of employment. Thus, for example, though "service delivery" might be affected by a number of factors not connected to pay, the parties have clearly recognized that pay levels may be one tool for addressing service delivery concerns. I am asked, in the case of the five factors, to draw some inference about whether pay levels might ameliorate issues that might also be influenced by other things.

The MSRC report of May 2012 was based on information provided by six health regions. These included the Saskatoon Health Region (SHR) and the Regina Qu'Appelle Health Region (RQHR), which employed by far the largest number of Respiratory Therapists (92 of the 104 budgeted positions considered in the report). Though none of the regions reported "significant" service delivery impacts, three regions reported moderate service delivery impacts, and one region reported minor impacts. Since in neither 2010 or 2011 were minor service delivery impacts differentiated from "no issues" it is hard to assess that category, but it may be noted that in those two years no moderate impacts were reported, as compared to the three in 2012. As Ms. Robinson pointed out, these categories are of necessity somewhat subjective, but she argued that the information indicates that there are more reported stresses on service delivery that in the past. She presented some evidence of instances where staffing in RQHR had fallen below minimum service levels mandated by region policy. She argued that the difficulties with delivering service might be addressed at least in part by an increase in wage levels.

Mr. Hallson, on the other hand, argued that the rather sparse information included in the report pointed to difficulties in recruiting part-time and casual staff. As I have noted in the past, it is difficult to factor this kind of recruitment challenge into the market supplement assessment; part-time or casual positions may be less directly affected by wage levels than by their transient nature or by a preference for full-time employment in an environment where there is considerable demand for employees with these qualifications.

With respect to turnover rates, the MSRC report indicated that 15 employees in the Respiratory Therapist classification had left their employment at the time of reporting in 2012, as compared to 6 for all of 2011, and 10 for all of 2010. Seven of these departures were attributed by the employees to money. Information presented to me at the hearing indicated that one of the seven employees had moved to a better-paying job in the same health region, one had gone to Saudi Arabia, and five had moved to jobs in Alberta.

Mr. Hallson argued that five positions out of the total number of Respiratory Therapists was not a proportion that should be considered alarming, while Ms. Robinson pointed to the increase in the numbers of employees leaving their employment, and to the number citing wage levels as the impetus for their departure. Her written submission contained a table demonstrating that employee turnover as a proportion of full-time equivalents had moved from 5.2% in 2009, 9.9% in 2010 and 10.3% in 2011 to 13.6% in 2012.

The information about vacancy rates used by the MSRC shows rates for both full-time and part-time positions. Given the relatively small number of part-time positions, the data is difficult to interpret, as one vacancy in such a position can produce misleadingly large rates. The data for full-time positions are a better indicator, and these show that from a high of 11.8% in 2006, the rate decreased in stages to 2.8% in 2011 before rising to 7.6% by May of 2012. It should be noted that an increased market supplement was awarded for this classification in 2008.

With respect to recruitment strategies, the MSRC report listed a number of initiatives carried out by the health regions which had supplied information. These included attending career

fairs, paying relocation and training allowances, advertising and implementing practicum placements for students. The list also included "increasing the number of FTEs." Ms. Robinson indicated that the number of budgeted full-time positions had in fact been decreased by one, though there had been an increase of 4 part-time positions. She expressed the view that this modest increase would not materially affect the staffing shortages. She was skeptical about the effectiveness of some of the recruitment and retention initiatives reported. She presented information showing that when the RQHR posted 6 vacancies in the Respiratory Therapist classification in March 3012, they received no applications; she argued that this was a sign of the recruiting challenges for this classification.

The information used by the MSRC in relation to the final factor, salary market conditions, referred to wage rates for this classification in the four western Canadian provinces which all came into effect at the same time. This creates a basis for direct comparison of wage rates that has not always been possible in market supplement reviews. The data show, as has often been the case, that wages in Alberta are the highest of the four provinces, by close to $5.00 per hour at the minimum and close to $8.00 at the maximum step. Wage levels for this classification are lower in British Columbia and Manitoba than in Saskatchewan.

Mr. Hallson argued that wages in Saskatchewan are unlikely to achieve parity with those in Alberta, and that the second place status of Saskatchewan on this table indicates that Saskatchewan is in a competitive position. Ms. Robinson submitted that the data on turnover rates show that the primary competition for Saskatchewan health care employers comes from Alberta. She also suggested that there is competition from private employers in Saskatchewan; even though their wage rates may not differ significantly from those in the public health care sector, they can provide a range of perks in addition to wages that are attractive.

As I have said earlier, it is quite true that not all of the things that lead employees to take a job or remain in a job can be attributed to wage levels. The parties to the collective agreement, however, have agreed to a program based on the premise that a change in wage levels is one of the instruments that may be used to address skill shortages in health care. In this case, the information presented to the MSRC indicated that there had been a fairly sharp turn upwards in turnover rates over the previous year; this is particularly striking given that the information covered only part of the 2012 year. Moreover, the explanation by a number of employees of the decision to leave their jobs was linked explicitly to wages, and in particular to the comparative wage levels in Saskatchewan and Alberta. This evidence does not, of course, explain the decisions of all the employees who left their jobs; it suggests, however, more clearly than in many other instances where I have been asked to examine the five factors the parties consider to be relevant, that wage levels, particularly in Alberta, exert a noticeable pull for this group of employees.

The vacancy rate has also taken a noticeable upturn over the preceding couple of years, and the information appended to Ms. Robinson's written submission shows that employers have had some difficulty attracting applicants to fill these vacancies. Both parties acknowledged in their submissions that there is competition for the limited number of persons qualified to be

Respiratory Therapists. Again, wage levels cannot be seen as the only factor contributing to the vacancy rate. On the other hand, the award of an additional market supplement to the Respiratory Therapist classification in 2008 appears to have coincided with a lowered vacancy rate in several subsequent years. No doubt the reasons for this coincidence were complex, but it does seem to bear out the premise of the market supplement program that there is a link between wage levels and the attractiveness of employment.

I am unable to agree with the MSRC that the award of a market supplement would be unwarranted. I have concluded that the information presented to me in relation to the five factors shows that there are increasing difficulties with recruitment and retention in this classification and this can be at least in part characterized as a “pay related skill shortage.” I therefore find that an additional market supplement should be awarded to the Respiratory Therapist classification.

DATED at Saskatoon the 6th day of February, 2013.

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Beth Bilson