IN THE MATTER OF AN EXPEDITED ARBITRATION BETWEEN:

REGINA QU'APPELLE HEALTH REGION

Employer

- and –

CANADIAN UNION OF PUBLIC EMPLOYEES, Local 3967

Union

AWARD

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before

Daniel Ish, Q.C. **Arbitrator**

Heard in Regina, Saskatchewan on September 14, 15, 16, 23, 2010.

For the Employer: **Michele Vogt**

For the Union: **Suzanne Posyniak**

Decision issued: **September 28, 2010**

INTRODUCTION

[1] The dispute in this case arises as a result of two initiatives implemented by the RQHR as a means of increasing the number of procedures it does in the health region. One initiative involves surgical procedures, specifically arthroscopy knee surgeries and dental surgeries, and the other involves CT scans. In both situations the contracting out of services to a third party contractor is involved. In the first instance, a contract has already been entered into to perform between 300 and 500 procedures before March 31, 2011. This contract with the clinic, which operates under the name OMNI, was signed on July 28 or 29, 2010 and expires on March 31, 2011.

[2] The initiative with respect to CT scans has involved the issuance of a request for proposals (RFP) to which RQHR has received three viable responses.

[3] It is a well established principle of arbitral jurisprudence that, in the absence of specific language in a collective bargaining agreement, management has the right to contract out work provided the contracting out is genuine and is done in good faith. The Collective Agreement which governs the relations between RQHR and Local 3967 contains a provision that limits the Employer's right to contract-out work or services. The provision, which is Article 6.02, dates back to 1998-2001, although some changes in wording have been made since that time. In its entirety it states:

> **ARTICLE 6 – WORK OF THE BARGAINING UNIT**
>
> 6.02 **Restrictions on Subcontracting and Contracting Out**
>
> In order to provide job security for the members of the bargaining unit, the Employer(s) agrees that all work or services performed by the Employees shall not be subcontracted, transferred, leased, assigned or conveyed, in whole or in part, to any other plant, person, company or non-bargaining unit Employee, unless it can be established by the Employer(s) that contracting out of such services will significantly increase the cost effectiveness and maintain the quality of health services provided.
>
> Before any work is contracted out, Management will discuss its intentions with the Local of the Union. In such discussions, the Employer(s) will fully disclose its reasons for the tentative decision to contract or subcontract such work and give the Local of the Union an opportunity to suggest ways which the work might otherwise be performed. In the event the Employer(s)' action is disputed,

> prior to any contracting out, the dispute will be forwarded directly to the Expedited Arbitration for settlement.
>
> In the case of existing contracts, provided the Local of the Union can establish the bargaining unit can maintain the cost effectiveness and quality of health services provided, the Employer(s) agrees not to renew the contract or shall terminate within the condition of such contract.
>
> It is agreed that transfer of services within the bargaining unit between the Health Care Employer(s) does not constitute contracting out.

[4] Article 6.02 is a significant barrier to the Employer's ability to contract out work. In the present case, the Union disputed both of the Employer's initiatives as not complying with the article. As provided in the article, any disputes with respect to it will be dealt with by the expedited arbitration procedure in the agreement. Those provisions, contained in Article 12.04, require the arbitrator to render a decision within two working days of the expedited arbitration hearing and that no written reasons for the decision will be provided beyond that which the arbitrator deems appropriate to convey decision. As a result, notwithstanding the four day hearing in this matter and the reliance on no fewer than 96 documents, the present decision will be more constrained in length and reasoning (and perhaps not as well written) than it might be if the quite restricted time limits were not in effect. The expedited arbitration procedure also requires that no legal counsel will be used at the hearing.

[5] The issues presented in the present case are ones that have been at the forefront of the public policy debate surrounding the provision of healthcare in Canada for many years. However, I remind myself and others that my task as arbitrator in this matter is to interpret one clause of one collective bargaining agreement based on very particular facts.

BACKGROUND

[6] In 2009 the Ministry of Health (Saskatchewan) encouraged the formation of a group (known as the Guiding Coalition) for the purpose of considering ways and means of improving access to surgical procedures (including CT scans) within the Saskatchewan healthcare system. The Guiding Coalition was a large group of people, growing ultimately to approximately 65 participants, composed of a broad range of people, including healthcare professionals, representative groups, individual patients and unions.

The primary strategy that flowed from the Guiding Coalition was one aimed at clearing the backlog for surgical procedures and reducing the waiting time for all patients.

[7] In March 2010 a document was produced, called "Sooner, Safer, Smarter: A Plan to Transform the Surgical Patient Experience". It appears that it was also referred to as the "Saskatchewan Surgical Initiative". This document pointed out that at the end of 2009 approximately 28,700 people were waiting for surgery in the province, that 4,300 of those had been waiting for longer than twelve months, and nearly 1,700 had been waiting for longer than eighteen months. The goal, referred to as a "pledge" in the document, was that by 2014 no Saskatchewan resident will wait more than three months for surgery. The document points out that the healthcare system will need to increase its present surgical volume by over 8% in order to eliminate the surgical backlog and achieve the three month wait time target. The funding to support this enhancement of services was promised.

[8] In the shorter term, the "Sooner, Safer, Smarter" document identified that an additional 3,000 surgeries should be performed in Saskatchewan in the 2010-11 fiscal year "while changes are implemented to help the system perform more effectively and efficiently". It also identified a need to perform 2,500 more CT scans in 2010-11. To achieve these targets and increase the capacity to do so, a number of efforts were identified, including renovations to enhance operating rooms and post-operative bed capacity, implementation of electronic surgical information systems in two regions (Saskatoon and Regina) and numerous other system improvements. Also identified was the possibility of third party facilities operating within the single-payer Medicare system. Reference is made in the document to the requirement that third party delivery must be financially responsible and "that the cost and services must be equal to or less than the cost of publically-delivered services". It goes on to state:

> Third-party facilities will also be required to meet all safety and quality standards. These facilities will be authorized to provide limited services under contract with a regional health authority…

[9] The RQHR, and other health regions, saw the enhanced goals as a required mandate. The targets for RQHR were to increase surgeries from 21,000 per year to 22,500 for the 2010-11 period and to increase its CT scan numbers from approximately 80,000 per year to 90,000 per year.

[10] As I will later point out in this decision, the increased targets for both surgical procedures and CT scans are ones that I see as an operational requirement of the Employer. The Union did not challenge the need to meet the enhanced targets; rather, the challenge of the Union is with respect to the means utilized to meet those targets.

THE FACTS SURROUNDING THE PRESENT DISPUTE

[11] RQHR reviewed its operations both with respect to surgeries and CT scans to determine where increased efficiencies could be found. A number of areas were reviewed including such things as pooling of surgeons for the supply of services, increased use of operating theatres and CT scanners, more efficient patient pathways between initial contact and the ultimate procedure/post-procedure activity and increasing staffing capacities. After implementing some changes, ultimately RQHR concluded that its internal capacity to meet its short term targets of increasing procedures and removing the backlog was at its optimum point. Stated another way, it was at maximum capacity and other alternatives would have to be pursued to meet the targets in the short to medium term. The use of third party contractors was then considered and turned to.

[12] It is important, and a fundamental grounding of my ultimate decision in this case, that third party contracts is seen by RQHR as temporary and only necessary for the purposes of removing the backlogs as it increases internal capacity by approximately 8% to avoid future backlogs. This was underscored by several of the Employer witnesses in the hearing.

[13] The Ministry of Health (MOH) in June 2010 issued a policy framework for the retention of third party services. The Policy does not require that third party services be

utilized by the health regions but it sets out a number of principles to be followed. The sixth and last principle outlined on page 4 of that document states:

> Third-party delivery must be financially responsible and the cost of the services must be equal to, or less than, what is offered by the publicly delivered health system.

These words are virtually identical to those in the "Sooner, Safer, Smarter" document that was published in March 2010, which I referred to earlier. To meet the requirement that the cost of services must not exceed what is offered by the publicly delivered health system, it was necessary for RQHR to engage in a complex costing exercise to determine a point of comparison between internal costs and the cost of services obtained externally. Of course, in addition to the requirements set out by the MOH, RQHR had to be mindful of Article 6.02 of the Provincial Collective Agreement with CUPE. Article 6.02 requires that the Employer must demonstrate that the "contracting out of such services will significantly increase the cost effectiveness…of health services provided". This provision uses the phrase "cost-effectiveness" which arguably is different than equal or less cost for services – a point that will be returned to later in this decision.

Surgical Services

[14] RQHR concluded that a third party provider would be necessary to do a number of surgical procedures in order that its short term goal of increasing the procedures by 1,500 for 2010-11 could be met. In addition, it has served notice that a longer term contract will be sought for the medium term to have some surgeries done by a third party contractor in order to eliminate the backlog and allow it to increase its internal capacity. At this stage, this longer term contract is only a matter of notice and because its details are not in place cannot be an issue for this arbitration.

[15] Article 6.02 requires that the Employer fully disclose its reasons for its tentative decision to contract or sub-contract any work and give the Local of the Union an opportunity to suggest ways by which the work might otherwise be performed. Beginning in May 2010, the Union was advised of the impending contract for surgical services – arthroscopy knee surgery and dental surgery. A series of communications and meetings took place between the Union and the Employer. It appears that there were no fewer than

five meetings and several written communications. The focus of the meetings was initially on the rationale for the decision to contract out and then later focused on the costing comparisons. The Union raised a number of points with respect to cost and in effect challenged the Employer in several of these meetings, as it did in this arbitration. The Union did not agree to the contracting out of the surgical services and asked that the matter be referred to arbitration through the expedited procedure as is provided for in Article 6.02. Attempts were made to have the matter go to arbitration in mid-August but it appears the Union was not available. The Employer acted prior to the arbitration by entering into a contract with OMNI for the provision of arthroscopy knee surgeries and dental surgeries. As previously stated, the contract was signed at the end of July and went into effect August 15, 2010. Thus, it appears that the contract was signed prior to any issue arising with respect to a delay in the expedited arbitration procedure.

[16] Aside from the procedural aspects of Article 6.02, it says that contracting out cannot be done "unless it can be established by the Employer(s) that contracting out of such services will significantly increase the cost-effectiveness and maintain the quality of a health services provided". The preponderance of the evidence put forward both by the Employer and the Union, and the challenges by the Union in the arbitration hearing, focused on the cost of the services provided internally in RQHR. Article 6.02 provides that the contracting out can only occur if it will significantly increase the cost-effectiveness of health services provided. The position of the Union was that the contracting out to OMNI, and the future intended contracting out of CT scans, do not "significantly increase the cost-effectiveness of health services provided". Its argument was that the Employer overstated its internal costs because of flaws in its methodology and application of the methodology when it calculated the internal cost of surgical procedures and CT scans.

[17] RQHR established a mechanism to allocate to each procedure the cost of the procedure when done in-house. The costs included direct costs, such as salaries, and indirect costs primarily composed of general overhead costs, including allowances for capital depreciation. Once the cost per procedure was ascertained then could it determine

whether the expense of third party contracting for those procedures met both the requirements of the MOH costing framework and Article 6.02. The initial cost of arthroscopy knee surgery procedures was determined to be $1,679.48 and for dental procedures was $1,041.54. The OMNI contract provides that these procedures will be performed for $1,500.00 and $965.00 per procedure respectively.

[18] As a result of questions posed in cross-examination in the present arbitration, RQHR revised its figures by reducing some of its internal costs but also increasing others. The result was that the differential between performing arthroscopy knee surgery internally as opposed to OMNI doing it increased from $179.48 to $189.61 and for dental surgeries the differential decreased from $76.54 to $73.89.

[19] In the arbitration the Union challenged the Employer's calculations on a number of matters. The main challenge was that the Employer used average or full costing as opposed to marginal costing for the additional procedures. It is estimated that OMNI will do no fewer than 300 surgical procedures in the current fiscal year and possibly as high as 500 procedures. The Union's expert evidence was to the effect that costing these additional 300-500 procedures at full cost quite seriously overstated the internal cost. Rather, they should have been costed on a marginal basis which in effect means that indirect costs are not taken into account because the addition of a relatively small percentage of procedures should not affect those indirect costs. The Employer's evidence was that since it was at maximum capacity and beyond what the Union experts referred to as the "relevant range", it was appropriate to use average or full costing for the internal costs of the procedures.

[20] In addition the Union challenged the Employer with respect to its numbers concerning the direct costs for health records personnel, non-productive time (which was determined to be 20% of salary costs), benefit costs (20%) and some overhead costs.

[21] The Union also specifically referred to the OMNI contract, referring to two provisions that suggest a subsidization of OMNI by RQHR which were items that were not costed, as well as administrative and legal costs associated with the OMNI contract.

[22] The upshot of the Union's evidence, and ultimately its argument, was that the Employer overstated the internal costs by using incorrect methodology and by making errors with respect to the application of the cost formula to certain activities involved in and surrounding surgical procedures.

The RFP and Responses for CT Services

[23] The CT services contract has not yet been signed but a Request for Proposals has been issued. In response to that Request three vendors have submitted proposals which, of course, include pricing information. The process is that RQRH will enter a round of negotiations with one or more of the vendors before settling on a final contract. The precise numbers with respect to pricing, and other elements of the contract, may vary from what is contained in the RFP and what is contained in response to the RFP. However, for the purposes of comparison, which is necessary for the present arbitration, the vendor proposal containing the highest cost was used.

[24] The focus in this arbitration was on the costing by RQRH with respect to the CT scan procedures that are to be covered by the contract – a total of 15 different types of procedures in all. In a manner similar to what occurred with respect to the surgical procedures, RQRH calculated the cost of each item that would be associated with each of the CT scans. Again this included direct costs such as salaries and supplies, and indirect costs being a proportion of general overhead.

[25] The initial determined internal cost for the required extra 10,000 CT scans was in total [redacted]. When compared to the highest cost vendor proposal of [redacted] the differential is [redacted].

[26] A series of meetings occurred with the Union in which the RFP was discussed and the internal costing was discussed. The Union did not accept the internal cost numbers and challenged them in the meetings. Further, the challenge to these numbers continued into the arbitration hearing both by the submission of evidence by the Union, partly through expert testimony, and by challenges in cross-examination of the methodology and the application of the methodology.

[27] One shortcoming in the Employer's calculations, revealed in cross-examination and subsequently adjusted by the Employer, related to a number of items that were calculated on a per procedure basis when in fact they should have been calculated on a per visit basis. The evidence was that approximately 80,000 procedures are done each year for 30,000 patients. This means that each patient receives on average 2.63 CT scans. Some items, such as admitting registration clerk time is not utilized for each procedure; rather, it occurs only once per visit. This resulted in a significant over-costing of some items by a factor of 2.63. This shortcoming in costing was acknowledged by the Employer and later rectified with new figures submitted in evidence.

[28] When the adjustment was made, the result was that some of the cost items were lowered in value but, as was the case with the surgical procedures, an additional item was added into the costing which was an adjusted overhead cost of $26 million to the overhead pool for depreciation. [redacted]

[29] An additional cost item that accounted for an internal cost increase both with respect to the CT scans and the surgical procedures was direct salary costs. The original numbers were based on the salary amounts contained in the collective bargaining agreement for the year 2007. A new agreement has just been ratified with higher salary numbers and these numbers were used to adjust the internal costs which are reflected in the numbers outlined above.

[30] In the readjusted figures an amount was added for legal fees associated both with the CT contract and the surgical contract, but nothing was included for continuing oversight costs by employees of RQRH or negotiating costs, ie. costs associated with employee's time to negotiate the contracts and oversee the contractor's performance. The evidence of the Chief Financial Officer was that oversight and negotiation costs are in effect "no cost items" because the work was done, and was to be done, by management staff who are paid a flat salary regardless of the number of hours they work. In essence, the suggestion was that management employees' time is "elastic" in that if extra hours are required for oversight they will simply be done by the employees without detracting from other work.

[31] Evidence was also submitted by the Employer with respect to capacity limiting factors for CT scans. Four factors were listed, they are equipment, staffing, operational funding and availability of radiologists. Although the three scanners owned and operated by RQHR are not used to full capacity in terms of potential time use of the machines, it was the evidence of the Employer witnesses that staffing and radiologist availability did in fact limit the use of the machines. For instance, during the evening shift each of the two scanners at Regina General Hospital utilize one technician and only emergency procedures are performed whereas during the day each of the machines has two technicians and one RN and respond to scheduled appointments, in-house requirements and emergencies. If the day time configuration could be duplicated on the evening shift, then it seems obvious that there would be increased capacity.

[32] The evidence was that recruitment and retention of Medical Radiation Technicians is not a problem and that training of MRT's for CT scanner work involves six weeks on-the-job training plus an eight week course. The evidence was that recruiting for MRT's and training for CT scanners was not a major issue. When additional MRI capacity was achieved, it was by utilizing MRI machines more effectively on weekends.

Evidence Relating to Both Surgical Procedures and CT Scans

[33] There will be no immediate job losses as a result either of the OMNI contract or the proposed CT contract. Indeed, one of the Employer witnesses went further and stated, "I can promise you there will be no job losses"... and "we are committed to not using fewer employees".

[34] There was also evidence of current wait lists. On the surgery wait list there are now approximately 8,500 people, 1,800 of which were described as "long waiters". Of the "long waiters", some will wait as long as twelve months for day surgery and eighteen months for in-hospital patient surgery. The current wait list estimated for CT scans exceeds 1,100 patients with wait times ranging from 32 days to nearly one year. There are four categories of wait lists for CT scans with the most critical receiving almost immediate treatment and the least critical delayed for nearly one year in some cases.

[35] There was considerable testimony concerning the patient mix both with respect to in-house procedures and those contracted, or to be contracted, to a third party. The Employer witnesses agreed with the Union's suggestion that the least complex cases will go to third party service providers. This led to the suggestion by the Union that because the full range of complexity of cases will stay in-house and because no consideration was factored in for the different complexity in the costing, this would result in an over-costing of in-house procedures as compared to those to be contracted out.

[36] The Employer witnesses made clear, and this is a repetition, that the underlying rationale for contracting out was to remove the backlog over the short to medium term so as to reduce the waiting lists to the time frame set out by the Ministry of Health, which is that no patient should have to wait more than 90 days for a procedure. The contracting out in the short to medium term will free up in-house capacity and allow in-house capacity to increase to a point where backlogs should not accumulate in the future.

ANALYSIS AND DECISION

[37] The broad issue to be determined in this arbitration is whether Article 6.02 of the Collective Bargaining Agreement has been breached. Article 6.02 is a rather formidable provision which contains a number of elements; thus, the more precise issues to be addressed include the following:

(a) Is Article 6.02 only limited to situations where current members' job security is immediately threatened?

(b) Has the Employer established that the contracting out to OMNI and the proposed contracting out of CT scanning services will significantly increase the cost-effectiveness of health services provided?

(c) Has the Employer established that the contracting out of the services will maintain the quality of health services provided?

(d) Has the Employer fully discussed its intentions with the Local of the Union and fully disclosed its reasons for the decision to contract out?

(e) Has the Union Local been given an opportunity to suggest ways which the work might otherwise be performed?

(f) Did the Employer breach the agreement by contracting with OMNI prior to the dispute being forwarded to expedited arbitration?

[38] The Employer argued that the opening sentence of Article 6.02 informs the remainder of the Article. If there are no job losses and it can be said that there will be no effect on job security for the current members of the bargaining unit, Article 6.02 places no limitation on the Employer's ability to contract out the health services in question. The evidence was that there were no job losses as a result of the OMNI contract and there will be none as a result of the CT contract, thus it was submitted that the Employer's ability to contract out is not fettered in any way by Article 6.02.

[39] In support of its argument the Employer relied upon Black's Law definition of job security which states it is "[p]rotection of an employee's job, often through a Union contract". Also, reference was made to the position taken by Mr. John Weldon in a 1999

decision of Arbitrator Pelton involving Article 6.02. Mr. Weldon was the Chief Negotiator for the Union when the article was put into effect. Mr. Pelton in his decision stated the following:

> Mr. Weldon's principle argument, and one that he advanced forcefully, was that first and foremost the purpose of Article 6.02 is to provide job security for members of the bargaining unit rather than to be consumed with cost savings, profit margins or the "bottom line.

[40] The Union responded by arguing that the opening words of Article 6.02 referring to "job security for the members of the bargaining unit" must be interpreted broadly. Rather than focusing on specific job losses that might be currently occurring or immediately about to occur, the focus is overall on Union jobs. In support of its argument two arbitration decisions were relied upon.

[41] In *Conception Bay South (Town)* and *CUPE, Local 3034* (1992) 26 C.L.A.S. 182 Arbitrator Browne had occasion to interpret a clause in a collective agreement which restricted contracting out. The opening words of the clause are identical to the opening words of Article 6.02, they were:

> In order to provide job security for members of the bargaining unit…

Arbitrator Browne rejected the argument put forward by the Employer that because no member of the bargaining unit was out of work at the relevant time that the clause should not be engaged. The Arbitrator said:

> While I accept the evidence that all bargaining unit members were working at the time, that fact does not provide the Employer with a license to contract out work under Article 26.01. If the parties had intended that contracting out was permissible when all members of the bargaining unit were already working that provision would have been expressly stated in Article 26.01. …Article 26.01 expresses the intention of the parties to bar all contracting out for works and services performed by employees. If there were to be exceptions to this total ban these should have been stated in the article. Article 26.01 is written in clear language. The Union concedes nothing in the article. Based on this article I must find that all contracting out for works and services performed by employees is prohibited under this agreement.

[42] The clause under consideration in the *Conception Bay* case prohibited all contracting out which, of course, Article 6.02 does not. However, Arbitrator Browne's reasoning with respect to the opening words have full application to Article 6.02. Even though "job security" is referred to, it would be an unusually narrow construction of the

words to conclude that the clause was intended only to apply where there were actual and immediate job losses of the members of the bargaining unit.

[43] In another case Arbitrator Keller arrived at a similar conclusion. In *York Federation of Students* and *CUPE Local 1281* (2004), 132 L.A.C. (4th) 444 again the identical opening words were used in a clause designed to limit the Employer's right to contract out. Arbitrator Keller said:

> In dealing with the Collective Agreement it was suggested that a purposive approach to the interpretation of the language has to be taken. That is, it is clearly the intent of contracting out language to ensure either that jobs are protected and/or that the integrity of the bargaining unit be maintained. In this case, no jobs have been lost and the integrity of the bargaining unit has not been affected. As a result, there was no prejudice to the Union or its members.

The Arbitrator found that the opening words were not to be interpreted so narrowly but that if bargaining unit work was contracted out, the remaining provisions of the article in question came into play. Similarly, it is my finding that the opening words of Article 6.02 are intended to not be limited to situations where actual job losses have occurred.

[44] The second issue that I will deal with rather quickly is that of quality. Article 6.02 requires that in any contracting out the Employer must establish that the quality of the health services provided will be maintained. I find that the Employer has established that there will be no threat to quality. Indeed, the Union did not raise this as a substantial issue.

[45] Two other sub-issues arising out of Article 6.02 relate to discussions and disclosure to the Union and the providing of opportunity to suggest ways that the work might otherwise be performed. Based on the testimony heard, it is my conclusion that the Union was given the full opportunity for discussions and was given disclosure as fully as the Employer was able to do at the time leading up to the OMNI contract. Also, I come to the conclusion that sufficient discussions and disclosure were made with respect to the proposed CT contract. I will reserve for later in this decision a discussion of whether Article 6.02 was breached when the OMNI contract was entered into prior to arbitration.

[46] Another issue is whether the Union was given opportunity to suggest alternative ways of having the work done. It seems that sufficient opportunity was given by the Employer to the Union. I do not accept, however, the Employer's argument that the sentence in Article 6.02 referring to an "opportunity" imposes an obligation on the Union to suggest other ways of having the work done as a precondition to the exercise of its other rights under the clause. It seems quite clear that it is a permissive provision allowing the Union to put forward suggestions but certainly not one requiring the Union to do so.

[47] The last two issues to be addressed are the most important ones. The first of the two, relating to cost-effectiveness, occupied the vast preponderance of time at the arbitration hearing. There are three determinations that I will make that lead to the final conclusions in this decision.

[48] The first I have already alluded to. It is that RQHR was mandated by the Province to increase its output of surgical procedures and CT scans. The effect of the increases is intended to eliminate the backlog and to position RQHR to conduct these procedures in the future in a timely manner without the accrual of backlogs.

[49] The second finding is one of interpretation of Article 6.02. It is that reference to "cost-effectiveness" in Article 6.02 is a concept broader than simply cost savings or lesser costs. It is not an absolute term and must be read within a contextual framework including the circumstances in which contracting out arises. One of those circumstances is outlined in the previous paragraph. Thus, what might be cost-effective in one context and against a backdrop of one set of circumstances might not be cost-effective in another.

[50] The third finding I make, which is the foundation for the ultimate determination, is that both surgical procedures and CT scans at RQHR are presently at full capacity. I accept that in the *short term* RQHR has found its maximum efficiencies so that without assistance from a third party contractor it cannot meet its 2010-11 targets. In making this finding I emphasize that it is one of short term to medium term capacity. In the longer

term there is sufficient evidence to indicate that greater capacity can be obtained in-house at RQHR. Even if additional capital expenditures have to be made, in the long term there is little doubt that the internal costs of carrying out both surgical and CT procedures would be less than the costs associated with the provision of those services by a third party if the costs are similar to those contained in the OMNI contract and the proposed CT contracts as reflected in the vendor responses.

[51] The reason for the conclusion in the last paragraph relates to marginal costs. My finding that RQHR is at current capacity is very important because it justifies the Employer using full or average costs to determine the cost of surgical and CT procedures. If there was present capacity, or as the expert witnesses referred to as being within the "relevant range", clearly the cost of doing 300-500 additional surgical procedures would not be equivalent to the average cost of the current in-house procedures. The economic literature, including the study by Mogyorosy and Smith, support this conclusion. If not for the finding that present capacity is at its maximum, it would be difficult to conclude that the OMNI contract and the proposed CT contract "will significantly increase the cost-effectiveness…of health services provided". Again, the primary reason is that if marginal costing was used the figures produced by RQHR would be significantly lower.

[52] It is necessary to take a broad view of cost-effectiveness to find that the Employer's met the burden imposed upon it by Article 6.02. The costing that was done by RQHR was a first-time exercise. While on its surface it initially appeared accurate, the Union's challenge in cross-examination, the adjustments made by the Employer during the course of the arbitration and uncertainty with respect to many of the items in the costing calculation lead me not to feel fully confident in its ultimate conclusions. Indeed, it may be that a more rigorous costing exercise may disclose that the MOH principle, imposed in its third party framework, that third party contracts must be less costly than in-house procedures might not be met. It is interesting that in July 2010 the MOH made funding commitments for third party surgical procedures based on $1,400 per patient, although subject to review "following negotiations with OMNI".

[53] The Union did an effective job of calling into question a number of uncertainties in the costing including, but not limited to, the number of minutes attributed to direct staff costs for each procedure, the data leading to the conclusion of non-productive time costing the equivalent of 20% of salary costs, the data with respect to benefits costing 20% of salary costs, the subsidizing effect of clauses in the third party contracts relating to information technology and EMS transport, and the lack of costing for oversight of the contracts. A more accurate costing must occur before a precise comparison can be made between the cost of in-house procedures and third party costs in the longer term.

[54] Notwithstanding my observations in the last paragraph, because of the immediate need to meet increased targets, it is my finding that the short term contract with OMNI based on the costs in the contract meets the obligations of the Employer under Article 6.02. It has established that the contracting out of the services will significantly increase the cost-effectiveness of those health services. I also come to a similar conclusion with respect to the contracting out of CT scanning if the proposed contract is a relatively short term contract. The conclusion with respect to both of these contracts is premised on the short term to medium term needs of RQHR which is to allow sufficient time to eliminate backlogs and increase capacity. The question then becomes, without more accurate costing, what is considered to be short or medium term. More accurate costing may render a different conclusion regardless of the length of time of the third party contract but at present it does not lead to that conclusion.

[55] The OMNI contract which runs to March 31, 2011 with no fixed requirement of minimum procedures clearly meets the standard of enhancing short or medium term capacity in a cost-effective manner. An extension of this contract or a contract for CT services to the end of 2013, the MOH target date for the elimination of backlogs, is the absolute maximum reasonable period during which RQHR can rely on its present capacity and its current costing mechanisms to justify third party contracting. On the costing information provided, the OMNI contract and the RFP for CT scans, I find that third party contracts on the terms addressed in evidence in this arbitration meet the Employer's obligations in Article 6.02 provided that the contracts do not go beyond the

end of 2013. I underscore once again, and perhaps once too often in this decision, that my reasoning is based on the need to meet short to medium term targets to remove backlogs and to allow internal capacity to increase.

[56] The final issue that must be determined is whether or not the collective agreement was breached when the contract was entered into with OMNI before the dispute went to expedited arbitration. The contract was signed on July 28 or 29, 2010 and the first requests for expedited arbitration were in early August. It was clear to the Employer that the Union did not agree with its costing. It appears that Article 6.02 may have been breached but the evidence of when the contract was formally disputed is not clear. It was argued that dates for the expedited arbitration were put forward in early August but this was after the OMNI contract was signed. My finding that the terms of the OMNI contract do meet the cost-effectiveness requirements of Article 6.02 do not change the fact that the Employer appears to have ignored Article 6.02 and its provisions for expedited arbitration. However, the evidence is not sufficiently clear to make a definitive finding.

[57] For the foregoing reasons, I find that the Employer has not demonstrated that the third party contracts are less costly than doing the work in-house. However, I find that the meaning of "cost-effectiveness" in Article 6.02 can be more broadly interpreted to take into account the particular context within which the third party contracting is occurring – that context includes externally imposed targets for increased procedures and limited ability to increase capacity in the short term to medium term. The result is that I find that the third party contract in place (the OMNI contract) and those contemplated can be utilized to no later than the end of 2013 to eliminate backlogs.

[58] One final note. The issues presented in this expedited arbitration were very complex, as are almost all matters related to healthcare costs. The two representatives, Ms. Posyniak and Ms. Vogt, did an exemplary job. The parties were served well by their diligence and capable representation, without which my difficult task would have been even more difficult. I express my appreciation to both of them.

Dated at Saskatoon, Saskatchewan this 28th day of September, 2010.

Daniel Ish, Q.C.
Arbitrator

- Some "vendor costing" cited in the arbitration decision is confidential and cannot be reported publicly. Those sections are blacked-out.