THIS AGREEMENT made as of the 1st day of April, 2006,

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, as represented by the Minister of Health

(the "**Government**")

AND:

BRITISH COLUMBIA MEDICAL ASSOCIATION

(the "**BCMA**")

AND:

MEDICAL SERVICES COMMISSION

(the "**Commission**")

WITNESSES THAT WHEREAS:

A. The parties, following an interest based, without prejudice approach, leading to a broader range of discussions and proposals than the parties were obligated to negotiate, have reached agreement with respect to:

(a) the following Working Agreement issues:

(i) adjustments to Fees, Service Contract Rates, Sessional Contract Rates and Salary Agreement Rates:

(A) in full and final resolution of the requirement in the 2004 Working Agreement for the parties to negotiate such changes for the Fiscal Year commencing on April 1, 2006; and

(B) for the Fiscal Years commencing on April 1, 2007, April 1, 2008 and April 1, 2009 with re-opener provisions for the Fiscal Years commencing on April 1, 2010 and April 1, 2011;

(ii) the funding of new fees; and

(iii) the review and funding of rural programs and the MOCAP, and the funding of physician benefits;

(b) other issues regarding system redesign and renewal through:

(i) supporting access and improvement to services provided by Specialist Physicians;

(ii) supporting access and improvement to full service family practice;

(iii) enabling shared care between and appropriate scopes of practice for General Practitioners, Specialist Physicians and other health care professionals;

(iv) enabling the use of alternative payment plans to enhance patient care; and

(v) enabling the use of electronic technology for physician practice to support patient care; and

(c) the principles, processes and key content for a new agreements structure, including the health authorities as a party to the agreements;

B. The parties have agreed to enter into this Agreement to set out their agreements with respect to the foregoing;

NOW THEREFORE in consideration of the premises and the agreements of the parties as set out herein, the parties agree as follows:

PART 1 - GENERAL ISSUES

ARTICLE 1 - INTERPRETATION

1.1 Definitions

In this Agreement including the recitals and Appendix C (but excluding Appendices A and B) the following definitions shall apply:

"**this Agreement**" means this document including Appendices A, B and C, as amended from time to time in accordance with section 1.8.

"**Alternative Payments Program**" means the Government program designed to fund physician services through means other than fee-for-service;

"**Alternative Payments Working Committee**" means the committee referred to in section 9 of the 2004 Working Agreement;

"**Amended Second Master Agreement**" means the agreement attached as Appendix A to this Agreement, including the underlined portions;

"**APC**" has the meaning given in section 9.1;

"**April 2003 Memorandum of Understanding (MHO Placement on Salary and Service Payment Grids)**" means the memorandum of understanding bearing the date April, 2003, between the Government and the BCMA;

"**Canadian Medical Protective Association Rebate Program**" means the program referred to in Article 7.3 of the 2004 Working Agreement;

"**Continuing Medical Education Fund**" means the fund referred to in Article 7.2 of the 2004 Working Agreement;

"**CPRSP**" means the plan which is the subject of the Contributory Professional Retirement Savings Plan Agreement referred to in Article 7.4 of the 2004 Working Agreement;

"**CPRSP Administrative Committee**" means the joint BCMA and Government committee established to administer the CPRSP;

"**December 13, 2002 Letter of Agreement (Dispute Resolution)"** means the letter of agreement dated December 13, 2002 among the Government, the Commission and the BCMA replacing Article 11.3 of the Second Master Agreement;

"**e-Health Steering Committee**" has the meaning given in section 1.1 of Appendix C;

"**e-Health Strategic Framework**" has the meaning given in recital A of Appendix C;

"**EMC**" has the meaning given in section 3.1(h);

"**Fees**" means the fees set out in the payment schedule established by the Commission under section 26 of the *Medicare Protection Act* (British Columbia);

"**Fiscal Year**" means the 12 month period commencing on April 1 of a calendar year and ending on March 31 of the following calendar year;

"**General Practitioner**" means a physician who is not a Specialist Physician;

"**GPSC**" means the General Practice Services Committee referred to in Article 5 of the 2004 Subsidiary Agreement for General Practitioners, as reconstituted in Article 7 herein;

"**Health Authority**" means a board as defined in section 1 of the *Health Authorities Act* (British Columbia), and also the Provincial Health Services Authority;

"**Isolation Allowance Fund"** means the fund referred to in Article 14 of the 2004 Subsidiary Agreement for Physicians in Rural Practice;

"**JSC**" means the Joint Standing Committee on Rural Issues referred to in Article 6 of the 2004 Subsidiary Agreement for Physicians in Rural Practice;

"**Laboratory Services Fees**" means all fee items within Service Codes 93 and 94 and fee item 00012 of the payment schedule established by the Commission under section 26 of the *Medicare Protection Act* (British Columbia);

"**Letter of Agreement (Related Matters)"** means the agreement made as of July 27, 2004 between the Government and the BCMA;

"**MANDI**" has the meaning given in section 6.3(b);

"**Maternity Care Network Initiative Payment**" means the payment that was available between December 3, 2004 and June 30, 2005, through the GPSC, to General Practitioners who formed shared care maternity networks in accordance with eligibility criteria established by the GPSC;

"**Maternity Leave Benefit Program**" means the maternity leave benefit program referred to in Article 6 of the 2004 Working Agreement;

"**May 29, 2002 Memorandum of Agreement**" means the memorandum of agreement bearing the date May 29, 2002 among negotiators for the Government and negotiators for the BCMA;

"**May 30, 2005 Letter of Agreement (Renewal of 2004 Working Agreement)**" means the agreement dated May 30, 2005 between the Government and the BCMA, which describes the process for resolving the dispute between them concerning the renewal of the 2004 Working Agreement;

"**Ministry**" means the British Columbia Ministry of Health;

"**MOCAP**" means the medical on-call/availability program referred to in Article 5 of the 2004 Working Agreement;

"**MSP**" means the division of the Ministry responsible for the administration and operation of the Medical Services Plan continued under the *Medicare Protection Act,* RSBC 1996, c. 286;

"**Northern and Isolation Travel Assistance Outreach Program**" means the two-component program consisting of the Physician Outreach Program and the Northern and Isolation Travel Assistance Program;

"**Northern and Isolation Travel Assistance Program**" means the component of the Northern and Isolation Travel Assistance Outreach Program that provides funding for travel expenses incurred by approved Specialist Physicians for travel to rural and isolated communities for the purpose of such Specialist Physicians providing medical services to residents of such communities;

"**Payment Grids**" means, collectively, the payment grid attached as Appendix A to the 2004 Provincial Salary Agreement and the payment grid attached as Appendix A to the 2004 Provincial Service Agreement, as any such payment grid is amended from time to time pursuant to this Agreement, and Payment Grid means one of the Payment Grids as the context dictates;

"**Parental Leave Program**" has the meaning given in section 5.2(g);

"**PDI/MLB Plan Trustees Committee"** means the joint BCMA and Government committee established to administer the Physician Disability Insurance Program and the Maternity Leave Benefit Program;

"Physician Benefit Plans" means programs established by the Commission pursuant to section 26(6) of the *Medicare Protection Act;*

"**Physician Disability Insurance Program**" means the program referred to in Article 7.1 of the 2004 Working Agreement;

"**Physician Health Program**" means the program established in the late 1970's to support and assist physicians, including physicians in training, and their families;

"**Physician Master Agreement**" has the meaning given in Article 11 herein and includes the Physician Master Subsidiary Agreements;

"**Physician Master Subsidiary Agreements**" has the meaning given in section 11.3(a);

"**Physician Outreach Program**" means the component of the Northern and Isolation Travel Assistance Outreach Program that provides funding for travel honorariums for Specialist Physicians and General Practitioners, and travel expenses for General Practitioners, for approved travel to rural and isolated communities for the purpose of such physicians providing medical services to residents of such communities;

"**Physician Section**" means a group of physicians recognized by the BCMA Board as a section pursuant to article 4 of the Constitution and By-Laws of the BCMA;

"**PITO**" has the meaning given in section 2.1 of Appendix C;

"**Renegotiation Notice**" has the meaning given in section 11.3(c);

"**RRP**" means the Rural Retention Program referred to in Article 7 of the 2004 Subsidiary Agreement for Physicians in Rural Practice;

"**Rural Continuing Medical Education Program**" means the program referred to in Article 9 of the 2004 Subsidiary Agreement for Physicians in Rural Practice;

"**Rural Education Action Plan**" means the plan referred to in Article 10 of the 2004 Subsidiary Agreement for Physicians in Rural Practice;

"**Rural Locum Program**" means the program referred to in Article 8 of the 2004 Subsidiary Agreement for Physicians in Rural Practice;

"**Rural Recruitment Contingency Fund**" means the fund referred to in Article 11.4 of the 2004 Subsidiary Agreement for Physicians in Rural Practice;

"**Salary Agreement**" means a "Salary Agreement" as defined in section 3.10 of the 2004 Provincial Salary Agreement;

"**Salary Agreement Rates**" means the rates set out on the 2004 Provincial Salary Agreement Payment Grid, as such rates may be amended from time to time pursuant to this Agreement, and the corresponding rates in individual Salary Agreements;

"**SCSPC**" has the meaning given in section 8.1;

"**Second Master Agreement**" means the agreement made as of February 28, 2001 among the Government, the BCMA and the Commission;

"**Service Contract**" means a "Service Contract" as defined in section 3.9 of the 2004 Provincial Service Agreement;

"**Service Contract Rates**" means the rates set out on the 2004 Provincial Service Agreement Payment Grid, as such rates may be amended from time to time pursuant to this Agreement, and the corresponding rates in individual Service Contracts;

"**Sessional Contract**" means a "Sessional Contract" as defined in section 3.8 of the 2004 Provincial Sessional Agreement;

"**Sessional Contract Rates**" means the rates set out in sections 4.1 and 8.3 of the 2004 Provincial Sessional Agreement, as such rates may be amended from time to time pursuant to this Agreement, and the corresponding rates in individual Sessional Contracts;

"**Specialist Physician**" means a physician who is a certificant or fellow of the Royal College of Physicians and Surgeons of Canada;

"**Specialist Sections**" means those Physician Sections for areas of Specialist Physician practice;

"**SSC**" has the meaning given in section 6.2;

"**Working Agreement**" means the agreement(s) established from time to time between the parties for the purpose of determining compensation, reserve accounts, on-call issues, Physician Benefit Plans and any other issues which the parties agree to negotiate at the Working Agreement(s) negotiations, and includes subsidiary agreements;

"**1993 Contributory Professional Retirement Savings Plan Agreement**" means the agreement made as of December 21, 1993 between the Government and the BCMA;

"**2000 Framework Memorandum**" means the agreement made as of February 15, 2000 between the Government and the BCMA;

"**2002 Subsidiary Agreement for General Practitioners**" means the agreement titled "Subsidiary Agreement for General Practitioners" made as of November 4, 2002 among the Government, the BCMA and the Commission;

"**2004 Provincial Salary Agreement**" means the agreement titled "Provincial Salary Agreement" made as of July 27, 2005 among the Government, the BCMA and the Commission;

"**2004 Provincial Service Agreement**" means the agreement titled "Provincial Service Agreement" made as of July 27, 2005 among the Government, the BCMA and the Commission;

"**2004 Provincial Sessional Agreement**" means the agreement titled "Provincial Sessional Agreement" made as of July 27, 2005 among the Government, the Commission and the BCMA;

"**2004 Subsidiary Agreement for General Practitioners**" means the agreement titled "Subsidiary Agreement for General Practitioners" made as of July 27, 2005 among the Government, the BCMA and the Commission;

"**2004 Subsidiary Agreement for Physicians in Rural Practice**" means the agreement titled "Subsidiary Agreement for Physicians in Rural Practice" made as of July 27, 2005 among the Government, the BCMA and the Commission;

"**2004 Subsidiary Agreement for Specialists**" means the agreement titled "Subsidiary Agreement for Specialists" made as of July 27, 2005 among the Government, the BCMA and the Commission;

"**2004 Subsidiary Agreements**" means, collectively, the 2004 Provincial Salary Agreement, the 2004 Provincial Service Agreement, the 2004 Provincial Sessional Agreement, the 2004 Subsidiary Agreement for General Practitioners, the 2004 Subsidiary Agreement for Physicians in Rural Practice and the 2004 Subsidiary Agreement for Specialists;

"**2004 Working Agreement**" means the Working Agreement made as of July 27, 2005 among the Government, the BCMA and the Commission;

"**13050 CDM Incentive Payment**" means the payment available, in accordance with guidelines and criteria set out by the GPSC, for the provision of guideline based chronic care for patients with diabetes or congestive heart failure.

1.2 Meaning of "Consensus Decision"

In this Agreement, a committee shall be deemed to have made a "**consensus decision**" if:

(a) a resolution of the committee is passed by at least a majority of the members of the committee after the committee has gone through a reasonable process to reach unanimous approval of the resolution by the members of the committee; and

(b) either:

(i) the Government and the BCMA both express in writing their support of the resolution by notice in writing to the other; or

(ii) the resolution is not objected to in writing by either the Government or the BCMA by notice in writing to the other within 30 days after the date such resolution is passed by the committee.

1.3 Successor to Commission

The words "**the Commission, or its successor,**" in sections 3.1(h)(iv), 6.2(d), 7.1(b), 8.1(d), 9.1(d) and Appendix C, do not include a public administrator appointed pursuant to section 3(13) of the *Medicare Protection Act*, and if such a public administrator is so appointed, the parties agree to amend this Agreement to provide for an alternate process for the

determination of issues that under those sections are to be or may be referred to "**the Commission, or its successor,**" for determination.

1.4 Special Meaning of "Parties" in Certain Cases

For the purposes of sections 6.7(b), 7.2(b), 8.4(b) and 9.4(b), "parties" means the Government, the BCMA and the Health Authorities.

1.5 Miscellaneous Interpretation

In this Agreement:

(a) words in the singular include the plural and vice versa, and words in one gender include all genders;

(b) the headings of Articles, sections and Appendices are for convenience of reference only and do not form part of this Agreement and shall not affect the construction or interpretation of this Agreement;

(c) the words "**Article**" and "**section**" mean and refer to the specified Article or section of this Agreement unless reference is made to another agreement;

(d) the words "**include**", "**includes**" or "**including**" mean "include without limitation", "includes without limitation" and "including without limitation" respectively, and the words following "include", "includes" or "including" shall not be considered to set forth an exhaustive list;

(e) all references to money or currency refer to lawful money of Canada and all amounts to be calculated or paid pursuant to the Agreement are to be calculated and paid in lawful money of Canada;

(f) the words "**this Agreement**", "**herein**", "**hereof**" and "**hereunder**" and other words of similar import refer to this Agreement as a whole and not to any particular Article, section or Appendix of this Agreement; and

(g) unless reference is made to a statute in effect at a particular time, each reference to a statute is deemed to be a reference to that statute and any successor statute, and to any regulations and rules made under that statute and any successor statute, each as amended or re-enacted from time to time.

1.6 Binding Effect

This Agreement shall enure to the benefit of and be binding upon the parties hereto and their respective successors and assigns.

1.7 Governing Law

This Agreement will be governed by, and construed in accordance with, the laws of the Province of British Columbia.

1.8 Amendment and Waiver

This Agreement may be amended at any time but only by written agreement of the parties. Any waiver of any provision of this Agreement shall only be effective if in writing signed by the waiving party, and no waiver shall be implied by indulgence, delay or other act, failure to act, omission or conduct. Any waiver shall only apply to the specific matter waived and only in the specific instance and for the specific purpose for which it is given.

ARTICLE 2 - EFFECT OF AGREEMENT AND RELATED AGREEMENTS

2.1 Ratification

This Agreement is not binding on the Government or the BCMA until it is ratified by both of them, and the terms of this Agreement and all information, documents and other materials exchanged between the parties in the negotiation of this Agreement are without prejudice to any party if this Agreement is not ratified by the Government and the BCMA within the time provided in section 2.2.

2.2 Failure to Ratify

If this Agreement is not ratified by both the Government and the BCMA in accordance with section 2.1 on or before May 31, 2006, this Agreement will be null and void and will not be used by any party in any proceeding or in any other way.

2.3 Further Assurances

The parties agree to execute and deliver all such further documents and do all such further things as may be reasonably required to carry out the purpose and intent of this Agreement.

2.4 Conflicts

If there is any conflict or inconsistency between, on the one hand, any terms of this Agreement, and on the other hand, any terms of the Amended Second Master Agreement, the 2004 Working Agreement, the 2004 Subsidiary Agreements, or any other agreements between the parties, the terms of this Agreement shall govern and take precedence.

2.5 Amended Second Master Agreement

The Amended Second Master Agreement shall be executed and delivered by the parties and take effect and be binding on the parties at the same time as this Agreement is executed and delivered by the parties, at which time the Second Master Agreement shall be amended so as to be in the form of the Amended Second Master Agreement attached hereto as Appendix A, and

the 2000 Framework Memorandum, the December 13, 2002 Letter of Agreement (Dispute Resolution) and the May 30, 2005 Letter of Agreement (Renewal of 2004 Working Agreement) shall all terminate and be of no further force or effect.

PART 2 - WORKING AGREEMENT ISSUES

ARTICLE 3 - ADJUSTMENTS TO FEES, SERVICE CONTRACT RATES, SESSIONAL CONTRACT RATES AND SALARY AGREEMENT RATES

3.1 Compensation Changes in 2006/07

(a) The adjustments described below to be effective April 1, 2006, represent full and final satisfaction of the physician compensation adjustments, including changes to the Payment Grids, contemplated by Articles 4.1 and 4.2 of the 2004 Working Agreement, and those Articles of the 2004 Working Agreement have no further force or effect.

(b) Effective April 1, 2006, Fees (excluding Laboratory Services Fees), Service Contract Rates, Sessional Contract Rates and Salary Agreement Rates paid to physicians, will be increased overall by 3%, subject to and in accordance with section 3.1(c).

(c) Effective April 1, 2006:

(i) Sessional Contract Rates will be increased by 8.34% over the Sessional Contract rates in effect on March 31, 2006;

(ii) Service Contract Rates and Salary Agreement Rates will be increased by 2.84% over the Service Contract Rates and Salary Agreement Rates in effect on March 31, 2006; and

(iii) Fees (excluding Laboratory Services Fees) in effect on March 31, 2006 will be increased by an average of 2.84%, to be allocated pursuant to Articles 16 and 17 of the Amended Second Master Agreement.

(d) A physician who is currently compensated through a Salary Agreement or Service Contract, and who is paid above the maximum amount of the relevant range of the applicable Payment Grid, will only be entitled to the compensation increases in sections 3.1(c), 3.2(a), 3.2(e) and 3.2(f) to the extent that the resulting compensation is within the new relevant range of the Payment Grid applicable to that physician.

(e) Effective April 1, 2006, the Government will increase annual funding by $4 million, such increase to be used to fund adjustments to be made by the APC to the Payment Grids (excluding the classifications on the Payment Grids applicable to the emergency medicine services in hospitals provided by physicians under Service Contracts referred to in section 3.1(g)), to address:

(i) income disparities among physician classifications; and

(ii) market comparisons.

Affected physicians under existing Service Contracts and Salary Agreements will be placed within the relevant amended range of the applicable Payment Grid at the same level as their current placement (eg. low, mid, or high). In no event shall the total cost to the Government under this section 3.1(e) exceed $4 million in any one Fiscal Year.

(f) Following the implementation of section 3.1(e) and/or section 3.2(b), in subsequent negotiation or re-negotiation of a Service Contract or Salary Agreement, a physician's placement within the relevant range of the applicable Payment Grid will be the subject of an agreement between the physician and the employer or contracting agency and will be governed by the terms of the relevant province-wide agreement(s). In no case will a physician's compensation be reduced as a result of the implementation of section 3.1(e) or section 3.2(b).

(g) The Government will increase annual funding by $9 million ($4.5 million commencing on October 1, 2006 and $4.5 million commencing on April 1, 2007), such increase to be used to fund the creation of new emergency medicine rates on the 2004 Provincial Service Agreement Payment Grid for physicians (including General Practitioners, and physicians with a CCFP-EM designation or a FRCP in emergency medicine designation) providing emergency medicine services in hospitals under Service Contracts. In no event shall the total cost to the Government under this section 3.1(g) for all Service Contracts existing as at April 1, 2006 for the provision by physicians of emergency medicine services in hospitals, exceed $4.5 million in the Fiscal Year commencing April 1, 2006 and $9 million in any one Fiscal Year thereafter.

(h) An Emergency Medicine Committee (the "**EMC**") will be created as follows:

(i) the EMC will be composed of nine members with three members appointed by each of the Government, the BCMA and the Health Authorities;

(ii) the EMC will be co-chaired by a member chosen by the Government and a member chosen by the BCMA;

(iii) the purpose of the EMC will be to:

(A) within the additional funding provided pursuant to section 3.1(g), create the new emergency medicine rates referred to in section 3.1(g), such rates to be effective October 1, 2006;

(B) determine criteria for placement of emergency medicine physicians within the new rate range created pursuant to section 3.1(g), that ensure continuity of services for the term of this Agreement; and

(C) develop recommendations on a new emergency medicine workload model;

(iv) if the EMC cannot reach a consensus decision on any matter referred to in sections 3.1(h)(iii)(A) and (B) by September 30, 2006, the Government and/or the BCMA may make recommendations to the Commission regarding such matter and the Commission, or its successor, will determine the matter; and

(v) if the EMC cannot reach a consensus decision on recommendations for a new emergency medicine workload model pursuant to section 3.1(h)(iii)(C) by June 30, 2006, the Government and the BCMA will appoint a conciliator to assist them in settling upon such recommendations. If they are unable to agree upon the conciliator either of them may request the Chief Justice of the Supreme Court of British Columbia to make the appointment and the person so appointed will be the conciliator. If by September 30, 2006, a consensus decision has still not been reached by the EMC on recommendations for a new Emergency Medicine workload model, the conciliator will make recommendations to the Government and the BCMA in that regard.

(i) The Government and the BCMA agree to conduct a review and, by December 31, 2006, make recommendations for any adjustment to non-MSP insured pathology fees and to assess their relative value compared to the rate range(s) for the pathology classification(s) on the 2004 Provincial Service Agreement Payment Grid.

3.2 Compensation Changes in 2007/08, 2008/09, 2009/10, 2010/11 and 2011/12

(a) Effective April 1, 2007, Fees, Service Contract Rates, Sessional Contract Rates and Salary Agreement Rates paid to physicians will be increased by 2%. In the case of Fees, the increase will be an average of 2% and will be allocated pursuant to the Physician Master Agreement or, if no such agreement exists at that time, Articles 16 and 17 of the Amended Second Master Agreement.

(b) Effective April 1, 2007, the Government will increase annual funding by $4 million (in addition to the increase provided under section 3.1(e)), such increase to be used to fund adjustments to be made by the APC to the Payment Grids in the same manner and to the same intent as contemplated by section 3.1(e). In no event shall the total cost to the Government under this section 3.2(b) exceed $4 million in any one Fiscal Year, and in no event shall the total cost to the Government under section 3.1(e) and this section 3.2(b) together exceed $8 million in any one Fiscal Year.

(c) Effective April 1, 2007, the reading fee for a screening mammogram shall be $13.80 per screen. This reading fee for a screening mammogram will be increased by 2% on April 1, 2008 and 3% on April 1, 2009.

(d) Effective April 1, 2007, existing MRI fees will be standardized at one rate of $143.00. This MRI fee will be increased by 2% on April 1, 2008 and 3% on April 1, 2009.

(e) Effective April 1, 2008, Fees, Service Contract Rates, Sessional Contract Rates and Salary Agreement Rates paid to physicians will be increased by 2%. In the case of Fees, the increase will be an average of 2% and will be allocated pursuant to the Physician Master Agreement or, if no such agreement exists at that time, Articles 16 and 17 of the Amended Second Master Agreement.

(f) Effective April 1, 2009, Fees, Service Contract Rates, Sessional Contract Rates and Salary Agreement Rates paid to physicians will be increased by 3%. In the case of Fees, the increase will be an average of 3% and will be allocated pursuant to the Physician Master Agreement or, if no such agreement exists at that time, Articles 16 and 17 of the Amended Second Master Agreement.

(g) Effective April 1, 2010, and covering the period from April 1, 2010 to March 31, 2012, physician compensation (Fees, Service Contract Rates, Sessional Contract Rates and Salary Agreement Rates) may be adjusted by agreement of the Government and the BCMA or, failing agreement by January 31, 2010, either the Government or the BCMA may refer the matter to binding arbitration pursuant to section 3.2(h).

(h) If a reference to arbitration occurs pursuant to section 3.2(g):

(i) the Government and the BCMA will each appoint one member to a three member arbitration panel, the parties will agree on the third member of the panel who will be the chair of the panel, and if the parties are unable to reach agreement on the chair of the panel within 15 days after the referral to arbitration either of them may request the Chief Justice of the Supreme Court of British Columbia to make the appointment and the person so appointed will serve as the chair of the panel;

(ii) the panel will retain an independent expert to assist it in determining costing issues and verifying comparators;

(iii) the panel will conduct the arbitration in accordance with procedures that it will determine and will issue a decision consistent with the provisions of the *Canada Health Act*;

(iv) in reaching its decision, the panel must consider the following factors:

(A) the need to be consistent with the law;

(B) the Government’s fiscal situation, including its ability to pay;

(C) the need to provide reasonable compensation to physicians for the services rendered; and

(D) the operational and medical resource needs of the Health Authorities; and

(v) except as provided in section 5.1(e), the decision of the panel will be final and binding upon the parties unless the Government rejects it through an Act of the Legislature.

ARTICLE 4 - FUNDING NEW FEES

4.1 Allocation for New Fees

In each of the Fiscal Years from April 1, 2008 to March 31, 2012, the Government will make an additional annual allocation of $1 million for new fees (that is, fees to be added to the payment schedule established by the Commission under section 26 of the *Medicare Protection Act* (British Columbia). These funds will be allocated to new fees pursuant to Articles 16 and 17 of the Amended Second Master Agreement or the corresponding provisions of the Physician Master Agreement, whichever is in force at that time. Any monies that are unused in one year will be carried forward to the next. The funding obligation under this section ends on March 31, 2012.

ARTICLE 5 - RURAL PROGRAMS, PHYSICIAN BENEFITS AND THE MEDICAL ON-CALL/AVAILABILITY PROGRAM

5.1 Supporting and Enhancing Care for Rural British Columbians

(a) Between April 1, 2006 and March 31, 2012, the Government will fund the RRP at a level sufficient to maintain the 2005/06 fee for service (the "**FFS**") percentage and flat payment premium values by community, except for changes resulting from the application of the RRP rules, guidelines and policies by the JSC, including the annual application of the rural isolation points to determine eligibility for FFS percentage and flat payment premiums as described in the 2004 Subsidiary Agreement for Physicians in Rural Practice. For such purposes, surplus funds from the Rural Education Action Plan, the Rural Locum Program, the Physician Outreach Program, the Isolation Allowance Fund and the Rural Recruitment Contingency Fund in any Fiscal Year between April 1, 2006 and March 31, 2012 will be directed toward RRP expenditures in that year prior to the Government providing any additional funds over the amounts expended on the RRP in the Fiscal Year commencing April 1, 2005. The funding obligation under this section ends on March 31, 2012.

(b) The professional component of radiologists' and pathologists' in-patient and emergency services will be included under the RRP effective April 1, 2006.

(c) The Government will increase the combined existing funding levels for the Rural Education Action Plan, the Rural Locum Program, the Physician Outreach Program and the Rural Continuing Medical Education Program by providing to the JSC a total of $3.2 million between April 1, 2007 and March 31, 2010. The JSC will apply these funds among the rural programs referred to in this section

5.1(c) toward maintaining the value of the benefits paid to individual physicians under these rural programs at the levels in existence at the end of the Fiscal Year commencing on April 1, 2006, subject to the rules, guidelines and/or policies applicable to each of these rural programs.

(d) The Government will provide additional funding as necessary in each of the two Fiscal Years commencing on April 1, 2010 and April 1, 2011 to maintain, but not increase, the value of the benefits paid to individual physicians under the Rural Education Action Plan, the Rural Locum Program, the Physician Outreach Program and the Rural Continuing Medical Education Program at the levels in existence at the end of the Fiscal Year commencing on April 1, 2009, subject to the rules, guidelines and/or policies applicable to each of these rural programs. The funding obligation under this section ends on March 31, 2012.

(e) The JSC will conduct a review of the rural programs referred to in the 2004 Subsidiary Agreement for Physicians in Rural Practice to assess their effectiveness in achieving appropriate levels of physician services in communities in which such programs are applicable and, by October 1, 2009, the JSC will provide recommendations from this review to the Government and the BCMA. The Government and the BCMA will enter into negotiations with respect to any issues raised by these recommendations. If the Government and the BCMA are unable to reach agreement with respect to any such issues, either of them may refer the issues to an arbitration panel constituted under section 3.2(h), except that the panel's authority in this regard will be limited to making non-binding recommendations.

5.2 Physician Benefits

(a) In each Fiscal Year from April 1, 2006 to March 31, 2012, the Government will provide to the Physician Health Program the sum of $600,000, provided that in each such Fiscal Year the BCMA and the College of Physicians and Surgeons of British Columbia, together, contribute an equal amount.

(b) The Government will increase the combined existing funding levels (as set out in Articles 7.1 through 7.4 of the 2004 Working Agreement) for the Physician Disability Insurance Program, the Continuing Medical Education Fund, the Canadian Medical Protective Association Rebate Program and the CPRSP by a total of $1.3 million in the Fiscal Year commencing on April 1, 2006, an additional total of $1.44 million in the Fiscal Year commencing on April 1, 2007, an additional total of $1.5 million in the Fiscal Year commencing on April 1, 2008 and an additional total of $1.75 million in the Fiscal Year commencing on April 1, 2009. These funds will be applied toward maintaining the value of the benefits paid to individual physicians under these benefit programs at the levels in existence at the end of the Fiscal Year commencing on April 1, 2005, subject to the rules, guidelines and/or policies applicable to each of these benefit programs.

(c) If in any year there are surplus funds in any of the benefit programs referred to in section 5.2(b), such surplus funds will be added to the available funding for the Maternity Leave Program.

(d) The Government will provide additional funding as necessary in each of the two Fiscal Years commencing on April 1, 2010 and April 1, 2011 to maintain, but not increase, the value of the benefits paid to individual physicians under the Physician Disability Insurance Program, the Continuing Medical Education Fund and the Canadian Medical Protective Association Rebate Program at the levels in existence at the end of the Fiscal Year commencing on April 1, 2009, subject to the rules, guidelines and/or policies applicable to each of these benefit programs. The funding obligation under this section ends on March 31, 2012.

(e) Effective April 1, 2010, the Government will increase the annual CPRSP funding by $10 million, and the funding level established by such increase shall continue for each of the fiscal years commencing April 1, 2010 and April 1, 2011. Such increase shall be allocated by the CPRSP Administrative Committee, or its successor committee, to enhance the value of the CPRSP in ways that will encourage physicians to remain in practice longer than would otherwise be the case.

(f) The Maternity Leave Program will continue to be funded by the Government at the 2005/06 level of $1.3 million annually until March 31, 2010.

(g) Effective April 1, 2010, the Maternity Leave Program will be discontinued and will be replaced by a Parental Leave Program that will provide up to $1000 per week (dependent upon specific terms of eligibility to be determined by the PDI/MLB Plan Trustees Committee, or its successor committee), for up to seventeen consecutive weeks leave, to eligible male and female physicians who have become parents of a newborn or newly adopted child or of a newborn through a surrogate mother. In each Fiscal Year from April 1, 2010 to March 31, 2012, the Government will fund the Parental Leave Program at the level of $4.3 million per year (which will include the transfer of the $1.3 million annual budget from the discontinued Maternity Leave Program).

5.3 The Medical On-call/Availability Program

(a) A tripartite review team, composed of nine members with three members appointed by each of the Government, the BCMA and the Health Authorities, will conduct a review of the MOCAP as described in section 5.3(b);

(b) The tripartite review team will:

(i) evaluate the impact of MOCAP on patient care, physician work life and other health professionals;

(ii) where problems are identified, recommend solutions, mechanisms and/or alternatives (including redistribution or reallocation of MOCAP funding)

to effect greater patient access to time emergent care, to address inequities in MOCAP implementation, and to increase value to patients and the public, within the MOCAP budget allocation;

(iii) establish indicators to monitor and track MOCAP performance and set out evaluation criteria;

(iv) deliver a report to the Government, the BCMA and the Health Authorities by December 31, 2006, as the basis for changes or modifications, new mechanisms and/or allocations within the existing MOCAP budget; and

(v) conduct an evaluation of the changes implemented pursuant to section 5.3(b)(iv) and recommend appropriate further revisions to the MOCAP to the Government, the BCMA and the Health Authorities by April 1, 2009.

(c) Any changes to the MOCAP provisions of the 2004 Working Agreement resulting from any recommendations made pursuant to section 5.3(b)(iv) or section 5.3(b)(v) will require the agreement of the Government and the BCMA.

(d) For each of the Fiscal Years from April 1, 2006 to March 31, 2012, the budget for the MOCAP will be maintained at the current level of $126.4 million annually.

PART 3 - OTHER ISSUES REGARDING SYSTEM REDESIGN AND RENEWAL

ARTICLE 6 - SUPPORTING ACCESS AND IMPROVEMENT TO SPECIALIST SERVICES

6.1 Collaboration with Specialist Physicians

The Government and the BCMA agree to collaborate with Specialist Physicians to improve access to needed, evidence-based, quality services to meet patients' medical needs for optimum health outcomes. This approach will be built on understanding population health needs, linked to optimizing the mix of service delivery options, technology options and health human resource options.

6.2 Specialist Services Committee

(a) A Specialist Services Committee (the "**SSC**") will be created to facilitate collaboration between the Government, the BCMA and the Health Authorities on the delivery of services of Specialist Physicians to British Columbians and to support the improvement of the specialist care system.

(b) Each of the Government, the BCMA, and the Health Authorities as a group, shall be entitled to appoint an equal number (not to exceed four each) of members to the SSC.

(c) The SSC will be co-chaired by a member chosen by the Government members and a member chosen by the BCMA members.

(d) If the SSC cannot reach a consensus decision on any matter that it is required to determine, the Government and/or the BCMA may make recommendations to the Commission regarding such matter and the Commission, or its successor, will determine the matter.

6.3 Disparity Funding

(a) The Government will increase annual funding by $13 million in the Fiscal Year commencing on April 1, 2006 and an additional $7 million in the Fiscal Year commencing on April 1, 2007, such increases to be used to address income disparities among Specialist Sections. This $20 million aggregate increase in annual funding will be combined with the $10 million annual funding previously made available pursuant to article 5.1 of the 2004 Subsidiary Agreement for Specialists, to create a total allocation effective April 1, 2007 of $30 million to address disparities between Specialist Sections.

(b) The specific allocation of the funding referred to in section 6.3(a) will be determined by the SSC and will be based upon the Modified Adjusted Net Daily Income (the "**MANDI**") model (attached as Appendix B) or a revised version of the MANDI as agreed to by the SSC.

(c) The general compensation increases to Fees that are identified in sections 3.1(b) and 3.2(a) will each be applied to Fees for the Specialist Sections prior to the application of the disparity correction funding pursuant to section 6.3(a). In other words, such disparity correction funding will not attract the general Fees increase in the year in which such disparity correction is introduced. The base years for application of the disparity correction funding will be the Fiscal Year commencing on April 1, 2005 for corrections introduced on April 1, 2006 and the Fiscal Year commencing on April 1, 2006 for corrections introduced on April 1, 2007.

(d) Compensation adjustments resulting from section 6.3(a) will be effective on April 1, 2006 and April 1, 2007, as appropriate.

6.4 Funding for Medical Consultant Services

The Government will increase annual funding by $1 million in the Fiscal Year commencing on April 1, 2007, an additional $1 million in the Fiscal Year commencing on April 1, 2008 and a further additional $2 million in the Fiscal Year commencing on April 1, 2009, to be allocated by the SSC to Health Authorities to contract (using alternative payment mechanisms) specific services from medical consultants to support primary care for specific patient populations (including populations at risk) and those with complex problems such as chronic conditions, mental illnesses, addictions and disabilities.

6.5 One Time Specialist Physician Funding

The Government will provide, from funds available in 2005/06, new one time funding of $10 million to be allocated by the BCMA and paid through the MSP to Specialist Physicians who are registered as such on March 31, 2006 for specialist services rendered by them on or before March 31, 2006. The BCMA will use its best efforts to provide the Government with the allocation as soon as possible and in any event shall provide the Government with the allocation by not later than December 15, 2006.

6.6 Additional SSC Functions

(a) The SSC will identify possible time limited projects that have measurable patient-centred goals focused on the following areas:

(i) system redesign initiatives to achieve increased and faster access to medically needed surgical specialist assessment for hip, knee and other joint replacement; and

(ii) working with the GPSC and based upon patient needs, determining up to four other non-surgical priority areas to expedite access to assessment and treatment for specialty care.

(b) The SSC will create a surgical specialist sub-committee to work with Health Authorities and the Ministry to analyze and make recommendations to reduce the number of urgent and elective surgeries occurring outside of normal working hours, in particular between 10PM and 6AM.

(c) The SSC will consult with representatives of allied health professionals as necessary in the completion of its mandate.

(d) On an annual basis, the SSC will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the work plan, and report annually on progress and outcomes to the Government, the BCMA and the Health Authorities.

6.7 Costs of SSC

The costs of:

(a) administrative and clerical support required for the work of the SSC; and

(b) physician (other than employees of the parties) participation in the SSC;

will be paid from the funds provided by section 6.3(a) of this Agreement, such costs not to exceed $400,000.

6.8 Surgical Registry Project

The Government will provide new one time funding of $1 million to support participation by Specialist Physicians in the surgical registry project.

6.9 Funding for Alternative Payment Arrangements

The Government will increase the annual funding level of the Alternative Payments Program by $6 million in the Fiscal Year commencing on April 1, 2006, an additional $4 million in the Fiscal Year commencing on April 1, 2007, an additional $3 million in the Fiscal Year commencing on April 1, 2008 and an additional $3 million in the Fiscal Year commencing on April 1, 2009, to increase the number of Specialist Physicians practising under alternative payment arrangements (by such Specialist Physicians transferring from fee for service payment arrangements in British Columbia) to better meet patient needs and align with Health Authority strategic priorities.

ARTICLE 7 - SUPPORTING ACCESS AND IMPROVEMENT TO FULL SERVICE FAMILY PRACTICE

7.1 General Practice Services Committee

(a) Effective April 1, 2007, the membership of the GPSC will be reconstituted such that there is equal representation from the Government, the BCMA and the Health Authorities. The total number of members of the reconstituted GPSC will be nine.

(b) All decisions of the GPSC will be consensus decisions. If the GPSC cannot reach a consensus decision on any matter that it is required to determine, the Government and/or the BCMA may make recommendations to the Commission regarding such matter and the Commission, or its successor, will determine the matter.

7.2 Costs of GPSC

The costs of:

(a) administrative and clerical support required for the work of the GPSC; and

(b) physician (other than employees of the parties) participation in the GPSC,

will be paid from the funds to be allocated by the GPSC pursuant to this Agreement.

7.3 Full Service Family Practice Funding

(a) The vehicle of the re-constituted GPSC will be used to further collaborate with General Practitioners to encourage and enhance full service family practice and benefit patients through increases to the existing $10 million annual funding level for full service family practitioners, as follows:

(i) effective April 1, 2006, $60 million (inclusive of $5 million for a Maternity Care Network Initiative Payment);

(ii) effective April 1, 2007, an additional $20 million;

(iii) effective April 1, 2008, an additional $25.5 million; and

(iv) effective April 1, 2009, an additional $31 million;

such increases to be allocated by the GPSC to the areas identified in sections 7.4(a) and 7.5, or to any other areas that may be determined by the GPSC.

(b) The parties agree that no further funds will be available or provided pursuant to Article 6.6 of the 2004 Subsidiary Agreement for General Practitioners.

7.4 Allocation of Full Service Family Practice Funding to March 31, 2007

(a) The priorities for the allocation of the funds referred to in section 7.3(a)(i) up to March 31, 2007 will be as follows:

(i) General Practitioners who:

(A) as of April 1, 2006, have provided care and billed the 13050 CDM Incentive Payment for at least ten patients with diabetes or congestive heart failure; or

(B) in the 12 months preceding April 1, 2006 have performed at least five deliveries;

will receive a one time payment of $2500. This payment will be funded first from the unexpended portion of the full service family practice fund referred to in Article 6.1 of the 2002 Subsidiary Agreement for General Practitioners (approximately $4.7 million) and the balance from the funds referred to in section 7.3(a)(i);

(ii) General Practitioners who:

(A) as of June 30, 2006, have provided care and billed the 13050 CDM Incentive Payment or the new incentive payment referred to in section 7.4(a)(iii) for at least ten patients with diabetes, congestive heart failure or hypertension; or

(B) in the 12 months preceding June 30, 2006 have performed at least five deliveries;

will receive a one time payment of $7500 (approximately $25 million expenditure);

(iii) effective April 1, 2006, the 13050 CDM Incentive Payment will be increased to an annual amount of $125 per patient. In addition, a new incentive payment will be implemented effective April 1, 2006, in the annual amount of $50 per patient, for the guideline based chronic care of hypertension where this is not covered in treating diabetes or congestive heart failure, which will be paid in accordance with guidelines and criteria set out by the GPSC;

(iv) effective April 1, 2006, a patient case management conference fee and a complex patient clinical action plan fee will be implemented, in accordance with guidelines and criteria set out by the GPSC, for General Practitioners providing longitudinal care to their patients. These fees will not be available to physicians who are compensated through a Service Contract, Sessional Contract or Salary Agreement;

(v) $5 million will be available in each year to reinstate and support the Maternity Care Network Initiative Payment; and

(vi) any of the funds referred to in section 7.3(a)(i) that remain unexpended for services rendered on or before March 31, 2007 will be paid as a one time payment to those General Practitioners who:

(A) have provided care and billed the 13050 CDM Initiative Payment or the new incentive payment referred to in section 7.4(a)(iii) for at least ten patients with diabetes, congestive heart failure or hypertension; or

(B) in the 12 months preceding April 1, 2007 have performed at least five deliveries.

(b) Physicians who are compensated through a Service Contract, Sessional Contract or Salary Agreement, and who have provided the services identified in sections 7.4(a)(i), 7.4(a)(ii) and/or 7.4(a)(vi), will be eligible to receive the one time payments identified in those sections in addition to their service, sessional or salary payments.

7.5 Allocation of Full Service Family Practice Funding Commencing April 1, 2007

Commencing April 1, 2007, the GPSC will use the funds then available to it pursuant to section 7.3(a) as follows:

(a) the payments referred to in sections 7.4(a)(iii), 7.4(a)(iv)and 7.4(a)(v) will continue;

(b) five percent (5%) of the funds will be allocated by the GPSC to improved disease prevention;

(c) a complex care fee (which will be billable no more than six times per year, per patient) will be developed and implemented by the GPSC on April 1, 2007 which, provided its billing includes the diagnostic codes for each chronic disease with which the patient presents, will be payable in addition to an office visit (fee items 12100, 00100, 16100, 17100 and 18100 in the MSP payment schedule) for patients with two or more chronic diseases, including:

(i) asthma or chronic obstructive pulmonary disease;

(ii) diabetes;

(iii) hepatitis;

(iv) hypertension;

(v) chronic kidney disease; and

(vi) congestive heart failure;

(d) $5.5 million will be made available to provide funding to Health Authorities for contracts with General Practitioners for targeted populations and to support General Practitioners who, whether directly or through Health Authorities, wish to contract with other healthcare providers for multidisciplinary care; and

(e) the GPSC will set patient centred measurable goals and will place priority on the following areas:

(i) improved chronic disease identification and management for:

(A) depression/anxiety;

(B) arthritis;

(C) asthma and chronic obstructive pulmonary disease;

(D) gastro esophageal reflux disease; and

(E) two or more chronic conditions;

(ii) improved care for the frail elderly, including those in Long Term Care and Assisted Living facilities;

(iii) increased support to patients requiring end of life care; and

(iv) increased multi disciplinary care between General Practitioners and other healthcare providers.

7.6 Carry Forward of Funding

Any funds identified in sections 7.3(a)(ii), 7.3(a)(iii) and 7.3(a)(iv) that remain unexpended for services rendered in a Fiscal Year will be available to the GPSC in the subsequent Fiscal Year for use as one time allocations in that subsequent Fiscal Year.

7.7 Support for General Practitioners' Role in Hospital Care

The GPSC will review and recommend approaches that support General Practitioners' continued role in providing hospital care, including the relationship between that role and the role of hospitalists. The GPSC will determine the key elements or models of care with indicators that demonstrate and support optimum patient outcomes. The recommendations will propose how best to utilize existing allocations for primary care support of hospitalized patients.

7.8 One Time Funding to Attract and Retain Full Service Family Practitioners

In addition to the funds referred to in section 7.3(a), the Government will provide new one time funding of $10 million to be used by the GPSC to attract and retain additional recently qualified physicians in full service family practice in those areas of the province where the GPSC determines that there is a demonstrated need for additional full service family practice practitioners. Physicians will be eligible to receive support from such funds only if they commit to full service family practice to meet patient needs in the area and are recently qualified General Practitioners (i.e. those within five years of licensure to practice). In exceptional circumstances where an insufficient number of recently qualified physicians is willing to commit to providing full service family practice in areas of the province where the GPSC determines that there is a demonstrated need for additional full service family practitioners, the GPSC will have discretion to provide funds to General Practitioners with more than five years of practice since licensure if the GPSC believes doing so will attract and retain full service family practitioners on a long term basis in such areas of the province. The GPSC may use these funds to provide:

(a) repayment of student loan debt of up to $40,000 under a return of service agreement scheme that requires five years of service for the full amount;

(b) support for the costs of establishing a new full service family practice group to a maximum of $40,000 (support for solo practices may be considered for remote rural areas); and/or

(c) alternative payment arrangements for these full service family practice recruitments for a limited time while they build up a patient base to provide patients with access to full service family practice.

A formal application and approval process and guidelines will be established by the GPSC to implement this initiative.

7.9 Non-Compensation Funding

One time non-compensation support for full service family practice will be provided using the $20 million fund for primary care renewal referred to on page 8 in Article 5(b)(ii) of

the Letter of Agreement (Related Matters). This funding will be used to support the achievement of the GPSC priorities referred to in section 7.5(e) and to provide change management support through regional full service family practice patient access and clinical improvement initiatives in the following specific priority areas:

(a) improving clinical practice through e-Health technology;

(b) increasing group and multi-disciplinary practices;

(c) retraining and upgrading physician skills to better meet the needs of priority patient groups; and

(d) establishing cross-disciplinary quality improvement and provincial learning networks.

7.10 GPSC Work Plans

On an annual basis, the GPSC will develop a work plan, ensure that evaluations to measure outcomes are an integral part of the plan, and report annually on progress and outcomes to the Government, the BCMA and the Health Authorities.

ARTICLE 8 - ENABLING SHARED CARE AND APPROPRIATE SCOPES OF PRACTICE

8.1 Shared Care and Scope of Practice Committee

(a) A trilateral Shared Care and Scope of Practice Committee (the "**SCSPC**") will be created to enable shared care between General Practitioners, Specialist Physicians and other healthcare professionals.

(b) The SCSPC will be a sub committee of each of GPSC and the SSC. It will be composed of eight members, two appointed by the Government/Health Authorities from their appointees to the SSC, two appointed by the Government/Health Authorities from their appointees to the GPSC, two appointed by the BCMA from its appointees to the SSC and two appointed by the BCMA from its appointees to the GPSC.

(c) The SCSPC will be co-chaired by one member appointed by the members appointed by the Government/Health Authority and one member appointed by the members appointed by the BCMA.

(d) If the SCSPC cannot reach a consensus decision on any matter that it is required to determine, the Government and/or the BCMA may make recommendations to the Commission regarding such matter and the Commission, or its successor, will determine the matter.

8.2 SCSPC Functions

(a) The SCSPC will develop recommendations to the SSC and the GPSC, including the creation of new fees (that is, fees to be added to the payment schedule established by the Commission under section 26 of the *Medicare Protection Act* (British Columbia), to enable shared care and appropriate scopes of practice between General Practitioners, Specialist Physicians and other healthcare professionals, and, specifically, will develop recommendations regarding:

(i) changes to, or full use of, General Practitioner scopes of practice to free up Specialist Physician time;

(ii) refining and supporting the appropriate allocation of services between General Practitioners and Specialist Physicians to meet patients' medical needs;

(iii) collaboration between General Practitioners, Specialist Physicians and other healthcare professionals to meet the medical needs of patients; and

(iv) facilitating access to advice from Specialist Physicians by General Practitioners.

(b) The SCSPC will commence its work no earlier than April 1, 2007 and will issue its report to the SSC and the GPSC by no later than March 31, 2009.

8.3 Funding for SCSPC

The Government will provide new one time funding of $100,000 to support the work of the SCSPC.

8.4 Costs of SCSPC

The costs of:

(a) administrative and clerical support required for the work of the SCSPC; and

(b) physician (other than employees of the parties) participation in the SPSPC,

will be paid from the funds provided by this Agreement to support the work of the SPSPC.

ARTICLE 9 - ENABLING THE USE OF ALTERNATIVE PAYMENT PLANS TO ENHANCE PATIENT CARE

9.1 Alternative Payments Committee

(a) The Alternative Payments Working Committee will be renamed the Alternative Payments Committee (the "**APC**").

(b) The APC will be advisory to the Government, the BCMA and the Health Authorities except where specific issues are referred to it for a decision by this Agreement, the Physician Master Agreement, the Physician Master Subsidiary Agreements or any subsequent agreement of the parties.

(c) The membership of the APC will be reconstituted such that the BCMA, the Government and the Health Authorities will each appoint three members.

(d) If the APC cannot reach a consensus decision on any matter that it is required to determine, the Government and/or the BCMA may make recommendations to the Commission regarding such matter and the Commission, or its successor, will determine the matter.

9.2 APC Functions

The responsibilities of the APC will include:

(a) collection and analysis of data on patient benefits resulting from the use of APPs;

(b) collection and analysis of data on the productivity of APPs in comparison to other payment models;

(c) recommending a model to determine total compensation relativity between the different payment models;

(d) recommending standards and criteria for assessing any proposed movement from one payment method to another;

(e) in collaboration with the relevant Physician Sections, the development and recommendation of workload models for physicians providing services on APPs (not including Emergency Medicine);

(f) recommending minimum and maximum hours of work for service contracts and salary contracts (not including Emergency Medicine);

(g) within the funding identified in sections 3.1(e) and 3.2(b), determining changes to the Payment Grids to address market comparisons and income disparities; and

(h) recommending the conditions under which the ranges on the Payment Grids may be exceeded.

9.3 Funding for APC

The Government will provide new one time funding of $400,000 to support the work of the APC.

9.4 Costs of APC

The costs of:

(a) administrative and clerical support required for the work of the APC; and

(b) physician (other than employees of the parties) participation in the APC,

will be paid from the funds provided by this Agreement to support the work of the APC.

ARTICLE 10 - ENABLING THE USE OF INFORMATION TECHNOLOGY FOR PHYSICIAN PRACTICE TO SUPPORT PATIENT CARE

10.1 BCMA Participation in e-Health

The BCMA will participate in the leadership structure for e-Health in British Columbia. It will appoint one senior representative to the Ministry's e-Health Steering Committee and will participate on the e-Health Steering Committee's subcommittees.

10.2 Physician Information Technology Office

To further facilitate and support coordination of physician participation in Government/Health Authority information technology planning and implementation as it relates to the Ministry's e-Health Framework, the Government will establish the PITO to facilitate the timely and optimal care of patients by encouraging and supporting the continued implementation of information technology for General Practitioners and Specialist Physicians. Consistent with the Ministry's e-Health Strategy, the PITO will be responsible for the disbursement of information technology funding to physicians as provided in Appendix C.

10.3 PITO Structure and Functions

The structure, purpose and activities of the PITO are detailed in Appendix C to this Agreement. Appendix C forms a part of this Agreement.

10.4 Funding for PITO

(a) The Government will provide new one time funding of $20 million, to support the work of the PITO.

(b) In the Fiscal Year commencing April 1, 2006, the Government will establish an annual funding level of $3 million to support the work of the PITO.

(c) The Government will increase the annual funding level of the PITO as follows:

(i) by $5 million in the Fiscal Year commencing April 1, 2007;

(ii) by an additional $6 million in the Fiscal Year commencing April 1, 2008;

(iii) by an additional $1.5 million in the Fiscal Year commencing April 1, 2009;

(iv) by an additional 6.9 million in the Fiscal Year commencing April 1, 2010; and

(v) by an additional $2.5 million in the Fiscal Year commencing April 1, 2011.

(d) The funding for the PITO will be allocated as follows:

(i) $2 million will be allocated for administrative costs of the PITO under section 2.4 of Appendix C; and

(ii) the balance will be allocated under section 3.5 of Appendix C.

PART 4 - A NEW AGREEMENTS STRUCTURE

ARTICLE 11 - PRINCIPLES, PROCESSES AND KEY CONTENT

11.1 Principles for a Physician Master Agreement

The parties agree to negotiate a new master agreement among the Government, the BCMA and the Health Authorities (the "**Physician Master Agreement**") based on the following principles:

(a) the Physician Master Agreement will define a multi-lateral relationship between the Government, the Health Authorities and the BCMA built upon transparency, constructive collaboration and mutual respect;

(b) the Physician Master Agreement will recognize the shared obligation and responsibility of the parties to meet population and patient medical needs through evidence-based, quality care provided through an integrated, sustainable, accountable, efficient and effective health care system;

(c) the Physician Master Agreement will be patient-focused, strategically enabling the Government's agenda for the healthcare system as set out in the service and operational plans for the Ministry and Health Authorities, physician supportive and provide for appropriate accountability of the parties;

(d) the Physician Master Agreement will recognize that Government has an obligation to maintain and improve the health status of the population; to create health legislation, regulation and policy; to determine service organization and enable that organization through Health Authorities; and to determine the allocation of provincial funding for health services;

(e) the Physician Master Agreement will recognize that Health Authorities are responsible for regional service planning and operations and allocation and management of their fiscal, human and capital resources to meet the health service needs of residents;

(f) the Physician Master Agreement will recognize the BCMA's goals of maximizing physicians' professional satisfaction and achieving fair economic compensation for the services rendered by physicians;

(g) the Physician Master Agreement will contain a new conflict resolution framework that includes a conflict resolution team, including a mutually agreeable external member who is experienced in conflict resolution. The conflict resolution framework will, at a minimum, include measures to avoid the interruption of services to patients as a result of disputes. In addition, the parties will attempt to reach agreement on a final adjudicative process that resolves disputes without interruptions of services to patients; and

(h) the Physician Master Agreement will recognize and give effect to measures that will support the compliance by Health Authorities, physicians, the Government and the BCMA with the terms of all of the agreements between the Government and the BCMA.

11.2 Process and Timelines for the Negotiation of the Physician Master Agreement and the Physician Master Subsidiary Agreements

Unless otherwise agreed by the Government and the BCMA in writing, the process for the negotiation of the Physician Master Agreement and the Physician Master Subsidiary Agreements shall be as follows:

(a) within thirty days after the signing of this Agreement the Government, the BCMA and the Health Authorities will meet and in good faith negotiate the provisions of the Physician Master Agreement, including the Physician Master Subsidiary Agreements, in accordance with this Article 11. Matters already resolved in this Agreement will not be the subject of further negotiations;

(b) if, by December 31, 2006, the Physician Master Agreement and the Physician Master Subsidiary Agreements are not agreed upon by the Government, the BCMA and the Health Authorities (subject to no conditions except ratification), either the Government or the BCMA may request the assistance of a conciliator agreed to by them. If they are unable to agree upon the conciliator either of them may request the Chief Justice of the Supreme Court of British Columbia to make the appointment and the person so appointed will be the conciliator. The conciliator will work with the Government, the BCMA and the Health Authorities in an attempt to resolve all outstanding issues. If, by February 28, 2007 the Physician Master Agreement and the Physician Master Subsidiary Agreements have not been agreed upon by the Government, the BCMA and the Health Authorities (subject to no conditions except ratification), the conciliator will issue a report to the Government, the BCMA and the Health Authorities with recommended terms of settlement of the outstanding issues. Following the receipt of the conciliator's report the Government, the BCMA and the Health Authorities will meet to attempt to resolve the outstanding issues;

(c) if, by March 31, 2007, the Physician Master Agreement and the Physician Master Subsidiary Agreements are not agreed upon by the Government, the BCMA and the Health Authorities (subject to no conditions except ratification), either the Government or the BCMA may elect by notice in writing to the other that the Amended Second Master Agreement will continue, and upon such election:

(i) the Amended Second Master Agreement will continue in effect;

(ii) the Government and the BCMA will forthwith proceed to negotiate in good faith amendments to the 2004 Working Agreement and the 2004 Subsidiary Agreements:

(A) to reflect a new term for each of them from April 1, 2006 to March 31, 2012;

(B) to incorporate into them the provisions of Articles 3 through 10 of this Agreement and, to the extent applicable to such Articles, the provisions of Article 1 of this Agreement; and

(C) to provide that effective March 31, 2012 and thereafter, either the Government or the BCMA may terminate the 2004 Working Agreement as so amended and the 2004 Subsidiary Agreements as so amended, by giving the other at least 12 months prior written notice of the effective date of such termination, and that if that notice is given, the 2004 Working Agreement as so amended and the 2004 Subsidiary Agreements as so amended, will all terminate on such effective date;

and

(iii) the Government and the BCMA will have no further obligation under this Agreement to negotiate and/or settle the Physician Master Agreement or any of the Physician Master Subsidiary Agreements;

(d) if there is a dispute between the Government and the BCMA as to the matters referred to in section 11.2(c)(ii) such that, within 120 days after the date of election under section 11.2(c) that the Amended Second Master Agreement will continue, the Government and the BCMA have not agreed upon the amendments to the 2004 Working Agreement and the 2004 Subsidiary Agreements (subject to no conditions except ratification), all as contemplated by section 11.2(c)(ii), either of them may refer the dispute to arbitration by a single arbitrator under the *Commercial Arbitration Act* (British Columbia), such arbitrator to be chosen by agreement of the Government and the BCMA, provided that if the parties are unable to agree upon the arbitrator within 15 days after the referral to arbitration, either party may request the Chief Justice of the Supreme Court of British Columbia to make the appointment;

(e) if either the Government or the BCMA elects under section 11.2(c) that the Amended Second Master Agreement continue, then this Agreement will terminate and be of no further force or effect when:

(i) the Government and the BCMA execute, deliver and, if required, ratify the amendments to the 2004 Working Agreement and the 2004 Subsidiary Agreements; or

(ii) any dispute regarding the amendments to the 2004 Working Agreement and the 2004 Subsidiary Agreements is finally resolved by arbitration under section 11.2(d);

whichever occurs first; and

(f) if each of the Physician Master Agreement and the Physician Master Subsidiary Agreements are executed, delivered and, if required, ratified by the parties to them, the following agreements shall terminate and be of no further force or effect:

(i) the 2004 Working Agreement and the 2004 Subsidiary Agreements;

(ii) the April 2003 Memorandum of Understanding (MHO Placement on Salary and Service Payment Grids);

(iii) the 1993 Contributory Professional Retirement Savings Plan Agreement;

(iv) the May 29, 2002 Memorandum of Agreement;

(v) this Agreement; and

(vi) the Amended Second Master Agreement.

11.3 Key Content of Physician Master Agreement and Physician Master Subsidiary Agreements

Unless otherwise agreed by the Government and the BCMA in writing, the Physician Master Agreement shall provide for the following:

(a) the Physician Master Agreement will have five trilateral (among the Government, the BCMA and the Health Authorities) subsidiary agreements (the "**Physician Master Subsidiary Agreements**") as follows:

(i) Primary Care Agreement;

(ii) Specialist Agreement;

(iii) Rural Agreement;

(iv) Alternative Payments Agreement; and

(v) Benefits Agreement;

(b) the initial term of each of the Physician Master Agreement and the Physician Master Subsidiary Agreements shall be from April 1, 2006 to March 31, 2012, and they will continue thereafter until amended as provided in section 11.3(c) or terminated as provided in section 11.3(d);

(c) effective April 1, 2011 and thereafter, either the Government or the BCMA may, without terminating the Physician Master Agreement or the Physician Master Subsidiary Agreements, give notice to the other (the "**Renegotiation Notice**") that the party giving notice wishes to renegotiate all or any of the provisions of the Physician Master Agreement and the Physician Master Subsidiary Agreements, in which event the following shall apply:

(i) unless the parties to the Physician Master Agreement and the Physician Master Subsidiary Agreements otherwise agree in writing, any amendments will have effect not sooner than April 1, 2012;

(ii) not later than 60 days after the Renegotiation Notice is given, the Government, the BCMA and the Health Authorities will meet and commence to renegotiate all or any of the provisions of the Physician Master Agreement and the Physician Master Subsidiary Agreements; and

(iii) if within 180 days after commencement of the negotiations contemplated by section 11.3(c)(ii) the Government, the BCMA and the Health Authorities have not executed, delivered and, if required, ratified an agreement amending the Physician Master Agreement and the Physician Master Subsidiary Agreements, as applicable, the Government, the BCMA and the Health Authorities will, at the option of the Government or the BCMC, engage in a conciliation process similar to that contemplated in section 11.2(b), with such changes in detail as may be necessary so that the conciliation process contemplated in section 11.2(b) will apply in the circumstances contemplated by this section 11.3(c)(iii);

(d) effective April 1, 2011 and thereafter, either the Government or the BCMA may terminate the Physician Master Agreement and the Physician Master Subsidiary Agreements, by giving the other at least 12 months prior written notice of the effective date of such termination, and if such notice is given, the Physician Master Agreement and the Physician Master Subsidiary Agreements will all terminate on such effective date;

(e) upon a notice of termination being given as contemplated in section 11.3(d), the parties will commence negotiation of replacement agreements for the Physician Master Agreement and the Physician Master Subsidiary Agreements and if such replacement agreements have not been executed, delivered and, if required, ratified at least 180 days before the effective date of the termination contemplated in section 11.3(d), the Government, the BCMA and the Health Authorities will

engage in a conciliation process similar to that contemplated in section 11.2(b), with such changes in detail as may be necessary so that the conciliation process contemplated in section 11.2(b) will apply in the circumstances contemplated by this section 11.3(e); and

(f) the Physician Master Agreement and/or the Physician Master Subsidiary Agreements will include:

(i) the provisions of Articles 3 through 10 of this Agreement and, to the extent applicable to such Articles, the provisions of Article 1 of this Agreement; and

(ii) the provisions of the Amended Second Master Agreement shown shaded on Appendix A.

IN WITNESS WHEREOF the parties have executed this Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, 2006.

SIGNED, SEALED and DELIVERED on behalf of **HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA**, by the Minister of Health or his/her duly authorized representative, in the presence of:

Signature of Witness

Name
Rod Frechette

3-2, 1515 Blanshard St., Victoria BC
Address

THE CORPORATE SEAL of the **BRITISH COLUMBIA MEDICAL ASSOCIATION** was hereunto affixed in the presence of:

Authorized Signatory

Authorized Signatory

MEDICAL SERVICES COMMISSION

per:
Authorized Signatory

per:
Authorized Signatory

Note: "shaded" identifies provisions that must be in a new Physician Master Agreement.

AMENDED SECOND MASTER AGREEMENT

THIS AGREEMENT made as of the 1st day of April, 2006

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF
THE PROVINCE OF BRITISH COLUMBIA,
as represented by the MINISTER OF HEALTH
(the "Government")

AND:

MEDICAL SERVICES COMMISSION
(the "Commission")

AND:

BRITISH COLUMBIA MEDICAL ASSOCIATION
(the "BCMA")

WHEREAS:

A. THE parties entered into a Master Agreement on December 21, 1993 for a term, which was extended to March 31, 2001.

B. THE parties entered into a Second Master Agreement for the purpose of continuing an ongoing relationship.

C. THE parties have amended the Second Master Agreement as provided for in this Agreement.

D. THE parties wish to work as partners in the health care system to achieve certain objectives including the following:

1. To maintain and enhance the principles of Medicare;

2. To ensure a stable long term relationship between the Government and the BCMA;

3. To ensure and enhance the delivery of medically required services to residents of the Province in an efficient, high quality and effective manner;

4. To ensure that physicians are appropriately compensated for providing services covered by the Medical Services Plan, or under other alternative payment arrangements;

5. To ensure that the medical care system will continue to function well;

6. To contribute to the achievement of a mix and distribution of physicians based upon British Columbia's needs.

NOW THEREFORE the parties agree as follows:

1. DEFINITIONS

In this Agreement:

(a) **"Act"** means the ***Medicare Protection Act****;*

(b) **"Advisory Committees"** means committees established under the *Act* which shall include advisory committees established by the Commission as required by this Agreement or other committees established by the parties during the term of this Agreement;

(c) **"Alternative Payments Program"** means the Government program designed to fund physician services through means other than fee-for-service;

(d) **"Available Amount"** means the amount of funding allocated to the MSC for the payment of fee-for-service physician services provided in a specified fiscal year established under Section 25 of the *Act* and includes any adjustments which may be specified within a Working Agreement;

(e) **"Commission"** or **"MSC"** means the Medical Services Commission established under the *Act*;

(f) **"Conflict Resolution Team"** means the team as described at Article 12.6 herein;

(g) **"Consult"** means providing a meaningful opportunity for advice to be provided and for an exchange of views or concerns prior to the making of a decision or the finalization of a policy initiative as the context may require, and "Consultation" has a similar meaning;

(h) **"Differential Billing"** means the difference that can be billed in accordance with Section 30(c) of the Medical and Health Care Services Regulations, BC Reg. 426/97;

(i) **"Dispute Resolution Committee**" means the committee as described at Article 24.1(c) herein;

(j) **"Fiscal Year"** means the period commencing April 1st and concluding March 31st;

(k) **"Government"** means Her Majesty the Queen in right of the Province of British Columbia;

(l) **"Guide to Fees"** means the BCMA Guide to Fees or the Relative Value Fee Guide;

(m) **"Health Authority"** means a board or council as defined in Section 1 of the *Health Authorities Act* and includes a Community Health Services Society;

(n) **"Insured Medical Services"** means medical services, which are benefits under the *Act;*

(o) **"Medical Services"** means medical services performed by a medical practitioner;

(p) **"Medical Services Plan"** or **"MSP"** means the division of the Ministry of Health responsible for the administration and operation of the Medical Services Plan continued under the *Medicare Protection Act*;

(q) **"Minister"** means the Minister of Health and includes the Deputy Minister or a person designated to act on the Minister's behalf;

(r) **"Ministry of Health"** means the Ministry of Health of the Government of British Columbia, including the Minister of Health where the context may require;

(s) **"MSC Total Claims Cost"** or **"Total Claims Cost"** means the actual paid value of all fee-for-service insured medical services provided by medical practitioners within BC during a specified fiscal year, inclusive of any percentage premium payments under the Rural Retention Program but exclusive of any interest payments related to the late payment of claims or as otherwise made under the terms of this Master Agreement or the Working Agreement;

(t) **"Payment Schedule"** means a payment schedule established under Section 26 of the *Act;*

(u) **"Physician Benefit Plans"** means programs established by the Commission pursuant to Section 26 (6) of the *Act*;

(v) **"Physician Resource Template"** means the document which is prepared and maintained by the Physician Resource Planning Committee and which identifies the general and specific needs of residents of the province and each region of the province for physician services, including an identification of current and prospective need for specialty services;

(w) **"Proration"** means a temporary reduction to payment under the Payment Schedule pursuant to Section 24 (1) and (2) of the *Act*;

(x) **"Regulations"** means regulations made under the *Act*;

(y) **"Reserve Account"** means a fund established in Article 13 of this Agreement;

(z) **"Subsidiary Agreement"** means agreements negotiated pursuant to Article 11.1 which address issues of unique application to identifiable groups of physicians and which are part of the Working Agreement;

(aa) **"Tariff Committee"** means the BCMA Economics Committee as described in the Constitution and By-Laws of the BCMA in effect on the date of execution of this Agreement;

(bb) **"Working Agreement"** means the Agreement(s) established from time to time between the parties for the purpose of determining compensation, reserve accounts, on-call issues, Physician Benefit Plans and any other issues which the parties agree to negotiate at the Working Agreement(s) negotiations, and includes subsidiary agreements; and,

(cc) Words used in this Agreement that are defined in the *Act* or *Regulations* have the same meaning as in the *Act* or *Regulations* unless otherwise defined in this Agreement or any Working Agreement.

2. APPLICATION AND REPRESENTATION

2.1 This Agreement applies to those physicians resident within the Province whose services are compensated by funds provided by the Government either directly or through other public agencies.

2.2 The Government hereby grants to the BCMA the sole and exclusive right, and the BCMA hereby undertakes the obligation, to represent the collective and individual interests of those physicians where the funding for their services is, in whole or in part, provided by the Government either directly or through other public agencies.

2.3 The Government undertakes to include within funding contracts for physician services with institutions and Health Authorities a clause requiring the institution or Health Authority to advise physicians of their right to be represented by the BCMA, and to negotiate in good faith when establishing contracts with physicians.

2.4 The Government further undertakes that institutions and Health Authorities using an alternative payment mode for physicians will recognize the BCMA's right to represent physicians who request the assistance of the BCMA in negotiating contracts with those organizations.

2.5 The BCMA undertakes that, in exercising its representation rights, it will advise physicians that all matters within the ambit of this Agreement, including matters within the ambit of any Working Agreement, must comply with the provisions of this Agreement.

3. COOPERATION AND CONSULTATION

3.1 While the primary responsibility of the Commission is, as described in Section 3(3) of the *Act,* to facilitate reasonable access throughout British Columbia to quality medical care, health care and diagnostic facility services for residents of British Columbia under the Medical Services Plan, it is understood and agreed that physicians fulfill a key leadership role in the delivery of healthcare and that their primary and paramount responsibility is to advise and treat their patients and to otherwise discharge their responsibilities.

3.2 The Government and the BCMA agree that they will work together to ensure the provision of high quality medical services to the residents of British Columbia.

3.3 It is acknowledged and agreed that the partnership envisaged by this Agreement requires ongoing dialogue and consultation on matters of significance to the provision of medical care, including policy, whether such care is funded directly or indirectly by the Government.

3.4 In particular, the BCMA shall be consulted prior to the adoption of policy initiatives by the Minister or the Commission which would affect the provision of medical care by physicians.

3.5 The primary vehicle for the consultation(s) described in Articles 3.3 and 3.4 will be the Liaison Committee which will be comprised of three representatives of the Government, and three representatives of the BCMA and the Chair of the Commission as determined under Article 13.6.

3.6 The Government will consult with the BCMA and the Commission, prior to the tabling of the Ministry of Health's Spending Estimates, on the amount of annual funding for the provision of physician services to the residents of British Columbia in each year.

3.7 It is acknowledged and agreed that the Commission will be a party to the Working Agreement described in Article 11 and that, prior to ratification of the Working Agreement, the BCMA and Government will consult with the Commission on the Working Agreement.

4. SHARING OF INFORMATION

4.1 Each party acknowledges and agrees that the sharing of relevant information and data in a timely way is critically important to the achievement of the objectives established in this Agreement, and to the administration of the *Act.*

4.2 Each party agrees to share relevant information that is requested by the other party. Relevant historical and predictive data prepared by any party will be fully shared. In cases where the information is not readily accessible or is not provided

on request, the matter may be referred to the Commission. Where the Commission provides prior approval, the parties will expeditiously fill any such requests for data.

4.3 In order to foster and encourage mutual cooperation, the parties shall consult on ways and means to improve the timely collection and analysis of information and data and the method by which the data can be effectively and meaningfully communicated to each other. This process of consultation shall continue on an ongoing and regular basis.

4.4 On behalf of the Commission, the MSP shall provide to the BCMA aggregate information on Total Claims Cost on a monthly basis, and detailed information on fee-for-service claims semi-monthly. Sessional, service contract and salary data will be transmitted on an annual basis or more frequently if it is available.

5. CONFIDENTIALITY

5.1 It is understood and agreed that the open sharing of information, statistics, advice and points of view exchanged in consultation requires a degree of confidentiality.

5.2 It is understood and agreed that certain information exchanged between the BCMA and the Government will be confidential information under the *Act* and the *Freedom of Information and Protection of Privacy Act.* The BCMA will comply with the required statutory confidentiality.

5.3 Certain information that contains the identification of physicians or beneficiaries may be provided to the Advisory Committees of the Commission and to the BCMA for the purposes of the administration of the *Act*.

6. ADMINISTRATION

6.1 In addition to consultation on policy issues, it is acknowledged that administrative systems and processes which help to ensure that quality health care is maintained are desirable and appropriate, and should be developed in a cooperative way.

6.2 Similarly, systems and processes for predicting required funding and for planning medical care resources and expenditures are desirable and appropriate and will be developed by the Commission as an integral part of consultation.

6.3 It is acknowledged and agreed that there exists a common interest in ensuring that medical accounts are processed and paid promptly. To facilitate adjudication of a particular medical account or an audit of a particular physician's services, the Commission may require copies of specific clinical records. The Commission may determine the routine data and format and transmission protocols required for processing a routine medical account.

6.4 Should a need to review the routine data requirements, formats and/or transmission protocols arise, part of the review must consider the efficacy of the modification and the cost to the physicians of implementing such a change. Attempts will be made to conclude an agreement as a subsidiary agreement under the Working Agreement on costs, if any, and for the compensation of same.

6.5 When the Commission makes unilateral modifications to the routine data requirements, submission formats or transmission protocols, the net average cost of implementing these modifications shall be jointly determined and appropriate compensation, including retroactivity, if any, provided to the affected physicians.

6.6 If no satisfactory agreement concerning Articles 6.4 and 6.5 can be achieved after one year the dispute will become a matter for arbitration pursuant to the *Commercial Arbitration Act.*

6.7 The provisions of Articles 6.5 and 6.6 can be renegotiated under the Working Agreement. Should the provisions be altered in the Working Agreement, then those provisions shall govern.

6.8 On behalf of beneficiaries, the Commission will promptly pay in accordance with the Payment Schedule established by the Commission medical accounts submitted by physicians for the provision of services covered by the Plan, subject to Sections 27(4), 24(2) and 26(3) of the *Act* and further subject to the provisions of this Agreement, and any Working Agreement.

6.9 If any beneficiary shall incur a private liability with respect to a Differential Billing, the MSP shall pay to the physician only the amount set by the Commission.

6.10 Normally the Commission makes general remittances for fee-for-service claims on a regular cycle which is at least semi-monthly. If the Commission is unable to make a general remittance within five working days of the end of a payment cycle, an advance against accounts payable will be paid by the Commission. This will be limited to the physician's average regular cycle payment, measured over the previous 12 months or over the length of time the physician has participated in the Plan, whichever is the lesser period of time.

6.11 Consideration may also be given on an individual basis, at the discretion of the Commission, to physicians requesting an advance because they are encountering temporary difficulty submitting their medical accounts or having those accounts processed by the Commission.

6.12 Such advances will be applied against subsequent remittances to the physicians until the advance is fully repaid. Interest at the same rate and under the same conditions specified in Working Agreements shall apply.

6.13 Interest, as described in Working Agreements, shall apply and be paid by the Commission on overdue medical accounts as permitted by law.

6.14 When the Commission accepts the recommendation of the Reference Committee as defined under Article 14.1 of this Agreement to pay a medical account as submitted by a physician, the MSP shall pay interest pursuant to Article 6.12 on the account.

7. MEDICAL SERVICES COMMISSION

7.1 The Medical Services Commission, established under the *Act*, will be continued, unless amended under the *Medicare Protection Act*, by the Government.

7.2 The following process will be used to appoint the members to the Commission:

(a) The Minister will advise the BCMA of the three individuals who will be recommended to the Lieutenant Governor in Council for appointment under the *Act* as representatives of the Government.

(b) The BCMA will advise the Minister of the three individuals it wishes to have appointed as representatives of the BCMA. The Minister will recommend to the Lieutenant Governor in Council the appointment of those three individuals under the *Act.*

(c) The Minister and the BCMA will consult as to the names of three individuals who will be appointed under the *Act* as representatives of beneficiaries. The Minister and the BCMA must agree on a joint recommendation of the three individuals who will be recommended to the Lieutenant Government in Council for appointment. If the parties are unable to agree, either the Minister or the BCMA may request the Chief Justice of the BC Supreme Court to name the representatives of the beneficiaries.

(d) A Commissioner will be appointed for a term of three years and may be reappointed.

(e) Upon the expiry of the term of any member of the Commission or, in the event of death, disability, incapacity or resignation during the term of appointment, the above-described process will be utilized to the extent necessary to replace such member or members.

7.3 It is acknowledged that Section 3(4) of the *Act* requires that the Lieutenant Governor in Council must designate a member of the Commission appointed by the Government as the Chair of the Commission. The Minister will consult with the BCMA prior to the appointment or reappointment of the Chair of the Commission.

7.4 The parties agree that it is in the best interests of all parties and in the public interest for the Commission to exercise its full legal authority in an independent manner under the management of the members of the Commission.

7.5 The Chair of the Commission must act in a manner that is consistent with the purpose of the *Act* and in the spirit of this Agreement and shall not execute or initiate matters or changes not previously authorized or agreed to by the Commission in the period between meetings of the Commission.

7.6 The Ministry and the BCMA each retain the right to remove any member of the Commission appointed as its representative and the Government will pass any necessary Order-In-Council.

7.7 It is understood that an alternate Commissioner may be appointed to serve in the absence of a Commissioner as permitted by Section 23 of the *Interpretation Act*.

8. THE AVAILABLE AMOUNT

8.1 There will be one Available Amount centrally administered by the Medical Services Commission. This does not preclude segmenting components of the Available Amount for analysis of expenditures of the Available Amount for purposes of planning, evaluation and management.

8.2 The Government will advise the full Commission of the budget for the Available Amount within 15 days of the approval of the Health Estimates by the Legislature. Adjustments as a result of the negotiation of agreements will be disclosed following the resolution of those agreements.

9. TRANSFERS TO AND FROM THE AVAILABLE AMOUNT

9.1 Adjustments to the value of the Available Amount will occur as a result of the transfer of physicians' payments and services to, or from, the Alternative Payments Program. Upon notice to the BCMA, the funds will be transferred to the Alternative Payments Program subject to the ability of the BCMA to submit any disputes with respect to the transfer to expedited arbitration under the *Commercial Arbitration Act*.

9.2 The amount of the adjustment will equal the value of the payment to the affected physician(s) for the provision of the identified services in the 12 months immediately preceding the effective date of the transfer of the physician and the services.

9.3 Where the physicians providing the services have retired, moved to another location or voluntarily withdrawn from providing the services, the condition that the physician(s) transfer to the other mode of payment is waived.

9.4 Expedited Adjudication

(a) Any disputes respecting a funding transfer will be resolved through arbitration under the *Commercial Arbitration Act*.

(b) The parties will select a mutually agreed upon adjudicator.

(c) Should the parties be unable to agree on the selection of an adjudicator within seven days after notice is served by any party seeking the appointment of an adjudicator, the Chief Justice of the Supreme Court of British Columbia will be asked to appoint the adjudicator.

(d) The adjudicator will issue a final and binding decision on the matter(s) in dispute within ninety days of the notice of the dispute.

(e) Each party will be responsible for its own costs in participating in this adjudication and will share equally all other costs of the adjudication.

10. WAIT TIME REDUCTION FUND

10.1 The parties agree that the Government, at its discretion, may provide funding and implement wait time reduction procedures, or other additional procedures, over those that would have been provided without the additional funding and that will not become part of the Available Amount, nor will the claims cost be charged against the Available Amount.

11. WORKING AGREEMENT

11.1 There will be one Working Agreement which addresses all matters of common interest to physicians and subsidiary agreements, each addressing those matters of unique interest and applicability to specialists, general practitioners, salaried physicians, physicians providing services on service contracts, physicians providing services on a sessional basis and physicians practicing in rural areas, as appropriate. The Government and the BCMA will periodically review the number and structure of subsidiary agreements with a view to ensuring that they appropriately address the needs of the parties. Changes, as agreed, will be implemented in the renegotiations of Working Agreements.

11.2 No later than October 1 of the year immediately preceding the expiry of a Working Agreement or subsidiary working agreement, the Government's negotiator(s) and the BCMA will meet to negotiate a new Working Agreement or subsidiary working agreement, as appropriate.

11.3

(a) The Government and the BCMA will appoint an individual to act as chair of a conciliation panel in future Working Agreement negotiations.

(b) If the Government and the BCMA are unable to agree upon the chair of the conciliation panel either of them may request the Chief Justice of the Supreme Court of British Columbia to make the appointment and the individual so appointed will be the chair of the conciliation panel.

(c) If, in the negotiation of future Working Agreements, the Government and the BCMA are unable to reach agreement on any or all of the outstanding matters either the Government or the BCMA may request the intervention of the chair of the conciliation panel.

(d) Once either the Government or the BCMA has requested the intervention of the chair of the conciliation panel he/she will work with the BCMA and the Government negotiators in an attempt to mediate an agreement on the outstanding issues.

(e) At any point during the mediation after the expiry date of the current Working Agreement, either the Government or the BCMA may request the chair of the conciliation panel to discontinue the mediation and to assemble the conciliation panel. The Government and the BCMA will each name one representative to the three-person panel.

(f) The panel will conduct the conciliation in accordance with procedures agreed to by the Government and the BCMA, which may include formal hearings with the parties, to review the issues in dispute. The panel must retain an independent expert to assist the panel in determining costing issues and verifying comparators. The terms of reference of the panel will include the need to be consistent with the law and this Amended Second Master Agreement, reflecting the Government's fiscal situation, including its ability to pay, the need to provide reasonable compensation to physicians for the services rendered, and the operational and medical resource needs of the Health Authorities. The panel will publish a report containing the recommended terms of settlement on all of the outstanding issues, such report to be in two parts, the first part to contain the recommended terms of settlement on those issues of compensation contained in Article 3 of the Letter of Agreement (the "LOA") dated April 1, 2006 between the parties to this Agreement (to which Letter of Agreement a form of this Agreement is attached as Appendix A), on-call issues, issues regarding the physician benefits referred to in section 5.2 of the LOA, and any other issues which the parties have agreed in writing to submit to binding conciliation under this Article 11.3 (collectively, the "Central Recommendations"), and the second part to contain all recommended terms of settlement other than the Central Recommendations (collectively, the "Other Recommendations"). The report must also set out reasons and the estimated cost for both the Central Recommendations and the Other Recommendations.

(g) The Central Recommendations will be binding on the parties unless, within 10 days of its receipt of the report, the Government refuses to accept the Central Recommendations in their entirety, and upon such refusal, the Central Recommendations will not be binding upon the Government. All Other Recommendations will not be binding on the parties unless agreed to by the parties in writing.

(h) If the Government refuses to accept the Central Recommendations, the Government and the BCMA will resume negotiations on the areas in dispute with respect to the Central Recommendations, and the BCMA will be relieved of its obligations under Articles 12.3.1, 12.3.2, 12.3.3 and 12.5 of this Amended Second Master Agreement, subject to Article 11.3(i) below, until a new Working Agreement is concluded.

(i) Prior to the commencement of any service disruptions the Government and the BCMA will seek guidance from the British Columbia College of Physicians and Surgeons on what services should be maintained to ensure that the safety of British Columbians is protected and the BCMA will not condone or support a withdrawal of services contrary to the College guidance.

11.4 Any Working Agreement, including subsidiary agreements, shall be subject to the provisions of the Master Agreement and shall not contradict, nullify or alter any term contained in the Master Agreement.

12. PRORATIONING AND CONTINUITY OF CARE

12.1 It is agreed that the Commission will not use its power to prorate except as provided in Article 12.2.

12.2 If the Government decides that it wishes the Commission to exercise its authority to prorate, it will provide12 months' notice to the Commission and the BCMA. Upon the expiry of the notice period, the Commission will determine whether prorationing measures are required.

12.3 As long as there is no prorationing in effect, it is agreed:

12.3.1 The BCMA will not sponsor, support or condone withdrawals of service by physicians and shall take necessary steps that are available to prevent such initiatives.

12.3.2 Services shall include serving on hospital committees, participating on the active staff of hospitals and other administrative, educational, management and related non-clinical services.

12.3.3 It is agreed that the Government and the BCMA will work together to prevent disruptions in the provision of services to patients as a result of disputes between doctors and the Government or its agents.

12.4 Should the Government serve notice under Article 12.2, the Government and the BCMA will meet and attempt to agree on various utilization limitation measures, including any agreed upon reductions in service, to attempt to make it unnecessary to implement prorationing. Such reductions in services will not be affected by Article 12.3.

12.5 The BCMA agrees that, once an agreement is entered into, physicians who are covered by it should not limit Medical Services for the purpose of pressuring the Government or its agents to change the terms and conditions of the agreement. The BCMA will take all appropriate measures to encourage physicians to comply with applicable agreements once they are ratified and concluded.

12.6 In the event of a threat of a withdrawal of Medical Services, the dispute will be referred to the Conflict Resolution Team. The Conflict Resolution Team will consist of four members made up of one representative from each of the BCMA, the Health Authorities, the Ministry of Health and an external member who is trained in conflict resolution and is experienced in resolving disputes between parties related to contracts in the workplace. The Conflict Resolution Team will define the issues in dispute and make recommendations to facilitate resolution consistent with the provisions of this Agreement.

12.7 Notwithstanding Articles 12.5 and 12.6, in the event a physician intends to withdraw clinical services, the physician must provide a minimum 90 days notice to the applicable Health Authority and the College of Physicians and Surgeons of BC.

12.8 Following the conclusion of the report of the Commission of Inquiry headed by Judi Korbin with respect to withdrawal of services, the Government and the BCMA will meet to discuss its recommendations. Nothing in this Article will prevent the Government from proceeding unilaterally with the implementation of any of those recommendations.

12.9 The parties will attempt to agree in Working Agreements, including subsidiary agreements, upon various utilization limitation measures to attempt to make it unnecessary to implement prorationing.

12.10 It is acknowledged that certain difficulties have arisen due to the concern of physicians that they have not been provided with suitable support, working conditions or access to public facilities. When such concerns arise the Government and the BCMA will form task forces to work together to attempt to relieve such concerns. Such task forces will be jointly chaired by a representative of the government and a representative of the BCMA and will issue a report to the parties within thirty days of their appointment.

13. MONITORING AND MANAGING THE AVAILABLE AMOUNT

13.1 On behalf of the Commission, the MSP will track Total Claims Cost against the Available Amount at the conclusion of each month and the Commission will make a forecast concerning the adequacy of the Available Amount. The results will be immediately forwarded to the BCMA. The Commission will give the BCMA written notice when the Commission's projections indicate that the Available Amount will be exceeded immediately after such a projection is accepted by the Commission. The notice will include the specific date on which the Available Amount is projected to be exceeded.

13.2 If the Commission concludes on the basis of a reasonable forecast that the total cost of claims for a fiscal year is likely to exceed the Available Amount, the Chair of the Commission shall immediately call a meeting of the Commission and, prior to that meeting, the Commission will forthwith consult with the BCMA and the Ministry on the matter. Immediately following the Commission meeting, the Commission will report to the Minister and the BCMA:

(a) the fact of the forecast that the Available Amount may be exceeded;

(b) the apparent reasons for the forecast overrun of the Available Amount; and

(c) in consultation with the BCMA, the Commission's suggestions for preventing the overrun of the Available Amount.

13.3 Reconciliation of the MSC Total Claims Cost with the Available Amount shall take place and be concluded by October 31 of the following fiscal year. In the event the reconciliation identifies that the Available Amount was still exceeded after the implementation of all measures contemplated by this Article 13, the amount of the excess will be recovered by, and in order of priority, the use of the Reserve Account, and, where the Reserve Account is insufficient to recover the amount of the excess, the Commission will determine the mechanisms for recovering the remaining difference.

13.4 It is agreed and understood that the Commission has a responsibility to manage Total Claims Cost to stay within the Available Amount.

13.5

(a) The parties further agree that the Commission must exercise this responsibility through the use of all reasonable methods within its jurisdiction, subject to the specific provisions of any Working Agreement, and this Agreement. An integral part of that management process will be the development of protocols and billing guidelines. The BCMA will participate in the development of those protocols and guidelines and the medical profession will make every effort to adhere to such protocols and guidelines once implemented.

(b) It is agreed and understood that insured benefits are medically required services which fall within defined, approved protocols and practice guidelines and those medically required services where no protocols or practice guidelines exist.

13.6 In recognition of the need for all parties to this Agreement to be satisfied that the Commission continues to be effective in managing the Available Amount, the Chair of the Commission will meet with the Liaison Committee at regular intervals as required to assess the management process. The parties will report the results of these meetings to the Minister, the Commission and the Board of Directors of the BCMA on a timely basis.

14. ADVISORY COMMITTEES

14.1 Reference Committee

(a) The Reference Committee of the BCMA shall be considered to be an advisory committee to the Commission under Section 5(l)(o) of the *Act.*

(b) The MSP shall inform physicians of their opportunity to refer to the Reference Committee matters relating to medical accounts submitted by the physician where:

i. there is a continuing disagreement between the physician and the MSP which exceeds 60 days from the date the physician first raises a written enquiry to the MSP with respect to an account or accounts; or

ii. there is a continuing dispute with the physician over payment for services or procedures which exceeds 60 days from the date the physician first raises a written enquiry to the MSP for which no fee has been established and approved by the Commission.

(c) The Reference Committee shall promptly review all matters referred to it and shall forward its report or recommendations to the Commission and the BCMA within one month of its meeting or to the Tariff Committee or MSP as appropriate.

(d) The Reference Committee shall meet to review matters referred to it at least three times per calendar year and the period between successive meetings is not to exceed six months. A report or recommendation by the Reference Committee is not binding on the Commission. However, the Commission will endeavor to follow the recommendations of the Reference Committee.

(e) The approved costs of the Reference Committee will be shared equally by the BCMA and the MSP.

14.2 Patterns of Practice Committee

(a) The current Patterns of Practice Committee of the BCMA shall continue as an advisory committee to the Commission under Section 5(l)(o) of the *Act.*

(b) The approved costs of the Patterns of Practice Committee will be shared equally by the MSP and the BCMA.

(c) It is agreed that the Patterns of Practice Committee shall continue its function and work during any period when no Working Agreement exists.

14.3 Joint Utilization Committee

(a) The Joint Utilization Committee shall continue as an advisory committee to the Commission under Section 5(l)(o) of the *Act*.

(b) The Joint Utilization Committee shall consist of equal numbers of representatives of the BCMA and the Ministry, and will be jointly chaired. The membership may be expanded to include lay representation on agreement of the parties.

(c) The objective of the Joint Utilization Committee will be to measure and evaluate the utilization of medical services, and, where appropriate for complete understanding, drug and hospital services. The committee will also assist in coordinating the development, measurement and monitoring of utilization management initiatives and regularly reporting to the parties on those initiatives. Such initiatives may address healthcare expenditures other than those directly attributable to the provision of physician services.

(d) The Commission shall refer to the Joint Utilization Committee issues which may affect utilization, the cost of services and means to affect utilization of medical services. Examples include physical resources, alternative payment mechanisms, physician supply, protocols and guidelines, determination of services, public education, agency billing and the use of technology.

(e) The Joint Utilization Committee shall promptly review all matters referred to it and shall forward its report and recommendations to the Commission and the BCMA within one month of its meeting.

(f) The Joint Utilization Committee shall meet to review matters referred to it at least six times per calendar year and the period between successive meetings is not to exceed three months. A report or recommendation to the Commission is not binding on the Commission.

(g) The approved costs of the Joint Utilization Committee meetings shall be shared equally by the BCMA and the MSP.

15. AUDIT AND INSPECTION COMMITTEE

15.1 The Commission has the right and responsibility to audit claims for payment by practitioners and the patterns of practice or billing of physicians as part of a random review or in response to service verification irregularities. The BCMA will support and participate in the Commission's audit program. This audit program will be funded by the MSP.

15.2 An Audit and Inspection Committee shall be created and delegated the powers of the Commission under Section 36(1) to (12) of the *Act* to audit and inspect medical practitioners and shall consist of representatives of the BCMA, College of Physicians and Surgeons, the public and the Government.

15.3 The Committee's responsibilities may include random audits and inspections referred to the Committee by the Commission, MSP or any physician peer review committee, including the Patterns of Practice Committee

15.4 Inspectors are to be appointed from a list maintained by the Committee and proposed jointly by the BCMA and the College of Physicians and Surgeons.

15.5 Notice of review and inspection must be provided to the medical practitioner(s) in question. Except in extraordinary circumstances, which in no case would include a random audit, notice of inspection must be provided at least 14 days prior to the inspection.

15.6 Inspection guidelines are to be clearly laid out and communicated to the medical practitioner(s) prior to inspection.

15.7 The confidential nature of medical records will be protected. The identity of patients shall be protected except to the extent necessary for verification or as evidence for a hearing.

15.8 Prior to any decision being made by the Commission resulting from a referral of the Committee, it is understood that the physician shall be entitled to be heard by the Commission, is entitled to have legal counsel present and may have one or more colleagues present to comment on the practice of the physician.

15.9 Prior to a hearing before the Commission, the Committee will communicate in writing to the physician its concerns and provide copies of all relevant documents to the physician at least 21 days prior to the hearing.

15.10 The approved costs of the Audit and Inspection Committee shall be funded by the MSP.

16. REVISION AND MAINTENANCE OF THE GUIDE TO FEES

16.1 Subject to Article 17, upon conclusion of an agreement, the amount of funds to be made available for revisions to the Payment Schedule will be allocated by the BCMA to fee items in the Guide to Fees in accordance with the Agreement(s).

16.2 Subject to Article 11 of this Agreement and except where otherwise specifically and mutually agreed, revisions to the Guide to Fees allocating amounts of money made available under an agreement will be effective April 1 of the appropriate year during the term of the Agreement(s).

16.3 When the Tariff Committee of the BCMA has prepared recommendations for revisions of the Guide to Fees for consideration by the Board of Directors of the BCMA, prior to transmission of its recommendations to the Board of Directors the Tariff Committee will:

(a) inform the Commission, the MSP and the Health Authorities of the recommendation; and

(b) consult with the Commission, the MSP, and the Health Authorities to identify any comments or concerns they may have respecting such recommendations in order that the Tariff Committee may have the Commission's, MSP's, and Health Authorities' comments or concerns before them at the time of finally recommending a revision of the Guide to Fees to the Board of Directors. For the purpose of this consultation, the Health Authorities will designate a single representative group to participate in the consultation.

16.4 When the Government wishes to recommend the creation of a new fee or any revisions to existing fees it will:

(a) consult the Tariff Committee of the BCMA and the Health Authorities to identify any comments or concerns they may have respecting such recommendations;

(b) attempt to achieve agreement with the Tariff Committee of the BCMA on the recommended changes;

(c) if agreement is not reached under "b", the Government may refer the matter to a joint review panel pursuant to Articles 16.5 through 16.8.

16.5 The composition of the joint review panel shall be one member appointed by the BCMA and one member appointed by the Government and a Chair acceptable to both parties from a roster of mutually acceptable names. The members appointed shall be chosen so as to avoid direct conflict of interest. If the Government and the BCMA have not agreed upon the roster, the Commission will make the appointment.

16.6 The joint review panel must render a majority recommendation to the parties and the Commission within three months of its appointment.

16.7 If the Government and the BCMA support the recommendation of the joint review panel, the Commission will implement it.

16.8 If either the Government or the BCMA does not support the recommendation of the review panel, the Commission will decide the matter.

16.9 The Commission agrees that, should it introduce any redefinition of insured medical services, it will provide at least 30 days' notice to all physicians enrolled in the Medical Services Plan.

17. APPROVAL OF PAYMENT SCHEDULE

17.1 The Commission shall adopt as part of its Payment Schedule additions to, deletions from or other modifications of the BCMA Guide to Fees, provided that:

(a) the BCMA and the Government agree to the additions, deletions or other modifications;

(b) the Commission agrees such modifications are consistent with the requirements of the *Act* or *Regulations;*

(c) the Commission agrees that the services covered by a given fee item are medically necessary; and

(d) the Commission agrees to the estimated projected net cost effect on the MSC Total Claims Cost which would result from such recommended changes.

17.2 Where there is no agreement between the BCMA and the Government on recommended changes to the Payment Schedule the BCMA and the Government may make separate recommendations to the Commission and it will determine the changes, if any.

17.3 Subject to Article 11, addition, deletion or modification of an individual item or items in the Guide to Fees shall not be given effect in the Payment Schedule until it has been agreed to by the parties.

17.4 For the purpose of calculation of the estimated effect in MSC Total Claims Cost of changes in a fee item or items of the Payment Schedule, the most current usage data as provided to the Commission will be used and adjusted as appropriate for trends in usage when trends can be established or predicted.

17.5 It is understood and agreed that no addition to, deletion from or modification of the Payment Schedule or of any item or items therein under or resulting from any

provision of this Agreement shall have effect without prior agreement and approval in writing of the Commission.

18. PHYSICIAN BENEFIT PLANS

18.1 The Government agrees to enter into a contract with the BCMA for the term of this Agreement to administer the physician benefit plans including the following terms:

(a) It is understood and agreed that where an agreement permits or requires the BCMA to administer a benefit program, the responsibilities of the BCMA includes the verification that public funds have been properly used for the purposes intended, including such audit and inspection procedures as may be necessary and required.

(b) The BCMA acknowledges and accepts its responsibility to administer the Physician Benefit Plans available to all physicians who have not made an election under Section 14 of the *Act* or who are not subject to an order made under Section 15(2)(b) of the *Act,* and acknowledges and accepts its responsibility to provide the same standard of administration to both members and non-members of the BCMA.

(c) It is understood and agreed that the BCMA may charge physicians who are not members of the BCMA an administrative fee when non-members apply for a negotiated benefit to which they are entitled. It is further understood and agreed that non-members will not be charged administrative fees that exceed the equivalent of dues and levies charged to BCMA members in the calendar year in which the non-member applies for a benefit or benefits.

(d) The detailed description of, and funding levels for, the Physician Benefit Plans will be contained in Working Agreements. The parties agree that such plans will include a Continuing Medical Education Program, a Physician Disability Plan, a CMPA Cost Reimbursement Plan and a Physician RRSP Plan.

19. GEOGRAPHIC RETENTION PROGRAMS

19.1 The Commission is committed to developing and maintaining incentives for practice in northern and isolated communities and/or other communities with a demonstrated retention problem. In this regard, the Rural Retention Program, the Northern and Isolation Travel Assistance Outreach Program, including the Joint Standing Committee on Rural Issues, will be continued until amended or replaced pursuant to Article 19(b).

19.2 Any modifications to existing program(s) in Article 19.1 will be negotiated as part of the Subsidiary Agreement for Physicians in Rural Practice.

20. VOLUNTARY AND COMPULSORY NON-PARTICIPANTS

20.1 Any physician may elect to be paid for benefits directly from a beneficiary pursuant to Section 14 of the *Act*, and by so doing gives up access to benefits under the Physician Benefits Plans. BC residents who are eligible beneficiaries under MSP may remain or become patients of such a voluntary non-participating physician without loss of their right to reimbursement in accordance with the *Act* or *Regulations.*

20.2 The Commission will be responsible for the direct payment of a non-participating physicians accounts only where that physician has rendered emergency services in circumstances where the medical condition or state of mental incompetence of the beneficiary prevents the physician from properly informing the patient of the physician's non-participation, and from obtaining the beneficiary's informed consent.

20.3 Where the Commission has, for cause, made an order under Section 15 of the *Act* canceling enrollment of a physician in the Medical Services Plan, that physician is no longer entitled to access to benefits under the Physician Benefit Plans.

21. PHYSICIAN RESOURCE PLANNING

21.1 The Physician Resource Planning Committee as established by the Commission will review and update the physician resource template and examine the issue of the physician resource needs which are currently facing the Province and which will develop in the next five years. Issues to be examined will include the effect of retirements and other departures, whether areas of the province have distributional issues and the effect of in-migration and out-migration of physicians. Establishment of the Committee will not preclude the Government and/or the Commission from taking any actions with respect to physician resource issues that they deem appropriate.

22. MISCELLANEOUS

22.1 The parties agree that individual physicians will not be compelled to modify their practice form or compensation method

22.2 [not used]

22.3 This Agreement will be governed by, and construed in accordance with, the laws of the Province of British Columbia.

22.4 This Agreement will be construed in accordance with the *Act.* In the event that the *Act* is amended, rendering any part of the Master Agreement or a Working

Agreement to be invalid or unenforceable, the balance of those Agreements will be deemed to be severed and to remain in full force and effect.

23. AMENDMENTS

23.1 This Agreement or any of the terms of this Agreement may be amended at any time with the mutual written consent of the parties.

23.2 No amendment or modification to this Agreement will become effective unless the same will have been reduced to writing and duly executed by the parties hereto.

24. DISPUTE RESOLUTION

24.1 Disputes with respect to the interpretation, application or alleged breach of this Master Agreement will be resolved as follows:

(a) The party raising the dispute must first advise the designated representative of the other party, in writing, of its view of the dispute with full particulars of the facts upon which it relies, articles of the Agreement alleged to be violated and citing any relevant law upon which it relies

(b) Following receipt of the written advice containing details of the issue in dispute, the designated representatives of the parties will meet in an attempt to resolve the dispute or to narrow the issues in dispute.

(c) Prior to any referral to arbitration, the dispute will be considered by the Dispute Resolution Committee in an attempt to reach an agreement on the matter. The Dispute Resolution Committee will be composed of two representatives of the Government and two representatives of the BCMA and it will be a standing committee.

(d) The Government may designate the Health Employers' Association of British Columbia (HEABC) to represent its interests under this Master Agreement and will advise the BCMA of any such designation.

(e) Each party will be responsible for the cost of its own participation in the Dispute Resolution Committee process.

(f) If there is no resolution of a dispute under Article 24.1c., either party may refer it for final resolution to arbitration pursuant to the *Commercial Arbitration Act.* Should the parties be unable to agree on the selection of an arbitrator within seven days after notice is served by any party seeking the appointment of an arbitrator, the

Chief Justice of the Supreme Court of British Columbia will be asked to appoint the arbitrator.

25. EFFECTIVE DATES AND TERMINATION OF AGREEMENT

25.1 This Agreement comes into force upon execution and delivery by the parties of this Agreement and the LOA (as defined in Article 11.3(f) of this Agreement) and will terminate upon the conclusion of a Physician Master Agreement and Physician Subsidiary Agreements pursuant to section 11.2 (f) of the LOA, or in accordance with Article 25.2.

25.2 After April 1, 2011, unless this Agreement is terminated earlier pursuant to Article 25.1, either party may give the other twelve months notice of its wish to terminate this Agreement, in which case it will terminate at the end of the twelve months.

25.3 Unless this Agreement is terminated earlier pursuant to Article 25.1, the parties agree to meet on or after April 1, 2011 to negotiate its replacement.

25.4 If, by December 31, 2011, there are any outstanding issues with respect to the replacement of this Agreement, either party may request the assistance of a conciliator agreed to by them. If the parties are unable to agree upon the conciliator either of them may request the Chief Justice of the Supreme Court of British Columbia to make the appointment and the person so appointed will be the conciliator. The conciliator will work with the parties in an attempt to resolve all outstanding issues. If, by February 28, 2012 an agreement has not been reached, the conciliator will issue a report to the parties with recommended terms of settlement of the outstanding issues. Following the receipt of the conciliator's report the parties will meet to attempt to resolve the outstanding issues.

DATED AT Vancouver, British Columbia, as of the 1st day of April, 2006.

SIGNED, SEALED and DELIVERED on behalf of **HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA**, by the Minister of Health or his/her duly authorized representative, in the presence of:

_____

Signature of Witness

_____

Name

_____

_____

Address

THE CORPORATE SEAL of the **BRITISH COLUMBIA MEDICAL ASSOCIATION** was hereunto affixed in the presence of:

_____

Authorized Signatory

_____

Authorized Signatory

MEDICAL SERVICES COMMISSION

per:

Authorized Signatory

per:

Authorized Signatory

Appendix B

Modified Adjusted Net Daily Income (MANDI) Model

MANDI formula

Gross daily income
X sessional adjustment
X non MSP adjustment
X training adjustment
X intensity/ stress adjustment
X overhead adjustment
= *modified adjusted net daily income*

The components of the MANDI formula

1. *gross daily income* – Includes fee-for-service payments from MSP, and WCB & ICBC services submitted through and paid by MSP. It excludes all services rendered on weekends and holidays and services linked with out-of-office-hours services and surcharges. It is the income derived from the 67th percentile of every specialist in a section and their days worked. If 50 specialists in a section work 210 to 220 days in a year there are between 10,000 and 11,000 data points from which the 67th percentile is chosen. This percentile was selected because it best represents a typical full-time specialist working at maximum efficiency. It statistically has less variability than averaging the incomes or than the 50th and 75th percentiles. For those specialties with unlinked out-of-office-hours services, 10/24 of those services based on a 10 hour day would be included.

2. *sessional adjustment*[1]– This factor is based on MSP sessional information. Aggregate information is used to determine the ratio between sessional and sectional billing. The 67th percentile was chosen for both. Since it is not fee-for-service MSP funded and represents time not allotted to fee-for-service work it has to be factored in so that fee-for-service earnings do not appear artificially low. Sessional and fee-for-service MSP earnings accrue at approximately a 1:1 ratio so time is considered 1:1.

3. *non-MSP adjustment* – This factor is derived from information from the 1995 House Overhead study and represents earnings related to private practice (third party, medico legal and private billings). These earnings are used as ratios against MSP earnings to correct for time spent doing non-MSP work as in 2. above where if not corrected, the MSP earnings for a specialist working fulltime but doing this other work would be artificially low. Because non-MSP work is paid at a higher rate, it accrues more quickly than MSP work therefore the time money correlation is not 1:1. After reviewing

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[1] The sessional adjustment factor is calculated as follows: 1) Determine the 67th percentile of total billings (FFS + ICBC + WCB) for each section (67th Percentile is based on total payments for each physician), 2) Determine the 67th percentile of total billings (FFS + ICBC + WCB + **Salary + Sessional**) for each section (67th Percentile is based on total payments for each physician), and 3) Calculate the ratio of the 67th percentile of total billings including Salary & Sessional to the 67th percentile of total billings excluding Salary & Sessional.

time-money correlations for cosmetic surgery, medico legal activities and WCB sessional rates, it was felt that non-MSP work accrues money at a 3:1 ratio and the original income percentage from the House study is adjusted by 1/3.

4. *training adjustment* - Increased training has two factors associated with it. One is the lost opportunity cost (LOC), or the earnings lost during training averaged over the specialist's career. Studies have calculated this loss at 4 per cent per year. The second area is the added skills, complexity and responsibilities (ASCR) that training has brought to the specialist's practice. This value is harder to quantify and after reviewing the literature is in the range of 2 to 4 per cent per year.

This training adjustment is applied to Royal College licensed fellowships (i.e. most specialties would be assigned 5 years and 3 – CVT, Cardiac and Neurosurgery – would count 6 years).

5. *intensity/stress adjustment* – This area is very difficult to quantify, but it is felt it is necessary to include. There are no good studies or hard data that adequately deal with this issue. The best available data are the Canadian Medical Protection Association (CMPA) premiums that are based on actuarial data. The problem is that they also mirror award values that do not adequately reflect stress. This factor needs to be reviewed regularly to adjust for new information and/or better proxies. To compensate for the award bias of CMPA rates, 3 levels of stress factor based on the CMPA premiums with low percentages apply:

Level 1: 0%
Pathology

Level 2: 1%
pediatrics, internal medicine, dermatology, radiology, psychiatry, rheumatology, anaesthesia, ophthalmology, urology, neurology, emergency medicine, otolaryngology

Level 3: 2%
thoracic surgery, vascular surgery, general surgery, obstetrics and gynecology, plastic surgery, cardiovascular surgery, orthopedics, neurosurgery

6. *overhead ratio* – This factor is derived from the 1995 House Overhead study. This information is dated but it is the most accurate information available. The ratios have been modified to capture cost of practice and fee increases. The overhead ratios are also modified to account for the fact that several sections earn a significant part of their gross earnings out of office hours (OOH). These groups have an artificially low daytime overhead since OOH overhead should be similar to those sections that are not office based and total overhead is a combination of both daytime and OOH overhead.

APPENDIX C

PHYSICIAN INFORMATION TECHNOLOGY OFFICE

WHEREAS:

A. The e-Health Steering Committee has developed, and the Ministry has published, the e-Health Strategic Framework dated November 2005 which describes British Columbia's long-term vision for e-Health initiatives, including the components related to the Electronic Health Record (the "**e-Health Strategic Framework**");

B. In order to enhance the effective delivery of services by physicians in British Columbia, the Government and the BCMA have agreed to work collaboratively to co-ordinate, facilitate and support information technology planning and implementation for physicians as it relates to the e-Health Strategic Framework, including the development and implementation in British Columbia of standardized systems of electronic medical records;

C. For the purposes described in recital B, the Government has agreed to establish and support a physician information technology office;

ARTICLE 1 - INTERPRETATION

1.1 Definitions

In this Appendix including the recitals to this Appendix, the following words and expressions have the following meanings:

(a) "**Agreement**" means the agreement between the Government, the BCMA and the Commission to which this Appendix is Appendix C.

(b) "**ASP**" has the meaning given in paragraph 1 of Schedule 1 to this Appendix.

(c) "**BC Leadership Council**" means the council comprised of the chief executive officers of the Health Authorities in British Columbia, which provides advice and recommendation to the Deputy Minister of the Ministry on the strategic direction, management and accountability of the health care system.

(d) "**Core Data Set**" has the meaning given in Schedule 2 to this Appendix.

(e) "**e-Health Steering Committee**" means a committee of representatives of the Ministry, the Health Authorities, the BCMA and other health care provider groups, whose mission is to accelerate the development and implementation of e-Health systems for British Columbia.

(f) "**e-Health Strategic Framework**" has the meaning given in recital A of this Appendix.

(g) "**EMR**" means a standardized system of electronic medical records described in Schedule 1 to this Appendix.

(h) "**Physician Network**" has the meaning given in Schedule 1 to this Appendix C.

(i) "**PITO**" has the meaning given in section 2.1 of this Appendix.

(j) "**PITO Program Director**" has the meaning given in section 2.3 of this Appendix.

(k) "**PITO Steering Committee**" has the meaning given in section 2.2 of this Appendix.

(l) "**SPEED Committee**" means the Special Physician Engagement Expert Delegate Committee, which was established on August 15, 2005 and reports to the e-Health Steering Committee, and is responsible for building the capacity of physicians to adopt and implement electronic health systems in British Columbia.

(m) "**Term**" has the meaning given in section 2.1 of this Appendix.

ARTICLE 2– FORMATION AND STRUCTURE OF PITO

2.1 Formation of PITO

The Government will establish a physician information technology office for British Columbia (the "**PITO**"). The PITO shall operate as necessary during the term commencing on April 1, 2006 and ending on March 31, 2012 (the "**Term**").

2.2 PITO Steering Committee

Management of the business and affairs of the PITO shall be governed by a steering committee (the "**PITO Steering Committee**") comprised of six members, three of whom shall be appointed by the Government, and three of whom shall be practising physicians appointed by the BCMA. The PITO Steering Committee shall report to the e-Health Steering Committee. The PITO Steering Committee and the e-Health Steering Committee shall communicate on a regular basis and shall meet at least twice during each year of the Term. The PITO Steering Committee shall be responsible for the carrying out of the mandate of the PITO as provided in this Appendix. The PITO Steering Committee shall act by consensus decision. If the PITO Steering Committee cannot reach a consensus decision on any matter requiring a decision by it, the matter shall be referred to the Commission, or its successor, which shall determine the matter.

2.3 PITO Program Director

The business and affairs of the PITO shall be managed by a program director (the "**PITO Program Director**") who will report to the PITO Steering Committee. The PITO Program Director shall be jointly selected by the BCMA and the Government. The responsibilities of the PITO Program Director shall include:

(a) setting up an office for the PITO in Vancouver, British Columbia, and hiring staff, within administrative budgets established by the PITO Steering Committee in accordance with section 2.4;

(b) providing progress reports on the work of the PITO to the Board of Directors of the BCMA and to the BC Leadership Council twice annually; and

(c) carrying out the purpose of the PITO and other duties as may be assigned by the PITO Steering Committee.

2.4 PITO Administrative Budgets

For each Fiscal Year of the Term the PITO Steering Committee shall establish a budget for the administrative costs of the PITO, which shall be provided within the funding to be provided pursuant to section 10.4 of the Agreement, provided that the aggregate of all the yearly budgets for administrative costs of the PITO over the Term shall not exceed $2,000,000 (although that figure may be increased if funds are made available for that purpose from sources other than the funds referred to in section 10.4 of the Agreement). The administrative costs of the PITO for the purposes of such budget shall include:

(a) office costs;

(b) PITO Program Director and staff salaries, benefits and expenses;

(c) costs of BCMA physician appointees' participation (other than employees of the BCMA) on the PITO Steering Committee, the SPEED Committee and the e-Health Steering Committee; and

(d) costs of administrative and clerical support required for the work of the PITO Steering Committee.

If the PITO Steering Committee cannot reach a consensus decision on the budget for administrative costs for any Fiscal Year of the Term, the matter shall be referred to the Commission, or its successor, which shall determine the matter.

2.5 SPEED Committee and e-Health Steering Committee

The SPEED Committee and the e-Health Steering Committee shall:

(a) provide advice and input to the PITO on the establishment and implementation of the use of information technology by physicians, including appropriate provincial EMR standards to enable connectivity; and

(b) coordinate information technology activities identified by the GPSC, the SSC, the SCSPC, the JSC and the APC which shall facilitate the achievement of the objectives of those committees.

ARTICLE 3– PURPOSE AND ACTIVITIES OF PITO

3.1 Purpose

The Government and the BCMA agree that the purpose of the PITO is:

(a) to promote the use by all physicians in British Columbia of an EMR as their principal method of record keeping for patient/clinical records

(b) to develop a program to advise, assist and provide support to physicians in connection with such physicians subscribing to and adopting an EMR as their principal method of record keeping for patient/clinical records;

(c) to facilitate the adoption by physicians of an EMR and other information technology solutions for their practices by supporting interested physicians in expanding their use of information technology and providing technical support and advice to physicians with respect to:

  (i) information technology training services and information technology change management services, for physicians and their staff;

  (ii) the purchase by physicians of suitable hardware and software packages;

  (iii) the acquisition by physicians of secure, high speed internet and email service for their offices;

  (iv) access by physicians to approved EMR applications with built in chronic disease management toolkit functionality, including licensing and maintenance; and

  (v) access by physicians to e-prescribing of pharmaceuticals and to lab test results, if and when these services become available;

(d) to consult with other jurisdictions on approaches to expanding the use of information technology by physicians, in collaboration with the e-Health Steering Committee and the SPEED Committee;

(e) to facilitate the sharing of best practices and experiences among physicians and physician groups, in collaboration with the SPEED Committee;

(f) to facilitate the development of change management strategies and educational strategies to assist physicians in adopting the EMR and other information technology solutions in their practices; and

(g) to participate in regular evaluation of the effectiveness of the PITO and the adoption by physicians of the EMR and other information technology solutions, such evaluations to be:

(i) prepared jointly by the Ministry, the BCMA and the Health Authorities; and

(ii) provided by PITO to the e-Health Steering Committee and the BCMA Board when completed.

3.2 Product Packages for the EMR

The PITO will work with third party suppliers to develop and define packages of hardware, software and other products and services (including secure high speed internet and email services) that will facilitate the adoption by physicians of an EMR as their principal method of record keeping for patient/clinical records, and to make such packages (as they may exist or be altered from time to time) available to physicians on a standing offer basis. Physicians will then be free to choose their EMR solution from those standing offers.

3.3 EMR Products

The EMR products referred to in section 3.2 must:

(a) automatically generate the Core Data Set as a normal business practice;

(b) automatically deliver or "push" the Core Data Set generated by a physician's EMR application to a local or regional ASP;

(c) support a high level of integration into regional and provincial systems as interfaces to these systems are developed; and

(d) meet provincial standards for EMR products.

3.4 Access to EMR Information

The Government, through the Ministry, and the BCMA shall jointly develop and maintain a policy and clearly defined rules regarding the use, disclosure and access to EMR data and information in compliance with all applicable freedom of information and privacy legislation and any other relevant legislation. It is the intention of the parties that the policy and rules developed and maintained pursuant to this section will contemplate the availability of and allow to be used certain EMR data and information on an aggregate basis for health system planning by the Government, with appropriate protections for the privacy of individuals.

3.5 Program and Budget for Implementation of PITO Purposes

The PITO Steering Committee shall develop a program, strategy and timetable for:

(a) the implementation and adoption by physicians in British Columbia of an EMR as their principal method of record keeping for patient/clinical records;

(b) for other IT solutions for physician practices; and

(c) for other purposes of the PITO set out in section 3.1;

and for each Fiscal Year of the Term the PITO Steering Committee shall establish a budget therefor, consistent with the Ministry's e-Health Strategy, within the funding provided for the PITO pursuant to section 10.4 of the Agreement. If the PITO Steering Committee cannot reach a consensus decision on such a budget for any Fiscal Year of the Term, the matter shall be referred to the Commission, or its successor, which shall determine the matter.

3.6 Voluntary Implementation of the EMR by Physicians

Physicians shall adopt an EMR as their principal method of record keeping for patient/clinical records on a voluntary basis.

3.7 Financial Assistance to Physicians Adopting the EMR

As part of the program for implementation of an EMR by physicians in British Columbia, the PITO Steering Committee shall provide a program and policies for providing financial assistance to physicians adopting an EMR as their principal method of record keeping for patient/clinical records, within the budgets determined pursuant to section 3.5. This will include reimbursement for 70% of the cost paid by physicians for product packages made available to them pursuant to section 3.2.

SCHEDULE 1 to APPENDIX C

DESCRIPTION OF THE ELECTRONIC MEDICAL RECORDS SYSTEM

1. Each EMR shall be hosted in a securely managed non-Government and accredited third party service provider ("**ASP**") environment connected to a secure British Columbia physician network (the "**Physician Network**") Individual physician practices will have a secure, private and separate database or virtual database for their data in this professionally managed environment.

2. The principal responsibility for custodianship of the EMR data of a physician shall reside with the physician.

3. The EMR shall include the Core Data Set which shall be a key tool in providing patient care and health system planning. The Core Data Set for each patient shall be available to health care providers, other than the primary physician, in compliance with all privacy laws and regulations, and any other relevant legislation, and on a need to know basis, in order for those health care providers to administer health care services to a particular patient.

4. The Core Data Set may reside in a number of locations, including with a local or regional ASP, in order to facilitate direct patient care and/or health system planning. Information will be transmitted via the Physician Network. The use or disclosure of the Core Data Set must comply with all privacy laws and regulations, and any other relevant legislation.

5. The establishment and operation of Core Data Set projects shall include physician participants.

6. The EMR shall follow a distributed model which provides that the Core Data Set is delivered or "pushed" to a local or regional ASP so that the updated data is available at all times to manage planned and unexpected data queries.

7. EMR products, the availability of which is arranged by the PITO, will automatically generate the Core Data Set as a normal business practice.

SCHEDULE 2 to APPENDIX C

DESCRIPTION OF THE CORE DATA SET

The "**Core Data Set**" includes the following information with respect to a patient:

(a) demographic information;

(b) current conditions;

(c) past medical and surgical history;

(d) allergies/alerts;

(e) current medications;

(f) immunizations;

(g) advance directives; and

(h) most recent and critical diagnostic data;

and will be further defined with data elements and data standards.