Physician Fee Decisions, the Medicare Basket and Budgeting: A Three-Province Survey

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INTRODUCTION

Canada's public Medicare system, it seems, is stuck for solutions to the health human resource (HHR) crisis; more pointedly, for answers to the dire shortage of physicians. Our public system, in essence, is increasingly pressured upward toward U.S.-driven levels of compensation for all health care providers. Yet the recurring mantra of reform here at home is downward: more productivity (to borrow from Senator Kirby), and more cost containment (from the Kirby and Romanow Reports): better management, in other words. No other OECD nation has quite the same problem.

The intense craving for physician skills in Canada appears to have pitted have provinces in a bidding war that includes a magnetic labour market to the south, leaving the other provinces struggling even more. Indeed, the many and varied buyers of physician skills in the U.S.'s persistently anomalous two-tier system drives up the price of physician skills even more than any interprovincial competition. In Canada, then, governments are thrust into what is in substance a continental, multi-tiered market for physicians.

This is the context in which physicians and governments negotiate fee increases. Two developments bring fee setting decisions – the main subject of this paper – to the attention of this project. The first is that fee increases are an important background cost lever (among many others) in the system that, depending on government responses, can make Medbasket decisions that much more difficult. The economics are fairly simple. Fees are the unit cost of listed services; when they increase, global costs increase, regardless of how increases are apportioned among listed services. Thus fee increases, even commingled with other cost levers, are still a large and unmistakable factor in Medbasket issues.

The second development is that claims to privacy and exclusivity by governments and physicians on fee setting are receiving less deference from health policy observers. Until recently, it might be said that health economists and other observers would have deferred to freedom of contract: Fees are wages, wages are considered private matters between the parties, and external parties should have no part in those matters. However, at least as early as the Romanow Report and since, wage increases for physicians and other groups have drawn increasing attention for many reasons, not least of which is that they evidence a reversion to peace pacts in lieu of the much-called for structural reforms. Moreover, the broader 'health human resource' crisis in Canadian (and almost every other nation's) health care has brought forth a mature and

sophisticated science to address it. “HHR Policy” is a mix of economics, law and a great deal of evidence-based predictions. Within this emerging subset of health policy, wages are bundled in with many other issues once considered off-limits to academics and other observers. The HHR crisis, if nothing else, has lowered the drawbridge on the physician-government bargaining relationship.

In this paper, we compare fee setting decisions in Ontario, Alberta and British Columbia (B.C.). First, let us review some terminology. By “Medbasket” decisions we mean decisions about coverage: what physician services are paid for by public plans. By “fee setting” (or just “fee”) decisions we mean decisions on the global increase in fees. In this paper, we also parse out increases in professional fees from the myriad other fees and their increases. Professional fees are the basic fees for physicians’ time. Technical and overhead fees are a different kind of fee, although still negotiated with professional fees (Facility fees for independent health facilities are the best analogy to these fees). Further, professional fee increases are distinct from increases targeted at specific initiatives such as rural recruitment, specialist retention, or alternative funding or payment models.

We also do not wish to confuse fee decisions with fee *allocation* decisions, which are part of Medbasket decision-making. Medbasket decision-making usually takes fee increases as ‘found’ increases in spending that can be allocated among existing (and new) services. Under an allocation, some services may receive an increase larger than the global increase, others less - or even a decrease. The global increase, which is our focus, remains the same. As well, fees can be and have been ‘clawed back’, although government enthusiasm for such measures has waned in the face of an increasing shortage of physicians.

A final point on fees: What we call ‘decisions’ on fees are actually not decisions at all, but the result of compromise in negotiation. Fees are people’s wages. Fee decisions are fee agreements. Concerns about these and a growing number of other ‘terms of the bargain’ between governments and health professions too often overlook that these terms are the result, as is often the case in collective bargaining, of the interplay of economic and political power. We, as analysts, may critique terms of these bargains, and try to find flaws with how they are reached; we may even do so on the basis of shared standards. We may try to make a science out of labour policy and strive to engineer outcomes, yet in doing so we may ignore very un-scientific factors that drive joint decision-making.

Therefore, while we may critique the form and place of fee decisions within the broader milieu of Medbasket decisions, we must also be careful not to blame too much on process and structure. As noted earlier, HHR crises are having profound effects on labour market trends

across all health care systems, Canada included. The balance of political power between physicians and governments, and as between physicians and other professionals, is seldom predictable, yet it, coupled with economic realities in the current health care labour market, is the best explanation for many 'decisions' in this setting. Our critiques of the current decision making structures on fees will therefore be offered in this light.

We present our findings on fee setting decisions in each province within a broader discussion of the Medbasket and budget-setting processes with which they interact. To illustrate some of the processes at work we have included some recent bargaining and other Medbasket experiences, although of necessity this paper will be dated. Colleen Flood and Joanna Erdman have already thoroughly reviewed Ontario's primary site of Medbasket decision-making, the Physician Services Committee. Here, we hope to complement their work with additional findings on the PSC's institutional cousins in Alberta and B.C.

(1) ONTARIO

(a) Overview and Recent Bargaining Experience

Though akin to a legally formalized collective bargaining relationship, that between the MOH and OMA is technically not – physicians are not employees and in any case cannot form unions under Ontario law. Rather, the OMA is recognized by the MOH as the exclusive bargaining agent for physicians in Ontario.[1] The OMA's exclusivity is backstopped by the *Ontario Medical Association Dues Act, 1991*,[2] which requires all Ontario doctors[3] to submit annual dues to the OMA as a condition of their right to practice, much like the 'Rand' formula does in the traditional labour relations context.[4]

In part due to history, the MOH prefers to deal with just one bargaining agent for physicians. In 1995 the government began having the MOH bargain directly with groups of physicians divided by specialty. However, the duplication was a nightmare for the MOH, as newly established groups threatened to withdraw or reduce services. .In 1996, the government passed Bill 26, an omnibus piece of legislation that, among many other public sector reforms, nullified the pre-existing framework agreements between the OMA and MOH. Soon afterward, the government reverted back to bargaining only with the OMA.

Since 1997, then, the result of this bargaining process is the OMA-MOH Memorandum of Agreement. It was renewed in 2000and 2004.[5] This agreement is a strictly economic contract between the OMA and MOH prescribing fee increases, both across the board and targeted. In addition, it creates

various committees – revolving around the Physician Services Committee outlined below – that make Medbasket decisions.

(b) Medbasket, Budgeting and Fee Decision-Making

As Flood and Erdmand discuss in their paper, the real hub of Medbasket decision making in Ontario is the Physician Services Committee constituted under the Framework Agreement. As well, the PSC is also designed to keep a lid on physician-government conflict. The importance of its industrial relations function should not be understated.

After rancourous disputes between the profession and the government in 1996, which nearly provoked job action by physicians, the PSC was seen by the parties as an on-going bilateral committee to take pre-emptive and innovative approaches to defusing potentially divisive problems. Mediative committees are a common facet of so-called "interest-based" approaches to bargaining. Sometimes called 'win-win' or mutual gains bargaining, this Harvard-inspired negotiation model claims greater openness with information, greater use of expert information, and ongoing problem resolution. In this mediative role, the PSC consists of ten members, five each from the MOH and OMA. It meets twice a month. *A propos* of the PSC's industrial relations function, both parties have retained lawyers and mediators on the Committee whose primary practice specialties are in union-management relations.

Medbasket decision-making, however, is the main ongoing work of the PSC. The PSC decides how to allocate increased funding to fee increases (or decreases) among existing services, and also what, if any, services to add or remove from the schedule of benefits. However, such decisions almost always have their genesis in the OMA itself.

The committee within the OMA that does this is called its Central Tariff Committee (CTC). The CTC solicits research and submissions from a wide variety of medical specialists and struggles to come up with changes to the schedule that, in its view, are most appropriate. It is a 10-person committee, all physicians or physician economists. The CTC operates independently from the formal OMA-MOH bargaining process. Unlike the PSC and other decision-making processes within the OMA-MOH bargaining relationship, its mandate is not to account for budget estimates, nor of fee increases, in making its recommendations.

The CTC's annual report is widely respected in the medical community and carries a great deal of weight in the Medbasket process The CTC reports annually to the MOH, which in turn considers it in consultation with the PSC and its subcommittees. In these committees, however, only Ministry and OMA representatives participate in the review of the CTC's proposals. While it is never

easy to assess, according to our MOH official, the CTC's recommendations are generally well received by the parties, and often implemented.

However, the CTC is still restrained, despite this influence. According to one MOH official we interviewed, the CTC has been more reticent of late in recommending the removal of services from the schedule.[6] In fact, since 1998 the CTC has not forwarded a report to the OMA or PSC containing any de-listings. In part this has to do with litigation by Ontario audiologists[7] and other groups to contest some of the de-listings that ultimately resulted. As well, difficult rationing decisions are made within the CTC before presenting its report, as it strives for a positive response from the PSC.

Physician fee increases can place a constraint on how receptive the MOH can be to the CTC report. For example, a 2% increase in 2001 means that this 2% can be used to add more services or be an across the board increase for existing ones. To bring sophistication to the exercise, the Resource-Based Relative Value Schedule Committee (RBRVSC) plays an important role as a fee increase allocation mechanism. The RBRVSC, which reports to the PSC on its recommendations for targeted increases, is a three-person bilateral committee. [8] Its task is "to determine the relative value of services provided by physicians on a revenue neutral basis."[9] That is, it is to review the schedule of benefits and assign relative "weights" among services depending on factors such as effectiveness, utilization, and cost. The RBRVSC's report bears directly on how fee increases negotiated in the Agreement[10] are to be allocated among the over 4,600 services set out in the Schedule.[11] In 2000, the parties devoted 1% to across-the-board increases, and 1% to targeted increases. In the 2003 round of bargaining (technically, a re-opener round provided for in the 2000-2004 agreement), the parties may devote the entire 2% for 2003-04 to targeted increases.

Behind and surrounding the PSC and its related Medbasket committees are the fee increase decisions. Fees are decided chronologically 'behind' Medbasket decisions, and are taken as 'found' – and therefore surround and constrain activity - at the PSC level. The Framework Agreement is renewed in cycles, as are fee increase agreements. However, both run in parallel streams.

We have much evidence about what factors drive joint OMA-MOH decisions in the Medbasket stream, but none on those in the fee stream. At present, fee increases – and how they are arrived at – remain shrouded by the privacy attendant in any sensitive economic negotiations. Public sector wage bargaining of any kind is hardly a private matter – but only when it breaks down. The real interplay of political and economic power which drives most wage settlements remains a mystery to external observers. Certainly, both sides use evidence and persuasion to

convince each other privately, so it cannot be said that politics determines the entire result in any given settlement. Yet we simply do not know how much of the result it determines.

(2) ALBERTA

(a) Overview and Recent Bargaining Experience

The Alberta Medical Association's (AMA's) authority to represent its 7,000 member physicians is derived from contractual agreements with AHW and nine regional health authorities. Provincial collective bargaining legislation does not recognize the association and specifically prohibits physicians from forming a union.[12] For physicians, membership in the association is voluntary and there is no Rand-style dues formula such as the one adopted by Ontario. However, physicians who wish to access benefit programs which the AMA negotiates with government must either be members of the association or pay an administration fee which is virtually identical to its annual dues.[13] At the same time, the Alberta government has committed that it will not negotiate fees and other related matters with groups other than the AMA.[14]

The AMA characterizes its relationship to government as one of shared responsibility. On this view, accountability for system management and the consequences of failing to meet goals established through negotiations are meted out in a reasonably even-handed way.[15] Certainly the current contract, which will be reviewed in more detail below, provides specific language around responsibility for budget over-runs related to factors such as greater-than-anticipated population growth and growth in the number of physicians practicing in Alberta as a result of recruitment drives.[16]

However, the foundation for an effective sharing of responsibility is established, not only at the negotiating table, but also through a relationship of elite accommodation that allows the AMA to extend its policy influence. Both the AMA and AHW view one another as key players on the health care stage with defined roles that each may influence but not usurp. In contrast to British Columbia where physician-government negotiations have acquired an adversarial labour versus employer tone, Alberta more closely resembles a truly contractual relationship in which each party's interests may collide or converge, depending on the issue at hand.[17] The roles of adversary and ally are not entrenched, leaving both parties room to cooperate when occasion demands without risking a loss of political face.

Disputes resulting in service disruptions have not been frequent or widespread in Alberta and binding arbitration has not been used to resolve any issues in at least the past decade. The

most recent service withdrawal occurred during bargaining in 2000 when doctors participated in an escalating 10-day action to press their case for an increase to the medical services budget beyond what the government was offering.[18] During this period AHW served notice that it would seek binding arbitration to resolve the fee dispute but the matter was eventually settled at the negotiating table. A year later, the AMA filed a letter serving notice the association would seek arbitration over a fee dispute which arose with respect to the 2001-02 fiscal year. This issue was also settled through agreement.[19]

"Prorationing" (a temporary claw-back or reduction of physician fees to keep the budget for insured services balanced) has been used only twice in recent history. In the early 1990s, the Alberta government made hundreds of millions of dollars in cuts to the health budget as part of a wholesale effort to reduce public-sector expenditures. Wages for government employees were rolled back by five per cent. Physician fees were decreased by 5.88 per cent, implemented in increments between August 1993 and April 1995. Since that time, fees have been rising.[20] However, an increase of 3.42 per cent in November 2001 reflected a 1.63 per cent reduction from target as a result of prorationing. This second reduction was reversed in April 2002 after it was determined that the 2001-02 budget was not over-expended. The aggregate fee increase implemented at that time was 10.93 per cent.[21]

In potential public spending terms, Alberta is now very much a have province, especially relative to its population health needs (it has one-fifth Ontario's population). In recent years, its energy wealth has allowed the government to realize multi-billion-dollar annual surpluses and has undoubtedly played a role in preserving the relatively smooth relationship between AHW and the AMA.

Physician-government relationships in Alberta are governed by a master agreement establishing, in general terms, the *Master Agreement Regarding the Tri-Lateral Relationship and Budget Management Process for Strategic Physician Agreements* (*Master Agreement)*[22] establishes the template under which working agreements and specific subsidiary agreements are negotiated. Finalized in November, 2003 and ratified by AMA members a month later, the *Master Agreement* spans eight years from April 1, 2003 to March 31, 2011. It provides for physician compensation increases for insured services of 2.7, 2.9 and 3.5 per cent in fiscal years 2003-04 to 2005-06. For the same time frame, there are additional increases related to expected population growth (1.95, 1.9 and 2.2 per cent respectively).[23] Financial re-openers are set for March 31, 2006 and March 31, 2008.

The new agreement is a departure from previous documents in structure and scope. Regional Health Authorities (RHAs) are party to the deal with the doctors for the first time since

health regions were established in 1995, giving them a direct voice in negotiations. Bringing the RHAs into the fold formalizes their relationship with the AMA and allows better coordination of hospital-based and community-based services. Language in the new document suggests it is to have far-reaching implications for the health care system rather than simply determining physician compensation for a set period of time. It stipulates that the Health Minister has offered "an expanded and enhanced role and relationship to the (AMA) regarding how to improve the Health Care Delivery System," a nod to the medical association's privileged position among health professions in helping to shape systemic changes.. The agreement also recognizes a "collective desire" among the parties to "work together and with other health care service providers in a collaborative and cooperative way…."[24]

The document acknowledges the report of the *Premier's Advisory Council on Health* (the *Mazankowski Report*) released in 2002 as well as "other reports and studies" identifying the need for systemic improvement to the national health care system.[25] However, it does not specifically link any of the contractual responsibilities under the *Master Agreement* to recommendations in any of these documents.

(b) Medbasket, Budgeting and Fee Decision-Making

The *Master Agreement* creates a hierarchical committee structure to provide "general guidance to the Relationship and budget management processes…"[26] It establishes a tri-lateral committee structure which governs management of the budgets for physician services, on-call remuneration, primary care restructuring and physician office information technology. The three parties are the AMA, the provincial Crown (represented by AHW) and nine RHAs. All decisions made by the various committees are made by consensus – essentially unanimous agreement by all members representing all parties.

At the top of the hierarchy is the three-member Master Committee comprised of the CEO of the AMA, the deputy minister of AHW and a CEO representing the RHAs who is chosen "from time to time" by the Council of RHA CEOs.[27] This committee oversees the Master Physician Budget (MPB), defined as the total budget for: physician services and benefit plans, primary care funding, on-call remuneration and funding for physician office computer technology. The Master Committee has final authority to adjust, reallocate or re-distribute money within the Master Physician Budget, including authority to move funds from one element to another, in order to keep the budget balanced.[28] It also has authority to determine the use of surplus funds and to make recommendations to AHW with respect to budget adjustments.

Consensus decisions by the Master Committee are final and binding. If the Master Committee is unable to agree on an issue, it may be referred to a binding arbitration process outlined in the agreement.[29]

The *Master Agreement* contains specific language for dealing with certain budget over-runs that the Master Committee can not resolve. Specifically, if the over-expenditures are attributed to:

> i) increases in the Alberta population above those already factored into the agreement,
> ii) the impact of agreed-upon physician recruitment plans, or
> iii) supplements to the Insured Services Element needed to fund approved alternate payment plans,

Then the Health Minister is "obliged to decrease or eliminate" the over-expenditure according to formulas set out in the agreement.[30] These provisions reflect the parties' understanding that physicians should not be responsible for matters that are beyond their control. As a final resort, over-expenditures in the insured services budget may be resolved by reducing scheduled budget increases or by adjusting fees paid to physicians.[31]

The Master Committee plays the key coordinating role through its mandate to oversee management of the budget for insured services and other physician compensation elements. This three-member, executive-level committee has significant authority to make rationing decisions. It reviews utilization issues, changes to insured services brought about by adding new items or de-listing existing ones and top-up payments in excess of provincial fee rates which are offered to physicians when market conditions or other factors dictate. Using information provided by the various committees within the structure, the Master Committee files annual reports to the government recommending budget adjustments.

There are a number of key decision-making sites within the hierarchy where issues of benefit schedule reform come into play. At each stage, these decisions are prioritized and shaped by the competing interests of the three parties represented in the structure and by the financial resources available. However, there are pools of funding beyond the basic fee increase to address needed reforms to the benefit schedule which makes this buckling of evidence and financial resources less restrictive than it might first appear.

Below the Master Committee in the Medbasket hierarchy is the Secretariat that represents the working arm of the committee structure. The Secretariat has nine members, appointees from each of the parties. AHW appointees must include the department's assistant deputy minister responsible for overseeing the *Master Agreement*. The RHA appointees include one person

appointed by each of the Capital Health and Calgary Health authorities as well as one other representative chosen by the Council of CEOs.[32] AMA representatives may, but need not be, doctors.[33]The Secretariat oversees the work of four strategic physician agreement committees, described in detail below, and prepares reports and recommendations on issues to be considered by the Master Committee. It also monitors the Master Physician Budget and, at the direction of the Master Committee, provides regular analyses of actual expenditures compared to budget for each element. If the Secretariat can not come to consensus on an issue it is forwarded to the Master Committee.

The Secretariat's four subcommittees govern separate sub-agreements on different physician and Medbasket issues. These committees are:

(1) The Physician Services Committee (PSC): This committee oversees the *Physician Services Agreement*[34] and manages the Physician Services Budget (PSB) in accordance with direction from the Secretariat and the Master Committee. The PSB ($1.341 billion in fiscal 2003-04) is comprised of funding for insured physician services (paid for either via fee-for-service or alternate payment mechanisms) and physician benefit plans.

The PSC plays a pivotal role in fee determination issues and schedule benefit reform. It is the central point for assessing the technical and evidence-based information that informs these decisions. Its mandate includes responsibility for expenditures and utilization related to insured services and physician fees.

Two significant sub-committees are responsible to the PSC. The tri-lateral Schedule of Medical Benefits Subcommittee (SOMBS) that deals with fee allocation and benefit schedule matters reports directly to the PSC. Reporting to the SOMBS is a bi-lateral committee, the Rules Redevelopment Working Group (RRWG) comprised of AMA and AHW members. As its name implies, the RRWG examines rules surrounding payments under the schedule and recommends changes.

Insured services which are not currently part of PSB (such as laboratory fees) may eventually be brought into this funding envelope with the agreement of the Master Committee. In the event such an expansion is contemplated, the PSC would provide the technical or other information required by the Master Committee.[35]

(2) The Primary Care Initiative Committee (PCIC): The PCIC oversees the *Primary Care Initiative Agreement*[36] and the expenditure of funds in the primary care budget. It is to establish province-wide standards for the local primary care initiatives, determine the process for selecting those that will be funded, and develop accountability mechanisms and remedies for non-compliance with service responsibilities.

The primary care initiative is the newest program brought under the mantle of the *Master Agreement* and represents a commitment to orchestrating change in the health system through the physician-government negotiating process. Using $100 million in funding over three years, the initiative is to create teams of doctors, nurses and other service professions who will provide enhanced primary care to patients, particularly those who have chronic conditions such as asthma and diabetes. The teams are established through contracts (local primary care initiatives) between participating physicians and regional health authorities. They are to provide coordinated 24-hour, 7-day-a-week management of a designated list of primary care services to a group of enrolled patients for whom they are the major health care provider.[37] Participating doctors may work under either a fee-for-service or alternate payment compensation scheme. The initiative provides up to $50 per enrolled patient per year to pay for additional services such as nursing, home care and other enhancements. Enrolled patients are not prohibited from seeking services elsewhere.

(3) Physician Office System Program Committee (POSPC): This committee oversees the Physician Office System Program which was established in 2001 to provide financial support for doctors wishing to expand the use of computer technology in their practices and is continued under the *Master Agreement*. Participants may receive up to 48 months of funding from the allocated budget ($65.6 million for fiscal 2003-04 to 2005-06) so long as they meet established criteria. Doctors involved in primary care reform and the move to a province-wide electronic health record system are given priority for funding.

(4) Physician On Call Programs Committee (POCPC): Both the Specialist On Call and Rural On Call programs fall under the mandate of this committee which oversees the budget ($215.6 million for fiscal 2003-04 to 2005-06), develops accountability and evaluation criteria, and reviews remuneration levels.

These four committees oversee four accompanying strategic physician agreements, included as schedules within the *Master Agreement*, each dealing with an element of the physician compensation package. As with other committees in the hierarchy, they operate by consensus. Disputes which can not be resolved by any of these committees are referred to the Secretariat and, if necessary, the Master Committee.

The tri-lateral committee structure represents a sophisticated political balancing act. It effectively gives each of the parties a veto at every step in the decision-making process, ensuring a balance of power is maintained. This structure also provides each party with an opportunity to bring its expertise to bear on an issue and share information. In this way, each committee becomes an arena for weighing information, communicating about the various interests at stake and negotiating acceptable outcomes.

Where consensus can be reached among the provincial government, the RHAs and the physician association, this powerful triumvirate has the capacity to effect significant change within the health care system, including the Medicare basket. However, the balancing required to achieve consensus ensures change in some areas may be incremental at best. As Dr. Ken Gardner, a member of the Secretariat and Vice-President of Medical Affairs for the Capital Health Region explains:

> The ultimate best consensus is everybody says that this is the best way to go. The more common is that it's not perfect for anyone but it is livable for all and that's often where you are at. If you get a situation where it is: 'Over my dead body,' it stops and you never get to a situation where there is a vote so one party can not be outvoted by the other two.[38]

Mike Gormley, Chief Executive Officer of the AMA, who represents the association on the Master Committee, notes that for each party in the agreement "it's not so much what we can do on our own, which is minimal actually, but it's what we can stop, which is a lot."[39]

Within this structure, the PSC plays a significant role with respect to decisions relating to the Medicare basket. The *Master Agreement* recognizes the "unfettered" discretion of the health minister to make such changes. But it stipulates that AHW will provide the AMA and the RHAs with at least 90 days prior written notice. Within 45 days of such notice being received, the PSC is to report to the Secretariat on the "direct financial impact" the government initiative will have on the Physician Services Budget. A report on the medical merits of adding or delisting a service may also be provided but is not required.[40] The Secretariat has 20 days to consider the PSC report and forward it to the Master Committee with its comments and recommendations. The Master Committee must forward a report or recommendation to the minister who "shall" consider it but shall not be obliged to act.[41] Significantly, if the minister proceeds with the proposed addition or de-listing, the budget adjustment required to fund the change is a matter for the Master Committee to decide. If the three members of this high-level committee are deadlocked, the matter may be referred to binding arbitration. Thus while the minister may unilaterally de-list or add services, he/she needs consensus among the AMA and RHAs with respect to the amount of money needed to fund a new service or how the money saved as a result of de-listing may be re-allocated.

Still, any comparisons to its namesake in Ontario need to take into account the Alberta committee's role in the hierarchy. Unlike Ontario's Physician Services Committee, Alberta's is interdependent with other joint structures. Although the Alberta PSC represents a key point where evidence for decision-making is collected and evaluated, its ability to make decisions is tempered by its responsibilities vis-à-vis the Secretariat and Master Committee.

Considerable political inertia would have to be overcome for the Alberta government to unilaterally set in motion a process to de-list publicly-funded services. Following the release of the *Mazankowski Report* the Expert Advisory Panel to Review Publicly Funded Health Services was established to review and make recommendations concerning public funding for Medicare services. Two years later, after reviewing the panel's recommendations,[42] the Alberta government elected to maintain the current basket of services and rejected the panel's recommendation to establish a permanent review body to review existing provincially-funded health services on an ongoing basis and to assess the feasibility and desirability of adding new services**.** Under the model recommended by the panel, the review body would have evaluated the technical, social and fiscal merits of publicly funded services and would have reported its recommendations to the public as well as to government.

Just as political realities provide a disincentive to de-list services, economic considerations may weigh against momentum to add them. Changes in the Medicare basket are influenced indirectly by fee negotiations, the benefit schedule reform process and re-structuring of service delivery. The tri-lateral committee structure exercises significant influence over these processes. It also has input into another over-arching factor, the available budget.

As noted briefly above, Alberta's favourable fiscal position has made flexible budgeting possible in response to fee increases as well as numerous other cost escalators. Budgeting decisions are a function of priority-setting within AHW and among other government departments. Within this context, insured medical services are a significant expenditure to be managed in a fiscally and politically prudent way as other spending priorities may depend upon the ability to effectively managing growth in this area. The Master Physician Budget totaled $1.455 billion for the fiscal year which ended March 31, 2004 - or nearly 20 per cent of ministry expenditures of $7.378 billion. Insured services funding made up the bulk of the MPB (more than $1.3 billion).[43] Under the terms of the Master Agreement, the MPB will rise to $1.652 billion by 2005-06, accounting for roughly the same percentage of health department spending which is forecast to be $8.45 billion.[44] Given the magnitude of this cost item and its susceptibility to growth pressures, it is difficult to unbuckle these decisions from economic considerations and the bargaining process, even in times of relative fiscal prosperity. During times of fiscal restraint such as those which Alberta experienced in the early to mid 1990's the link to economic considerations is stronger and cost containment becomes a more significant driver.

The tri-lateral committee structure affects budgeting decisions to some degree through its input into the Physician Services and Master Physician Budgets and, in particular, the insured services element. The PSC takes the lead in writing a report detailing budget versus expenditure

and indicating areas of growth and whether growth has matched projections. The MPB is set through the bargaining process and is then monitored and managed by the tri-lateral committee structure. Forecasting models for assessing the projected budget are determined by consensus or, if necessary, binding arbitration. If budget over-runs occur, as discussed above, both AHW and the AMA may be responsible for helping to eliminate them.

Most noteworthy from our perspective: the Master Committee, on the recommendation of the Secretariat, may also seek additional AHW funding to deal with budget over-runs. The fee increases scheduled for the first three years of the agreement are in addition to negotiated increases that compensate for utilization increased based on population growth. If growth exceeds the estimates, there is recourse to the government to add money, rather than expecting the system to absorb the increase. This kind of flexibility in the funding envelope provides more latitude within the fee structure to look at the addition of new items and reform to the benefit schedule to encourage certain types of practice.

Within these flexible budgetary parameters, decisions take place throughout the tri-lateral structure which decides how fee increases will be allocated. From the AMA's perspective, the government, not the profession, decides which services are publicly funded, although the AMA may provide expertise upon which decisions are based. Once government decides a service should be covered, the profession will get involved in determining cost. Mike Gormley of the AMA says physicians recognize the line between science, politics and the public interest.

> There are the technical issues about what works and all that stuff but the return to society paying for something is a question that goes beyond the science of medicine. You can have something that is very, very worthwhile and in some circumstances incredibly worthwhile and yet there is still a question of: 'Yes, but should it be covered?' In a social program, is it largely in the public interest?[45]

However, the size of the funding envelope will play a significant role in determining whether there are fee increases sufficient to ensure access to service and whether it is feasible to add new items to the schedule of benefits to reflect changes in practice and treatment. In this way the negotiating process clearly plays a role in shaping the Medicare basket.

Once an overall increase or decrease in the insured services element of the budget has been negotiated, internal AMA processes take the lead in deciding how it will be allocated across the profession. Gormley points out that while approval of the AMA proposal is "not a given," the other parties recognize that consensus within the physician community is important in finalizing the allocation.[46] At the end of the day, fee increases may be allocated across-the-board or, as is more likely, targeted in varying amounts among the sections of practice. Once targeted priorities set by the board, with the approval of the PSC, have been funded, sections may have additional

money (a discretionary increase) to allocate within their sections. For example, the most recent general increase (effective October 2003) totaled 2.9 per cent but was allocated differently across the various medical sections. Cardiovascular and Thoracic Surgery received a 1.12 per cent increase (of which .97 per cent was discretionary) while Infectious Diseases, Physical Medicine and Rehabilitation, and Rheumatology each received a five per cent increase Discretionary portions for each of these disciplines were 2.31 per cent, 2.96 per cent, and 1.89 per cent, respectively.

The AMA has two internal committees which have counterparts with the tri-lateral structure: an internal Schedule of Medical Benefits Subcommittee (SOMBS) and a Rules Redevelopment Working Group (RRWG). Although they have the same name, these are distinct committees from the tri-lateral SOMBS and bilateral RRWG which, as noted above report, to the PSC. The AMA's SOMBS is the clearing house for information from the physician association. It assesses information received from all quarters and presents options for the allocation to the board of directors for review. Input is gathered from fees representatives from each of about 30 specialty sections and the Representative Forum, a broad-based group that includes representation from across the association. The AMA's RRWG plays a similar role to its tri-lateral counterpart, gathering information related to the payment rules within the schedule of medical benefits. A Fees Advisory Committee, which provides input to the AMA members on the tri-lateral SOMBS, also assists in this internal process.

Alberta does not have an equivalent to Ontario's bilateral RBRVSC which tries to assign relative values to various physician services. However, fee equity, defined as ensuring fees reflect physician input in terms of time, intensity and complexity and non-physician expenses related to those services, is one of four key objectives which the AMA tried to achieve through the allocation.[47] In this way, the AMA balances issues of relative value, public interest and schedule benefit reform (to be discussed in more detail below). Acknowledgement of the tri-lateral agreement ensures this physician-centred process takes into account the objectives of government and the RHAs.

The tri-lateral structure thus serves a blended mandate to evaluate evidence, assist with list and de-listing decisions and manage expenditures. The primary care initiative will provide the chief proving ground for this new process since it holds the promise for the most significant change in the schedule of benefits. Success depends on the ability to involve other health professionals in the primary care initiative. Since these groups do not have direct input into the decision-making process, their participation will depend on the willingness of the parties at the table to share power. Dr. Gardner acknowledges the agreement has been criticized by the United

Nurses of Alberta and others for being physician-centered and giving the doctors such a prominent role in setting future care directions:

> The AMA is now challenged and faces an inherent potential conflict in what's good for the system may not always align with the pure physician advocacy role. I think there has been some concern voiced that the AMA will not be able to make that transition and so giving the AMA a potentially larger role in terms of issues that will affect how care is delivered is a potential concern.[48]

However, he says the collaborative opportunity arose out of the physician agreement negotiations and having the other parties at the table may act as a safeguard to balance physician interests.

(3) BRITISH COLUMBIA

(a) Overview and Recent Bargaining Experience

As with its counterpart in Alberta, the British Columbia Medical Association (BCMA) is recognized in contract as the exclusive bargaining representative for about 8,000 physicians who are paid, in whole or in part, from government funds.[49] Membership is voluntary and there is no Rand-style dues collection formula. As with Alberta, physicians who decide not to join the association may access benefits achieved through negotiations with the government by paying an administrative fee. In addition to contractual recognition, the BCMA is acknowledged in legislation. The *Medicare Protection Act*[50] recognizes the existence of the association for the purposes of appointing representatives to the Medical Services Commission (MSC), the body that oversees the budget and management of the Medical Services Plan (MSP).[51]

Despite its agreement recognizing the BCMA as the physicians' exclusive representative, the previous provincial government struck side-deals with doctors in remote and northern regions following a series of service withdrawals beginning in June 2000. After a one-week walkout, physicians in Prince George, located 780 kilometres north of Vancouver, reached a $10 million deal. The bulk of this funding ($5.2 million) provided a top-up to existing fees. Another $3.2 million was allocated for on-call payments and locum coverage. The balance funded new recruits and medical training. In the wake of this, physicians in the northern community of Williams Lake, formed their own society and, following a three-day withdrawal of services, reached a $1.7 million deal with the government for recruitment, retention, education and on-call funding. Following this deal, the provincial health ministry decided these issues should be bargained on a province-wide basis.[52]

The BCMA felt the side deals were bad public policy but did not enforce its exclusivity agreement because it would have put the association in the untenable position of blocking compensation increases for some physicians.[53] However, a *Framework Memorandum*[54] was subsequently finalized which set out the structure of future agreements, bringing the side deals back under the provincial bargaining umbrella.[55]

Representatives of both the BCMA and the Ministry of Health Services (MOHS) commented that physician-government bargaining was influenced by a tone which is generally associated with organized labour negotiations. Geoff Holter, Director of Negotiations for the BCMA, says this climate crosses political lines, continuing under the Liberal government which defeated the reigning New Democrats in 2001:

> The model they look at tends to be a collective bargaining model, trade union model. So, they have an expectation that when they sign a contract with us that somehow we'll discipline our members and every single one of them is bound by the contract. Well, there isn't such a legislative framework.[56]

Although many physicians welcomed the change of government, their enthusiasm was short-lived after legislation was introduced stripping existing agreements of their binding arbitration mechanism,[57] something Holter says "will never, ever be forgotten by the doctors in this province."[58] On the other side of the divide, Peter Van Rheenen, Executive Director of Physician Human Resource Management for MOHS, has his own frustrations:

> My counterparts in the physician negotiation area (elsewhere in the country) can't fathom the kind of service disruptions we've had here as either levers for opening up a discussion of certain benefits in the middle of an agreement or in fact trying to lever an agreement. Because it becomes typical, if you like, labour tactics when in fact the association is quite clear that they are an association. They are not a union.[59]

In her December 2000 *Report on the Contractual Relationship Between the B.C. Government and the Doctors*, government-appointed commissioner Judi Korbin concluded that "a lack of trust and mutual respect" pervaded the physician-government relationship. Korbin recommended the province follow Ontario's lead and establish a process modeled on that province's bi-lateral Physician Services Committee. However, that recommendation has not been followed by Premier Gordon Campbell's government.

The notion of sharing responsibility for physician service expenditures which has won favour with Alberta physicians is not popular with the BCMA. A co-management model established in the 1993 physician agreement turned out to be "very bad" for the profession, according to Holter. It set out the budget for publicly-funded physician services (the Available Amount) for the 1992-93 to 1996-97 fiscal years and established the physician fees to be paid

during that period. Physicians and government undertook to reduce utilization costs by $383.2 million during the life of the agreement. If the BCMA failed to meet its obligations, with the result that physician expenditures exceeded the Available Amount, the association was responsible for the excess costs.[60]

When targets weren't met, a new agreement covering the 1995-96 to 1997-98 fiscal years was established and the provincial government absorbed a $75 million cost overrun for fiscal 1995-96. When targets under the Renewed Working Agreement weren't met, prorationing was instituted. A 4.4 per cent across-the-board reduction was applied to fee-for-service claims beginning in August 1997 and lasting for the balance of the fiscal year. A similar reduction was applied to claims between April 1 and November 30, 1998 and a 3.3 per cent reduction was applied to claims between Dec. 1, 1998 and Jan. 31, 1999. In response to proration, the BCMA introduced Rationed Access Days (RADs), designated dates in which doctors were instructed not to schedule or provide elective office visits or procedures. Three days were announced in the 1997-98 fiscal year and 20 during the 1998-99 fiscal year.[61]

Holter estimates the experiment with shared responsibility for the physician services budget cost the doctors about $100 million and has significantly soured the bargaining relationship. He maintains that the agreement, negotiated prior to his tenure at the BCMA, ignored the government's overriding interest in controlling physician expenditures:

> Government, in fact, would negotiate a fee increase and then, in fact, take it back by reducing the amount of money that was available to fund it. That led to the office closures which was a B.C. disease as it was called across the country but it also lead to a very, very militant membership and the legacy is a lot of head-butting.[62]

B.C. doctors have continued to use service withdrawals during negotiations to lobby for fee increases and improved staffing levels. During bargaining in 2004, emergency physicians in the Vancouver Island community of Nanaimo withdrew their services in a dispute over staffing levels.[63] Physicians also complained the government refused to discuss health reform issues at the negotiating table. "B.C. doctors have recommendations for patient care guarantees, primary care renewal and ways to reduce wait lists," then-BCMA president Dr. John Turner wrote in a newspaper guest column. "We have ideas on how to manage the system better, including how to use new federal funding allocations….Today, however the government simply refuses to talk with us about these ideas."[64]

(b) Medbasket, Budgeting and Fee Decision-Making

Budgeting decisions in B.C. reflect priority-setting within the MOHS and among other government departments. The government sets the Available Amount – essentially the budget for physician-delivered insured services. The MSC is tasked with ensuring that its *meso* and *micro*-level decisions do not allow the cost of claims to exceed it.

In setting the amount, the province gathers input from the commission and the BCMA and the base budget for existing services is taken into consideration along with allowances for anticipated utilization growth. Figures from the 2004 provincial budget demonstrate the emphasis on cost containment. For the year ending March 31, 2004, spending on the Medical Services Plan totaled $2.559 billion or about 24 per cent of the $10.530 billion budget for health spending. Under the province's budget plan spending in health and for physician services is to remain relatively flat. MSP spending is forecast to rise to $2.568 billion in 2004-05 and remain at that level through 2005-06 while overall health spending for those years is forecast to be $10.558 billion and $10.785 billion respectively.[65]

Once the Available Amount has been set and negotiations have determined whether a there will be a physician fee increase, two sets of decision makers interact at the level of Medbasket decision making: one set from legislation, the other from contract. From legislation, the Medical Services Commission (MSC) is the central Medbasket decision-making structure. Originally established in 1967, the commission oversees the provincial Medical Services Plan (MSP) and has the authority to determine which services are medically necessary and eligible for public funding. The nine-member commission is comprised of three representatives each from the BCMA and provincial government. Another three members, representing MSP beneficiaries, are appointed upon the joint recommendation of government and the BCMA. All members are appointed by cabinet for three-year terms which are subject to renewal. The MSC chair is a government appointee who is obliged to call meetings at least once every two months.

Unlike the Alberta tri-lateral committee structure which operates by consensus, decisions of the MSC are made by a majority of members attending the meeting at which the vote is taken. By including beneficiary representatives, the MSC is the only major decision-making structure studied which attempts to bring members of the public to the table, a matter which will be discussed below in more detail. The MSC's legislated mandate is set out in the *Medicare Protection Act* which, among other things, provides that:

> i) the funding envelope for insured physician services (Available Amount) will be centrally administered by the MSC,
> ii) physician fee-for-service and benefit plan payments are limited to the amount of funding provided by the legislature in a given year for that purpose,

> iii) the MSC decides what is and what is not a medically necessary service for the purpose of public funding. No addition to, deletion from, or modification of the payment schedule has effect without written approval of the MSC,
> iv) the MSC has the authority to decide which diagnostic facilities may provide publicly-funded services,
> v) if the MSC introduces any redefinition of medical services, it will provide at least 30 days notice to all physicians enrolled under the plan,
> vi) the Lieutenant-Governor-in-Council may appoint a public administrator to discharge the powers, duties and functions of the MSC if to do so would be in the public interest. Upon the appointment of a public administrator, the MSC members cease to hold office unless otherwise ordered by the Lieutenant-Governor-in-Council.
> vii) the MSC is prohibited from operating in a fashion that is not consistent with the criteria established in Section 7 of the *Canada Health Act*.[66]

Reporting to the MSC are a number of committees which advise and assist in the management of the Medical Services Plan. They bring forward proposals related to managing utilization growth and improving practice models to benefit patient outcomes and reduce unnecessary billing. The committees are typically comprised of BCMA and government members and allow a non-confrontational exchange of evidence and information related to these issues that is outside the bargaining process and is not dictated by the government.[67]

From contract comes an equally influential set of decision makers. Physician-government relationships in British Columbia are governed by an overarching *Framework Memorandum.*[68] The *Framework Memorandum* establishes the structure for the series of agreements that define physician compensation arrangements. Tri-lateral working agreements (signed by the BCMA, MSC and MOHS) address issues of fees, benefits and other compensation matters as well as any other issues the parties agree to. Six subsidiary agreements are contained within and negotiated in tandem with the *Framework Memorandum*. They address issues of particular interest to specialists, general practitioners, salaried physicians, rural practice physicians, and physicians on service and sessional contracts. But while Alberta's *Master Agreement* creates a hierarchy of oversight committees to manage the subsidiary agreements and oversee the budgets allocated to those areas of the physician compensation package, B.C.'s *Framework Memorandum* relies upon a more ad hoc system of committees and working groups.

As noted above, the *Framework Memorandum* was negotiated shortly after the release of the Korbin report in the hope of resolving a number of outstanding issues related to fees, prorationing, and utilization growth. In addition to resolving some immediate issues, the *Framework Memorandum* established a "conceptual framework" for future negotiations by integrating several existing compensation agreements.[69]

The MSC is uniquely positioned vis-à-vis physician-government bargaining. It is a party to compensation agreements negotiated between the BCMA and MOHS but does not have its

own representative at the bargaining table. Still, the MSC has some role in the BCMA-government relationship. The *Second Master Agreement*[70] [*B.C. Master Agreement*] makes it clear that the MSC will be a party to working agreements and that both the government and BCMA will consult with the MSC prior to ratifying a working agreement. The government is also required to consult with the BCMA and the MSC prior to setting the budget for insured physician services.[71]Thus, while there is a measure of public representation at the MSC in the form of beneficiary representatives, the commission itself does not become involved in the closed-door negotiating process. Although the government has the legal authority to disband the MSC and install an administrator, both MSC and BCMA representatives who were interviewed suggested such a move would be so politically unpalatable that the government would be loathe to consider it.

However, despite being a key decision-making site for determining which services go into the Medicare basket, the MSC has an inter-dependent relationship to government and the BCMA. It determines which services are medically necessary but is also mandated to operate with in the budget set by the provincial government. Medical and technical expertise used to determine which services should be funded is provided, in large measure, by the BCMA.

Further, its authority may be tempered by the terms of the *Framework Memorandum*. Changes to the schedule of benefits, and the allocation of fee increases among services, are studied and reviewed by the BCMA Tariff Committee which draws on the expertise within the association's various sections to prepare recommendations for the BCMA's board of directors. The committee also consults with the Medical Services Plan while developing the recommendation. A non-voting government representative was added to the Tariff Committee in the late 1980s to observe and provide comment on the recommendation, potentially averting a stand-off before the recommendations reach the MSC. Once the board approves changes to the BCMA Guide to Fees, the MSC is required to adopt them as part of its payment schedule so long as:

> i) the changes are consistent with the *Medicare Protection Act* and its regulations,
> ii) the MSC agrees that the services covered are medically necessary,
> iii) the commission agrees to with the estimated projected net costs of the changes.[72]

Also, in an effort to diffuse conflict over prorationing and service withdrawals, the *Framework Memorandum* stipulates that the provincial government must provide 12 months notice before asking the MSC to exercise its authority to prorate physician fees. On the doctors' side the BCMA agrees that so long as prorationing is not in effect, the association "will not sponsor,

support or condone withdrawals of service by physicians and shall take necessary steps that are available to prevent such initiatives."[73]

Under the auspices of the *Framework Memorandum* a number of joint structures are created to assist in health reform and managing the budget for insured services. These committees inevitably intersect with the MSC. For example, the *Subsidiary Agreement for General Practitioners* [*GP Subsidiary Agreement*][74]creates a Full Service Family Practice Fund and a joint General Practice Services Committee (GPSC) to help determine how the money will be spent.[75] The GPSC makes recommendations to the MSC which has final authority for approving expenditures. In the event of a deadlock one or both of the parties may make separate recommendations to the MSC.[76] As a result of the 2004 negotiations, the GPSC has been assigned a lead role in allocating $25 million in dedicated funds for primary care, placing priority on allocating resources to nine specified areas.[77]

The MSC must also create five Best Practice Budget Management Working Committees. These committees are to harness best practice evidence to the task of fiscal constraint as part of an overall strategy to establish "realistic strategies" to stay within the Available Amount during fiscal 2004-05 to 2006-07. Strategies are to be "based on identified best practices and aligned with the public's priority medical needs.[78] At the time of writing (July 2004) it was not clear whether the new committees would be created from scratch or whether their mandate would be absorbed by existing joint committees.[79]

There is no counterpart to Ontario's bilateral RBRVSC which is to assign relative weights to various physician services on a revenue neutral basis. Holter says the BCMA experimented with its own relative-value process to re-align fees and compensation about a dozen years ago but the initiative "imploded". It created significant tensions within the profession and lead to the establishment of two sub-groups within the BCMA: the Society of General Practitioners, and the Society of Specialist Physicians and Surgeons. Both continue to operate within the association to represent the interests of their respective constituencies. The SGP represents the general practice section while the SSPS represents physicians from more than 20 individual sections within the profession.[80]

The MSC's legislative mandate gives the commission final authority with respect to changes in the schedule of benefits, making it a key site for decisions related to listing and de-listing services. But the commission is also constrained by its responsibility to manage the Available Amount that funds insured physician services. Where these two roles conflict, economic considerations may overwhelm science-based decision-making. Medical Services Plan officials track costs on a monthly basis and keep the MSC up to date on whether the budget is

likely to be exceeded. If overruns are forecast, the commission meets with the BCMA and MOHS officials to discuss measures for preventing an overrun.[81] Against this backdrop, the BCMA Tariff Committee evaluates proposed benefit schedule changes, drawing on the association's network of experts within the physician community and prepares recommendations which ultimately go to the MSC. But Cronin says that under the current fiscal climate it's difficult to consider implementing new fees without eliminating others. "At this point in time, because our budget is basically non-existent…we've basically said to the (BCMA) sections, if you want to put a new code in, which one are you going to eliminate?"

The MSC may influence benefit schedule reform through best practice committees which are struck to examine better modes of treatment using expertise from the BCMA and government. Recommendations made by these committees may result in changes to the benefit schedule. However, the decision to create MSC committees to examine best practice models in an effort to meet establish savings target once again ensures that practice management will be connected to financial considerations.

Further constricting decision-making is the political resistance to de-insuring listed services. Although some services were de-insured a couple of years ago, they were funded through the Available Amount and not subject to approval by the MSC. The services, which included podiatry, chiropractic, massage therapy, naturopathy and physio-therapy, were not defined as medically necessary and were not delivered by physicians.

The new fee agreement tries to overcome some constraints by encouraging benefit schedule reform in primary care. In addition to the $25 million, referenced above which the GPSC will help allocate, the provincial government is offering to provide $40 million to facilitate improvements to specified areas of general practice, beginning in April 2005. But $30 million of this annual funding is contingent upon "matching funds" being re-aligned across the general practice fees for service. These benefit schedule changes will apply only to primary care physicians.[82] Such provisions may leverage reform but they also reinforce the link between changes to the benefit schedule and economic considerations. While purse strings may loosen in the future, the coupling of medical necessity and fixed budgeting remains entrenched in legislation and is reinforced by physician compensation agreements.

The matter of whether there will be fee increases or other physician compensation targeted to particular health areas occurs at the negotiating table and remains isolated from the MSC. Although the commission will have to approve the final changes to fee and benefit schedules that arise as a result of these negotiations, the direction setting happens in this separate bargaining process. Further, the tri-lateral make-up of the commission means that where the

physician and government representatives agree, they will carry a clear majority in any vote of the MSC.

Cost containment is a driving force behind the current agreement which provides for zero per cent physician fee increases during the first two years.[83] Provisions are made to negotiate an increase for the third year of the agreement (2005-06) subject to binding arbitration. Peter Van Rheenen, Executive Director of Physician Human Resource Management for MOHS, says the B.C. government "has been quite clear over the last number of years that it has a public sector wage agenda. It has an access to care agenda and it is, I think, very committed to value for money."

Against this backdrop and bearing in mind the political difficulties associated with significant moves to de-list services, it will be difficult to add new fees to the schedule without dropping one or more corresponding fees in order to keep the budget balanced. During years when a fee increase is negotiated, it may be targeted to particular sections, but is typically negotiated as an across-the-board increase which the BCMA then takes a lead role in allocating among the various sections. Within this structure, a ** allocation is split between specialists and general practitioners then *micro* allocation decisions are made within the relevant sections.

Bob Cronin, one of the beneficiary representatives on the MSC, acknowledges that the commission may sometimes provide little more than a "rubber stamp" to changes where the input and expertise from the physician community has been extensive. "In the vast majority of circumstances, the hard slugging has been done somewhere else and it comes to us. Every once in a while we get them when there isn't any agreement and we labour over those and try to make our best decision."[84]

With respect to managing the funding for insured physician services, the MSC's options have been hampered by the government's commitment to provide a year's notice before instituting prorationing measures. This agreement has, in effect, removed prorationing as a budget-management tool, shifting focus to controlling utilization growth and restricting additions to the fee schedule.[85]

None-the-less, in the confrontational environment that characterizes physician-government bargaining in B.C., the commission provides a constructive environment for managing the Medical Services Plan. Cronin says the commission ensures day-to-day decision-making can continue, even when tempers are running high at the bargaining table:

> If the government agrees on something and the BCMA agrees on something, it doesn't really matter what we think. If it's one of those polarities then, I think the commission has a very moderating influence. If they are at each others' throats, and that has happened on occasion, the commission has been a really excellent

> forum because we are still talking there, even though the bargaining may be on very rocky ground.[86]

Within the MSC structure, the three beneficiary representatives are non-aligned, owing loyalty to neither the government nor the BCMA although they may side with either on a particular issue. Cronin is a former social worker who spent more than three decades in government (including work as an assistant deputy minister in the health department) before retiring. The other two beneficiary representatives are a retired forestry company executive and private operator who runs long-term care facilities.[87] The amount of detailed technical information which MSC members are required to deal with makes it difficult to include a particularly broad cross-section of the public in decision-making. Further, the beneficiary representatives must be palatable to both the government and the BCMA. Cronin was approached about sitting on the commission, having served as an alternate for one of the government representatives during his civil service career. He is reluctant to be saddled with representing the broad public interest:

> We are always conscious of what is in the beneficiaries' interests but it's a bit of a personal thing…I think you would have to be really egotistical to think you represent the public. They (the other parties) can't force anything on us. They can make a good rational argument and we'll listen and we'll do our best to reflect what's in the interest of the public.[88]

Beneficiary representatives may take some credit for recent changes to laboratories fees. Faced with information that fees in B.C. were running about 20 per cent higher than in other provinces, they initiated a motion to serve notice of a fee reduction that was eventually passed by the commission. The move sparked a power struggle over who would have the authority to re-allocate money which was saved by the laboratory fee changes. Under the *Medicare Protection Act*, the money would still be part of the Available Amount and hence could be re-allocated. However, the provincial government passed an order-in-council moving responsibility for non-hospital laboratory fees to the *Hospitals Act*.[89] Several laboratory owners took legal action and a B.C. Supreme Court ruled the order-in-council was ultra-vires.[90] The provincial government did not pursue the matter further and the bulk of the $60 million freed-up by the fee reduction was eventually re-allocated to utilization growth. About $20 million was poured back into non-hospital laboratories under a restructured system.[91]

(4) COMMENTARY

The physician-government processes at work in each province attempt to balance science, politics and economic considerations. Evidence-based decision-making plays a role in addressing

fee increases, changes to benefit schedules and the call to reform primary care. There are also attempts to address competing public values such as cost effectiveness and access to services. But even as public debate and discussion surrounding health care intensifies, the decision-making processes remain shielded from public scrutiny. In this closed arena, the medical profession exerts considerable control over the policy agenda. This state of affairs not only impacts the basket of Medicare services but also has far-reaching implications for the health system as fee negotiations are increasingly used to leverage structural reform in primary care, the use of health information technology and physician compensation models.

Further, so long as the public spotlight remains trained on health care, there are few incentives for governments to open these processes to scrutiny. Provincial governments in B.C. and Alberta appear particularly sensitive to the political stakes. Due to the highly-charged physician-bargaining climate in B.C., two of the three senior government officials who spoke to us would do so only on the condition they remained anonymous. Alberta Health and Wellness (AHW) would not agree to have any of its department staff interviewed for this project, preferring to send a two-page letter responding to the study. In explaining the decision, David Dear, Acting Assistant Communications Director, said department staff is reluctant to publicly discuss negotiations that typically occur behind closed doors.[92]

We note four broad similarities between the fee and Medbasket decision processes in each province.

(a) A Labour Relations Model

First, each province's bargaining relationship with its physicians is structured much like any collective bargaining system. Each province's dominant medical association enjoys more or less exclusive bargaining 'rights' on behalf of physicians in that province. The parties negotiate in cycles and strive to formulate framework agreements that resemble, at least in form, traditional collective agreements. Yet they differ in length (some provinces' master agreements extend past 2010) and certainly in subject matter. While collective agreements set boundaries around employer freedoms, physician-government framework agreements are just that: frameworks of price and other terms that govern contracts 'beneath' them, in this physician fee-for-service arrangements.

(b) Medbasket Processes: Accountability Gaps

The second broad similarity relates to the gaps in accountability that remain in each province.

(i) Ontario

In Ontario, the PSC process still remains fundamentally unaccountable and lacking in transparency. Given the importance of changes to the OHIP schedule to the broader public interest, these are the main weaknesses of the current MOH-OMA bargaining model. The process appears to gain peace for the parties at perhaps the cost of accountability to the public. Certainly, the PSC has various valuable functions, not least of which is the voice mechanism it provides between vital stakeholders – physicians – and government. By improving labour relations, it creates a better climate for innovative structural reforms that result in more disciplined use of health care resources. It fosters an incremental approach to fee and schedule of benefits changes, because both sides are keenly aware of the immediate issues faced by the other at any given time, and increased trust fosters less incentive to seek "big bang" approaches to problems. In short, co-management along the PSC model seems to be improving accountability as between physicians and government on these issues.

However, accountability to citizens and patients remains lacking. Much of the shift to the PSC model has involved more concealment of the precise issues that are in tension between the MOH, as representatives of citizens, and the OMA, as representative of its professional constituency. Certainly, these changes greatly facilitate smoother relations between the two parties, but result in less transparency for the process between them. In other words, improving labour relations by concealing them falls far short of meeting Canadian health policy demands for more accountability for key decision-making processes.

The fact that the CTC is now seen to work "better" because it is no longer bipartite and is shielded from *Privacy Act* intrusions is telling. Yet at the same time we see the "defensive medicine" approach of late by the CTC in being shy about delisting services. Were the CTC still bipartite, would the same occur? Or is it that the CTC essentially represents the consensus view (also not easy to reach within the OMA) of the OMA? It certainly lessens the risk of rancour and debate at the CTC, fostering an image of effectiveness, but does so at the expense of accountability and dialogue, pushing rationing decisions up the line to the PSC and the MOH.

And at these levels, the current structure of PSC decision-making remains firmly within the grasp of the medical profession. The PSC certainly succeeds as a labour relations tool – and perhaps is instructive beyond the physician sector – but does so at a familiar labour law price: more money or more power. Where funding doesn't allow extravagant compensation increases, health care providers can still be rewarded in non-monetary ways. In this case, the PSC represents an innovative way to improve labour relations (that is, reduce conflict), one that does not simply involve buying peace with raw cash. In this model, the professional and economic interests of physicians are treated with equal importance, and professional interests accommodated through mechanisms like the PSC that foster greater "partnership" between a unique (and not legally recognized as such, except where it might shield decision-making from public scrutiny)[93] kind of employer, and a similarly unique kind of employees' representative (also not recognized as such). The OMA-MOH relationship "quacks like"[94] collective bargaining; therefore, it is. If so, it is a relationship characterized by a much closer, more accommodating relationship as between the parties.

There is little participation in any of these processes by groups other than physicians, MOH officials, physician experts and other private consultants. Focus groups as were used in the 1998 SOB Group process may be as close as one can come to finding any other voices. Certainly, as Susan Fitzpatrick noted,[95] hospitals, other OHIP beneficiaries and dependents of the MOH all have expressed keen interest in what happens in these processes, but to date have not been formally involved.

While labour peace is vital as between physicians and the government, particularly at a time when Canada faces severe doctor shortages and, more recently, it may be the case that accountability is seen as too risky an element to include in the broader decision-making institutions relating to the content of the schedule of benefits.

(ii) Alberta

In Alberta, the AMA continues to wield significant influence by virtue of the expertise within its various committees and sections. Further, the new tri-lateral agreement gives the profession an enhanced role in determining the shape of health care delivery, especially with respect to the proposed overhaul to primary care delivery. Certainly the decision to allow physicians participating in the primary care initiative to choose fee-for-service or alternate payment mechanisms represents a significant victory for the doctors from a negotiations perspective. But it also represents a pragmatic decision to remove a potential stumbling block to change. Meanwhile, bringing the RHAs directly into the tri-lateral process provides something of

a counterweight to physician influence. Issues affecting regional delivery of hospital-based services are placed on more equal footing with the interests of community-based physicians.

Decisions on whether to list or de-list services in Alberta are aired through the tri-lateral committee structure. While the Alberta government retains discretion to proceed unilaterally, acting in the face of opposition from the other parties to the tri-lateral agreement risks a public outcry. Alterations to the schedule of benefits and the rules surrounding fee payments are to be decided by the committee structure where the consensus model ensures that change occurs when all parties are in lockstep or not at all.

Within the tri-lateral hierarchy, the parties are accountable to one another but there is no clear line of accountability to the public or to patients. The committee structure functions outside of public view yet it has considerable authority to influence health care services. The primary care initiative committee, for example, will select which local initiatives are approved for funding, set the parameters within which they operate and determine how they are to be evaluated.

An important goal of the *Master Agreement* is to purchase change in primary health care delivery by offering incentive funding that promotes new models of patient care. It attempts to resolve the riddle of primary care reform that plagues other jurisdictions. Evidence suggests patient outcomes would benefit from team treatment models but fee-for-service payments tend to work against them.[96] Alberta physicians are being encouraged to participate through a number of monetary and non-monetary incentives. They have been assured of a veto in the change management process, incentive funding to ensure the fee structure continues to recognize their contribution and capital funds to upgrade the information technology in their offices. Although all parties in the tri-lateral process agree that involving other professions is essential to the primary care reforms, the doctors will play a significant role in determining how those other professions are brought into the process.

Seen in this light, Alberta's tri-lateral structure most resembles a negotiated settlement covering compensation and working conditions rather than a blue-print for changes that enhance public interest objectives. The committee hierarchy that will evaluate the primary care initiatives, decide how the benefit schedule will be re-shaped and control the contributions by other medical professionals operates out of the public eye.

(iii) British Columbia

British Columbia's Medical Services Commission is, at least formally, the primary coverage decision body in that province, but as we discovered even that body is heavily constrained by the work of the parallel committee structures under that framework agreement.

In B.C., physician-government bargaining has been mired in conflict and the government's cost-containment continues to dominate decision-making. The dual mandate of the MSC, to stay within budget and to determine what services are medically necessary inevitably produces trade-offs. The most recent example is the move, referenced above, to create Best Practice Budget Management Working Committees that have the dual task of developing templates for good physician practice and restraining expenditures. Within these structures evidence-based decision-making is handmaiden to cost containment. The committees will be expected to meet quarterly "fiscal savings targets" set by the commission. Such agreements shift the MSC's role from being decision-making hub to one of refereeing cost-containment strategies which the BCMA and government have hammered out at the negotiating table.

The MSC is ultimately responsible for listing and de-listing decisions but this authority fluctuates with the terms of the *Working Agreement*. Under changes the July 2004 changes, for example, the bilateral General Practice Services Committee will take the lead role in allocating funds to improvements in primary care in consultation with the BCMA and the Leadership Council which represents the Health Authorities. These changes are expected to involve some reallocation of money currently within the General Practice fee schedule. The MSC is only expected to actively take part in the decisions that are made if there is a dispute between the government and BCMA members on the GPSC. This process circumvents the usual listing and de-listing decision-making which is handled through the BCMA Tariff Committee which brings recommendations to the association board of directors which, in turn, forwards them to the MSC.

Unlike Alberta which has a clear hierarchy of decision-making within the various elements of the compensation package, B.C. functions with an assortment of committees whose recommendations collide at the MSC. These ad hoc structures make it difficult to marshal resources within the system toward schedule benefit reform. In this context listing and de-listing decisions will be played out as a part of the hurly-burly of physician compensation negotiations.

In terms of public accountability in decision-making the B.C. process is not significantly better than Alberta's. Beneficiary representatives on the MSC do not represent a broad cross-section of the public and while their presence is certainly welcome it is not a substitute for more comprehensive process to ensure accountability and transparency. Beneficiary representatives may vote against individual decisions at the MSC but so long as the government and BCMA are in agreement, they have little hope of influencing the outcome. Further, because they are not present at the bargaining table when the core deal-making takes place, they are not in a position to provide a perspective at this crucial stage. They operate as swing votes which can carry or defeat a motion brought to the table by the doctors or government. The only window the public gains

into decisions is the rancorous give and take that often accompanies negotiations, and the real or threatened withdrawal of services.

(c) Fee Decisions: Place and Time

The third similarity is that fee decisions almost always occur at the top level of governance. Chronologically, fee increases are set 'in the morning' of the master agreement, when long term strategies and budget projections are finalized. Hence, they are final, taken as found at the meso level of coverage decisions. Fee negotiations also occur at more frequent intervals than those for the broader framework agreement. Typically, a framework agreement will provide for one or more 're-opener' periods when fee increases are once again on the table.

(d) Dynamic or Static Budgeting?

Our fourth similarity is actually a point of difference: budget flexibility in response to fee increases. Fee increases only conflict with coverage decisions to the extent government refuses to spend more money to minimize it. Faced with global fee increases, as well as many other escalatory factors in spending, ministries of health are always faced with claims for more funding.

In Alberta and Ontario, governments appear to have been more prepared to expand their budgets to meet going-contract fee increases; doing so frees more resources for coverage issues. In Alberta, the new tri-lateral agreement is a "budget management process" but it is not dominated by economic considerations in the way B.C.'s decision-making process is. Rather than operating under the shadow of financial constraint, Alberta's process operates within certain agreed-upon financial boundaries which may be expanded to take into account unforeseen costs, according to formulae and principles established through negotiations. Fee increases remain a matter to be resolved at the bargaining table at intervals during the life of the agreement while tri-lateral decision-making over budget management and schedule benefit reform continues to function throughout. In B.C., however, law mandates that the MSC work with the numbers (fee increases included) it receives.

(5) CONCLUSION

The simple problem is that while we see progress in the 'meso' level of decision making on Medbasket issues, we see a continued adherence to privacy and secrecy at the macro level of fees, one that directly involves balancing competing HHR and Medbasket demands. Few

governments wish to descend into the political quagmire that pitting physician against patient interests would produce. Yet the tension remains. Given the political sensitivity of this balancing act, it is obvious that the immediate parties to it want privacy. Yet health policy wants transparency and perhaps even participation.

In the fee decision arena, then, we too are stuck, and not easily extricated from, between labour law values and health policy values. "Wage setting can never be a science": this is Canadian labour law's historical admonishment to any political urge to engineer, legislate or otherwise dictate what our legal and political cultures tell us are private affairs. This, in fact, is labour law's original rebuke of the idea of direct legislative regulation of employment, and our historical reason for favouring a more laissez-faire union-driven model. Physician-government bargaining processes, like most in the Canadian public sector, borrowed their practice mostly from the traditional private bargaining model.

Parsing Medbasket issues from this private domain represents significant progress; inquiring into fee decisions with the same vigour, however, may be much more of a struggle – not with physicians, but with the persistent labour law values just described. These values resist the very inquiry we have undertaken here: to ask how, and why, fee decisions – wage decisions – are made. The difficulty is that while many things in HHR policy can be explained and predicted, the basic question of how much to offer physicians and nurses remains a decidedly un-scientific question. On this reasoning, all attempts to define and impose 'justice in work' from the outside will founder, regardless of how much evidence we have to back it. Further, at a time when Canadian governments are caught in the dilemma described at the start, the temptation to put fee increases first, ahead of all other priorities, remains palpable, and certainly not ill-advised. Hence, the difficulty is less about looking for a better way to set fees than about overcoming the current way at all.

Is labour law theory really a complete rebuke, or satisfactory answer, to criticisms of this mode of decision making? We cannot say because we do not even know what we are critiquing. Indeed, the simple summary of our observations is that we know much about how rationing occurs within a budgetary mandate, yet nothing about how budgetary mandates and fee decisions interact. We know how Medbasket decisions are made, but not about the decisions that come before, those that can in many cases limit options.

[1] Agreement between Ontario Medical Association and Ontario (Minister of Health and Long-Term Care, April 1, 2000 to March 31, 2004 (the *2000 Agreement*), Art. 1.1.
[2] Ontario Medical Association Dues Act, S.O. 1991, c. 51.
[3] **just those participating in OHIP or all?
[4] The 'Rand formula' is a term of art in labour law describing a unionized employer's obligation to deduct union dues from their employees' pay and remit it directly to the union, regardless of whether or not one or more employees are actually members of the union., On.
[5] ???recent dispute 04 ratification and cfpo…
[6] Interview with S. Fitzpatrick on 13 March 2003 (the "Fitzpatrick interview").
[7] *Shulman v. College of Audiologists and Speech Language Pathologists of Ontario*, [2001] O.J. No. 5057. Among other grounds, the applicant sought a declaration that the decision of the Ontario government to stop insuring costs of hearing aid evaluations and re-evaluations and to attach conditions to terms of payment to physicians for diagnostic hearing tests violates equality rights of persons with hearing disability as guaranteed by s. 15(1) of the Charter of Rights and Freedoms. The Court deferred to the government on policy-making grounds, concluding (at para. 43) that the "healthcare system is vast and complex. A court should be cautious about characterizing structural changes to OHIP which do not shut out vulnerable persons as discriminatory, given the institutional impediments to design of a healthcare system by the judiciary." In this case, the changes to the Schedule of Benefits were found not to discriminate within the meaning of s. 15(1) of the Charter and the application was dismissed on that ground.
[8] 2000 Agreement, Appendix E.
[9] 2000 Agreement, Art. 16.1
[10] 2000 Agreement, Art. 3.1. Fee increases for 2000-2004 are 1.95%, and 2% per year thereafter.
[11] 2000 Agreement, Art. 16.2: "The parties may agree that the implementation of the RBRVS be taken into consideration in deciding how to apply the percentage increases set out in Article 3 of this Agreement."
[12] *Labour Relations Code*, R.S.A. 2000 c. L-1, s. 1(l) (ii).
[13] Medical Liability Reimbursement Program; Continuing Medical Education; Compassionate Expense Program; Best Practices Initiatives Program; Rural Locum Program; Specialist Locum Program; Physician and Family Support Program; Parental Leave Program.
[14] Interview with Mike Gormley, Chief Executive Officer of the Alberta Medical Association, June 7, 2004 [*Gormley interview*].
[15] Ibid.
[16] *Master Agreement Regarding the Tri-Lateral Relationship and Budget Management Process for Strategic Physician Agreements*, made effective, April 1, 2003, Article 8.9 [*Master Agreement*].
[17] *Gormley interview*, *supra*, note 4 and telephone interview with Peter Van Rheenen, Executive Director Physician Human Resource Management, B.C. Ministry of Health Services, July 12, 2004.
[18] Ashley Geddes "Public esteem for doctors has fallen, says health minister: Gary Mar disputes AMA claims walkouts a success" Edmonton Journal (12 December 2000) A7.
[19] *Gormley interview*, *supra*, note 4.
[20] Alberta Medical Association, table provided by Chief Executive Officer Mike Gormley, "Increases by Section: 1993 to 2004" (2 July 2004).
[21] Alberta Medical Association, e-mail information provided by Chief Executive Officer Mike Gormley, (2 July 2004).
[22] *Master Agreement*, supra, note 6.
[23] *Master Agreement*, *supra*, note 6 at Article 8.4 (a), (b), (c) and Article 8.5 (a), (b), (c).
[24] *Master Agreement*, *supra*, note 6 at Article 2.1 (j).
[25] Canada, Commission on the Future of Health Care in Canada, *Building on Values: the future of health care in Canada* (Saskatoon, Sask. 2002) Commissioner Roy J. Romanow [*Romanow Report*] and Canada, Senate, Standing Senate Committee on Social Affairs, Science and Technology, "Study on the State of the Health Care System in Canada" Chairman Senator Michael Kirby [*Kirby Report*].
[26] *Master Agreement*, *supra*, note 6 at Article 3.1.
[27] Ibid at Article 3.1 (a). At the time of writing (July 2004), this position was held by the CEO of the Capital Health Authority which oversees services in Edmonton and the surrounding area.
[28] Ibid at Article 8.9. The only exception is money allocated to the Primary Care Initiative Budget Element which may not be moved to any other element of the budget.
[29] There are a number of items which are not subject to arbitration including, a decision by the Minister of Health to add or de-list a service.
[30] *Master Agreement*, *supra*, note 6 at Article 8.10.
[31] Ibid at Article 8.14.

[32] Ibid at Article 3.1 (b). The *Master Agreement* also stipulates that health authority appointees shall be senior level officials and may include a chief executive officer, chief financial officer or a chief medical officer. At the time of writing (July 2004) the Health Authority appointees to the Secretariat were Dr. Ken Gardner and his counterparts from the Calgary and Lethbridge-area health authorities. All are physicians.
[33] *Master Agreement*, *supra*, note 6 at Article 3.1 (b). At the time of writing (July 2004) two of the three AMA representatives on the Secretariat were physicians: an anesthesiologist from Edmonton and a general practitioner from Raymond, Alberta. The third representative was the Assistant Executive Director of Public Affairs for the Alberta Medical Association.
[34] *Master Agreement Regarding the Tri-Lateral Relationship and Budget Management Process for Strategic Physician Agreements*, made effective April 1, 2003, Schedule "E" *Physician Services Agreement*. [*Physician Services Agreement*]
[35] *Master Agreement*, supra, note 6 at Article 2.4. At the time of writing (July 2004) the AMA members of the PSC were: two physicians representing the anesthesia and emergency medicine sections; and the Assistant Executive Director of Health Policy and Economics for the AMA. The RHA representatives were all physicians: the Associate VP of Medical Affairs from the Capital Health Region, an Associate Chief Medical Officer from the Calgary Health Region and the Medical Director of the East Central Health Region. The Alberta Government representatives were:
[36] *Master Agreement Regarding the Tri-Lateral Relationship and Budget Management Process for Strategic Physician Agreements*, made effective April 1, 2003, Schedule "G" *Primary Care Initiative Agreement* [*Primary Care Initiative Agreement*].
[37] Services to be provided by the local primary care initiative are: basic ambulatory care and follow-up; care of complex problems and follow-up; psychological counseling; screening/chronic disease prevention; family planning and pregnancy counseling; well-child care; obstetrical care; palliative care; geriatric care; care of chronically ill patients; minor surgery; minor emergency care; primary in-patient care including hospitals and long-term care institutions; rehabilitative care; information management; population health.
[38] Interview with Dr. Ken Gardner, Vice-President of Medical Affairs for the Capital Health Region (21 July 2004) [*Gardner interview*].
[39] *Gormley interview*, *supra*, note 4.
[40] *Master Agreement*, *supra*, note 6 at Article 2.4.
[41] Ibid at Article 2.4 (c).
[42] Alberta, Expert Advisory Panel to Review Publicly Funded Health Services, *The Burden of Proof: An Alberta Model for Assessing Publicly Funded Health Services*, Alberta Health and Wellness, March 2003.
[43] "Budget 2004: On Route On Course Heading Toward Alberta's Second Century, Health and Wellness Business Plan, 2004-07, Ministry Statement of Operations (24 March 2004), online: Alberta Government http://www.finance.gov.ab.ca/publications/budget/budget2004/health.html#16
[44] Ibid.
[45] *Gormley interview*, *supra*, note 4.
[46] Ibid.
[47] "Allocation a step to fee equity" *The Alberta Doctors' Digest* (May/June 2004), online: Alberta Medical Association http://www.albertadoctors.org/bcm/ama/ama-website.nsf/AllDoc/06171C14815080D287256DE300616D7B?OpenDocument [*Doctors' Digest*] at 8. The other three are:

> i) patient access to quality care,
>
> ii) fee schedule modernization, allowing for fee adjustments, rule changes and the introduction of new items reflecting changes in technology and methods of service delivery and,

iii) compliance with the tri-lateral agreement
[48] Ibid.
[49] Interview with Geoff Holter, Director of Negotiations, British Columbia Medical Association (13 July 2004) [*Holter interview*]. Holter notes a minor exception to this definition involving physicians working in

the private sector for companies which may, from time to time, obtain small amounts of government funding.
[50] *Medicare Protection Act*, R.S.B.C. 1996, c. 286 [*Medicare Protection Act*].
[51] Ibid. at s. (3) (1) (a).
[52] British Columbia, Commissioner Judi Korbin, *Report on the Contractual Relationship Between the B.C. Government and the Doctors*, online: http://www.cua.org/socioeconomics/Korbin Report.pdf at 34-35 [*Korbin Report*].
[53] *Holter interview*, *supra*, note 12.
[54] *Framework Memorandum*, 2000 [*Framework Memorandum*].
[55] *Holter interview*, *supra*, note 12.
[56] Ibid.
[57] Bill 9, *Medical Services Arbitration Act*, 3rd Sess., 37th Leg., B.C., 2002.
[58] *Holter interview*, *supra*, note 12. Recourse to binding arbitration to resolve fee disputes has been re-instated in the physician agreement ratified in July 2004.
[59] Interview with Peter Van Rheenen, Director of Physician Human Resource Management with the B.C. Ministry of Health Services, (12 July 2004) [*Van Rheenen interview*].
[60] *Korbin Report*, *supra*, note 15 at 22.
[61] *Korbin Report*, *supra*, note 15 at 23-24.
[62] *Holter interview*, *supra*, note 12.
[63] "Doctors have to find a different way: Pressing their pay demands through a strike that uses patients as pawns is unprofessional and unethical," Editorial, *The Vancouver Sun* (26 January 2004) A6 [*Sun Editorial*].
[64] Dr. John Turner "Doctors protest being cut out of health care reforms" *The Vancouver Sun* (3 March 2004), A13.
[65] "Budget and Fiscal Plan 2004-05 – 2006-07"(17 February 2004) online Government of British Columbia http://www.bcbudget.gov.bc.ca/bfp/default.htm
[66] *Medicare Protection Act*, *supra*, note 14 at ss. 24, 25, 33, 3, 5.
[67] Interview with Bob Cronin, Beneficiary Representative on the B.C. Medical Services Commission, June 26, 2004 [*Cronin interview*].
[68] *Framework Memorandum*, *supra*, note 17.
[69] *Framework Memorandum*, *supra*, note 18 at Article 4.
[70] *Second Master Agreement*, February 2001 [*B.C. Master Agreement*]
[71] Ibid at Article 3.7.
[72] Ibid at Article 17.
[73] Ibid at Article 12.2 and 12.3.1.
[74]*Subsidiary Agreement for General Practitioners*, November 2002 [*GP Subsidiary Agreement*]
[75] Ibid at Article 6. The $10 million fund was to be provided in each of the 2002-03 and 2003-04 fiscal years.
[76] Ibid, at Article 5. As of July 6, 2004, the GP Services Committee had 10 members, eight of whom were physicians.
[77] *Letter of Agreement: Related Matters*, July 2004 [*Related Matters Letter*] at Article 5 and *Letter of Agreement: Negotiation of the 2004 Working Agreement (Including Subsidiary Agreements)*, July 2004 [*Working Agreement Letter*] at Article 10. The nine specified areas are: improved chronic disease management; maternity care enhancement; enhancement of hospital based care by General Practitioners; improved care for the frail elderly; increased support to patients requiring end of life care; improved care for patients with chronic mental illness; improved care for patients with addictions; 24/7 community based care; provision of advanced access.
[78] *Related Matters Letter*, *supra*, note 72 at Articles 6, 7 and 8.
[79] *Interview with Geoff Holter, Director of Negotiations for the BCMA*, July 29, 2004 [*Second Holter Interview*] and *Interview with Peter Van Rheenen, Executive Director of Physician Human Resource Management for MOHS*, July 29, 2004 [*Second Van Rheenen interview*].
[80] *Holter interview*, *supra*, note 12.
[81] *B.C. Master Agreement*, *supra*, note 64 at Article 13.
[82] *Working Agreement Letter*, *supra*, note 68 at Article 10 (g), (h).
[83] *Working Agreement Letter*, *supra*, note 72.

[84] *Interview with Bob Cronin, Public Beneficiary Representative on the Medical Services Commission*, June 26, 2004 [*Cronin interview*].
[85] Ibid.
[86] Ibid.
[87] Ibid.
[88] Ibid.
[89] *Hospital Act*, R.S.B.C. 1996, c. 200.
[90] Yu et al v. The Attorney General of British Columbia, 2003 B.C.S.C. 1869.
[91] *Related Matters Letter*, *supra*, note 72 at Article 1.2.
[92] Telephone conversation with David Dear, Acting Assistant Director of Communications, Alberta Health and Wellness, July 20, 2004.
[93] See Order PO-1721 of the Ontario Information and Privacy Commissioner, in which the MOH attempted to have certain records of the PSC's discussions exempted from disclosure on the grounds that, while the doctors are not directly employed by the MOH, it is their source of income and, as such, is in the nature of an employer to them. Thus, the MOH argued, the documents being sought were related to labour relations and therefore exempt. The Privacy Commissioner rejected this approach. See http://www.ipc.on.ca/scripts/index_.asp?action=31&N_ID=1&P_ID=4003, accessed 5 September 2003.
[94] McCutcheon interview.
[95] Fitzpatrick interview.
[96] *Gardner interview*, *supra*, note 45.