The fundamental rights protected by the Master Agreement

Although most physicians are quite familiar with the compensation arrangements of the Working Agreement, we know much less about the equally important Master Agreement. The Master Agreement is the blueprint that governs the role of physicians in providing medical care in BC. It provides the foundation for the working relationship with government and is often referred to as the physicians' Charter of Rights. Each re-negotiation of the Master Agreement is a significant undertaking.

Negotiations between the BCMA and the provincial government for the renewal of the second Master Agreement began last month. Since early 2005, your association has been emphasizing the importance of the Master Agreement, and in this month's issue of the *BCMJ* you will find a brochure and DVD that provide further details of the Master Agreement and the eight key issues that, if modified or eliminated, will change the way medicine is practised in BC. I urge you to review these at your earliest convenience.

The preamble in the current Master Agreement requires the parties to work toward achieving the following objectives:

- Maintain and enhance the principles of medicare.
- Ensure a stable and long-term relationship between the government and the BCMA.
- Ensure and enhance the delivery of medically required services to residents of the province in an efficient, high-quality, and effective manner.
- Ensure that physicians are appropriately compensated for providing services covered by the Medical Services Plan, or under other alternative payment arrangements.
- Ensure that the medical care system will continue to function well.
- Contribute to the achievement of a mix and distribution of physicians based upon the needs of British Columbia's population.

These objectives guided the development of specific provisions in the first and second Master Agreement and will set the stage for the current negotiations. They remain objectives the BCMA supports as it meets its mandate to advance the health and well-being of patients as well as the working environment for physicians.

The second Master Agreement has a number of key provisions that ensure the above objectives are met. Many of these provisions were won after hard-fought battles, and have a direct influence over how BC doctors practise medicine.

There are at least eight important provisions that provide considerable protection and certainty to BC's physicians and are considered fundamental rights that need to be defended. These provisions are as follows:

1. The maintenance of effective physician input into the negotiation of the fee schedule.

Physician input into a single provincial fee guide and compensation provisions means equity across the province. A single region or city can't outbid others in an effort to attract needed physicians, nor can the value of payments be driven down in areas of relative oversupply of physicians. In turn, this prevents government from coercing doctors into practising in areas of the province at its whim.

2. Protection against arbitrary prorationing.

While the government has the right to determine the medical services it wants to purchase, it has an obligation to pay the price it agreed to for those services. The protection in the current Master Agreement against arbitrary government prorationing needs to remain to ensure physician certainty and patient welfare.

3. The commitment to use binding arbitration in the event agreements can't be reached.

In order for two parties to conclude their differences, there must be an agreed-upon solution that is balanced, free of political or other interference, and acknowledges that both parties have a right to dispute resolution as part of the overall working relationship. The BCMA is prepared to work with the government to find a dispute resolution process that will be effective in dealing with negotiated agreements and local disputes. The belief is that physicians will commit to a binding process that is fair and objective.

4. The guarantee that physicians can't be compelled to change the nature of their practice or payment modality.

Because of the second Master Agreement, physicians retain a choice of what the payment method they believe best fits their individual practice. Currently, physicians can't be forced to accept any one form of payment for their services. In order to remain independent practitioners, the right to choose how to organize the business aspects of an individual practice is imperative for all physicians.

5. The right for physicians to choose to have the BCMA represent them in their negotiations with the government.

BC physicians have chosen to have the BCMA represent them in their negotiations with government for decades. The association's collective resources, the negotiating experience, and knowing who the players are has resulted in successful BCMA negoti-

Continued on page 472

Continued from page 470

ated agreements with government. Negotiating agreements is time consuming and resource draining, and choosing to have the BCMA represent physicians in this endeavor is central to maintaining an appropriate balance of power in the negotiation process between physicians and the government.

6. The requirement to have and negotiate Working Agreements on a regular basis.

The Master Agreement directs the creation of a Working Agreement and subsidiary agreements that address issues applicable to all physicians—specialists, general practitioners, salaried physicians, physicians providing services on service contracts, physicians providing services on a sessional basis, and rural physicians.

The Master Agreement provides the protection that these agreements exist and are negotiated on a regular basis. Without the Master Agreement's protection, there would be no clear commitment to have the Working and Subsidiary Agreements and no agreement to negotiate them on a predictable schedule. If this provision did not exist, the negotiation of physicians' economic interests would be, at best, ad hoc and unpredictable.

7. The right of the BCMA to negotiate physicians benefit plans enshrined through the Working Agreements.

The Master Agreement enshrines the right of physicians to negotiate benefits, and over the years, the number of negotiated benefits has grown. Included are the CME funding program, the physician disability plan, the CMPA cost reimbursement plan, the RRSP plan, and the maternity leave provisions.

8. The obligation for the government to consult with the BCMA on key issues affecting health care in the province.

The BCMA continues to advocate for an increased role for physicians in the management and reform of the health care system. The BCMA believes that physicians must have a meaningful role in the development of policy and health care delivery plans if they are to deliver the highest quality of patient care.

We don't expect the negotiations for the renewal of the Master Agreement to be easy or straightforward. I hope that each of you has the opportunity to familiarize yourself with the key provisions in the Master Agreement, and if necessary, stand up and defend it.

—Michael Golbey, MD
BCMA President

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editorials

Continued from page 469

a patella fracture was $100. By 2004, the fee had increase to $318. To put the inflation factor in context, the cost of a Vancouver house in 1944 was about $4000; in 1961 it was $13,900, and by 2004, the median price was $503,141. In 1981, the fee for arthroscopic meniscectomy (the most commonly performed orthopaedic operation) was $294, while today it is $236 (a 1981 dollar is worth $2.11 in 2004). I have cited examples from the field of orthopaedics, but similarities exist in all areas of practice. I will leave the interpretation of the above figures open for debate, but they may explain why newly qualified practitioners lag behind their predecessors in their ability to pay off debts or purchase a home. Even if some of the older fees were inflated, it remains clear that recent generations of doctors have helped curb rather than increase health care costs. This is confirmed by the fact that the percentage of the Canadian health care budget spent on physicians continues to fall and was estimated at 12.9% of total health expenditures in 2003, having declined steadily since 1987 when it peaked at 15.7% (CIHI). The anti-doctor campaign promoted by many has often focused on the overpaid doctor concept. "Doctors' fees and salaries combined now account for about two-thirds of total health care expenditures in Manitoba," wrote Peter Hudson, chair of a Canadian Centre for Policy Alternatives Health Reform Working Group in an article targeting so-called overpaid doctors. How would the average reader interpret such a statement? In a sentence deliberately worded to have a double interpretation, the "salaries" actually referred to all salaries of all workers in health care. This is just one example of deliberately misleading anti-physician propaganda.

The recent controversy regarding a new "boutique" clinic underlines some of the conflicts regarding health care financing. The reality is that spending more money will lead to better and quicker service. Patients are not getting the service we want to give them and our ability to deliver excellent care is constrained. Much has been made of waiting lists for access to specialists, surgery, MRIs and other technologies. We even have a national council and a federally appointed expert discussing how to study and manage wait lists. Waiting in our emergency rooms and in doctors' offices or clinics often causes great distress. In the free market, many such problems could be addressed by improved design and infrastructure and by increasing the numbers and quality of staff. The addition of nurse practitioners or physician assistants might create a better functioning office. The problem is, who pays? The experiments with many of the alternative funding mechanisms have met with variable success and mixed reviews. Despite incorporating additional staff in many hospi-

Continued on page 477