Report of Eric J. Harris, QC, the Chair of the Allocation Committee (the “Committee”) established under Appendix D of the Alternate Payments Subsidiary Agreement as Part of the 2019 Provincial Master Agreement Between the Government of B.C. (the “Government”) and the “Doctors of BC (the “Doctors”)

Dated this 4th day of February, 2021.

1. Introduction

1.1 This Report has been made necessary by the fact that the Committee, despite the best efforts of all members, has been unable to resolve all issues which are to be decided by the Committee.

1.2 As a consequence, I have been requested by the Committee to make a partial decision which will enable the full Committee to proceed to finalize a complete consensus decision.

1.3 In making the decision which has been referred to me, I intend to provide only a definition of the issues and my decision. I do not consider it helpful to the achievement of a final consensus decision to provide an extensive analysis which would require me to examine issues which the Committee is able to agree upon without my assistance. I also must be careful not to communicate through this decision any information which was provided to me in confidence in the mediation phase of the Committee’s work.

1.4 In the event that the Committee is unable to conclude a final consensus decision following the receipt of my decision, I reserve jurisdiction to make a decision on all remaining issues.

2. Background

2.1 The Committee was established under the provisions of the 2019 Provincial Master Agreement between the Government of BC and the Doctors of BC (“PMA”) and, specifically under the Alternative Payment Subsidiary Agreement (“APSA”) which forms part of the PMA.

2.2 The physicians who provide services under APSA receive compensation within salary ranges or service contract ranges.

2.3 The Committee is a temporary adjudication panel whose role it is to increase the salary agreement ranges and service contract ranges by allocating the funding identified in Appendix F to APSA.

2.4 That funding is as follows:

(a) April 1, 2019: $6.5 Million
(b) April 1, 2020: $7.5 Million
(c) April 1, 2021: $6 Million

Total: $20 Million

2.5 Once the service ranges and salary contract ranges are established by the Committee, the physicians will be placed on the applicable ranges at the same level as their current placement.

2.6 It was provided in Appendix D to APSA that the Committee is composed of equal members appointed by each of the Government and the Doctors. The Committee is chaired by me as the independent Chair. The duty of the Chair is to mediate and, if necessary, to render a binding decision which is consistent with the PMA and APSA. The members of the Committee are identified in the Schedule to this decision.

2.7 The Committee commenced its work in February of 2020 but its work was made more complicated by the presence of the COVID virus and the need to utilize Zoom technology. The Committee met together or separately with the Chair on many occasions.

3. Issues

3.1 In preparation for the work of the Committee, the members appointed by the Doctors conducted consultations with representatives of the Practice Categories and formulated a position on their desired priorities for the allocation of the funding. This priority position was supported by the appropriate committees of the Doctors Association.

3.2 The Government selected their members of the Committee in a manner which represented both the Health Authorities and the Ministry of Health. They also established a position on their desired priorities for the allocation of the funding.

3.3 The Committee has been able to agree upon a system of “point factors” which would allow a calculation to be made to differentiate the amount of funding given to different Practice Categories.

3.4 The Committee has been able to agree on the priority position of most practice categories and have assured me that once I issue this decision the Committee can achieve a final consensus decision on all issues.

3.5 I have been asked to make my decision by establishing a "band" for the practice categories referred to me rather than through an annual monetary amount. That is because my decision may influence the final monetary amounts available for all Practice Categories. Additionally, it would allow the Committee to apply further factors such as rurality, range factors or benefit factors to the final calculations.

3.6 The Practice Categories involving different forms of general practice have been referred to me as described in the 2018/2019 Allocation Committee consensus decision as follows:

"3.3.1 General Practice – Full Scope (Non-Joint Standing Committee (JSC) Community): General Practitioners who provide Full Service Family Practice (as the term is used by the General Practice Service Committee) in the community are assigned to the practice category "General Practice – Full Scope (Non-JSC Community)".

3.3.2 General Practice – Full Scope (Rural): General Practitioners who provide a full Service Family Practice (as the term is used by the General Practice Service Committee) in a rural community, as defined in the Rural Practice Subsidiary Agreement and provide one or more of anaesthesia, obstetrics, general surgery and emergency services in a hospital of designated D & T Centre, are assigned to the practice category "General Practice – Full Scope (Rural)" which shall have three associated Ranges. Assignment to Ranges A, B and C will be on the basis of the isolation point assigned by the JSC to a particular community from time to time and when changes to isolation points result in a change in the applicable Range, implementation of such change will be determined by JSC policy. Specifically, Range A is for practice in communities assigned 20 or greater isolation points, Range B for communities assigned 15-19.99 isolation points and Range C for communities assigned 6-14.99 isolation points.

3.3.3 General Practice – Defined Scope A: The "General Practice – defined Scope A" category is applicable to General Practitioners who do not provide a Full Service Family Practice (as the term issued by the General Practice Services Committee) but are contracted or employed by an Agency to provide Physician Services in a focussed area of practice (eg. palliative care, geriatrics, complex pain, mental health, sexual medicine). This category includes General Practitioners who provide cancer treatment services in a hospital and in the

community (commonly referred to as "GP Oncologists") under a contract with the BC Cancer Agency.

3.3.4 General Practice – Defined Scope B: General Practitioners who do not provide Full Service Family Practice (as the term is used by the General Practice Services Committee), limited to those who (i) provide services in student health centres or (ii) provide clinical associate services, are assigned to the practice category "General Practice – Defined Scope B.""

3.7 The Practice Category for Hospitalists was also referred to me. Hospitalists are based in a number of hospitals in British Columbia. They provide general medical care to hospitalized patients. The demands on them can be diverse and demanding depending on the patients who are provided care in the hospital where they work.

3.8 Lastly, the Practice Category for Internal Medicine Specialists was also referred to me. Internal medicine is the medical speciality which has its roots in primary care by providing primary and specialty care to adults. They are specially trained to manage seriously ill patients suffering from advanced illness and/or illness of more than one system.

3.9 During the Committee discussions, much time was spent on issues such as relative overheads, the availability of after hour payments and other premium pay, and most importantly, on the relative levels of responsibility, expertise and training of the physicians who provide these services. Consideration was also given to inter-provincial rates of payment where available and appropriate.

3.10 As stated earlier, the Committee was directed by Clause 4.2 of Schedule D of APSA to reach a consensus consistent with the provisions of APSA and the Provincial Master Agreement.

3.11 Clause 4.9 of Schedule D also provides that the funding will be allocated to consider Inter-Practice Category equity issues and inter-provincial disparity for non-fee for service compensation rates in other provinces. However, any inter-provincial disparities must not exacerbate inequity among BC physicians.

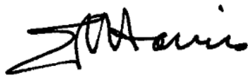
3.12 I am satisfied that these terms of reference were addressed in the course of our discussions and will be reflected in my decision.

4. Decision

I now provide the band values which I have decided will be applied over the three year term of the PMA in addition to the other independent fee value increases provided in Appendix "F".

Practice Categories	2018/2019 Rate	Band
General Practice Defined Scope A	$266,543	1.6
General Practice Defined Scope B	$238,363	1.6
General Practice Full Scope (Non-JSC Community)	$281,581	1.6
General Practice Full Scope (Rural) Area A	$312,587	1.0
General Practice – Full Scope (Rural) Area B	$302,722	1.0
General Practice – Full Scope (Rural) Area C	$294,045	1.0
Hospitalists	$266,543	1.2
Internal Medicine	$322,662	1.0

Signed on the 4th of February, 2021.



Eric J. Harris, Q.C.

Schedule
to the Report of Eric J. Harris, QC
Dated February 4th, 2021

The Allocation Committee exists of the following individuals:

For the Doctors of BC

Dr. Sanjay Khandelwal
Dr. Todd Sorokan
Dr. Rod Tukker
Tod MacPherson, Director of Negotiations, DOBC

For the Government of BC

Claire Brown, Executive Director, Capital Management and Physician Compensation, PHSA
Michael Ducie, Executive Director, Physician Engagement and Contract Strategies, VCHA
Joni Magil, Director of Physician Compensation, Ministry of Health
Liana Silver, Director of Physician Agreements and Negotiations, Ministry of Health
Chris Kincaid, Physician Services, HEABC

Chair

Eric J. Harris, Q.C.