ARBITRATION AWARD

BETWEEN:

NEWFOUNDLAND AND LABRADOR MEDICAL ASSOCIATION
(hereinafter called the "NLMA")

AND:

GOVERNMENT OF NEWFOUNDLAND AND LABRADOR
(hereinafter called the "Government")

AGREEMENT EFFECTIVE OCTOBER 1, 2002 TO SEPTEMBER 30, 2005

COUNSEL:

For the NLMA
Thomas J. O'Reilly, Q.C.
Michelle A. Willette

For the Government
Michael F. Harrington, Q.C.
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ARBITRATION BOARD:

James C. Oakley, Chairperson
Ronald A. Pink, Q.C., NLMA Nominee
Denis Mahoney, Government Nominee

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Background

The Newfoundland and Labrador Medical Association and the Government of Newfoundland and Labrador agreed to submit several outstanding issues to the Arbitration Board. The parties agreed to arbitration as part of a settlement to end a withdrawal of services by physicians in the province of Newfoundland and Labrador from October 1 to October 17, 2002. The parties agreed to arbitration pursuant to Terms of Reference dated October 17, 2002, which state, in part, as follows:

> TERMS OF REFERENCE
>
> The Newfoundland and Labrador Medical Association (the NLMA) and the Government of Newfoundland and Labrador (the Government) have agreed to submit outstanding issues to binding arbitration under the following terms:
>
> I ARBITRATION BOARD
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> 1. The Arbitration Board shall consist of three arbitrators: one each to be appointed by the parties hereto and the third, who shall be the Chairperson, shall be selected by the two so appointed.
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> 7. A decision of a majority of the members of the Arbitration Board shall be the decision of the Board and, and failing a majority decision, the decision of the Chairperson shall be the decision of the Board.
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> . . .
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> 9. Within 15 days of the acceptance of these Terms of Reference, the parties shall determine which items have been agreed upon and those items which remain outstanding for submission to the Arbitration Board. All issues not agreed upon are deemed to be outstanding issues and may be referred to the Arbitration Board.
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> 10. The Arbitration Board shall begin the arbitration proceeding within 45 days of being constituted and shall deliver its decision or award on the matters in dispute within 60 days of the commencement of the arbitration proceeding, unless otherwise agreed by the parties.
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> 11. The decision of the Arbitration Board is final and binding upon the parties.
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> II ARBITRATION BOARD TERMS OF REFERENCE
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> 1. In making its decision, the Arbitration Board shall utilize conventional arbitration and recognize the following factors:

a. reasonable and fair compensation and working conditions for physicians in rendering professional services;

b. the need for sufficient physician resources to provide for medical care in the Province;

c. the financial circumstances of the Government.

2. Governments submission to the Arbitration Board will not be less than the most recent negotiated package of $50 million dollars over the life of a 3-year agreement with effect from October 1, 2002.

3. The Arbitration Board's decision shall be limited to:

a. the total amount of money to be allocated to the physician services budget;

b. the allocation of the total amount of money among the various physician groups;

c. the allocation to fee-for-service physician groups is to be based on the results of the analysis confirmed by John Tarrel, actuary (after correction for errors of fact by mutual agreement);

d. outstanding items as identified in Clause 1.9;

e. application of monies to the fee codes shall be done by the parties.

Pursuant to the Terms of Reference, each party appointed its nominee to the Arbitration Board. By agreement, the Chairperson was appointed on December 9, 2002. Each party agreed to prepare a list of the outstanding issues to be referred to the Arbitration Board, pursuant to paragraph 9, of the Terms of Reference. The lists were prepared on January 10, 2003 and each list contained mostly the same issues. There were some issues identified by one party and not by the other party. The parties disputed the jurisdiction of the Board to settle some issues. The list of outstanding items referred to arbitration is as follows:

List of Items Referred to Arbitration

A. Fee for Service Issues

- Basic fee increases
- Emergency care service increases (category A)
- General sessional rate increases

- Locum tenens rate increases
- Recognition of professional advice by telephone (NLMA list only)
- Elimination of capping and thresholds
- Specialty corrections
- Deficit recovery (Government list only)

B. Salary Physician Issues

- Basic compensation increases
- Defined work week
- Compensation for additional workload
- Critical escort duty
- Clinical administrative benefit
- Oncology stipends
- Compensatory leave
- Equity for GFT bonuses
- FFS billings by salaried physicians (NLMA list only)

C. General and Other Issues

- Recognition of "on call"
- Representation of "public health specialists"
- Schedule of disbursements
- Maternity leave and benefits
- Service coverage (Government list only)
- After hours coverage - St. John's (Government list only)

D. Amount to be allocated to the Physician Services Budget (Government list)

The Government list also included the item "Duration of the Agreement". The parties agreed that the agreement would be for a period of three years commencing on October 1, 2002 and ending on September 30, 2005. It is noted that the Government's fiscal year end is March 31st.

The parties agreed to file written submissions and to make presentations to the Arbitration Board at a hearing. The Board received written submissions from the parties on January 27, 2003 and written replies on February 3, 2003. The Arbitration Board conducted a hearing in St. John's on February 5, 6, and 14, 2003. Following the hearing, supplementary briefs were filed on one issue on February 24, 2003. The parties were represented by counsel and resource personnel. The representatives for the NLMA were as follows: Mr. Thomas J. O'Reilly, Q.C., Counsel, Ms. Michelle A. Willette, Counsel, Dr. John Haggie, President of the NLMA, Dr. Lydia Hatcher, Immediate Past President of the NLMA, Dr. Ronan O'Shea, Chair Salaried Physicians Committee, Mr. Robert Ritter, CEO, NLMA, Mr. Stephen Jerrett, Director of Health, Policy and Economics, NLMA, Ms. Tamie Walsh, Administrative Assistant, NLMA. The representatives for Government at the hearing were as

follows: Mr. Michael F. Harrington, Q.C., Counsel, Ms. Judith K. Begley, Counsel, Dr. Cathi Bradbury, Director of Medical Services, MCP, Mr. Ed Galway, Director, Collective Bargaining Division, Treasury Board, Mr. Brian Miller, Staff Relations Specialist, Collective Bargaining Division, Treasury Board, Dr. Larry Alteen, Medical Director, Central West Health Corporation, and Mr. Roy Manuel, CEO, Peninsulas Health Care Corporation.

The Arbitration Board extends its appreciation to counsel and representatives of the parties for their comprehensive written submissions, and for their helpful and concise presentations at the hearing. The co-operation of the parties was of great assistance to the Board in the completion of the arbitration process. The Board will refer to summaries of the submissions by the parties in this Award. The Board has considered the presentations in their entirety, including any parts of those presentations that may be omitted from this Award.

At the hearing, the Board also heard submissions from representatives of specialty groups, in particular, from Dr. Dan Squire, Orthopaedic Surgery, Dr. Arthur Rideout, Plastic and Reconstructive Surgery, and Dr. Ken LeDez, Anesthesia. These presentations provided assistance to the Board in the understanding of the issues concerning these specialties and physicians generally.

The parties agreed that the Arbitration Board was properly constituted pursuant to the terms of reference and that the Board had jurisdiction over the issues referred to the Board. The parties did not agree with respect to the jurisdiction of the Board to decide certain issues, but agreed that the Board had the authority to decide whether these issues fell within the Board's jurisdiction. The Board heard argument and reserved its decision on questions of jurisdiction. The parties presented argument on the merits of the issues including those issues where jurisdiction was disputed, subject to the qualification that the submissions on the merits were made on the assumption that the Board finds it has jurisdiction over those issues. The parties also agreed to extend the time limit for the issuance of the award to a period of 90 days from the commencement of the arbitration proceedings. The parties agreed that the arbitration proceedings commenced upon the filing of written submissions on January 27, 2003.

The Board determined that it would benefit from expert actuarial advice to cost items in the Award for the purpose of deciding the total amount of money to be allocated to the physician services budget and the allocation of money among the various physician groups. With the agreement of the parties, the Board retained John Tarrel, actuary, for this purpose.

There were issues where the jurisdiction of the Board to address an issue was disputed. Jurisdiction was disputed by the Government for the issues of specialty corrections, specifically AFP for neurosurgery and internal parity for internal medicine, and fee for service billings for salaried physicians. Jurisdiction was disputed by NLMA for the issue of service coverage. Jurisdictional issues were also raised with respect to the issues of deficit recovery and recognition of professional advice by telephone.

The arbitration proceedings are also subject to legislation approved by the Government of Newfoundland and Labrador subsequent to the signing of the Terms of Reference. The legislation is set out in the *Medical Association Agreement Act*, SNL 2001, c. M-4.1 which states, in its entirety, as follows:

> 1. This Act may be cited as the *Medical Association Agreement Act*.
>
> 2. In this Act
>
> (a) "agreement" means the terms of reference agreed to by the Newfoundland and Labrador Medical Association and the Government of Newfoundland and Labrador on October 17, 2002, a copy of which is on file with the Clerk of the Executive Council; and
>
> (b) "association" means the Newfoundland and Labrador Medical Association continued under the *Medical Act*.
>
> 3. The decision of the arbitration board appointed under the agreement is final and binding on the province and the association.

History of Agreements and Negotiations

Health services are provided in the Province by the Government of Newfoundland and Labrador through the Department of Health and Community Services (the "DOHCS"). The delivery of services is delegated by the Department to 13 Health Boards and one Foundation, which are members of the Newfoundland and Labrador Health Boards Association ("NLHBA"). The responsibility of the Provincial Government to provide health care services is subject to the principles of medicare as set out in the *Canada Health Act*, R.S.C. 1995, c. C-6. The Provincial Government is required to comply with the conditions established by the *Canada Health Act* before a financial contribution is made by the Federal Government to the Provincial Government. There are five criteria that are set out in Section 7 of the *Canada Health Act* as follows:

> Program Criteria
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> 7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:
>
> (a) public administration;
> (b) comprehensiveness;
> (c) universality;

(d) portability; and
(e) accessibility

With respect to the criteria of accessibility, the *Canada Health Act* makes reference to compensation of medical practitioners in Section 12, which states as follows:

> 12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province
>
> (a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;
>
> (b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;
>
> (c) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and
>
> (d) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.
>
> (2) In respect of any province in which extra-billing is not permitted, paragraph (1)(c) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides
>
> (a) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practicing medical practitioners or dentists in the province;
>
> (b) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (a), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

> (c) that a decision of a panel referred to in paragraph (b) may not be altered except by an Act of the legislature of the province.

The Newfoundland and Labrador Medical Association represents the interests of the province's licenced medical practitioners. Membership in the NLMA is compulsory for physicians wishing to practice in Newfoundland and Labrador. The NLMA has the authority to negotiate on behalf of its members pursuant to the *Medical Act*, RSNL 1990, c M-4 which states as follows:

> . . .
> 3. The Newfoundland and Labrador Medical Association is continued as a corporation.
> . . .
> 5. The association may, in addition to the powers vested by law in a corporation,
> . . .
> (k) act on behalf of its members, or a group or section or division of its members, and negotiate for, and on their behalf, with other persons or agencies, including government agencies;
> . . .

The role of the NLMA with respect to the rates of payments to be made in respect of insured services by the plan of Medical Care Insurance in the province ("MCP"), is set out in Section 24 of the *Medical Care Insurance Act*, SNL 1999, c. M-5.1 which states as follows:

> 24. The medical association and the dental association shall be consulted by the minister with reference to the rates of payments to be made under this Act in respect of insured services provided to beneficiaries by physicians, the manner and form in which the payments to physicians shall be made and changes in connection with payments and, where the minister considers it necessary, with reference to general questions of principle concerning the practise of medicine.

The NLMA represents physicians who work on a fee for service ("FFS") basis and those who are employed as salaried physicians. Approximately two thirds of physicians practising in the province are compensated on a FFS basis. Within both the FFS and salaried physician groups there are specialists and general practitioners ("GPs"). Services by salaried GPs are more prevalent in rural and remote areas of the province where it is more difficult for a physician to maintain a livelihood on an FFS basis.

The number of physicians practising in the province, determined by the "snap shot" approach, as of March 31, 2002 were 886, comprising 574 FFS physicians (297 GPs and 277 specialists) and 312 salaried physicians (124 GPs and 188 specialists).

FFS physicians bill MCP for services which they provide in accordance with the MCP fee schedule. The fee schedule that was first implemented following introduction of Medicare in 1968, was patterned after the Ontario fee schedule. The Minister of Health and Community Services has the authority to establish the fee schedule and has followed, up to the last adjustment in 2002, the assignment of fee code rates to specific services based on the proposals of the NLMA. The process of assigning fee code rates to various services is called micro allocation.

Salaried physicians are employees of the Health Boards within the province. Their terms of employment are governed, in part, by terms negotiated between the Government and the NLMA. Some of the terms of employment are listed in a document referred to as the "Blue Book". It was submitted by the NLMA that salaried physicians generally do not have written contracts of employment and, as a result, the expectations and obligations of salaried physicians are not clear.

In the past, the NLMA has made representations to Government with respect to the terms of employment of salaried physicians and with respect to the MCP fee schedule. The first formal Agreement between Government and the NLMA, called the "Joint Management Committee Agreement" ("JMCA") was in effect from April 1, 1992 to March 31, 1997. The JMCA provided for a capped physician services budget with adjustments to eliminate cost overruns. The JMCA set out a base budget for fee for service physicians for the 1992-1993 fiscal year and stated that increases would be tied to the increases paid to Government management employees. During this period there was wage restraint within Government and there were no increases for FFS physicians.

The NLMA and Government entered into a Memorandum of Understanding ("MOU") that was in effect from April 1, 1998 to September 30, 2002. The MOU provided for a base budget for FFS and salaried physicians and increases in the budget up to the 2002-2003 fiscal year. Some of the relevant provisions of the MOU are as follows:

> The parties to the Memorandum have reached the following Understanding:
>
> The Government commits to increase funding for medical services, and to compensate physicians for delivery of these services in accordance with the negotiated fee schedules/salary rates. Physicians commit to provide, in accordance with the negotiated fee schedule/salary rates, the insured services which have been traditionally funded through MCP and which the public might reasonably expect to be available, subject to resource and skill limitations.
>
> . . .
>
> Physician Compensation Budget
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> Physician compensation will be increased during the term of this Memorandum, in accordance with the provisions of Appendix "A".
>
> The fee-for-service budget, before Budget Adjustments, in the respective fiscal years during the term of this Memorandum is as follows:

Fiscal Year	Fee-For-Service MCP Payments (Millions)
Base Amount	$ 116.32
1998-99	121.86
1999-00	126.20
2000-01	130.24
2001-02	135.96
2002-03	140.21

Payments to, or on behalf of salaried physicians, by MCP are projected to be in the following amounts, based on current physician compliments, for the respective fiscal years during the term of this Memorandum.

Fiscal Year	Salaried Physician MCP Payments (Millions)
Base Amount	$ 30.52
1998-99	31.88
1999-00	33.24
2000-01	35.30
2001-02	36.88
2002-03	38.63

The parties recognize that;

- With respect to fee-for-service physicians, these budgetary numbers are based on the assumption that medical services will continue to be delivered at approximately the same level in each year of this Memorandum as existed in the1997-98 fiscal year.

- With respect to salaried physicians, these budgetary numbers are based upon the assumption that approximately 195 full-time equivalent (F.T.E.) salaried physician positions, excluding locums, will be filled in each year of this Memorandum.

In the event that payments to fee-for-service physicians are projected to exceed the amount allocated for a fiscal year, the parties shall mutually agree on a formula for adjusting physician compensation to ensure that the budget is not exceeded.

The parties will review options for recovering deficits over periods which may extend beyond the fiscal year, subject to the limitations of the *Financial Administration Act*.

In the event payment to fee-for-service physicians are less than, or are projected to be less than, the amount allocated for a fiscal year, the parties shall mutually agree on how those funds shall be utilized.

In the event that payments to salaried physicians are projected to exceed the amount allowed for a fiscal year, additional funding will be allocated.

. . .

Deficit Recovery

Commencing with the fiscal year 2000-01, in the event of a projected deficit within the fee-for-service budget for a fiscal year:

- Physician compensation will be adjusted to recover a deficit up to an amount which equals the sum of the Demographic Adjustment ($3000,000), Physician Resource Adjustment (to be determined) and Other Adjustment ($250,000) in the same year.

- If the deficit exceeds the amount determined in accordance with (1) above the parties will share equal responsibility for the excess deficit to a maximum of $2 million. Physicians will assume their share of responsibility through compensation adjustment and Government/Hospital Boards shall assume their share by providing additional funding for that year.

- If the deficit exceeds the amount determined in accordance with (1) and (2) above combined, physician compensation will be adjusted to recover the excess deficit.

On-Call Policy

All physicians are expected to be available and accessible to their patients or to share in an on-call rota with other physicians in their community in order to provide shared on-call for periods of time when physicians clinics are closed for regular appointments.

For the purpose of receiving additional compensation, physicians who provide call to a Regional Board in excess of one in three for specialists and one in four for general practitioners will be remunerated according to terms and conditions to be negotiated. Until such time as this negotiation is completed, the current payment policy will remain in effect.

All funding for on-call shall be allocated from existing sources and/or new funds committed by way of this MOU.

. . .

Appendix "A"

Physician compensation will be increased during the term of this Memorandum in accordance with the attached Allocation Table and the following guidelines:

. . .

4. GP fees will be increased by the amounts indicated on the Allocation Table.

5. ER/OR/NH rates will be increased by the amounts indicated on the Allocation Table.

6. Specialist fees will be increased by the amounts indicated on the Allocation Table.

7. Unallocated FFS amounts, as indicated on the Allocation Table, will be used to increase specialist and GP fees in a manner to be determined by the parties. The parties may agree to use an independent consultant to assist in this process, with costs shared equally.

. . .

The MOU also contained provisions addressing budget adjustments, physician resource management, dispute resolution, incorporation, medical service review, return-in-service contract, income guarantee, alternate delivery models, and terms and conditions of employment for salaried physicians.

The MOU contained provisions for the macro allocation to the physician services budget. The parties also agreed to the micro allocations of funds to the fee for service fee codes.

In its submission, the NLMA described the period during which the MOU was in effect as a period of misunderstanding leading to acrimony. The NLMA also expressed frustration with respect to the current round of negotiations and Government's response to the NLMA proposals. The parties met to conduct negotiations commencing on May 16, 2002 and continuing on various dates. The parties met with the assistance of a mediator in September, 2002. Negotiations continued with the assistance of the mediator following the service withdrawal by physicians on October 1, 2002. During the negotiations the parties reached agreement on several issues which were incorporated in a written document provided to the Arbitration Board. The outstanding issues were referred to arbitration. The service withdrawal by physicians ended on October 17, 2002, upon the agreement of the parties to the Terms of Reference and the commitment by Government to enact legislation to make the arbitration award binding on Government.

Parity Review Exercise

The parties agreed that the most appropriate method to compare remuneration of fee for service physicians in Newfoundland and Labrador with those in other provinces was by a comparison of the fee codes for specific services. It was agreed that a comparison of annual incomes received by

general practitioners or specialists was not reliable because annual incomes are partly a result of the number of hours worked by particular physicians. The parties engaged the services of John Tarrel, an actuary, who completed an analysis of the fee codes in Newfoundland and Labrador compared to the Maritime provinces. His analysis compared the fees paid to GPs and specialists with the weighted average of the fee code rates in the Maritime provinces as of April 1, 2002. The result of the parity review exercise is a parity table showing a calculation of the amounts paid to physicians for the same services in this province as a percentage of the weighted average in the Maritimes. The parity table is as follows:

% of FFS Parity
By Physician Group

Physician Group	% of Parity
General practice	75.9
Anaesthesia	78.3
Cardiac surgery	86.8
Dermatology	110.1
Emergency Medicine spec.	105.2
General surgery	78
ICU	77.1
Internal Medicine	87.4
Neurology	79.4
Neurosurgery	91.5
Nuclear Medicine	112.5
Obstetrics/Gynecology	92
Ophthalmology	84.9
Orthopedics	90.4
Otolaryngology	80.2
Pediatrics	73
Plastic surgery	94
Psychiatry	78.9
Radiology	89.2
Urology	82.4

The physician groups listed in the parity table are the same groups referred to in paragraph II, 3 of the Arbitration Board's Terms of Reference. The Board's decision in this Award is restricted to the allocation of the total amount of money to these physician groups, which means the total amount of the physician services budget to be allocated to each group, such as general practice or the particular specialists listed. Paragraph II, 3, (b) of the Terms of Reference states that the application of monies to the fee codes, the micro allocation, shall be done by the parties. Therefore, the parties will adjust the fee codes so that the total allocation of money to each group will be achieved. According to the Terms of Reference, the Arbitration Board does not have jurisdiction over micro allocation.

Arbitration Principles

Paragraph II, 1 of the Terms of Reference states that the Arbitration Board shall utilize conventional arbitration. This means that the Board may set the terms of the agreement between the parties. The Board may accept a term as proposed by one of the parties or it may settle a term in the manner deemed appropriate by the Board. The Board is not restricted to the selection of either the NLMA proposal or the Government proposal. The parties have not disputed the Board's authority to either select a proposal from one of the parties or to settle the terms as deemed appropriate by the Board.

Paragraph II, 1 of the Terms of Reference also states that the Arbitration Board shall recognize three factors in making its decision. The Terms of Reference do not indicate that any greater weight should be given to any one of the three factors any more than any other factor. The parties made submissions to the Board with respect to how the Board should apply each of the factors. The Board will discuss the submissions of the parties and its findings in that regard.

Reasonable and Fair Compensation and Working Conditions for Physicians in Rendering Professional Services

The NLMA submits that its goal for fair and reasonable compensation would be achieved by parity with the highest paying provinces in Canada, such as Alberta or British Columbia. However, given the magnitude of the gap between remuneration of physicians in Newfoundland and Labrador and those provinces, this goal was considered unrealistic. As a concession to Government, the NLMA first agreed to accept parity with Nova Scotia and then as a further concession, agreed to accept parity with the weighted average of the Maritime provinces . The NLMA submits that this is a reasonable and achievable goal. The Maritime provinces are geographically close to Newfoundland and Labrador and, therefore, are likely provinces to be considered by physicians in Newfoundland and Labrador as an alternative place to practise. The NLMA submits that using the Maritimes as a comparator is realistic for the comparison of the FFS fee codes. Anything less than 100% parity with the Maritimes upon the implementation date of the Award would not be fair and reasonable. A comparison with the Maritimes may be one factor to consider with respect to other issues. For some issues, a comparison with the Maritimes is not appropriate. For example, with respect to additional compensation for salaried oncologists, the parties had agreed that an appropriate comparison was the higher paying provinces, such as Ontario or Alberta.

Government submits that the agreed standard for measuring what is fair and reasonable compensation for FFS physicians is the result of the parity review exercise and that a comparable analysis of salaried physician compensation can be made by reference to New Brunswick and Prince Edward Island. Government also refers to prior interest arbitration awards. Government submits that the concept of fair and reasonable compensation includes consideration of the Employer's ability to pay. The concept includes the Arbitration Board's view of what a majority of fair minded, well informed taxpayers would consider to be fair and reasonable, even if it meant a tax increase. Government submits that 100% parity with the Maritime provinces is not economically attainable within 3 years given Government's fiscal circumstances, and is not reflective of the compensation history of physicians in the province.

The Board will consider fair and reasonable compensation and working conditions, in part, by applying appropriate comparators. The compensation and working conditions of physicians in other provinces in Canada, in particular, the Maritime provinces, is an appropriate comparator. To a limited extent, it is appropriate to consider other public sector employees. For FFS physicians, the result of the parity review exercise is of primary importance. For example, it is clearly not fair and reasonable that general practice physicians are compensated at 75.9% of the amount paid to GP's in the Maritimes. The Board does not agree with Government's submission that Government's ability to pay is relevant to this factor. As discussed below, the ability to pay is properly considered as part of the factor of the financial circumstances of Government.

The Need for Sufficient Physician Resources to Provide for Medical Care in the Province

Government states that the population to physician ratio of 543/1 is the fourth lowest of all provinces. The demand for resources is subject to a number of factors including the decline in total population, the review of the location of medical services, action by the Department on Primary Care Reform and a review of the needs of the population. Government submits there have been several attempts to define the need for physician resources. The most recent exercise resulted in a Paper by the physician demand subgroup of the Physician Resource Planning Group. The Paper provided a detailed listing of the demand requirements for GPs and specialists in various centers throughout the province. Government submits that the Physician Demand Consultation Paper is a draft document. The Paper recommended further consultation that was never completed. The Government refers to Physicians Supply Reports prepared using methodology adopted in 2000 showing that the total physician supply has not changed significantly from March, 2000 to March, 2002. The Government refers to recruitment and retention issues and service coverage difficulties, particularly outside the St. John's area. The province retains approximately 40% of the Medical School graduates from Memorial University of Newfoundland and Labrador. Government described its recruitment and retention efforts. Compensation is only one aspect of recruitment and retention of physicians. Other initiatives are needed to provide sufficient physician resources. Government submits that maintaining the salaried GPs above equivalency with New Brunswick and Prince Edward Island is unnecessary. With respect to oncologists, the Government recognizes there is a nation wide recruitment and retention issue and that the province is not competitive nationally.

The NLMA referred to the Physician Demand Consultation Paper which found serious gaps between the number of physicians and the recommended levels required. There is a shortage of general practitioners and specialists in certain areas. There are long waiting times for routine appointments and problems with emergency department coverage. There is a direct correlation between patient waiting times and physician shortages. Specialists are leaving the province because their earnings have reached the individual earning cap. The demographics of the physician population is significant. For example, 36% of physicians are over 50 years of age. A recent survey of medical students at Memorial University of Newfoundland indicates that 65% felt strongly that low wages in the Province would deter them from practising here. The need for physician resources is demonstrated by the number of vacancies for physicians. A document was presented listing current vacancies. The NLMA referred to statistics showing net out-migration of physicians between Newfoundland and Labrador and other provinces. These statistics do not account for in-migration from other countries. The NLMA submitted that while total population is declining, the demographics of the population must be considered, in particular, the fact the aging population will have the most complex and time consuming medical problems.

The Board considers that this factor addresses the serious issue of physician recruitment and retention. While the total number of physicians licensed to practice in the Province has remained fairly constant in recent years, and the population to physician ratio is low compared to other provinces, there are unique circumstances in this province, such as the aging population and the wide geographic distribution of the population. A higher physician to population ratio is needed in this Province when compared to other provinces. There are serious issues related to the high turnover of physicians in particular areas. The age distribution of physicians is a factor. There is a need to recruit and retain young physicians. The Board is cognizant of the fact that this Award must address the issue of attracting physicians to practice in the Province and retaining their services. The jurisdiction of the Arbitration Board is limited to its decision on those issues that the parties have referred to the Board. The issue of physician recruitment and retention cannot be addressed by means of this Award alone. However, the Board will take into account that compensation and lifestyle issues are a significant aspect of the recruitment and retention issue, which is related to meeting the need for sufficient physician resources.

The Financial Circumstances of Government

The parties referred to financial and budgetary indicators and economic projections with respect to the financial circumstances of Government.

Government submits that $50 million is the maximum amount that can be added to the physician services budget while remaining within Government's ability to pay. It was not economically attainable for FFS physicians to achieve 100% parity with the Maritime provinces within three years. The Federal contribution to the health budget had declined from over 50% to 14%. Federal transfer payments were 41.4% of total provincial revenue in 2001-2002, which was a decline from 48.3% of total revenue in 1998-1999. Transfer payments will decline even further due to the 8.4% decline in population of the province in the most recent census. The amount of Federal funding to be added as

a result of implementing the Romanow Task Force Report is uncertain. Any additional funding will likely be dedicated to particular programs and will not be available for the physician services budget. Government is already spending a significant proportion of its budget on health care. Health care spending represented 30.9% of the total provincial budget in 2001-2002, an increase from 23.5% in 1997-1998. Reallocation of funds from other Government programs was not a realistic option. An increase in taxation was not acceptable. The provincial rate of taxation is the highest in the Atlantic provinces. The ability to generate tax revenue is the lowest in the Atlantic provinces. Borrowing to pay for increases in the physicians services budget was not an option. Newfoundland and Labrador has the highest level of public debt per capita of the Atlantic provinces. Increasing the total amount of the public debt was not a realistic option. There is a higher cost of providing goods and services in this Province given the geography and the distribution of the population.

The NLMA submits that its request for parity with the Maritime provinces was a concession from its original position of parity with the highest paying provinces. This concession took into account the financial circumstances of the Government. The NLMA submitted that physician services represent 5% of total annual provincial expenditures which is a relatively small percentage of the provincial budget. The amount of the physician services budget, as a percentage of total health spending, has declined from 15.8% in 1999-2000 to 13% in 2001-2002. The former amount of the physician services budget as a percentage of the total health care budget should be restored. Other components of the health care budget have increased while physician services has not increased at the same rate. The Government has the financial resources to pay the cost of parity when the resources of this province are compared with the resources of the other Atlantic provinces. The NLMA referred to recent speeches by the Premier and Government Ministers describing the glowing prospects for the provincial economy and the stable fiscal circumstances of the Government. The gross domestic product in the province has increased 24.3% from 1996 to 2001 compared to an increase in the Maritime provinces of 17.1%. Employment and retail sales have increased more than the other Atlantic provinces. The gross domestic product increased 7.5% in 2002. Government revenue is increasing. With the additional projected growth in GDP, the Provincial tax revenues are likely to increase. The province's credit rating has improved. Federal transfer payments for health care will be increased with implementation of the Romanow Report. There is public support for a tax increase to avoid a reduction in health care services.

The Board finds that the financial circumstance of the Government includes the Government's fiscal circumstances and Government's ability to pay. To pay for the cost of the physician services budget, the Government is required to allocate funds from its proposed expenditures. To provide for an increase in compensation for physicians, Government will need to increase revenue, increase borrowing or reallocate funds from other expenditures. An increase in revenue may be achieved by increasing taxation rates or introducing new taxation measures, or it may be achieved as a result of growth in the economy leading to growth in sales and higher personal and business incomes. It is relevant to consider the financial circumstances of the Government when compared to other provinces in Canada, in particular, compared to the Maritime provinces. Currently the financial circumstances of this Province are not equivalent to the Maritime provinces. However, economic indicators suggest that the economy is growing at a faster rate in Newfoundland and Labrador compared to other

provinces. The current agreement will expire on September 30, 2005. The parties will be in a position, upon the expiry of the current agreement, to assess the impact of the economic growth of the province between 2003 and 2005. The Board must give primary consideration to the current financial circumstances, with secondary consideration being given the projected financial circumstances, having regard to the inherent uncertainties of economic projections.

General Principles of Arbitration

The Arbitration Board will apply the three factors identified by the parties in the Terms of Reference. The Board will consider the interests of the physicians as represented by the NLMA and the interests of the Government of Newfoundland and Labrador. The parties have made submissions to the Board concerning the normative and accommodative approach to interest arbitration. These two approaches were referred to in *Newfoundland Association of Public Employees Correctional Officers Bargaining Unit v. Government of Newfoundland and Labrador*, September 9, 1991 (Alcock) at page 8 as follows:

> Whether or not the award should be normative or accommodative is the next question. Classic definitions for these two fundamental different kinds of award have been offered by J. Isaac as quoted in Labour Law at p. 282:
>
> > Normative arbitration. . .attempts to impose a "just" solution on the parties, taking into account the merits of the case rather than the power situations of the parties or the acceptability of the terms to both sides. . .
> >
> > Accommodative arbitration results in an award which embodies substantially the terms which the parties themselves would have reached, bearing in mind their bargaining powers. The "rules of evidence" of a purely judicial procedure, if not abandoned, are diluted and the main objective of arbitration is to find something close to a mutually acceptable solution. The award is thus a pragmatic attempt to resolve the dispute, to avoid a strike or to induce a return to work . . .

The parties have agreed that the normative approach is to be applied, meaning that the Board will search for a just solution and impose terms that are fair and reasonable. The Board has given consideration to the history of agreements between the parties and developments in the current negotiations. There is an evident need for improvement in the relationship between the parties. Physicians do not accept the compensation levels that have resulted from the JMCA and the MOU. Physicians do not want their compensation to fall even further behind their counterparts in the rest of the country. Physicians are easily mobile and have the option to relocate to other provinces.

The Board has considered that there has been a long term relationship between the Government and the NLMA and that the relationship will continue in the future. The agreement resulting from this Award will expire on September 30, 2005. It is likely that the parties will be negotiating future agreements. There are issues that the parties have resolved outside this arbitration process. In some cases, the terms of the agreement are better left to the parties to negotiate. This will be considered with respect to those issues where the details do not appear to have been the subject of much negotiation between the parties.

The Board will also give consideration to the terms of the agreements made between the parties in the past, including the MOU. The NLMA has described the MOU as an ineffective contract. However, the MOU represents a document negotiated in good faith between the parties. While there may be deficiencies in the document to the extent that some of its provisions are unclear, it remains the agreement that was in effect until September 30, 2002.

The Board will consider the background to the dispute and the objectives of the NLMA and Government. The parties cannot expect to achieve all of their objectives during a single round of bargaining. Some of the details of proposals were introduced during late stages of bargaining or during submissions to the Arbitration Board. In some cases where the Arbitration Board does not feel it to be appropriate to accept a proposal at this time, it reminds the parties that the parties may negotiate the issue in future bargaining. Even though a proposal may have merit, the Board will not impose a term on the parties where it is preferable that the issue be discussed in future bargaining.

Issues of Jurisdiction

Introduction

The jurisdiction of the Arbitration Board is set out in the Terms of Reference, in particular, paragraph II, 3. The jurisdiction of the Board includes deciding the total amount of money to be allocated to the physician services budget and the allocation of that amount among the various physician groups. The jurisdiction also includes the outstanding items identified in paragraph I. 9 of the Terms of Reference. Paragraph I. 9 states that the parties shall determine the issues which have been agreed upon and those items which remain outstanding and that all issues not agreed upon are deemed to be outstanding and may be referred to the Board. Pursuant to paragraph I.9, both the NLMA and Government prepared a list of items to refer to arbitration. Some of the items where jurisdiction is in dispute appear on one list or the other but not both lists. The Board will discuss three issues of jurisdiction in this part of the Award. Issues of jurisdiction with respect to deficit recovery and professional advice by telephone will be discussed later in the Award under the heading of those issues.

Specialty Corrections

Government objects to the jurisdiction of the Board over two issues that the NLMA claims are within the general issue of specialty corrections, namely, alternate funding plans (AFP) for neurosurgery and internal parity issues for internal medicine specialists. Government submits that the issue of AFP for neurosurgery was not raised in negotiations and therefore is not an outstanding issue. The issue was first raised in the NLMA brief submitted to the Arbitration Board. Government submits that the NLMA proposal will have an impact on the micro allocations and is therefore outside the Board's jurisdiction. Government agrees that the use of AFP's is an issue for ongoing dialogue with the NLMA, but it was not within the jurisdiction of the Board. With respect to internal parity for internal medicine specialists, Government submits that any inequities within the group of internal medicine can be addressed in the process of micro allocation to be done by the parties. No money in addition to the FFS allocation is required. The parity review exercise reviewed the fee codes. Any exception for oncologists is not relevant to this issue, because oncologists are salaried specialists and salaries were not part of the parity review exercise.

The NLMA submits that it is necessary for the board to review AFP's for neurosurgery given the challenge to attract these specialists. There are four approved neurosurgeon positions in the Province but the population can adequately support only three neurosurgeons on a fee for service basis and additional funding is needed. With respect to internal parity for internal medicine specialists, various subcategories were raised during negotiations. Government had accepted oncologist compensation as an issue to be decided outside the Maritime parity review exercise and has agreed to fund emergency services in addition to amounts required for the parity review exercise.

The Board finds that it has jurisdiction to address AFP's for neurosurgeons and internal parity for internal medicine specialists. The parties referred to the Board the issue of specialty corrections. The submissions made by Government in relation to jurisdiction may be considered when addressing the merits of the issue of specialty corrections.

Fee for Service Billings by Salaried Physicians

The Government submits that this issue was not identified as an outstanding item in the NLMA list of items referred to arbitration. The item is not necessarily linked to the issue of the defined work week for salaried physicians, because fee for service billings could be allowed by the Arbitration Board regardless of its decision on a defined work week.

The NLMA submits that it regarded this issue as included in the issue of the defined work week. There was a need for a mechanism to compensate salaried physicians for work outside the defined work week, which could include overtime compensation, time off in lieu of pay or fee for service billings. The NLMA proposal for a defined work week included allowing fee for service billings during the period from 4:00 p.m. to 8:00 a.m. During mediation sessions there was discussion about the cost of a defined work week including fee for service billings by salaried physicians. New Brunswick allows fee for service billings by salaried physicians.

The Arbitration Board finds that the issue of fee for service billings by salaried physicians may be considered in relation to the issue of the defined work week. The issue of "defined work week" is included on the list of items referred to arbitration. The Board finds that it has jurisdiction to consider the issue of fee for service billings by salaried physicians.

Service Coverage

The issue of "service coverage" was included on the Government list of items referred to arbitration but not included on the NLMA list.

Government proposes requiring a commitment to service coverage as a condition for physicians to receive the increase in the fee for service rates established by the Arbitration Board. As a consequence, there would be a two tier system consisting of the new FFS rates for physicians who agreed to the service commitment and the old FFS rates for physicians who did not agree to the service commitment. Government submits that, pursuant to the MOU, physicians committed to providing services, including on call services. The issue of service coverage was discussed during the negotiations and the parties exchanged proposals on the issue. The NLMA sought arbitration on all outstanding issues and this was one of the issues outstanding from negotiations. The NLMA bargains on other issues in addition to compensation issues, such as the issue of the defined work week. Prior agreements with the NLMA were enforceable, in particular, the JMCA and the MOU. Government is accountable to ensure that an adequate level of service is provided. Regional Health Boards have the obligation to provide access to health services which requires physician services. General practitioners who are paid on a fee for service basis have a relationship with their individual patients and not with the population at large. General practitioners do not have a requirement to affiliate with a regional health board and as a consequence that they would not have an obligation to do on call or to admit patients to hospitals without the proposed service commitment.

The NLMA submits that the Arbitration Board does not have authority to impose any order binding physicians to service coverage. The NLMA does not have authority to bargain on behalf of its members in the same manner as a union acting as bargaining agent under the *Labour Relations Act*. The authority of the NLMA to bargain is limited to the authority set out in Section 5 of the *Medical Act*. The NLMA submits it cannot impose any obligations on physicians who may opt out of the medicare system and collect fees directly from patients. The NLMA cannot bind its members to provide services. The NLMA has the right to negotiate only on issues of compensation. The NLMA cannot bind salaried physicians who have the right to negotiate individual contracts of employment. Under the *Canada Health Act* physician fees are considered to be reasonable if they are negotiated between the Government and the Association representing physicians. The agreement made under the *Canada Health Act* is for the purpose of compensation and not for the purpose of service commitments. The effect of the two tier system proposed by Government would be that physicians would leave the Province. Government regards fee for service physicians as independent business operators. The MOU did not contain a service commitment. It contained an agreement that physicians would be bound by their professional code of conduct. Past agreements between Government and the NLMA should not be considered by the Arbitration Board. There was no

evidence of any withdrawal of service prior to October 1, 2002, while the MOU was in effect. There are service coverage problems caused by an inadequate supply of physicians. These problems could be addressed by having the incentive of adequate compensation.

The Arbitration Board finds that it has jurisdiction to address the issue of service coverage. This was an issue outstanding from the negotiations . The NLMA advised its members by newsletters in 2002 when describing the negotiations, that it would negotiate service commitments if appropriate conditions were in place. Service commitments were addressed in general terms as a statement of principle in the MOU. The NLMA has authority pursuant to the *Medical Act* to negotiate on behalf of physicians. The *Medical Act* does not limit the issues for which the NLMA may negotiate. The NLMA has the authority to commit its members to service coverage by making compliance with the agreement between the NLMA and the Government a condition of membership in the NLMA.

Items Referred to Arbitration

A. Fee for Service Issues

Basic Fee Increases

The parties have accepted the joint parity review exercise results. When compared with the Maritimes, physicians in Newfoundland and Labrador are paid at the following levels:

general practice	-	75.9%
specialists	-	85.24%
all physicians	-	81.56%

The proposal of the NLMA is to achieve 100% parity with the Maritimes. The NLMA submits that it made a concession to accept the weighted average of the Maritime provinces as a reasonable comparator having regard to Government's financial circumstances. The NLMA proposes that 100% parity be achieved in year 1 for all groups. In addition, there would be a 3% general increase added in each year of the contract, representing the estimated annual increase to be applied in the Maritime provinces. The 3% general increase also applies in the first year because the implementation date is October 1, 2002 which is at the mid point of Government's fiscal year 2002-2003. The NLMA proposes a total of approximately $45.6 million be added to the fee for service budget over 3 years with the approximate amounts being distributed as follows: year 1 - $35.16 million, year 2 - $5.14 million and year 3 - $5.30 million. The three physician groups currently paid in excess of 100% parity, namely, dermatology, emergency medicine and nuclear medicine, would each receive 3% per year over the three year contract. The NLMA submitted that this proposal represents reasonable compensation. Government's proposal for 90% parity achieved at the end of three years would be devastating and would have the effect that physicians would leave the Province. Government's proposal for a total of $32 million dollars over three years, with the increase back loaded to the third year, means that Atlantic parity at 2002 levels would only be achieved in 2005, which is not parity at all. The NLMA proposed allocation to physician groups according to the following table:

NLMA PROPOSED FFS MESO ALLOCATIONS

	Total Allocations - $ Millions			
	2002-03*	YEAR 1	YEAR 2	YEAR 3
General Practice	54.11	72.29	74.46	76.70
Anaesthesia	8.39	10.91	11.24	11.57
Cardiac Surgery	1.87	2.21	2.27	2.34
Dermatology	134	1.38	1.42	1.46
Emergency Medicine	0.39	0.40	0.41	0.43
General Surgery	6.61	8.60	8.86	9.13
ICU	2.26	2.98	3.06	3.16
Internal Medicine (General)	15.35	17.95	18.49	19.04
Neurology	0.91	1.16	1.20	1.23
Neurosurgery	1.08	1.21	1.25	1.29
Nuclear Medicine	0.95	0.98	1.01	1.04
Obstetrics and Gynecology	5.03	5.60	5.76	5.94
Ophthalmology	4.56	5.48	5.65	5.82
Orthopaedic Surgery	4.09	4.63	4.77	4.91
Otolaryngology	3.37	4.27	4.40	4.53
Pediatrics (General)	3.62	5.02	5.17	5.32
Plastic Surgery	1.04	1.13	1.16	1.20
Psychiatry	4.15	5.34	5.50	5.67
Radiology	14.50	16.63	17.12	17.64
Urology	2.61	3.23	3.32	3.42
Total	**136.23**	**171.40**	**176.54**	**181.84**
New Funding - Annual		**35.16**	**5.14**	**5.30**
New Funding - Cumulative		35.16	40.31	45.60

* 2002-03 group bases estimated by applying 2001-02 payment distribution to total base of $136.23 million.

Government proposes that all groups would achieve 90% of parity with the Maritime provinces by October 1, 2004. This represents a significant increase over current rates during the time frame of the agreement. It would represent the first time since 1970 that physicians were paid at a level of 90% parity. Physicians have never had 100% parity on a fee for service basis with the Maritime provinces. The level of 90% parity was reasonable considering the financial circumstances of the Government relative to the Maritime provinces. The total amount allocated would be $31.5 million over three years with the approximate amounts being distributed as follows: $7.1 million in year 1, $12.2 million in year 2 and $12.2 million in year 3. The most disparate groups would be addressed first in priority meaning that all groups with less than 90% would receive varying increases, with the least increase being 1%, 3.6%, and 5.5% in each of the three years. The three groups that now

receive more than 100% parity would not receive any fee for service increase. The Government's proposal was based on three principles, namely (1) no group's relative parity position will diminish at any point during the life of the agreement, (2) no group remaining at or above parity will receive parity dollars and (3) less disparate groups will receive increases equal to the Maritime provinces, on average, while the most disparate groups are addressed first. Government submitted that by October 1, 2003, GP payments will have increased by almost 20% and specialist payments on average will have increased by 12%. The figures will increase further to almost 32% and 20% respectively by October 1, 2004. Government submitted that the NLMA made a proposal for a $48 million increase during negotiations that was calculated at the time to be an increase of 92.3%. When the figures were later recalculated, the NLMA retained its $48 million proposal which Government now calculates to be 98.5% parity. Government's proposal to allocate to physician groups by year in percentage terms is contained in the following table:

Percentage Increase Over Three Years by Physician Group

Specialty Group	# of Full-time Physicians	October 1, 2002	October 1, 2003	October 1, 2004	% increase over 3 years	% of Parity achieved
Pediatrics	11	11.76%	10.97%	14.26%	36.99%	90
General Practice	245	8.86%	10.97%	11.93%	31.75%	90
ICU/CCU	N/A	7.66%	10.97%	11.08%	29.70%	90
General Surgery	18	6.76%	10.97%	10.48%	28.21%	90
Anaesthesia	27	6.46%	10.97%	10.29%	28.04%	90
Psychiatry	16	5.86%	10.97%	9.92%	26.74%	90
Neurology	4	5.36%	10.97%	9.62%	25.94%	90
ENT	7	4.56%	10.97%	9.16%	24.69%	90
Urology	6	2.36%	10.97%	8.03%	21.36%	90
Ophthalmology	11	1.02%	9.81%	6.96%	17.79%	90
Cardiac Surgery	3	1.02%	8.62%	5.57%	15.21%	90
Internal Medicine	52	1.02%	8.02%	5.38%	14.42%	90
Radiology	38	1.02%	6.22%	4.87%	12.11%	90
Orthopaedics	14	1.02%	5.02%	4.58%	10.62%	90
Neurosurgery	2	1.02%	3.92%	4.35%	9.29%	90
Obs/Gyne	15	1.02%	3.62%	4.06%	8.70%	90

Plastic Surgery	3	1.02%	3.62%	1.75%	6.38%	90
Emergency Medicine (Specialist only)	2	-	-	-	0.00%	95
Dermatology	4	-	-	-	0.00%	100
Nuclear Medicine	2	-	-	-	0.00%	102

Government's monetary proposal, which includes amounts for other fee for service issues, is set out in the following table:

Monetary Proposal
Timetable of Increase to FFS Budget

Component of FFS budget	**October 1, 2002**	**October 1, 2003**	**October 1, 2004**
After hours coverage, St. John's		500,000	500,000
Maritime % increase to all disparate groups	1,312,861	4,659,370	6,895,825
FFS parity dollars above Maritime % increase	5,796,532	7,500,022	5,263,567
FFS Parity - surgical premium	40,000		
Emergency Care Services increases	873,941	873,941	873,941
Budget adjustment, Sub-total	8,023,334	13,533,333	13,533,333
Budget adjustment, total			35,090,000
No recovery of FFS deficit (one time)	2,800,000		
Total value of FFS proposal			37,890,000

The parties have agreed that the allocation of the FFS increase will be done in accordance with the parity review exercise. The NLMA submits that all three factors of fair and reasonable compensation, the need for sufficient physician resources and the financial circumstances of the Government are met

by an award of 100% parity in year 1, together with annual adjustments of 3% in all 3 years. Government submits that the three factors are met by an award of 90% parity in year 3. Parity is calculated by reference to the parity review exercise, based on a comparison with the weighted average of the Maritime provinces rates in effect as of April 1, 2002. The Maritime provinces rates will be adjusted annually from 2002 to 2005, with an estimated general increase of 3% annually according to the NLMA's submission. Government's proposal to pay 90% of the 2002 Maritime fees in 2004 is actually less than 90% of the Maritime rates that will be in effect in 2004. In the Board's view, the Government's proposal does not adequately address the factors of fair and reasonable compensation or the need for sufficient physician resources. The NLMA proposal of 100% parity in year 1, together with an additional 3% each year, does not adequately address the factor of Government's financial circumstances. The Board has considered such issues as revenue generating ability, provincial debt levels and taxation levels relative to the Maritime provinces. There are also population distribution factors that affect health care expenditures. The objective of 100% parity is a reasonable long term objective subject to financial circumstances.

The Board finds that there should be an increase in the percentage of parity achieved in each of the three years of the agreement, with the effect that the final year will be closer to 100% parity than Government's proposal. It would not be reasonable, having regard to the factor of financial circumstances, that the total amount of the parity increase be applied in the first year. The increase should be applied incrementally over the 3 year term. Therefore, the Board orders that FFS compensation be adjusted for all affected physician groups, to increase compensation, where appropriate, to 90% parity in year 1, 92.5% parity in year 2 and 95% parity in year 3. It is estimated that the percentage parity will correspond to the Maritimes' rates that are in effect at the relevant times by also providing that there be a general increase to all groups. The Board also orders that there be a general increase in each year to allow for increases in the Maritime rates and the fact that the parity review exercise was effective as of April 1, 2002, and the effective date of the agreement is October 1, 2002. The general increase shall be 1.5% in year 1, 3% in year 2 and 3% in year 3, compounded annually. Each physician group will receive any increase required for that group to reach the appropriate level of parity in each year plus the general increase in each year. For example, nuclear medicine specialists, who are currently at 112.5% parity, will not receive a parity increase, but will receive the general increase in each year. Obstetrics/gynecology specialists, currently at 92% parity, will not receive a parity increase in year 1, but will receive an increase to 92.5% parity in year 2 and a further increase to 95% parity in year 3, together with a general increase in each year. It would not be fair and reasonable that any physician group receive no increase over 3 years. The Board's decision on this issue takes into account the principle of relative parity with the Maritimes and all three of the factors listed in the Terms of Reference. The budget allocation in each year is the amount required for the parity increase and general increase as outlined. The monetary allocation to each physician group is made according to the following table (total for all groups may vary as a result of rounding):

Allocation to FFS Physician Groups
Parity Increase and General Increase
($millions)

Physician Group	Current Estimate 2002-2003		Year 1 October 1, 2002 90% Parity 1.5% General	Year 2 October 1, 2003 92.5% Parity 3% General	Year 3 October 1, 2004 95% Parity 3% General	Total
General Practice	54.11	Parity General Total	10.05 0.81 10.86	1.78 1.65 3.43	1.78 1.70 3.48	13.61 4.16 17.77
Anaesthesia	8.39	Parity General Total	1.25 0.13 1.38	0.27 0.25 0.52	0.27 0.26 0.53	1.79 0.64 2.43
Cardiac Surgery	1.87	Parity General Total	0.07 0.03 0.10	0.05 0.06 0.11	0.05 0.06 0.11	0.17 0.15 0.32
Dermatology	1.34	Parity General Total	0.00 0.02 0.02	0.00 0.04 0.04	0.00 0.04 0.04	0.00 0.10 0.10
Emergency Medicine	0.39	Parity General Total	0.00 0.01 0.01	0.00 0.01 0.01	0.00 0.01 0.01	0.00 0.03 0.03
General Surgery	6.61	Parity General Total	1.02 0.10 1.12	0.21 0.20 0.41	0.21 0.21 0.42	1.44 0.51 1.95
ICU	2.26	Parity General Total	0.37 0.03 0.40	0.07 0.07 0.14	0.07 0.07 0.14	0.51 0.17 0.68
Internal Medicine (General)	15.35	Parity General Total	0.45 0.23 0.68	0.44 0.47 0.91	0.44 0.48 0.92	1.33 1.18 2.51
Neurology	0.91	Parity General Total	0.12 0.01 0.13	0.03 0.03 0.06	0.03 0.03 0.06	0.18 0.07 0.25
Neurosurgery	1.08	Parity General Total	0.00 0.02 0.02	0.01 0.03 0.04	0.03 0.03 0.06	0.04 0.08 0.12

Physician Group	Current Estimate 2002-2003		Year 1 October 1, 2002 90% Parity 1.5% General	Year 2 October 1, 2003 92.5% Parity 3% General	Year 3 October 1, 2004 95% Parity 3% General	Total
Nuclear Medicine	0.95	Parity General Total	0.00 0.01 0.01	0.00 0.03 0.03	0.00 0.03 0.03	0.00 0.07 0.07
Obstetrics and Gynecology	5.03	Parity General Total	0.00 0.08 0.08	0.03 0.15 0.18	0.13 0.16 0.29	0.16 0.39 0.55
Ophthal-mology	4.56	Parity General Total	0.27 0.07 0.34	0.13 0.14 0.27	0.14 0.14 0.28	0.54 0.35 0.89
Orthopaedic Surgery	4.09	Parity General Total	0.00 0.06 0.06	0.10 0.12 0.22	0.11 0.13 0.24	0.21 0.31 0.52
Otolaryn-gology	3.37	Parity General Total	0.41 0.05 0.46	0.11 0.10 0.21	0.10 0.11 0.21	0.62 0.26 0.88
Pediatrics (General)	3.62	Parity General Total	0.85 0.05 0.90	0.12 0.11 0.23	0.12 0.12 0.24	1.09 0.28 1.37
Plastic Surgery	1.04	Parity General Total	0.00 0.02 0.02	0.00 0.03 0.03	0.01 0.03 0.04	0.01 0.08 0.09
Psychiatry	4.15	Parity General Total	0.59 0.06 0.65	0.13 0.13 0.26	0.13 0.13 0.26	0.85 0.32 1.17
Radiology	14.50	Parity General Total	0.13 0.22 0.35	0.41 0.44 0.85	0.41 0.45 0.86	0.95 1.11 2.06
Urology	2.61	Parity General Total	0.24 0.04 0.28	0.08 0.08 0.16	0.08 0.08 0.16	0.40 0.20 0.60
Total	136.23	Parity General Total	15.82 2.04 17.86	3.97 4.15 8.12	4.13 4.27 8.40	23.92 10.46 34.38

Emergency Care Service Increases

Emergency departments are available to the public at facilities designated by the DHOCS. Physicians who contract to provide emergency services are paid hourly rates. In category "A" facilities, physicians remain on site 24 hours a day. In category "B" facilities, physicians are not required to remain on site, but must be available to respond to calls. The parties settled the issue of FFS hourly rates for category "B" facilities. The rates for category "A" facilities remain in dispute.

Government submits that its proposed increase in rates for category "A" facilities would achieve and maintain parity with the Maritime provinces. It submits that its proposal recognizes the recruitment and retention difficulties associated with emergency department coverage. The cost of Government's proposal is $2.6 million. The NLMA's proposal for payment of an additional $15.63 per hour for nights, weekends and holidays would cost an additional $1 million. None of the Maritime provinces pay such an evening or weekend premium. Government's proposal results in a 50% increase to the emergency care services budget. The rates proposed by Government are as follows:

Current Rate*	As of October 1, 2002	As of October 1, 2003	As of October 1, 2004
77/hour	88.67	103.33	125.00
91/hour	104.00	118.00	125.00
*The differential between the two rates was intended to recognize the overhead expenses of community-based FFS GP's			

The NLMA submits that for category "A" facilities the FFS hourly rate should be $125.00 per hour, effective October 1, 2002, and in addition physicians would be paid $15.63 per hour for nights (12:00 a.m. to 8:00 a.m.), weekends and holidays. The NLMA submitted that there are chronic physician vacancies in the emergency care system. To ensure the viability of the system it is necessary provide adequate compensation to recruit and retain physician resources. The NLMA submitted that this objective would be achieved by its monetary proposal.

The Board finds that it is appropriate to increase the rate to $125 per hour. To meet the need for physician recruitment in this critical area of emergency care, the rate in effect as of October 1, 2002 should be increased to the amount proposed by Government, with the rate increasing to $125 effective October 1, 2003. The incremental increase to the physician services budget will remain at the total increase proposed by Government at $2,621,823 ($873,941 per year X 3), but one third of the total will be added in year 1 and two-thirds of the total will be added in year 2. A premium for evenings and weekends is not ordered by the Board having regard to comparability with the Maritime provinces. The rates ordered are as follows:

Current	As of October 1, 2002	As of October 1, 2003
77	88.67	125
91	104.00	125

General Sessional Rate Increases

Sessional rates are payments made to physicians on a per diem basis in lieu of FFS payments for work at institutions, such as penitentiaries (category "A") and organized clinics (category "B"). The payments are claimed by FFS physicians in situations where FFS compensation is not viable because of low volumes. Current sessional rates per half day are as follows: category "A" - GPs - $128.84, specialists - $167.74, category "B" - GPs - $170.52, specialists - $223.48.

The NLMA submits there should be one rate for both category "A" and category "B" facilities. The rate should be equivalent to its proposed daily locum rate of $850 for GPs and $1,000 for specialists or $425 and $500 per half day session respectively. The NLMA estimates the cost of its proposal to be $180,000.

Government submits that sessional rates are considered a unique fee for time payment rather than a fee for service payment. Government submits that there should be no increase in sessional rates. The current rates are equal to or higher than the rates paid in other Atlantic provinces. Government also submits that sessional clinics are assigned fee codes and therefore these fees were assessed during the parity review exercise. Any adjustment of sessional rates is required to be done as part of the micro allocation process which is outside the jurisdiction of the Board.

The Board accepts the position of Government that sessional rates are to be adjusted as part of the micro allocation process. The Terms of Reference state that the parties, and not the Arbitration Board, will complete the micro allocations. Therefore the Board does not order any change in sessional rates.

Locum Tenens Rate Increases

A locum is a short term replacement position for a salaried physician or a funded vacant salaried post. Locums are used for replacement of physicians absent on illness or vacation. The current locum rate is $550 per day for GPs and $650 per day for specialists.

The NLMA proposes that the daily locum rate be increased to $850 for GPs and $1,000 for specialists, with an estimated annual cost of $1.5 to $1.7 million. The increase is necessary to enable Health Boards to recruit physicians for locums. Recruitment and retention would be more readily attainable by offering more competitive compensation rates.

Government proposes that the daily locum rate be retained, but physicians who perform locums would be allowed to claim "on call" payments where applicable. Government submits that the locum

rate should not be made so attractive that salaried physicians are enticed to resign their positions to locum around the Province in various positions. By permitting locums to receive "on call" payments there would be an additional payment at the rate of $160. to $250. per day, which would amount to an average 15% to 20% increase.

The Board finds it would be fair and reasonable to have an increase in the daily locum rate over the three year term of the agreement. It is appropriate that the daily locum rates be increased by an amount that is proportionate to the increases to salaried physicians, i.e. 8%, 5% and 5%, not compounded. The rates will be as follows:

	Current	Year 1 October 1, 2002	Year 2 October 1, 2003	Year 3 October 1, 2004
General Practice	550	594	622	649
Specialists	650	702	735	767

Recognition of Professional Advice by Telephone

The fee codes do not permit compensation for professional advice or services over the telephone.

The NLMA submits that whether a physician provides a medical service in person or electronically, including by telephone, there should be compensation paid for the physician's expertise, skill and time. The NLMA proposes that the amount paid would be equal to 60% of the rate for a partial assessment, which on the current scale would be $11.69. The impact on the FFS budget would be cost neutral because there would be reductions in other areas. The existing Regulation prohibiting these charges could be easily changed by Government by an Order-in-Council.

Government submits that professional advice by telephone is not permitted to be charged pursuant to Regulation. Section 4 of the *Medical Insurance Insured Services Regulations*, enacted under the *Medical Care Insurance Act*, lists services which are not insured services, including any advice given by a physician to a beneficiary by telephone. Government submits that the Arbitration Board does not have authority to amend a Regulation.

The Board finds that it does not have the authority to grant the proposal by the NLMA. The Board cannot order that a payment be made in violation of a Regulation. The Board cannot change a Regulation, which must be enacted by the Lieutenant Governor in Council (Provincial Cabinet).

Elimination of Capping and Thresholds

A capped fee for service budget was implemented in the 1991 to 1992 fiscal year and continued through the period of the JMCA and the MOU. The Government and the NLMA negotiated the amount of the physician services budget for both FFS and salaried physicians. During the period of the JMCA, fee discounting was implemented. Physician claims to MCP were discounted to achieve

a balanced budget by year end. During the period of the MOU deficits in the FFS budget were experienced, according to the calculation of Government. The claim by Government for a cumulative $2.8 million deficit is disputed by the NLMA and is a separate issue at this arbitration.

Individual income thresholds are part of a proration policy that was first introduced in 1992 and continued until the expiry of the MOU. The individual income threshold is also described as an individual cap on earnings. At the first threshold, payments are reduced by 33%, and at the second threshold, payments are reduced by 66%. There are different thresholds for GPs and specialists. The threshold levels increase at the same time as any increase in the GP and specialist budgets.

There is currently a global cap in New Brunswick but not in the other Maritime provinces. There is currently an individual threshold in Prince Edward Island but not in the other Maritime provinces. Nova Scotia does not have either a global cap or an individual threshold. Newfoundland and Labrador is the only Atlantic province that has both a global cap and an individual threshold.

The NLMA proposes eliminating both global capping and individual thresholds. The NLMA submits that the global cap unfairly shifts the physician services funding responsibility from Government to physicians. Physicians have no control over the utilization of physician services. A global cap, in effect, costs physicians money because fee for service physicians continue to pay overhead expenses, but do not receive income. The submission by Government that it would cost $5 million if global capping is eliminated amounts to an admission that the budget is underestimated by that amount. Specialists whose billings are approaching the individual threshold level have left the Province to perform locums in other provinces for the rest of the year. This has the effect of removing specialist services from this province. It is possible to apply for exemptions from the individual thresholds, but the exemption process is not working adequately. The NLMA submits that it is not adverse to a daily workload cap.

Government submits that both the global cap and individual thresholds should be continued. The global cap is a fiscally responsible measure and is crucial to controlling the fee for service budget. It is reasonable for Government and physicians to cost share deficits in the budget on a 50/50 basis. Physicians would be required to share future deficits by the process of discounting. Individual thresholds currently affect a small group of physicians. However, other physicians whose current billings are close to the threshold, would likely exceed the threshold amount of it was eliminated.

The Board observes that the parties negotiated the amount of a capped FFS budget from 1991 to 2002. The purpose of the capped budget is to control FFS physician expenditure. By having any deficit shared on a 50/50 basis by physicians and by Government, there is a shared responsibility to control expenditures to the extent possible within the budgeted amount. The efficient utilization of physician services impacts upon expenditures. To eliminate global capping would not be fiscally responsible and would not adequately address the factor of the financial circumstances of Government. Appropriate increases in the FFS budget will address the factors of fair and reasonable compensation and the need for physician resources. There is a global cap in New Brunswick. The Board finds it appropriate to continue the global cap on FFS physicians expenditure with 50/50

sharing of the deficit. At the same time, there should be recognition given to the possibility of a surplus in the budget, in accordance with these principles. An appropriate mechanism should be applied to give effect to carrying forward a surplus or deficit to the following year to avoid anomalies, and to adjust for a deficit on a multi-year basis and not a single year. Therefore, the Board finds that a global capped FFS budget shall be in effect for the term of the Agreement. Any surplus or deficit in the budget from year 1 (2002-2003) shall be carried forward to year 2 (2003-2004). If at the end of year 2 there is an accumulated deficit from those 2 years, then the parties shall meet and decide upon an allocation of the deficit. In the absence of agreement within 90 days of year end, i.e. 90 days after October 1, 2004, 50% of the accumulated deficit shall be deducted from the FFS budget in year 3 and payments to FFS physicians discounted as required. If there is an accumulated surplus at the end of year 2, it shall be carried forward into year 3 for the purpose of calculating the accumulated surplus or deficit at the end of year 3. The allocation of any surplus or deficit at the end of year 3 will be subject to negotiations between the parties at that time and is beyond the scope of this Award because it is outside the 3 year term of the Agreement. In the event of a dispute at any time regarding calculation of the deficit or surplus, the dispute may be referred by either party to arbitration under the *Arbitration Act*, RSNL 1990, c. A-14.

Individual income thresholds result in proration of FFS billings that exceed threshold levels. The Board observes that the only province with an individual threshold in the Maritimes is Prince Edward Island. Individual thresholds are not fair and reasonable in circumstances where physicians are required to work lengthy hours because there is a physician shortage in the area. The process to grant exemptions from individual thresholds appears to be unsatisfactory. Eliminating individual income thresholds is not expected to have any impact on FFS global expenditures given that a global cap is maintained. It is unnecessary to budget for an expenditure in the physician services budget as a result of eliminating individual thresholds. The Board orders that individual thresholds be eliminated.

Specialty Corrections

The NLMA submits that certain inequities or anomalies need to be addressed for some specialties including plastic surgery, orthopaedic surgery, neurosurgery, emergency medicine, dermatology, and internal medicine subspecialties. These were groups with insufficient economies of scale. The NLMA proposed an allocation of $2.5 million for a corrections reserve to address inequities compared to other specialties. In the case of neurosurgeons this would be addressed by an AFP. The corrections reserve fund would be administered by a liaison committee.

Government submits that there should be no additional funds provided for select groups. The increases to FFS physicians were to be based on the fee schedule comparison. Anomalies in the fee code were matters of micro allocation, which were excluded from the jurisdiction of the Arbitration Board by the Terms of Reference. A specialty corrections fund would negatively affect the application of the parity review exercise and would create new and different internal disparities. There was no specific proposal as to how the $2.5 million fund would be spent. Government was prepared to discuss with the NLMA the reallocation of fees within the specialist groups provided there was no change in the total amount of the fee for service budget. Government was also prepared

to discuss with the NLMA the concept of alternate funding plans (AFP's), but did not agree that the Board had jurisdiction to order AFP's.

The Board has considered the NLMA proposal to address disparities within certain specialities. The Board has considered the presentations made at the hearing by specialists in orthopaedic surgery, plastic and reconstructive surgery and anesthesia. The parties are attempting to resolve disparities on the basis that all specialists would be treated equally by the application of the parity review exercise. However, even if all groups achieve 100% parity, there will be internal disparities, according to the NLMA. Government is prepared to respond to this issue, provided any amount allocated is part of the FFS budget and is not additional funding. The Board finds that funding ought to be set aside to address specialist disparities. The amount allocated to the specialty corrections fund shall be $2,000,000 commencing in year 2. The allocation of the fund to specialist groups to resolve disparities shall be done by agreement of the parties. The parties shall form a specialty corrections fund committee, with equal representation of at least two members each, together with a chairperson appointed by the NLMA. If the parties do not agree on the allocation of all or any part of the fund allocated in the applicable year on or before the last day of that year, that amount shall be added to the FFS budget for that year.

Deficit Recovery

Submissions by the parties on the merits of the deficit recovery issue are subject to the decision by the Board on whether this arbitration is the proper forum to adjudicate upon the amount claimed by Government. According to Government's calculation there was an accumulated deficit of $2.8 million in the fee for service budget during the period of the MOU .

Government proposes that the outstanding deficit of $2.8 million be recognized and included within Government's $50 million proposed increase. Government submits that in effect it is providing FFS physicians with $2.8 million in additional funding by agreeing not to recover that amount. Additional funds were added to the physician services budget in every year during the period of the MOU. The FFS budget was adjusted for new technology, changes in demographics, changes in FFS personnel and net transfers between FFS and salaried physicians. The budget adjustments and the annual deficits were communicated to and confirmed by the NLMA. The first time Government heard that the amount was in dispute was at the arbitration hearing. In the first two years of the MOU the deficit was the responsibility of the NLMA, and then, commencing in 2000-2001, the deficit was cost shared 50/50 between the NLMA and Government. The MOU provided that the parties would agree on a formula to adjust physician compensation. The NLMA did not agree on the terms of the formula. In early 1999, MCP started to recover the accumulated deficit from physician fee payments. The NLMA objected on the grounds that no formula had been agreed. The Department of Health directed that the deductions be refunded to physicians. The issue was never resolved. There was no further attempt by Government to make a deduction from physicians' fees during the life of the MOU. Government provided the Arbitration Board with copies of the year end budget summaries that were provided to the NLMA on a regular basis. Government submitted that signed offers by the NLMA

during the current round of negotiations included the application of deficit recovery in the amount of $2.8 million.

The NLMA submits that the amount of $2.8 million should not be recognized as part of Government's $50 million proposal. The parties did not agree to a deficit recovery formula under the MOU, as required by the MOU. The accuracy of the deficit amount shown in the FFS budget and the actual expenses were questioned. The NLMA was not satisfied that the amount of $2.8 million was owing. The NLMA had never agreed with the calculation of the amount. The Arbitration Board was not the correct forum to adjudicate this dispute. The determination of the amount owing was a matter that should properly be dealt with under the relevant provisions of the JMCA or the MOU. The NLMA, in a further written submission following the hearing, advised that it consulted with its former director of health, policy and economics and reviewed its records and could not find any evidence that an agreement had been reached on the calculation of the amount owing. The NLMA acknowledged receiving various FFS budget reports generated by MCP, but denied that the NLMA was ever asked to agree that the calculations were correct. Accordingly, the Board was not in a position to make a determination of the amount owing. The NLMA submits that Government should fully honour its commitment to provide new funding in the total amount of $50 million, exclusive of the amount claimed for deficit recovery.

The Board finds that the arbitration process is not the appropriate forum to decide any dispute about the amount of the deficit claimed for the period ending September 30, 2002 unless the parties agree. The parties did not agree to a deficit recovery formula, as contemplated by the MOU. The Board does not have jurisdiction to interpret and enforce the MOU. Where the parties have not agreed on the amount of the deficit, and the Board does not have jurisdiction to adjudicate the amount of the deficit, the Board is unable to deduct any amount from the FFS budget to account for deficit recovery. This finding does not interfere with any right held by Government to collect the amount it claims is owing.

B. Salary Physician Issues

Basic Compensation Increases

Approximately one third of physicians are salaried in Newfoundland and Labrador, compared with about 5% in most other jurisdictions in Canada. The current budget for salaried physicians is $60 million dollars which represents 30% of the total physician services budget. The terms and conditions applicable to salaried physicians were set out in the Blue Book, and in the MOU. Most salaried physicians do not have individual contracts of employment. There were no increases for salaried physicians during the period of the JMCA. During the period of the MOU, the average GP received a 31% increase and the average specialist received a 52% increase, according to Government's calculation. As of April 1, 2002, the base compensation ranges for salaried physicians, including retention bonuses are as follows:

	Salary (5 step scale)	Retention Bonus (3 step scale, depending on geographic location)	Total
General Practitioners	100,000-120,000	2,500-30,000	102,500-150,000
Specialists*	120,000-144,000	4,000-36,000	124,000-180,000

*excluding Oncologists, whose compensation structure is addressed separately.

Government proposes salary increases based on equivalency with the non-weighted average of salaried physicians in New Brunswick and Prince Edward Island. There are a very small number of salaried physicians in Nova Scotia. Government provided further information with respect to Nova Scotia salaried physicians at the hearing which it submitted supported its position. Government proposes salary increases amounting to 15% over three years. The total increase would be $6.4 million, with $2.1 million for GPs and $4.3 million for specialists. Government agrees that salaries ought to be competitive with the Maritime provinces. Government submits that the amount it proposes would place specialists at the level of equivalency and place GPs above equivalency. The GP salaries are proposed to maintain the historical 1:1.2 ratio between GPs and specialists. There was never any historical relationship between payments to salaried and FFS physicians. Government disputes the figure presented by the NLMA of the average weekly working hours of salaried physicians. Government proposes that retention bonuses be considered when calculating salary increases. The proposal by Government for salaries is as follows:

Year 1

	Salary	**Retention Bonus**	**Total**
General Practitioners	105,000-126,000	2,500-30,000	107,500-156,000
Specialists	126,000-151,200	4,000-36,000	130,000-187,200

Year 2

	Salary	**Retention Bonus**	**Total**
General Practitioners	110,000-132,000	2,500-30,000	112,500-162,000
Specialists	132,000-158,400	4,000-36,000	136,000-194,000

Year 3

	Salary	**Retention Bonus**	**Total**
General Practitioners	115,000-138,000	2,500-30,000	117,500-168,000
Specialists	138,000-165,600	4,000-36,000	142,000-201,000

The NLMA proposes a salary increase in line with the increases for FFS physicians. The NLMA proposes a 26% increase over three years comprised of a 20% increase in the first year and 3% in each of the next two years. The total increase is $12.32 million, with $4.1 million for GPs and $8.22 million for specialists. The proposal was submitted by the NLMA to be reasonable compensation on the assumption that the Arbitration Board also granted its proposal for a defined work week. The Government proposal did not represent parity with the Maritimes, having regard to the AFP compensation paid in Nova Scotia. The NLMA calculated that the effective hourly rate for salaried physicians, based on 62 working hours per week, was $46.00 per hour, which was at the lower end of the scale for the Atlantic provinces. When comparing salaries, it is important to consider that in New Brunswick and Prince Edward Island salaried physicians have a defined work week. The NLMA proposal for salaries for GP's is as follows:

Salary Range	Step 1	Step 2	Step 3	Step 4	Step 5
Current	100,000	105,000	110,000	115,000	120,000
Year 1	120,000	126,000	132,000	138,000	144,000
Year 2	123,600	129,780	135,960	142,140	148,320
Year 3	127,308	133,673	140,039	146,404	152,770

The NLMA proposal for salaries for specialists is as follows:

Salary Range	Step 1	Step 2	Step 3	Step 4	Step 5
Current	120,000	126,000	132,000	138,000	144,000
Year 1	144,000	151,200	158,400	165,600	172,800
Year 2	148,320	155,736	163,152	170,568	177,984
Year 3	152,770	160,408	168,047	175,685	183,324

The Board finds that a comparison of salaries with the Maritime provinces is appropriate. The current salary range is comparable with New Brunswick and Prince Edward Island. However, those provinces have defined work weeks. In this province, there is no defined work week, but the information available suggests that most physicians have considerable workloads and work long hours. Therefore, in the absence of a defined work week, there is justification for slightly higher salaries compared to the Maritimes, having regard to all factors, in particular the factor of the need for sufficient physician resources. Salaried physicians are essential to meet the physician demand in certain geographic areas or for certain specialties. Considering the factors in the Terms of Reference, it is appropriate to award an increase that provides a higher percentage increase in year 1 when compared to Government's proposal. The proposal by the NLMA is excessive, having regard to the

factors in the Terms of Reference. The Board awards increases of 8% in year 1, 5% in year 2, and 5% in year 3 not compounded.

When determining the amount to be applied to the physician services budget, the Board has applied the appropriate increase to the base budget. When examining the proposals submitted by the parties, the Board determined that Government was using a base figure for salaries of $42,660,000 and the NLMA was using a base figure for salaries of $45,000,000. For the purpose of allocating increases to the budget, the Board will apply the increases to the base figure of $42,660,000. Therefore, applying increases of 8%, 5% and 5% not compounded, the budgeted increases are $3,414,000 in year 1, $2,133,000 in year 2 and $2,133,000 in year 3, for a total of $7,680,000. The total increase is applied to the salary scales according to the following tables:

General practice:

Salary Range	Step 1	Step 2	Step 3	Step 4	Step 5
Current	100,000	105,000	110,000	115,000	120,000
Year 1	108,000	113,400	118,800	124,200	129,600
Year 2	113,000	118,650	124,300	129,950	135,600
Year 3	118,000	123,900	129,800	135,700	141,600

Specialists

Salary Range	Step 1	Step 2	Step 3	Step 4	Step 5
Current	120,000	126,000	132,000	138,000	144,000
Year 1	129,600	136,080	142,560	149,040	155,520
Year 2	135,600	142,380	149,160	155,940	162,720
Year 3	141,600	148,680	155,760	162,840	169,920

Defined Work Week

Salaried physicians do not have a defined expectation for the number of working hours per week. The Arbitration Board was informed that salaried physicians work the hours required to meet the demand for services and complete their work. There is a defined work week for salaried physicians in New Brunswick of 37.25 hours and in Prince Edward Island of 37.5 hours.

The NLMA proposes that there be a defined work week of 37.5 hours per week between 8:00 a.m. and 6:00 p.m. from Monday through Friday unless otherwise agreed between the physician and the

employer. Physicians would be allowed to bill on a FFS basis for work outside the defined work week. Salaried physicians who participate in an on call rota during the defined work week would not be permitted to bill FFS during regular working hours but would be permitted to do so outside regular working hours. There should be a clearly defined policy regarding hours of work. The NLMA submits that it would consider alternatives to unlimited FFS billings by salaried physicians. The options would include placing a cap on FFS billings, defining working hours on an annual or monthly basis instead of a weekly basis, and time off in lieu of overtime. The NLMA submits that if FFS billings are allowed outside regular hours, then a cap in the amount of $30,000 annually would be reasonable.

Government submits that accepting the proposal of a defined work week would cause a significant change in the manner in which physician services are provided in the province. The defined work week would have far reaching and unknown consequences on operations and physician compensation. Government proposes maintaining the status quo with no defined work week for salaried physicians. In New Brunswick and Prince Edward Island, the salaried physician system developed with a defined work week policy from the outset. The salaried physician utilization in this Province evolved to address the need for medical services in areas of low population density and poor transportation systems, and in areas where the volume of work was not adequate to support a FFS method of remuneration. There would be an administrative cost to keep time records of physicians. Adoption of the defined work week would require the elimination of the $2.6 million additional workload policy, which addresses the situation of excess workload, and the elimination of various leave provisions, such as compensatory leave, which are intended to provide compensation in lieu of overtime for additional work.

The Board observes that the terms and conditions of employment of salaried physicians do not include an expectation for hours of work on a weekly basis or otherwise. Physicians are expected to complete the work that is required. This situation can produce unfair results, where lengthy hours of work are required as a result of demand for services and shortage of physician supply in a geographic area or area of practice. The purpose of a defined work week is to provide consistency in working conditions and to avoid excessive workload without adequate compensation. There are defined work weeks in New Brunswick and Prince Edward Island. However, the introduction of a defined work week will have significant consequences that have not been discussed by the parties. It is likely that compensatory leave, compensation for additional workload and other terms will be affected by a defined work week. The details of such related issues should be the subject of negotiations between the parties. The Board is not prepared to order a defined work week on the basis of the current submissions and without prior discussion by the parties of the details of the proposal and its implications. Further study of the issue is required to assess the implications. There is no order for a defined work week.

Compensation for Additional Workload

The salaried method of remuneration does not address the need for a physician to provide additional services because of vacancies in other salaried positions. Government introduced a policy in 1995

providing for payment of one half of a salary per vacancy in a salaried position with the amount to be distributed to salaried physicians who take on the responsibility of additional work resulting from the vacancy.

Government proposes to increase funding of this item in the budget by $200,000, as the result of increased salary scales. Government proposes to continue to pay one half of the salary of the vacant position to the remaining salaried physicians who take on the work. The payment for additional workload would continue on the assumption that there is no defined work week.

The NLMA submits that the current policy is unfair because it does not provide compensation where a vacancy arises from the departure of a FFS physician from a group of physicians offering a particular service. The NLMA proposes that compensation for additional work be paid regardless of whether the physicians doing the work are replacing a salaried or FFS position. The NLMA also proposes allowing for "on call" payments at the same time as compensation for additional workload. The total cost would be relatively small.

The Board agrees with Government's position. The concepts of additional workload, the method of calculating compensation, and the issue of the recruitment of the replacement salaried physician are related to the additional workload of the salaried physician. The Board orders that the current policy continue, with the effect that one half of the salary of a vacant salaried position will be paid to the remaining salaried physicians who take on the additional work.

Critical Escort Duty

Salaried physicians receive additional payment for escorting the transportation of critically ill patients from one location to another. The current hourly rate is $36.50.

Government proposes that the hourly rate be increased to $73 per hour, which it submits is fair and reasonable compensation. Government did not assign any amount for budget adjustment for the rate proposed by Government. It estimated the NLMA proposal would cost $100,000.

The NLMA refers to escort duty as highly stressful and hazardous. The NLMA submits that the hourly rate should be the same as the category "A" emergency rate of $125 per hour.

The Board agrees with Government's submission. There is currently a distinction between the rate for critical escort duty and the emergency rate. Government's proposal increases the current rate by 100%, which is a greater percentage increase than the emergency rate increase that was agreed by the parties. The hourly rate shall be increased to $73 as proposed by Government.

Clinical Administrative Benefit

There are five salaried positions where there is payment of additional compensation of $10,000 per year in recognition of administrative duties.

Government proposes to maintain the current policy with the condition that when a current incumbent vacates a position, the employer Health Board would have the full responsibility and authority to administer the benefit. This would allow the Health Board to pay the benefit to a number of physicians including FFS physicians who are not currently eligible.

The NLMA submits that the administrative benefit should remain tied to the position and not to the incumbent. The administrative function is a significant duty and the Government proposal would permit the benefit to be eliminated at the discretion of the Health Board. There should be no change in the current policy.

The Board agrees with the NLMA position that the policy not be changed. This will avoid the situation where the benefit could be eliminated at the discretion of the Health Board. The administrative benefit will continue to be tied to the position.

Oncology Stipends

Services at the Newfoundland Cancer Treatment and Research Centre are provided by specialists in medical oncology and radiation oncology, who have historically been salaried. As a result of a 1993 review, additional funding was allocated by payment of a stipend and an annual retention bonus to enable the Province to be competitive nationally.

Government proposes to increase the salary scale for oncologists by the same amount as other salaried specialists and in addition to increase the stipend scale by $30,000 per year. Government submits that its proposal addresses the national recruitment and retention issue for oncologists and meets the standard of equivalency. The Government proposal compares well with compensation paid to oncologists in other provinces, in particular, Alberta and Ontario. Government submits that the NLMA proposal is excessive and that the NLMA's proposal refers to Alberta FFS rates and not salary scales. The total amount of salary, stipend and retention bonus proposed by Government is as follows:

	Step 1	Step 2	Step 3	Step 4	Step 5
Oct. 1, 2002	170,000	186,550	200,600	206,900	213,200
Oct. 1, 2003	176,000	192,850	207,200	213,800	220,400
Oct. 1, 2004	182,000	199,150	213,800	220,400	227,600

The NLMA submits that there is a high turnover rate for oncologists in Newfoundland and Labrador. The position is stressful and there is a heavy workload. The NLMA proposes that salaries should be benchmarked at 85% of the upper threshold of $300,000 in Ontario and Alberta, which is equivalent to $255,000. The annual budget cost would be $750,000.

The Board has reviewed the information provided on this issue, in particular the compensation rates in other provinces. Oncology is a critical service, and the need for sufficient physician resources is a significant factor for this issue. The total compensation needs to be comparable with the higher paying provinces in the country. The increase needs to be consistent with the salary increases awarded generally to salaried physicians. The Board has considered the adjustment made in the Award to Government's proposal for physician's salaries. It is appropriate to increase the stipend scale by a further $10,000 with the effect that total compensation is increased by that amount at each step on the scale. There are currently 18 physicians eligible to receive the oncology stipend resulting in a budget adjustment of $180,000 in addition to Government's proposed increase. The oncology scales proposed by Government shall be adjusted by adding the additional 3% salary increase (8% ordered in year 1, compared to Government's 5% proposal) and the additional $10,000 stipend. The retention bonus is not changed. The oncology scale, including salary, stipend and retention bonus is therefore adjusted as follows:

	Step 1	Step 2	Step 3	Step 4	Step 5
Oct. 1, 2002	183,600	200,330	214,560	221,040	227,520
Oct. 1, 2003	189,600	206,630	221,160	227,940	234,720
Oct. 1, 2004	195,600	212,930	227,760	234,540	241,920

Compensatory Leave

Government proposes that there be no change in compensatory leave. Government refers to the negotiated term of the MOU stating that all salaried physicians will be entitled to five working days of compensatory leave after one year of service. Government submits that compensatory leave was a term in the Blue Book commencing from April 1, 1990 and was intended to acknowledge that salaried physicians do not have defined hours of work. Compensatory leave would be eliminated if there was a defined work week.

The NLMA agrees that compensatory leave remain unchanged at five days. The NLMA does not agree that compensatory leave was intended to provide compensation for "on call" services. It was agreed that compensatory leave would be eliminated if there was a defined work week.

The Board finds that compensatory leave will remain unchanged during the current Agreement.

Equity for GFT Bonuses

Some salaried physicians are also employed with Memorial University of Newfoundland and Labrador Medical School where they have teaching and research commitments and are designated geographic full time ("GFT"). GFT salaried physicians provide a reduced level of patient care services, and therefore receive a maximum of 80% of the established salary scale. In addition, the payment of the

retention bonus to GFT physicians is prorated at the same percentage as the applicable proration of salary.

Government proposes continuing the existing prorating of the salaried physician retention bonus for GFT designated physicians. There is no estimate of cost for the NLMA proposal.

The NLMA submits that there is no rational basis to prorate the retention bonus, which is paid as an incentive to attract physicians to the province. The full amount of the retention bonus should be paid whether the physician works on a full time or part time basis.

The Board agrees with the NLMA position that the retention bonus not be prorated. These positions are essential and the need to recognize these physician resources requires the elimination of proration.

Fee for Service Billings for Salaried Physicians

The NLMA submits that salaried physicians should be permitted to bill for services outside of regular duties. A reasonable ceiling would be $30,000. In New Brunswick salaried physicians are allowed to bill on a fee for service base with a ceiling of $40,000.

Government submits that the situation in this Province is not comparable to New Brunswick, where salaried physicians are permitted to provide fee for services in private practice clinics outside regular working hours. Government objects to salaried physicians being permitted to bill on a FFS basis. Government also submits this issue is outside the jurisdiction of the Board, as discussed above.

The Board has decided not to order a defined work week. The issue of FFS billings by salaried physicians is connected to the issue of the defined work week. Therefore, there is no order by the Board that salaried physicians be permitted to bill FFS.

C. General and Other Issues

Recognition of "On Call"

"On call" refers to a method by which physicians provide services to the general population, which may be for a discipline, a region or period of time, for example, services to patients who present to an emergency department.

Government proposes a universal "on call" payment policy with application of provincial standards, and that the "on call" budget be capped at $9.5 million annually. The rates would be adjusted to stay within the capped budget. Nova Scotia and Prince Edward Island, at present, compensate only specialists. The Government estimates current "on call" payments to be $4.5 million. Current payments are site specific and are paid to salaried physicians who provide services at their own facility in excess of one in three for specialists and for one in four for GPs. The payments proposed for "on call" shifts are $20 per hour for GPs and $25 per hour for specialists. This amount recognizes the

inconvenience to a physician who is required to remain available to respond to calls. Government submits that these rates mean an average "on call" payment of $194 per day, which is in excess of rates in the Maritime provinces. The "on call" policy would not be retroactive to October 1, 2002. The significantly different eligibility requirements mean there would be overwhelming logistical and administrative hurdles to make the policy retroactive.

The NLMA proposes that all physicians who provide "on call" coverage would receive compensation. The payments recognize the restriction on the life of a physician who is "on call". There is a need for a clearly defined "on call" policy. The NLMA agrees with Government's proposed hourly rate, subject to clarification of coverage and assuming the rate is retroactive to October 1, 2002. The NLMA also proposes that there be a call back fee of $250 per episode.

The parties do not dispute the proposed hourly rates for "on call" shifts of $20 for GPs and $25 for specialists. The Board agrees with the rates proposed. The parties disagree as to the effective date. Other increases provided by this Agreement take effect in full or in part on October 1, 2002. Any administrative difficulties should not operate to penalize physicians who provide this important service. The Board finds that the new rates shall come into effect on October 1, 2002. The Board does not agree with payment of a call back fee, given that alternate compensation is available.

Representation of "Public Health Specialists"

Public health is considered an area of practice that is a clinical specialty. There are 7.5 approved positions of medical officer of health in the Province of which 5 positions are filled. The medical officer of health is employed by a Health Board. There is also a director of disease control and epidemiology, who provides services on a provincial level to the Department of Health and Community Services. There is no direct reporting relationship between the medical officers of health and the director of disease control and epidemiology.

Government proposes that these are management positions that should be excluded from representation by the NLMA. These positions do not provide clinical services. The medical officer of health develops policy, is involved in executive decision making and performs management functions. Within the health boards these are senior management roles similar to the medical director, who is considered to be management. The medical officer of health for the Health Care Corporation of St. John's attends management meetings and is currently excluded from those meetings for discussion of issues of negotiations with physicians. With respect to the medical officers of health, organizational charts were entered into evidence showing the structure of various Health Boards. For some Health Boards, position descriptions were approved. At the provincial level, the director provides policy advice to Government and directs a staff of seven. There is no approved position description for this position. A draft position description was provided to the incumbent currently occupying the position in January, 2003, prior to the arbitration hearing, and the incumbent responded that the position description contained inaccuracies and further time was needed to review it.

The NLMA objects to Government's proposal. These positions were always represented by the NLMA. There was no reason to exclude the positions from representation. They are not management positions. Their role is consultative in clinical medicine. The usual tests applied by Labour Relations Boards to determine managerial exclusions do not indicate the positions ought to be excluded. They do not exercise effective control over other physicians. Even if the positions are management positions there is no reason to exclude them from representation by the NLMA. The Government's analysis is based on the assumption that the NLMA is a trade union, however this assumption is erroneous and the analysis is not correct.

The Board finds that to apply the usual tests applied to determine management exclusions under traditional labour relations principles would not be the appropriate analysis. It is appropriate to consider the exercise of management functions in relation to other physicians. However, these positions do not exercise effective control over the economic lives of other physicians. The NLMA may continue to represent these positions.

Schedule of Disbursements

The schedule of disbursements refers to the allocation of expenses to various items in the physician services budget. This is listed under part D below "Amount to be Allocated to the Physician Services Budget".

Maternity Leave and Benefits

The NLMA submits that about 30% of physicians in Canada are women. In Newfoundland and Labrador there are about 254 female physicians including 106 holding salaried positions. The NLMA proposes that maternity leave provisions should be adequate to attract female physicians to remain within the profession. The NLMA proposes that the amount of $1,500 per week be paid for maternity leave benefits for 26 weeks. The estimated cost is $600,000. In Nova Scotia there is currently paid maternity leave that is funded through a member benefit fund administered by the Nova Scotia Medical Society. In New Brunswick there is a "top up" of maternity leave employment insurance benefits to 75% salary.

Government does not accept the proposal for paid maternity leave. Government agrees to increase the length of unpaid maternity leave for salaried physicians to 52 weeks. FFS physicians are independent business owners/operators for which there is no employer obligation and no basis for the "earning" of a maternity leave benefit. There is currently no paid maternity leave for any Government employee and to provide paid maternity leave for physicians would be without precedent in the Province. Salaried physicians would be eligible for unpaid maternity leave and would be eligible to receive EI benefits.

The Board finds that an award of paid maternity leave would be inconsistent with appropriate comparators. The Board does not find that such an award is necessary to meet any of the three factors in the Terms of Reference.

Service Coverage

Government submits that service coverage is a critical issue. It is necessary to develop new mechanisms to ensure that the current range of services will be continued. An attempt was made to address the issue in the MOU, but there was no means to enforce it. The Arbitration Board has jurisdiction and the NLMA has the legislative authority to bargain on this issue, as discussed above. Government proposes that physicians who do not accept the service coverage commitment proposed by Government, would not receive the increase in FFS payments set by the Arbitration Board. As a result there would be a two tier system, with those physicians committing to service coverage receiving the new rates and those physicians not committing to service coverage receiving the old rates. Government provided several examples of lack of adequate service coverage, including coverage for admissions to hospitals, escort duties and emergency departments. Government provided a detailed proposal that would apply to all physicians and with details under headings including factors to consider, physician resource plan, operational schedules for the comprehensive range of services, dispute resolution, period of notification for decreases in existing service levels, non-conformance to service agreement, general practice, and specialty services.

The NLMA submits that the Board does not have jurisdiction to address the issue of service coverage, as discussed above. With respect to the merits of the proposal, the NLMA submits that Government's proposal should be rejected because it contains too many uncertainties.

Government has an obligation to meet the conditions under the *Canada Health Act* for federal funding. It seeks a service commitment in writing from physicians that may be enforced by establishing a two tier payment system, with the effect that the new rates will not be paid to physicians who do not provide the service coverage required. Government has not established the necessity for this approach. However, the principle of service coverage is important and needs to be promoted. The NLMA has the authority to negotiate service commitments and to enforce such terms as a condition of membership in the NLMA. The Board finds it appropriate to order continuation of the statement of principle as set out in the MOU, as follows:

> Physicians commit to provide, in accordance with the negotiated fee schedule/salary rates, the insured services which have been traditionally funded through MCP and which the public might reasonably expect to be available, subject to resource and skill limitations.

The Board orders that the parties establish a Service Coverage Committee to be chaired by a representative of Government and with two members appointed by each of the parties, with a mandate to review and report to the parties any service coverage issues and to recommend the terms of any physician service commitments, which may be implemented subject to the approval of both parties.

After Hours Coverage - St. John's

Government proposed allocating $1 million for the development and implementation of after hours emergency coverage in St. John's. The NLMA does not oppose Government's proposal provided that the allocation commences October 1, 2002 and is intended exclusively for physicians' compensation.

The Board accepts Government's proposal. However, the funding should be applied retroactive to October 1, 2002 to be consistent with other terms of this Agreement.

D. Amount to be Allocated to the Physician Services Budget

The total amount added to the physician services budget is $54,194,373 allocated as follows:

Time Table of Budget Allocations

	Year 1 October 1, 2002	Year 2 October 1, 2003	Year 3 October 1, 2004
Fee-for-service			
FFS Parity increase 90%, 92.5%, 95%	15,820,000	3,970,000	4,130,000
FFS general increase 1.5%, 3%, 3%	2,040,000	4,150,000	4,270,000
FFS Parity - surgical premium	40,000		
ER adjustments	873,941	1,747,882	
Specialty Corrections		2,000,000	
After hours coverage St. John's	1,000,000		
Salary			
Increases to salary scales	3,414,000	2,133,000	2,133,000
Oncology	690,000		
Increase in locum rates	347,800	217,375	217,375
General			
On-call	5,000,000		
Total	29,225,741	14,218,257	10,750,375

Summary

Fee for Service Issues

Basic Fee Increases

Fee for service compensation to be adjusted for all affected physician groups, to increase compensation, where appropriate, to 90% parity in year 1, 92.5% parity in year 2 and 95% parity in year 3. All physician groups to receive a general increase of 1.5% in year 1, 3% in year 2 and 3% in year 3, compounded annually. Parity is determined from the parity review exercise completed by John Tarrel, actuary.

Emergency Care Service Increases

Emergency care rates for category A facilities shall be $88.67 and $104 as of October 1, 2002 and $125 as of October 1, 2003. There is no order for premium for nights and weekends.

General Sessional Rate Increases

There is no order by the Board. Any adjustment of sessional rates is to be done as part of the micro allocation process and is outside the jurisdiction of the Board.

Locum Tenens Rate Increases

The locum rate shall be increased by an amount that is proportionate to the increases to salaried physicians, i.e. 8% in year 1, 5% in year 2 and 5% in year 3, not compounded. The locum rates will be as follows:

	Current	Year 1 October 1, 2002	Year 2 October 1, 2003	Year 3 October 1, 2004
General Practice	550	594	622	649
Specialists	650	702	735	767

Recognition of Professional Advice by Telephone

There is no order for compensation for professional advice or services over the telephone. The Board does not have authority to grant an order that is in conflict with a Regulation.

Elimination of Capping and Thresholds

Global capping of the fee for service budget shall continue in effect. Any surplus or deficit in the budget from year 1 (2002-2003) shall be carried forward to year 2 (2003-2004). At the end of year

2, if there is an accumulated deficit, then the parties shall meet and decide on the allocation of the deficit. In the absence of agreement within 90 days of year end, 50% of the accumulated deficit shall be deducted from the FFS budget in year 3 and payments to FFS physicians discounted as required. Any accumulated surplus at the end of year 2 should be carried forward to year 3 for the purpose of calculating the accumulated deficit at the end of year 3. Disputes regarding calculation of the deficit or surplus shall be resolved by arbitration under the *Arbitration Act*, RSNL 1990, c. A-14.

Individual income thresholds shall be eliminated.

Specialty Corrections

The amount of $2,000,000 shall be allocated commencing in year 2 to address disparities within specialties. The allocation of this fund to specialist groups to resolve disparities shall be done by agreement of the parties. The parties shall form a specialty corrections fund committee. If the parties do not agree on the allocation of all or any part of the fund allocated in the applicable year on or before the last day of that year, that amount shall be added to the FFS budget for that year.

Deficit Recovery

The Board does not have jurisdiction to adjudicate the amount of the deficit accumulated during the period of the MOU. The Board does not make any order to deduct from the FFS budget the amount of the deficit claimed by Government. This finding does not interfere with any right held by Government to collect the amount it claims is owing.

Salary Physician Issues

Basic Compensation Increases

Basic compensation increases shall be 8% in year 1, 5% in year 2 and 5% in year 3 not compounded. The total increase is $7,680,000. The increase is applied to the salary scales according to the following tables:

General practice:

Salary Range	Step 1	Step 2	Step 3	Step 4	Step 5
Current	100,000	105,000	110,000	115,000	120,000
Year 1	108,000	113,400	115,500	120,750	126,000
Year 2	113,000	118,650	124,300	129,950	135,600
Year 3	118,000	123,900	129,800	135,700	141,600

Specialists

Salary Range	Step 1	Step 2	Step 3	Step 4	Step 5
Current	120,000	126,000	132,000	138,000	144,000
Year 1	126,000	132,300	138,600	144,900	151,200
Year 2	135,600	142,380	149,160	155,940	162,720
Year 3	141,600	148,680	155,760	162,840	169,920

Defined Work Week

There is no order for a defined work week.

Compensation for Additional Workload

The current policy shall continue with the effect that one half of the salary of the vacant salaried position will be paid to the remaining physicians who take on the additional work.

Critical Escort Duty

The hourly rate shall be increased to $73 as proposed by Government.

Clinical Administrative Benefit

The administrative benefit will continue to be tied to the position as per current policy.

Oncology Stipends

The total amount of salary, stipend and retention bonus paid to oncologists shall be the amount as proposed by Government adjusted by adding the additional 3% salary increase (8% in year 1 compared to Government's 5% proposal) and an additional $10,000 stipend per year added at each step of the scale. The scale for salary, stipend and retention bonus shall be as follows:

	Step 1	Step 2	Step 3	Step 4	Step 5
Oct. 1, 2002	183,600	200,330	214,560	221,040	227,520
Oct. 1, 2003	189,600	206,630	221,160	227,940	234,720
Oct. 1, 2004	195,600	212,930	227,760	234,540	241,920

Compensatory Leave

Compensatory leave will remain unchanged during the current agreement.

Equity for GFT Bonuses

The proration of the retention bonus shall be eliminated with the effect that GFT salaried physicians will receive the full amount of the retention bonus.

Fee for Service Billings for Salaried Physicians

Salaried physicians shall not be permitted to bill FFS.

General and Other Issues

Recognition of "On Call"

The new hourly rates for "on call" shifts of $20 for GPs and $25 for specialists shall be implemented effective October 1, 2002. There is no order for a callback fee.

Representation of "Public Health Specialists"

The NLMA may continue to represent the positions of medical officer of health and director of disease control and epidemiology.

Maternity Leave and Benefits

There is no order for paid maternity leave.

Service Coverage

The parties shall comply with the following statement of principle:

> Physicians commit to provide, in accordance with the negotiated fee schedule/salary rates, the insured services which have been traditionally funded through MCP and which the public might reasonably expect to be available, subject to resource and skill limitations.

The parties shall establish a Service Coverage Committee to review and report to the parties any service coverage issues and to recommend the terms of any physician service commitments, which may be implemented subject to the approval of both parties.

After Hours Coverage - St. John's

Government shall allocate $1 million for the development and implementation of after hours emergency coverage in St. John's, with the amount to be allocated in year 1.

Amount to be Allocated to the Physician Services Budget

The total amount to be allocated to the physician services budget is $54,194,373. The amount allocated in year 1 is $29,225,741, in year 2 is $14,218,257, and in year 3 is $10,750,375. The particulars of the allocations are set out in the Award.

The Board retains jurisdiction for a period of 60 days from the date of the Award to correct any clerical error or in the event the parties do not agree on the interpretation or implementation of the Award.

DATED this 15th day of April, 2003.