（出國類別：考察）

加拿大健康保險醫療費用總額協定制度 考察報告

服務機關：全民健康保險醫療費用協定委員會

出國人：職　稱：主任委員

姓　名：吳凱勳等二人

出國地區：加拿大

出國期間：90年6月10日至90年6月16日

報告日期：90年10月

存檔完成
本筆資料於貴機關專則人員尚未點收前,
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列印提要表

系統識別號	C09003315
出國計畫/報告名稱	考察加拿大健康保險醫療費用總額協定制度
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	參考類號：J0
類名	主題類名：綜合（醫藥類）
	參考類名：綜合（醫藥類）
計畫主辦機關	全民健康保險醫療費用協定委員會
出國人員	吳凱勳　主任委員　政務官-含政務官以上，及比照簡任十四職等人員　全民健康保險醫療費用協定委員會 蘇久惠　研究員　聘、雇　行政院衛生署全民健康保險監理委員會
出國地區	加拿大
出國類別	考察
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關鍵詞	健康保險，總額預算制，加拿大健保制度
報告書摘要	我國為有效控制醫療費用的上漲，自民國87年開始試辦牙醫總額支付制度迄今，除醫院總額部門仍在研議與協商階段外，中醫與西醫基層總額部分已陸續實施中；然面臨人口老化與民眾對高科技醫療的需求日趨殷切，如何因應醫療費用上漲的壓力，維護民眾醫療照護品質與有效整合健保資源，均是我國全民健保所須解決的問題。經由本次考察加拿大辦理醫院與醫師總額預算制度，瞭解該國為因應人口增加、人口高齡化、醫藥費用不斷上漲與民眾對高科技醫療的需求漸殷等問題，而對總額預算制不斷進行改革，並整合相關的醫療資源，以提昇資源分配公平性與效率性。然對聯邦政府補助經費的縮水，使各省推動健保總額制度的經費受限，不得不以縮小給付範圍與減少醫護人員的開支等措施因應。因此，加國民眾對自付比率漸高與醫院排定手術等待期過久等現象，滋生不滿。加拿大全民健保體制與總額預算制度已實施四十年，有許多前瞻性的制度興革，可供我國未來全面推動總額支付制度的借鏡參考。
資料最後修改者帳號	327550000B

摘　　要

我國為有效控制醫療費用的上漲，自民國 87 年開始試辦牙醫總額支付制度迄今，除醫院總額部門仍在研議與協商階段外，中醫與西醫基層總額部分已陸續實施中；然面臨人口老化與民眾對高科技醫療的需求日趨殷切，如何因應醫療費用上漲的壓力，維護民眾醫療照護品質與有效整合健保資源，均是我國全民健保所須解決的問題。

經由本次考察加拿大辦理醫院與醫師總額預算制度，瞭解該國為因應人口增加、人口高齡化、醫藥費用不斷上漲與民眾對高科技醫療的需求漸殷等問題，而對總額預算制不斷進行改革，並整合相關的醫療資源，以提昇資源分配公平性與效率性。然對聯邦政府補助經費的縮水，使各省推動健保總額制度的經費受限，不得不以縮小給付範圍與減少醫護人員的開支等措施因應。因此，加國民眾對自付比率漸高與醫院排定手術等待期過久等現象，滋生不滿。

加拿大全民健保體制與總額預算制度已實施四十年，有許多前瞻性的制度興革，可供我國未來全面推動總額支付制度的借鏡參考。

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行政院及所屬各機關出國報告

一、考察目的

為瞭解加拿大醫療費用總額協定制度推動的成效，以供我國全民健康保險實施總額支付制度的借鏡參考。

二、考察人員

姓　名	職　稱	單　　位
吳凱勳	主任委員	全民健康保險醫療費用協定委員會
蘇久惠	約聘研究員	全民健康保險醫療費用協定委員會

三、出國期間：

民國九十年六月十日至同年六月十六日

四、考察行程

日　期	內　容	拜　會　單　位
6/10（週日）	啟程	抵多倫多
6/11（週一）	1. 安大略省醫療保健體系 2. 安大略省健康保險計畫 Ontario Health Insurance Plan (OHIP)	1. 安大略省衛生廳 Ministry of Health and Long-Term Care 2. 安大略省健保局
6/12（週二）	飛亞伯達省	抵愛德蒙頓 Edmonton
6/13（週三）	亞伯達省醫療保險體系	1. 亞伯達省衛生廳 Ministry of Health and Wellness 2. 亞伯達省健保局
6/14（週四）	亞伯達省健康保險計畫 Alberta Health Care Insurance Plan (AHCIP)	1.亞伯達省衛生廳 Ministry of Health and Wellness 2.亞伯達省健保局
6/15（週五）	返台	搭機
6/16（週六）	抵台北	

五、考察內容

(一) 背景

1. 人文社會環境

加拿大人口約3千萬人，過去五年間以1%的速度緩慢增加，平均餘命為78.4歲，其中男性為75.4歲，女性為81.2歲，粗出生率為11.0‰，粗死亡率為7.4‰。加拿大地廣人稀，大部分土地附蓋著冰雪與高山，人口分布極不均勻，大都集中在南邊靠近美國的邊界，其中約有85%的人口分別集中在安大略省(Ontario, 38%)、魁北克省(Quebec, 24%)、英屬哥倫比亞省(British Columbia, 13%)及亞伯達省(Alberta, 10%)(表一)。

表一 加拿大人口成長趨勢(1996-2000年)

單位：千人，%

年 省別	1996	1997	1998	1999	2000	2000年占率
Canada	29,671.9	29,987.2	30,247.9	30,493.4	30,750.1	100%
Newfoundland	560.6	554.1	545.4	540.8	538.8	2%
Prince Edward Island	136.2	136.9	136.9	137.6	138.9	5%
Nova Scotia	931.2	934.5	936.1	939.2	941.0	3%
New Brunswick	753.0	754.2	753.4	754.3	756.6	2%
Quebec	7,274.0	7,302.6	7,323.5	7,349.1	7,372.4	24%
Ontario	11,100.9	11,249.5	11,386.1	11,517.3	11,669.3	38%
Manitoba	1,134.3	1,136.6	1,137.9	1,142.6	1,147.9	4%
Saskatchewan	1,019.5	1,022.0	1,024.9	1,025.7	1,023.6	3%
Alberta	2,780.6	2,837.2	2,907.0	2,959.4	2,997.2	10%
British Columbia	3,882.0	3,959.7	3,997.5	4,028.1	4,063.8	13%
Yukon	31.9	32.2	31.5	31.1	30.7	0.0%
Northwest Territories	41.8	41.8	41.1	41.1	42.1	0.1%
Nunavut	25.7	25.9	26.5	27.0	27.7	0.0%

資料來源：加拿大統計局網站90/10/02資料。
http://www.statcan.ca/english/Pgdb/People/Population/demo02.htm

加國為加速國家經濟成長，採行寬鬆的移民政策。由外國移民入籍加拿大的趨勢來看，亞洲移民的成長速度為其他洲移民之冠，其中又以東亞人（如香港、中國大陸與台灣）的移民成長最速（表二）。截至 1996 年，亞洲移民已占總移民人口比率高達三成，僅次於歐洲移民的四成七，顯見亞洲移民對加拿大的社會、經濟與政治層面的影響將愈來愈大。

表二　加拿大移民的來源地概況（1961-1996 年）

單位：人、%

來源地	移民總數	時期				
		1960 年前	1961-1970	1971-1980	1981-1990	1991-1996
總數	4,971,070	1,054,930	788,580	996,160	1,092,400	1,038,990
美洲	797,920	465,310	112,880	237,510	224,040	162,675
增加率				110.4%	-5.7%	-27.4%
美國	244,695	450,550	50,200	74,015	46,405	29,025
中南美洲	273,820	6,370	17,410	67,470	105,230	76,335
加勒比海/百慕達	279,405	8,390	45,270	96,025	72,405	57,315
歐洲	2,332,060	953,360	543,840	356,700	280,695	197,480
增加率				-34.4%	-21.3%	-29.6%
英國	655,540	265,580	168,140	132,950	63,445	25,420
其他西北歐	514,310	284,205	90,465	59,850	48,095	31,705
東歐	447,830	175,430	40,855	32,280	111,370	87,900
南歐	714,380	228,145	244,380	131,620	57,785	52,455
非洲	229,300	4,945	25,685	58,150	64,265	76,260
增加率				126.4%	10.5%	18.6%
亞洲	1,562,770	32,580	96,945	328,375	512,160	662,710
增加率				238.7%	56.0%	29.4%
西中亞與中東	210,850	4,975	15,165	30,980	77,685	82,050
東亞	589,420	20,555	38,865	104,940	172,715	252,340
東南亞	408,985	2,485	14,040	111,700	162,490	188,265
南亞	353,515	4,565	28,875	80,755	99,270	140,055
太平洋州/其他	49,025	4,250	9,240	15,420	10,240	9,875

資料來源：加拿大統計局網站 90/10/02 資料。
http://www.statcan.ca/english/Pgdb/People/Population/demo25a.htm

加拿大的行政區劃分為十個省與三個自治區，行政組織則分為聯邦與省二個層級。聯邦政府負責全國有關花費龐大的事務，如運輸建設、貨幣制度、國防外交、公民事務等；省政府則負責行政轄區內的教育、衛生、醫院經營、社會福利與天然資源等事項。由於行政分工的不同，致加拿大的健康照護服務，須仰賴各行政區負責組織與執行。

2. 聯邦照護體系

因體認普及健康保險的必要性，並維護加拿大人民基本的健康，1966 年加拿大政府通過「醫療保險法案」（Medicare Insurance Act），提供願意加入全民健康保險的各省政府財務誘因，確立醫療照護支出上，中央與地方政府「對等成本分攤」原則。加拿大的全民健康保險制度，簡稱 Medicare。

當時並確立以下四項迄今仍適用的基本原則：

（1）全民性（Universality）

各省健康保險必須對全省的居民提供一致的醫療服務。

（2）綜合性（Comprehensiveness）

每個人在投保條件相同下，皆享有必要的醫療與醫院照護。

（3）公營性（Public Administration）

由加拿大省政府或其所委任的非營利組織負責

經營。加拿大不允許私人保險公司將必要的醫療照護納入承保業務範圍。

（4）通用性（Portability）

醫療保險的權益可轉至加拿大境內各行政區行使。加拿大境外就醫的費用，以加拿大境內的醫療費用金額計算。

1977 年通過「聯邦／省政府財務處理及施政計畫法案」（Federal-Provincial fiscal arrangement and established Program Financial Act，EPF ACT），規範中央政府採「整額撥款」方式撥付地方政府，以代替過去的成本分攤方法。

由於聯邦政府財務緊縮，1977 年以後將其補助地方的額度減半，且持續減少，致許多省分尋求既不犧牲醫療品質又能維持健保體系運作的方法，如亞伯達省（Alberta）與英屬哥倫比亞省（British Columbia）採行收取醫療保險費，紐芬蘭省（Newfoundland）、魁北克省（Quebec）、安大略省（Ontario）、緬尼托巴省（Manitoba）則分別徵收薪資稅來支付部分醫療費用，其他省分則考慮重新檢討全民健康保險的給付範圍。

之後，因健保緊縮支付項目，致愈來愈多的醫師以「差額付費」增加收入。聯邦政府認為「差額付費」破壞民眾就醫的公平性與可近性，而於 1984 年通過加拿大健康法（Canada Health Act），除重申前述四項基本原

則（普及性、綜合性、公營性與通用性）外，更增列第五項可近性原則，明定每一加拿大人民均可自由選擇全民健康保險下的任何醫療服務，不論其居住地點、身分地位或經濟收入。此項新原則即明令禁止醫師另行收費，並公告違反第五項原則的懲罰條款。

3. 健康照護體系特色

此後，加拿大的健康照護體系大致確立，並具以下特點：

（1）衛生行政

聯邦設立衛生福利部，統籌全國衛生及社會福利事宜，包括疾病感染的監控、藥品與醫療設備使用的核可、全國健康促進方案的擬訂與推動、提供衛生服務及偏遠地區醫療補助方面的研究計畫。聯邦還負責海員、原住民、中央公務人員的健康服務、藥物食品出售的立法規定，直接支付各省原住民及軍隊的醫療費用、間接支付各省及地方的部分健康保險費用，並協助各省募集健保照護資金。

各省則設衛生部門或衛生暨社會服務部門，負責制定健康保險計畫、處理一般國民健康問題、負擔醫院、養護所、慈善機構等的興建與管理。此外，加拿大的醫院大部分為公立體系。

（2）服務體系

各省規劃的健康保險制度不一，但大致可分三類：

醫療服務（含診所、醫院的門診及出診服務）、醫院服務（含門診、急診、住院及復建等治療）、其他服務（含療養院、養老院與長期照護機構等）。

（3）財務體系

整體而言，加拿大健康照護體系的主要財源為一般稅收、薪資稅、保險費、聯邦補助款（由所得稅轉移或現金支付給地方政府）。1995 年聯邦政府通過「整額撥款」方案（The Canada Health and Social Transfer，CHST），使地方政府更有彈性運用中央補助款，以強化加拿大有關「健康促進」與「疾病防治」的政策方向。

（4）支付體系

加拿大維持單一支付體系，分為醫師費支付制度、醫院支付制度及藥物支付制度三大類。

支付醫師的方式有二種：論量計酬與薪資制，不論是一般科或專科的開業醫師，均以論量計酬支付；薪水制的醫師絕大部分為就職於醫院工作的見習醫師與住院醫師、在醫學院任教的醫師及社區醫療中心與偏遠地區的專任醫師。論量計酬的支付標準是根據省政府衛生廳所編的醫師服務支付標準表（Schedule of Benefits for Physician Services）。醫師收費的標準一般依據省醫師公會與省衛生廳協商所達成的協議。

醫院部分，由政府採總額預算方法支付，政府依據醫院類別、服務人口數、所屬服務地區的人口年齡與性

別分布、健康狀況的差異（城鄉或貧富）、偏遠地區、轉診型態、工作負荷量加以加權；以及教學計畫/重症醫療照護等因素，訂定年度總額預算。至購買昂貴儀器與醫院建築的擴建，則不包括在總額預算內。

藥品部分，目前僅薩克萬省的健保給付部分藥費，其他省則沒有給付。

（二）加拿大健康保險醫療費用總額預算制度

本次業務考察分別前往加拿大安大略省與亞伯達省的衛生廳與所屬健保局進行拜會，除相互交換有關雙方實施全民健康保險的經驗與資訊外，並探討加拿大總額預算實施問題。以下將分別就兩省的整體社會概況與健康保險體制分別介紹，健保部分則以問答方式進行。

1.安大略省健康保險計畫（OHIP）

Q1：國民對加拿大保健法(Canada Health Act,1984)規定五項基準-Universality、Portability、Comprehensiveness、Accessibility & Public Administration 的評價程度為何？其中是否以 C 或 PA 的評價較低，其原因為何？

A1：安大略省民對於 Canada Health Act 規範各省應提供的保險計畫須涵蓋五項原則，未見有很大的反對聲浪；目前約有八成的民眾對該省的健保制度

感到滿意，然而也有八成的民眾對現行的健保體制感到憂心。

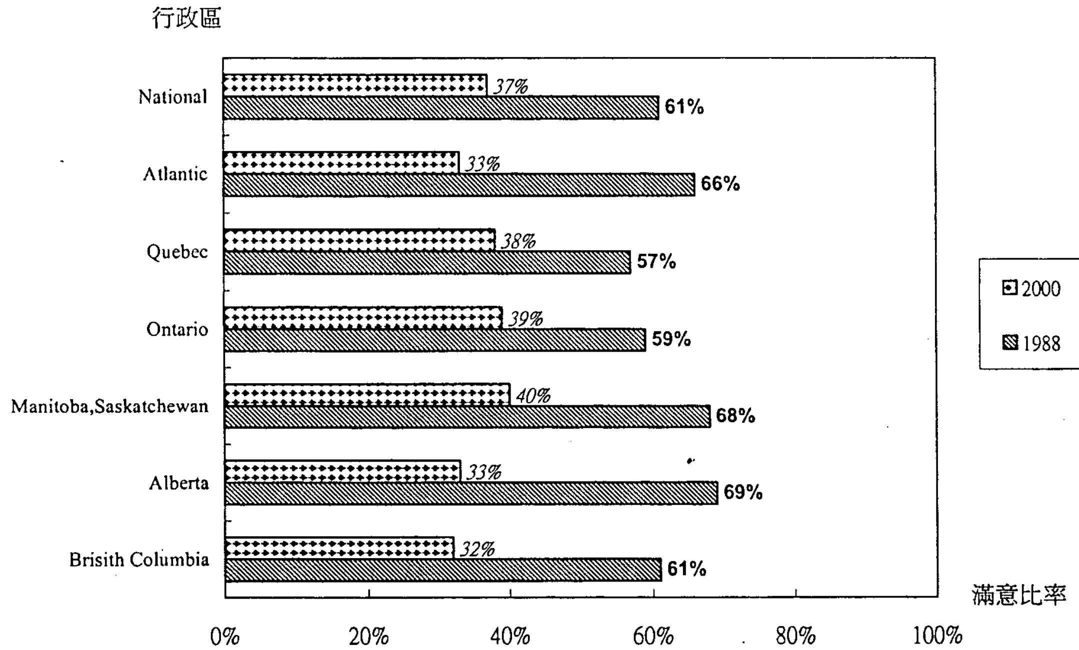
Q2：最近幾年消費者對醫療品質的滿意度有何變化？其中最滿意與最不滿意的項目為何？近年這方面的調查報告可否提供參考？

A2: 安大略省衛生廳為瞭解省民對健保體制的滿意情況，每年委託多倫多市柏格人口健康監控公司(Berger Population Health Monitor) 針對全國民眾進行抽樣問卷調查。該問卷內容係針對健保照護服務的可近性（access）、品質(quality)與可獲得性(availability)，進行民眾的滿意度調查。依據2000年進行的調查結果顯示：

（1）品質部分:

2000年各省的滿意度均較1988年的結果低許多，其中安大略省由59%(1988年)降為39%(2000年)，降幅較少；亞伯達省則降的最多，由69%降為33%（見圖一）。然對整體的健保服務品質，有82%的安大略省省民認為優異或良好（excellent or good），較全國80%的平均值略高。

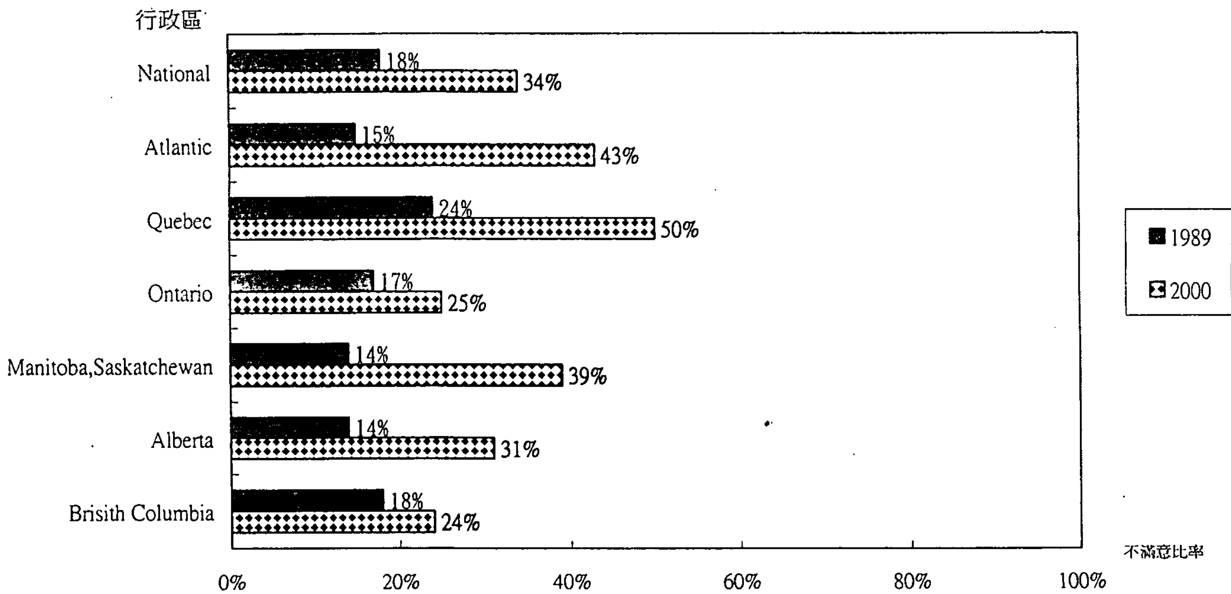
圖一 照護品質滿意情況



（2）可近性部分：

比較 1989 年與 2000 年的調查結果顯示，加拿大人對健保服務可近性的不滿意度有上升的趨勢，安大略省自 1989 年的 17%，上升至 2000 年的 25%。亞伯達省則由 14%遽增為 31%（全國比率由 18%增加為 34%）（見圖二）。然 2000 年的調查結果也顯示：有高達 74%的安大略省省民認為沒有困難接獲健保服務。

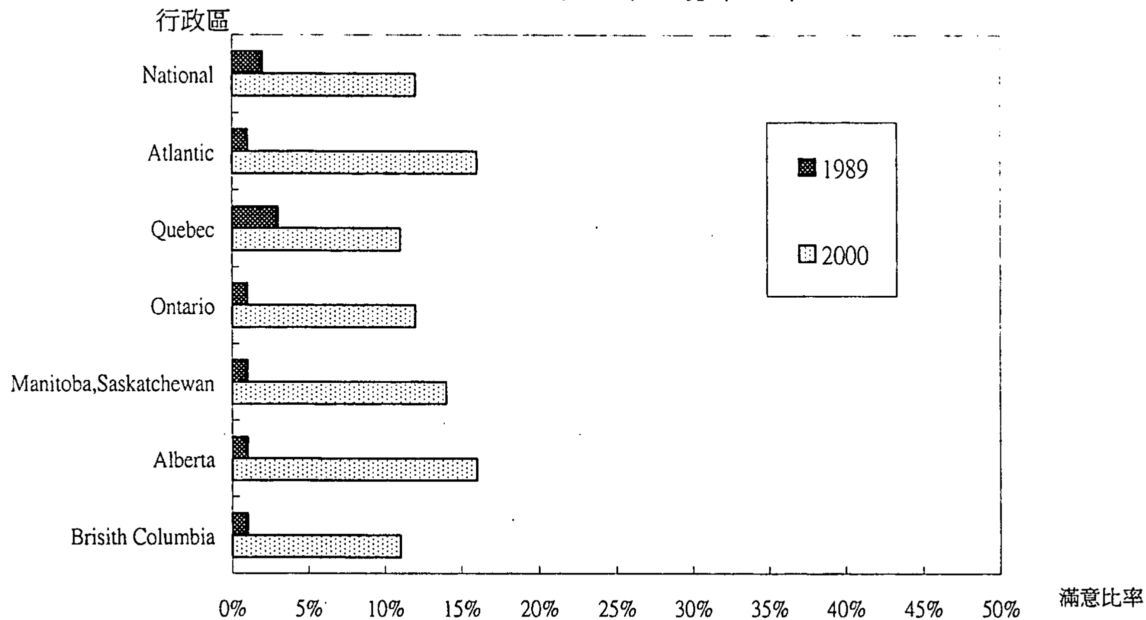
圖二 醫療服務可近性不滿意情況



（3）可獲得性部分：

比較 1989 年與 2000 年的調查結果顯示，有愈來愈多的加拿大人認為當需要醫療服務時，無法立即獲得。安大略省由 1989 年的 1%，遽增為 2000 年的 12%，亞伯達省則由 1%增加為 16%。（全國比率由 2%增加為 12%）。（見圖三）

圖三 醫療服務可獲得性情況



另對安大略省民眾對其醫院所提供服務的滿意度相關調查結果，可上網查詢醫院報告（The Hospital Report）的網站，網址為 http://www.oha.com。

Q 3：處方葯品不在保險給付範圍，是否符合 Comprehensiveness 原則？一般患者對此有何反應？患者自付葯費占醫療費用的比率多少？

A3：由於 Comprehensiveness 原則乃指必要的醫療服務，而省政府則負責界定何者為「必要的醫療服務」。因此 OHIP 不給付處方藥，並不違反上述原則。一般患者對藥品不給付的規定，未見有負面的反應。

安大略省的健康保險（Ontario Health Insurance Plan）雖不給付處方藥，但對65歲以上或領社會救助金的民眾，提供另一種給付處方藥的保險（Ontario Drug Benefits），但每年須自付100-200加幣的部分負擔，每次處方藥仍需自負6.11加幣。此外另提供省民一種保險（Trillium Drug Programs）給付藥費，保險費率約為薪資的4%，一家庭自負額（deductible）一年約為500加幣。

至1999-2000年，安大略省藥品費用占整體醫療支出的比率為6.5%。

Q4：為因應過度利用，有無恢復患者部分負擔(User Charge)的打算？或者加強國民衛生教育，其推動效果如何？

A4：患者部分負擔(User Charge)違反加拿大保健法（Canada Health Act）的可近性原則，違者受罰。加強國民的衛生教育，乃聯邦政府的權責，聯邦政府對推動國民的衛生教育一向不遺餘力，對改善民眾的健康則有不錯的成績。

Q5: 醫院總額(hospital budget)與醫師總額(GP budget)的協商機制及基礎有何不同？

A5：2000/2001 年前，安大略省的醫院總額預算是由各醫院分別提出營運計畫（Operating plan）與下

年度預算額度，經衛生廳所設的基金會（Board of Trustees and Medical Staff）審查是否符合該醫院所屬地區的醫療需求原則，再呈送省財政廳審核批准。公立醫院整年的財務運作必須受限於在所核定的預算內；營運有赤字時，醫院必須自己負責籌措資金。公立醫院的財源有 85%來自省政府總額預算，另 15% 則自行籌措（如醫院停車場收費、醫院出租場地的租金收入與民間捐款等）。預算額度是以歷史資料為主，再依據營運成本的增加與對高科技醫療利用率的需求增加等因素調整。各醫院的建築設備增修費用依比率由省政府另編預算支應。醫院總額預算制採 closed-ended 方式，該方式易產生就醫等候期增長與營運赤字。

96%的醫師費用採論量計酬方式，支付點數是由省衛生廳與醫師公會（Ontario Medical Association）協商訂定；但因採 open-ended 預算方式，費用成長較難控制。其他 4%的醫師費用則採彈性計酬（依合約內容計酬）、薪水制（適用於社區保健中心的醫師）、論人計酬（適用於健康服務組織 Health Service Organizations 的醫師）等。協商醫師服務支付標準表（Schedule of Benefits of Physician Services）時，醫師公會與

省衛生廳通常是以通貨膨脹作為最基本的指標，再考量其他經濟情況。醫師公會不僅代表其會員與省政府談判論量計酬，同時也涉及醫師福利與醫學院教學醫師的薪資問題。雙方協商過程中，若無法達成協議，依法由省高等法院指定一位仲裁人解決。

Q6: 安大略省有關醫院總額預算的分配方式，及決定分配的結構因素或指標為何？

A6：2000/2001 年的醫院總額預算，是依各醫院的營運計畫與歷史資料加以編列。由於營運計畫長期性難以預測，來自政府的財源分散，有分階段撥付(base funding)、一次撥付(one-time funding)及依政府的重點推動業務撥付(priority program funding 等三種方式)，以及人口增加與高齡化等因素，致撥付各醫院預算的總額呈現不甚公平。因此有新的醫院總額（Integrated Population-Based Allocation, IPBA）公式產生（見附錄一），並預定於 2001/2002 年實施。IPBA 公式是依醫院應診類型，區分為急診住院、同一天手術、持續性照護、門急診（Outpatient component of emergency）、<u>復健、電療與舒緩疼痛</u>等（畫底線者限於小型醫院），再依各醫院服務量與價的因素，加以調整各醫院的總額預算。價的因素分為

邊遠地區（isolation）、醫院規模（size）、教學活動、照護層次與三級照護（tertiary）；量的因素含病患的年齡/性別、死亡率、社會經濟狀況、原住民看診比率、鄉村地區、生育率與初生兒不足體重等。由於新的醫院總額預算公式預定於今年實施，本次參訪過程中，尚未有實施的成效資料可供參考。

Q7:醫院總額預算是否採取確保品質的支付制度(quality-based payment)?

A7:安大略省為確保公立醫院的醫療品質與保障省民的健康，建立以下監控機制：

(1)建立醫院通報卡制度（Hospital Report Cards）：

安大略省醫院聯盟(Ontario Hospital Association)2001年版的Hospital Report，依醫院的住院急診照護系統、急診服務系統、複雜性持續性照護系統、可行性研究與相關指標（如復建、精神醫療、看護、婦科醫療）等進行一系列的問卷調查，以評估所屬醫院的服務成效（performance）。

(2)建立病患契約

明定安大略省民參加全民健保的權利與義務，並由民眾共同監督醫院的服務品質。

(3)獎勵表現優良的醫院

以提供獎勵金方式，獎勵服務績效優良的醫院。

今年預定推動整合性醫院總額預算制(Integrated Population-Based Allocation, IPBA)是依醫院的服務類型與服務人口分配預算，其中醫院服務類型指標，含有品質確保的精神。

Q8: 在醫院總額預算中，有無所謂重點政策考量，對於小規模的社區醫院給予特別保障？

A8：新的醫院總額預算公式，對於小規模的醫院(small hospitals）方面，予以特別考量其復健、電療(eldcap)及舒緩性疼痛等照護類型。

Q9: 何項指標對總額預算的成長影響最大？其中，人口老化及平均住院日數對醫院總額預算的影響如何？

A9：人口成長與人口老化因素對總額預算的成長影響最鉅。平均住院日有逐漸下降趨勢，即自 1990/91 年的 8 日降為 98/99 年的 6 日，對總額預算影響不大。至人口老化部分，依據衛生廳的估計：2041 年，65 歲人口占總人口比率將達 23% ，較 2000 年的 12.5% ，遽增一倍，未來對總額預算成長將造成極大的壓力。

Q10:省政府在醫院總額預算之外，對於醫院的資本支出（設備投資）另編列預算給予補助，其補助比

率多少？又此項規定是否適用於非公立醫院？

A10：省政府對公立醫院的建築與設施進行經費補助。對核可的新建築物的計畫補助 5 成經費，對核可的擴建或整修建物的經費補助 7 成。對非公立醫院的經費補助規定，則無資料可尋。

Q 11:分配地區預算(regional budget)時，是否採風險校正論人計酬(risk-adjusted capitation)?並考量如年齡、性別、標準死亡比(SMR, standardized mortality ratio)等因素？

A11: 受訪人員表示該省已不採 SMR 為校正指標。

Q 12:安大略省對於醫師總額的超過請求部分做何處理？超過請求的醫師人數占率及費用占率各有多少？在全國各省此項占率中的排序為何？

A12：由於論量計酬支付標準點數是由衛生廳與省醫師公會（Ontario Medical Association, OMA）共同協商完成，醫師依規定可申報費用。然逢政府財政困難之際，與 OMA 協商的結果，醫師費用的成長率定為 2% ，若超過此項成長率，申報費用達一個額度時，即採折價支付方式（income thresholds for holdbacks)。若整體費用超過預設的額度時，由準備基金支付（reserve fund)；2001/2002 年的準備基金為 10 億加幣，但近年來準備基金少被動用。

對超過請求的醫師人數占率、費用占率與在全國各省占率中排名等統計，安大略省尚無此項資料可提供。

Q13:基於 Portability 原則，人民可以越省就醫，則其醫療費用依何標準計算及如何支付？各省是否有不同的規範？

A13：對越省就醫的醫療費用支付標準是以就醫省分的費用為準；然若屬安大略省所未給付的項目者（如處方藥、救護車費用與長期照護費用等），則須由被保險人自付。各省每月就跨省（跨進與跨出）醫療費用加加減減結算一次。各省對跨省就醫費用的給付原則大同小異。

Q14:目前安大略省非保險醫師的占率有多少？此項占率的增減趨勢為何？

A14：未有相關資料。

Q15: 安大略省規定公辦健康保險提供給付或不給付項目之標準（即醫療上非必要的服務項目）為何？

A15：安大略省以立法方式規定公辦健保提供給付或不給付項目，在 Health Insurance Act 法案中規範 OHIP（安大略省健保）的給付範圍、Health Care Accessibility Act 法案中禁止對必要醫療服務額外收費、Independent Health Facilities Act 法案允

許非醫院型診療設施的使用，但禁止醫師對病人收取診療費（technical components of diagnostic fees）。

Q16: 安大略省（或全國）民間健康保險的醫療給付金額占總醫療費用的比率為何？

A16: 安大略省 2000 年的整體醫療支出為 373 億加弊，其中有 32%(118 億加幣)來自私部門，含蓋私人保險（third-party insurers）與民眾自付，民眾自付花費在處方藥、牙科與眼科診療服務。加拿大全國私部門醫療支出占總支出約為 29%。

Q17:總額預算的實施，對醫療費用成長及其結構比有何變動影響？

A17：安大略省的醫療費用成長趨勢來看，1990-1998 年間的醫療費用成長控制在 18 億加幣左右，管控十分得宜；然 1999 年以後，醫療費用成長快速，2000 年遽增至 23.7 億加幣。

Q18:貴省或貴國在醫療費用不斷上昇當中，醫師與病床的供給量增加，高科技醫療的進步開發，以及人口高齡化因素，對於總額預算制度的衝擊為何？

A18：安大略省 1998/1999 與 2000/01 年間的醫療費用成長約 17.8%，然 2001/02 年預估醫療費用成長僅為 5.4%。未來將持續面臨人口自然成長快速

（預估 2000/05 成長 6.2%）、人口老化、服務利用率增加（尤其是藥品與論量計酬部分）、新醫療科技產生、服務強度的增加、醫療服務的變革、醫療照護的公營化、民眾對新醫療服務的需求增加，以及醫療人力日漸短缺等因素，均將造成總額預算額度擴增的壓力。

Q 19:總額預算的成長，對於政府財政的壓力如何？尤其經濟衰退時期，由於政府財力減弱，對總額預算制度的推展有何影響？

A19：由於總額預算的成長壓力，造成聯邦政府採取調降補助各省健保經費比率的措施，自 1994/95 年以來，由 18%調降為 14%。醫師為因應預算縮減的情形，紛紛採取威脅集體罷工、拒絕提供超時服務，及爭取提高薪資待遇等措施；醫院則以延長病人手術等候時間（long waiting list）予以因應。

Q 20:由於經濟低成長，聯邦財政困難及醫療費用上昇等因素，聯邦支出權(spending power)所要確保各省制度的同質性與同等性以及 EPF(Federal-Provincial Fiscal Arrangements and Established Programs Financing Act)對於各省的財源補助及控制影響力是否逐漸弱化，那麼安大略省對此有何因應對策？

A20：自 1994/95 年以來，聯邦政府持續調降對各省政府衛生保健經費補助的比率，自 1994/95 年的 18%，安大略省 2001/02 年調降為 12%。各省政府的首長們紛紛要求聯邦政府將補助各省的經費比率回復至 1994/95 年的水準（18%）。安大略省的省長則直接要求聯邦政府補助新計畫經費的 50%。

Q21:CIHI (Canadian Institute for Health Information)開發的 CMGs (Case Mix Groups) RIWs(Resourse Insensity Weights)，以及貴省開發的 OCCP(Ontario Case Cost Projects)，可否提供最新版資料以資參考？

A21：已提供所需的書面資料。

Q22:請約略介紹 1994 年起實施的多倫多醫療服務供給體系五年改革計畫的政策重點及其成效（如能提供書面資料更好）。

A22：醫療服務改革委員會（Health Services Restructuring Commission, HSRC）成立於 1996 年 4 月，為任務編組的組織，預定於四年內作出重整（restructuring）安大略省公立醫院的決策，並向省衛生廳長提出再投資與改善省屬整體衛生體系的建議，朝向建立優質的衛生保健體制的目標（該委員會雖有權決定那幾家醫院要關閉，

但醫院總額預算部分仍屬衛生廳的權責）。該委員會業於2000年3月28日提出219頁的建議報告書，並宣告解散，該報告資料已收錄於HSRC的網站（www.hsrc.gov.on.ca）。該報告所提的具體建議與成效如下：

（1）決定那些醫院應關閉或合併。有22個社區（communities）接受HSRC的指導，一旦所屬醫院完成重整作業，將關閉31個公立醫院、6個私立醫院與6個省屬精神療養醫院，另自其他公司接收4個醫院。

（2）整合各衛生部門與組織的聯繫與管理。如建立18個位於偏遠/北邊地區的醫院網（hospital networks），並建立多樣性的區域與省屬網路。

（3）改革精神醫療照護。1999年3月12日衛生廳長接受HSRC的建議，建立區域性的精神衛生執行小組，重整精神醫療照護體系。由於重整精神醫療院所的所有權與管理權十分費時，使得本項改革的速度緩慢。

（4）增加其他醫療照護部門的投資（如精神醫療、長期照護與居家照護）。1998年4月28日省政府宣佈增加20億加幣的預算，投資於加強居家照護與長期照護。

Q23:安大略省是少數向省民收取保險費的省分，請問從財源籌措方式而論，加拿大能否稱為實施全民健康保險的國家？

A23：安大略省 10 年前已停止向省民收取保險費。加拿大應可稱為實施全民健康保險的國家。

Q24:貴省健康保險體制是否考慮朝 NGO 或民營化方向改革發展？

A24: 尚在研議中，未有定案。

Q25:根據貴省的實際經驗，對於台灣實施總額預算制度有何建議？

A25：未表示意見，若有需要其他相關資料，可以電子郵件方式詢問本次受訪人員或進入該省網站搜尋（www.gov.on.ca）。

2.亞伯達省健康保險計畫（AHCIP）

Q1：國民對加拿大保健法(Canada Health Act,1984)規定五項基準-Universality、Portability、Comprehensiveness、Accessibility & Public Administration 的評價程度為何？其中是否以 C 或 PA 的評價較低，其原因為何？

A1：亞伯達省民對 Canada Health Act 所規範的五個原則表示贊同，然近年來對公立醫院手術有較長等候期之滿意度有下降趨勢。

Q2：最近幾年消費者對醫療品質的滿意度有何變化？

其中最滿意與最不滿意的項目為何？近年這方面的調查報告可否提供參考？

A2：依據亞伯達省 1995-1999 年的調查(Alberta Health Survey）結果顯示：省民對醫療服務的品質評價有微幅下降趨勢（自 1995 年的 78% 降為 1999 年的 75% ）、個人對使用的醫療服務的滿意度評為優異與良好（excellent or good）的比率有明顯下降趨勢（自 1995 年的 87% 降為 1999 年的 78% ）。

對醫療服務的可近性（access）評價結果：對社區內醫療服務的可獲得性（availability）的評價在 1996-1999 年間起伏不大、對醫療服務可近性評價優異或良好，則由 1996 年的 80% 降為 1999 年的 73% 、對需要醫療需求卻無法取得的部分評價優異或良好者有 1996 年的 6% 增加為 1999 年的 9% 。

另外對柏格人口健康監控公司(Berger Population Health Monitor)針對各省民所做的調查結果可參考安大略省部分的 A2。

Q 3：處方葯品不在保險給付範圍，是否符合 Comprehensiveness 原則？一般患者對此有何反應？患者自付葯費占醫療費用的比率多少？

A3：亞伯達省對處方藥的給付另闢一種保險給付，稱

之 Non-Group Alberta Blue Cross 。此保險的給付範圍涵蓋7成的處方藥費、救護車服務費、臨床精神服務費、居家照護費與其他。Blue Cross 的費率，個人按月付$20.5加幣；家庭按月付$41加幣。另 Blue Cross 免費給付65歲以上省民的眼鏡配置費、牙醫費與處方藥費，經費由省衛生廳全額補助。

Q4：為因應過度利用，有無恢復患者部分負擔(User Charge)的打算？或者加強國民衛生教育，其推動效果如何？

A4：由於加拿大保健法（Canada Health Act）明令禁止向患者收取必要醫療服務的部分負擔，因此各省均依法不得收取。然對加強國民衛生教育，在2000/2001年的預算中，亞伯達省撥付1.68億加幣（占衛生廳總預算的2.9%）推動宣導健康與疾病防治的重要性。由一項針對15-19歲青少年抽煙率的調查顯示，該年齡層的抽煙率由1996年的29%，降為1999年的25%，顯示亞伯達省對保健的宣導教育不遺餘力。

Q5: 醫院總額(hospital budget)與醫師總額(GP budget)的協商機制及基礎有何不同？

A5：亞伯達省的醫院總額依其17個地區的衛生主管機關（Regional Health Authorities）轄區內的人

口比例計算，計算基礎分為醫院營運成本、服務區內的人口量、醫院住院檔、長期照護、急診照護與居家照護五種基礎計算。

醫師總額採論量計酬，支付點數是由省衛生廳與醫師公會三年一次（Alberta Medical Association）共同協商訂定。預算訂定的基礎，考量人口的數量與醫師供給量增加所造成的費用增加等因素。協商的機制是由省衛生廳與醫師公會各派三位代表成立財務委員會（Finance Committee）進行協商下三年度的費用、費率、分配與是否納入新的服務項目等事宜。雙方若無法達成協議，將由雙方各指派至少二位代表再進行磋商。財務委員會至少每季開會一次，檢討實施的進度與概況。最近的一次協商完成於 1998 年 4 月 20 日，協商有效期含括 1998/99 年度、1999/2000 年度與 2000/2001 年度的醫師總額。醫師預算總額採上限制（Hard Cap），上述三年度的上限分別為 1.7%、1.6%與 1.6%。上限調整的基礎，為反映當年度 10 月 1 日實際人口的增減數。另為使醫師總額預算制度運作順暢，每年度另設 5 百萬加幣額度的創新基金（Innovation Fund），約為該年度總預算的 0.5% ，不含在上限額度內。若該預算在年度內未能分配完畢，則額

度自動消失，不可移為下年度使用。

Q6: 亞伯達省有關醫院總額預算的分配方式及決定分配的結構因素或指標為何？

A6：亞伯達省醫院總額的分配方式自 1997/98 年度開始改依 17 個區域衛生主管機關（Regional Health Authorities）進行區域預算的分配，不再有個別醫院總額預算。區域總額預算的分配，主要以該區人口數決定預算額度的多寡；此一分配方式稱為 Population based funding。同時依該區人口的組成成分（如年齡層、性別、收入額度等）與提供該區域的醫療服務型態。新的預算分配方式可確保公平分配各區域醫療資源。

Q7: 醫院總額預算(hospital budget)是否採取確保品質的支付制度(quality-based payment)?

A7：醫院總額預算是以 17 個區域總額預算統籌分配轄區內的全部醫院的預算，分析該區域醫院的服務類型（如緊急住院、門診照護、長期照護予居家照護），雖未有明確的品質確保方案，但各醫院的營運績效與病患的就診型態均列入主要因素考量，形同將醫療品質的確保併入考量。

Q8: 在醫院總額預算中，有無所謂重點政策考量，對於小規模的社區醫院給予特別保障？

A8：對區域醫院總額預算分配中，不特別考量小型社

區醫院，但為確保偏遠地區居民的醫療照護，以偏遠地區的距離加權該地區的醫院。亞伯達省約有 99,000 人居住在北方邊遠地區，對於離人口密集的鄉鎮 50-80 公里者，以每人醫療費用（per capita rate）預算加成 25% ；距離超過 80 公里者每人再加成 25% 。

Q9: 何項指標對總額預算的成長影響最大？其中，人口老化及平均住院日數對醫院總額預算的影響如何？

A9：外來移民增加與人口老化對總額預算的成長影響最大，尤其人口老化對費用成長造成很大影響，導致預算被迫有逐年增加的壓力。至平均住院日，並未對醫院總額造成很大影響。

Q10:省政府在醫院總額預算之外，對於醫院的資本支出（設備投資）另編列預算給予補助，其補助比率多少？又此項規定是否適用於非公立醫院？

A10：由於經營偏遠地區的醫療院所在營運、設施與交通成本較高，對北方五個衛生主管機關轄區內醫院，加成 20% 的區域內醫院的預算。

Q11:分配地區預算(regional budget)時，是否採風險校正論人計酬(risk-adjusted capitation)?並考量如年齡、性別、標準死亡比(SMR, standardized mortality ratio)等因素？

A11：區域總額預算以風險校正論人計酬方式（risk-adjusted capitation payments）計算，並以年齡與性別為主要考量因素，目前正在研擬將診療（diagnoses）與過去利用情形（previous utilization）列入風險校正的考量因素。

Q12:亞伯達省對於醫師總額的超過請求部分做何處理？超過請求的醫師人數占率及費用占率各有多少？在全國各省此項占率中，貴省的排序為何？

A12：由於亞伯達省對醫師總額預算採上限制，超出請求部分將由準備基金（reserve pool）支付，由於省衛生廳與醫師公會就醫師總額部分進行充分協商，因此醫師公會自1997年8月底以來，未發現有超出額度的情形。

Q13:基於Portability原則，人民可以越省就醫，則其醫療費用依何標準計算及如何支付？各省是否有不同的規範？

A13：對越省就醫的醫療費用標準係以就醫省分的費用為準，然若Alberta省所未給付的項目者，須由被保險人自付差額。各省的規範大致相同。

Q14:目前亞伯達省非保險醫師的占率有多少？此項占率的增減趨勢為何？

A15：無相關資料提供。

Q15:亞伯達省規定公辦健康保險提供給付或不給付項目之標準（即醫療上非必要的服務項目）為何？

A15：醫師總額的協商機制，是由省衛生廳與省醫師公會共同組成一個財務委員會（Finance Committee）協商下年度的預算額度、收費標準與決定給付與不給付項目。評估是否新增給付的項目的基礎為服務內容、服務價值（value of the service）、服務方式、與預估的服務利用量。新給付項目的經費來自創新基金（innovation fund），決定納入給付項目後，經費由創新基金移入預算上限額度中管控。

Q16:亞伯達省（或全國）民間健康保險的醫療給付金額占總醫療費用的比率為何？

A16：1996-2000年間，亞伯達省民間部門醫療費用占總醫療費用的比率維持在31-33%，至全國民間部門醫療費用佔總醫療費用比率則自30%稍微下降為29%。

Q17:總額預算的實施，對醫療費用成長及其結構比有何變動影響？

A17：總額預算實施因採上限制，對醫療費用成長控制在協商範圍內，然對人口老化與民眾需求高科技醫療日漸殷切之情況下，總額的額度勢必有增加

的壓力。

Q18:亞伯達省或加國在醫療費用不斷上昇當中，醫師與病床的供給量增加，高科技醫療的進步開發，以及人口高齡化因素，對於總額預算制度的衝擊為何？

A18：為因應高科技醫療的進步開發以及人口高齡化對醫療費用成長的衝擊，在醫師總額部分，採嚴加控制醫師人力的成長與總額額度不超過上限的措施。在區域總額部分，除區域預算外，另設立小規模的基金以提供區域轄區內醫院高費用、高科技與維持生命（life-sustaining）的服務如心導管手術、骨髓移植、頭顱切開術（craniotomies）、心臟瓣膜手術（cardiac valve procedures）、血管再造術（angioplasties）、洗腎治療等，予以因應高科技醫療與人口高齡化的衝擊。

Q19:總額預算的成長，對於政府財政的壓力如何？尤其經濟衰退時期，由於政府財力減弱，對總額預算制度的推展有何影響？

A19：由於總額預算的成長壓力，造成聯邦政府採取調降補助各省健保經費比率的措施，自 1994/95 年以來由 18%調降為 14%。醫師為因應預算縮減的情形，紛紛採取威脅集體罷工、拒絕提供超時服務與爭取提高薪資待遇等措施；醫院則以延長病

人手術等候時間（long waiting list）予以因應。

Q20:由於經濟低成長，聯邦財政困難及醫療費用上昇等因素，聯邦支出權(spending power)所要確保各省制度的同質性與同等性以及 EPF(Federal-Provincial Fiscal Arrangements and Established Programs Financing Act)對於各省的財源補助及控制影響力是否逐漸弱化，那麼亞伯達省對此有何因應對策？

A20：自 1994/95 年以來，聯邦政府持續調降對各省政府衛生保健經費補助的比率，自 1994/95 年的 18%，調降為 2001/02 年的 13%。各省政府的首長們紛紛要求聯邦政府將補助各省的經費比率回復至 1994/95 年的水準（18%）。

Q21:推動『鼓勵醫師前往偏遠地區應診計畫』(Rural Physician Action Plan)的成效如何？

A21：本次受訪中未有相關資料顯示，但由於區域總額預算制對偏遠地區的醫院有加成給付，相對鼓勵醫師前往偏遠地區服務。

Q22:由網站資料上顯示，Alberta 省正發展一套評估健康與健保制度的標準與指標？是否已具雛形？

A22：亞伯達省衛生廳下設健康監控部門（Health Surveillance Branch）監控人口的健康統計相關資

料，並將統計結果提供省衛生廳擬定、執行與評估衛生政策與醫療照護政策的依據；並確立健康的優先順序與整合相關議題；與提出民眾目前健康狀態的報告。為評估政府的衛生政策的實施成效與民眾的健康狀態，該部門建立相關的指標，此次訪查尚未有相關資料呈現。

Q23:貴省正在發展醫療網(alberta we/net)，以結合醫療提供者、醫院、藥局、診所、醫療團體與省衛生廳，共同改善病患照護、衛生體系管理與衛生研究等方面，請問該醫療網的架構如何？

A23：亞伯達省自 1998 年開始建置 alberta we/net 醫療網，預計於 2006 年建構完成。建構目的為整合與管理全省醫療資訊系統，希望藉由整合與分享醫療提供者、醫院、藥局、診所、醫療團體與省衛生廳等機構的醫療資訊，並強化衛生體系的管理，進而共同改善病患照護療效，並節省相關成本的花費（如醫師診療費、長期照護費與住院）。詳細資料亦可參考 alberta we/net 網址：http://www.albertawellnet. org/index.htm.

Q24:貴省自 1996 年患者負擔設施利用費敗訴後，政府方面迄今採取何種加強自律性策略措施，以為因應？對醫療費用的監控產生何種效用？又民間對此有何反應？

A24：未有相關資訊提供。

Q25:貴省是少數向國民收取保險費的省份，請問從財源籌措方式而論，加拿大能否稱為實施全民健康保險的國家？

A25：亞伯達省的整體健康照護預算中有 72% 來自公務預算、15% 來自保險費收入、13% 源自聯邦政府的補助，個人保費每月須繳交$20.5 加幣，一個家庭保費每月為$41 加幣。加拿大目前除亞伯達省外，僅有 BC 省尚收取保險費，其餘省分則自稅收中支付保險支出。加拿大應可稱為實施全民健康保險的國家。

Q26:貴省健康保險體制是否考慮朝 NGO 或民營化方向改革發展？

A26：尚在研議中。

Q27:根據貴省的實際經驗，對於台灣實施總額預算制度有何建議？

A27：未表示意見。

3.健康保險制度的改革方向

（1）安大略省

為因應目前與即將面臨高科技的發展與人口結構改變的壓力，並確保健保制度的永續經營，安大略省政府體認未來須進行健保體制的改革，其方向如下：

①確保聯邦政府提供安大略省公平的健康照護補助預算比率。

②為解決北方與偏遠地區醫師人力的短缺問題，將訂定鼓勵措施與提供訓練課程。

③將強化安大略省的家庭健康網（Ontario Family Health Network），以維護省民的健康照護。

④推廣電訊醫療服務（Telehealth service），以補助北方與偏遠地區民眾醫療照護不足的地方。

⑤倡導（introduce）健康資訊隱私的立法。

（2）亞伯達省

為因應人口結構改變（人口增加與高齡化）、高科技醫療的日新月異與醫療費用的上漲等壓力，並確保健保制度的永續經營與維護民眾醫療品質，亞伯達省政府未來將持續進行健保體制的改革，其方向如下：

①建立一個可預期與公平的總額預算制度。

②採取相關措施，以因應人口高齡化時代的來臨。

③確保新資訊的持續創新與整合。

六、心得與建議

（一）考察心得

經訪問加拿大兩省的相關單位，並以座談方式交換意見後，對加國實施全民健保總額預算制度等問題，獲得以下心得，並加以評論：

1. 加拿大全民健保業務的執行單位雖為各省政府，但聯邦政府卻負有分擔健保財務的責任，其補助額度逐年縮水，造成各省因經費不足，精減醫護人力，進而影響民眾就醫權益與照護服務品質。相較我國，健保資金近年來調度不甚順暢的主因之一，為地方政府的欠費不斷增加，致健保財務面臨嚴重周轉不靈問題。由加國的經驗得知，各級政府若不執行其財務責任，未來將影響民眾的權益與照護服務品質。
2. 為因應人口老化與民眾對高科技醫療的需求日漸殷切，進而造成醫療費用上漲的壓力，安大略與亞伯達兩省政府紛採改革其健保制度的措施。我國不僅面臨同樣的問題，且為求永續經營，更應持續進行健保體制的改革。未來是否可將長期照護、居家照護獨立成為附加保險個別管理；或對日新月異的高科技醫療項目，建立有效管理與給付的原則等均是考量改革我國健保體制時，列入重要研討的議題之一。

3. 安大略與亞伯達兩省對醫院總額預算近年來不約而同地採取新的計算公式，除因應預算緊縮問題，並以更有效率與公平的方式作預算的分配，如採每人醫療費用方式計算或以區域整體的資源考量等。觀察我國大總額的分配方式，自始即採每年每人醫療費用作為計算基礎，頗符國際的潮流。對 Alberta 省分配醫院預算，採區域總額資源分配方法，整合各區域內的醫院資源，如此可節省多餘的資源移作推動重點業務，照護更多的病患。如此有效運用有限醫療資源的方式，可供我國未來規劃及實施醫院總額支付制度時，頗具重要的參考價值。
4. 亞伯達省的醫師總額協商機制，是採由省衛生廳與醫師公會互推代表進行協商，並設有相關委員會（RVG Commission、Finance Commission、Physician Resource Planning Committee）負責設定未來年度的總額上限額度、支付點數、新給付或不予給付項目，並規劃全省未來醫師人力配置與供需量，乃是結合整體醫療資源與進行健保整體規劃的最佳典範。

我國健保給付範圍廣泛，對給付與不給付項目，未訂明確的原則，至遭受許多各類團體要求擴大給付範圍的壓力，對許多公共衛生範疇與社會福利範圍的項目，也被列入給付範圍，因而造成健保財務負擔的壓力。亞伯達省對給付原則建立特定機

構加以協商的機制，可供我國參考。

由於醫師人力的增加，相對增加醫療費用，因此該省的醫師總額的設計機制，含括供給面有效的控制，值得我國未來健保體制改革的參考。

另對藥費控制措施與共識明訂在合約上，將節省下來的藥費(50%存入 Innovation Fund)作為推動醫師總額業務彈性應用，建立供給者參與控制藥費成長的做法，值得參考。

5. 推動總額預算制度後，為維護病患的權益與醫療照護品質，在醫師總額協商合約中納入品質確保機制（Clinical Practice Guideline)，對建立品質確保準則所需費用，是由省衛生廳與醫師公會共同負擔（依據 98 年的合約每年度約為 550,000 加幣）；將品質確保方案列入協商合約中，不啻為要求醫師公會切實執行的有效方法。

6. 為利醫療費用總額協商的順遂，資訊分享與對等為必須要件之一。亞伯達省整合所有資訊系統，成立 alberta we//net 資訊網，讓所有相關機關團體與民眾有權共同使用，不但有利資訊資源的有效運用，協助協商過程所需資訊的透明化，並可協助衛生行政單位更有效率運用與集中資源，強化衛生醫療重點業務，值得我國衛生主管機關參考。

（二）建議事項

1. 為因應人口高齡化與民眾對高科技醫療需求的增加，對影響醫療費用成長最大的長期照護、居家照護，應及早擬定因應措施，或可將部分保險給付項目另外成立附加保險，收取附加保險費用，以專門提供該類醫療服務。
2. 為有效運用醫療資源，對我國未來規劃醫院總額支付制度時，可採區域性預算分配方式，而非個別醫院總額的預算計算。如此將可更有效地整合各區資源，將節省的資源用以照護偏遠地區或推動重點工作，期以照護更多的民眾。
3. 我國健保給付範圍廣泛，在有限的資源與經費下，無法負荷持續醫療費用上漲壓力，建議我國未來應建立健保給付優先順序與原則，以利有效管控醫療費用的成長。
4. 為有效控制我國藥費成長過高，建議可參考亞伯達省醫師總額協商模式，將控制藥費成長的責任，由醫師分擔，以有效抑制不當藥品的使用。
5. 可考慮仿行亞伯達省總額協商機制，由主導總額協商的第三者委員會，同時負責檢討給付項目的適當性，因應保險財務及總額協定結果，調整給付項目或給付標準。

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附　錄　一

OVERVIEW OF HOSPITAL FUNDING

Health Care Programs
Finance and Information Management
Ontario Ministry of Health and Long Term Care
Toronto, Ontario
Canada

MINISTRY VISION

VISION:

An accessible health system that promotes wellness and improves people's health at every stage of their lives and as close to their homes as possible.

Ontario Ministry of Health
and Long Term Care
Business Plan
2000-2001

KEY MINISTRY STRATEGIES

Key Strategies to achieve the vision are:

1. Integrating the delivery of services
2. Improving services and access to care
3. Re-engineering the Ministry

GUIDING PRINCIPLES

The guiding principles that will direct the Ministry's efforts are:

Put the patient first in the health care system.

Provide the highest quality health services as close to home as possible.

Spend health care dollars more wisely.

Improve the <u>accountability</u> of Ontario's health care system.

Ensure that dollars are being spent on front-line patient services.

Reinvest savings into health care services for patients.

Integrate the components of the system to service the patients.

HEALTH FUNDING OVERVIEW

Health care system is publicly administered and financed through the tax system

The current budget provides for an investment of $23.5 billion in health care

Base transfers to hospitals reduced by $365 million (5%) in 1996/97 and $435 million (6%)in 97/98

More than $2.5 billion is being invested in the restructuring of Ontario's community based health care system

the Ministry of Health and Long-Term Care provided over $850 million in increased hospital funding last year

HEALTH FUNDING OVERVIEW

Examples of Targeted Funding

Funds targeted to hospitals to help them deal with the pressures of restructuring

Funding to increase Nursing Staff at all hospitals

Funding to ensure 60 Hours Postpartum Care is available to all mothers requesting it

Additional funds to the most efficient hospitals

Additional funding to hospitals in high growth areas

HOSPITAL SYSTEM OVERVIEW

System Description

Policy Context

Funding Environment

HOSPITAL SYSTEM OVERVIEW

Government transfers to hospitals are the largest single transfer payment in Ontario - referred to as the "global funding allocation".

Government contributes approximately 85% of hospital sector spending.

Hospitals generate revenue from other sources e.g. private/semi private accommodation, chronic care co-payment, workers compensation, fundraising.

Hospitals receive funding from government three ways: 1) base funding, 2) one-time funding, and

3) priority program funding

SYSTEM DESCRIPTION

The management of hospitals is overseen by a board of trustees who are responsible for governance and management

Hospital trustees serve on the Board through 1 of 2 mechanisms:

- elected by members of hospital corporation
- appointment by Province

The Public Hospitals Act (1931) sets out the powers of the Minister, the Board of Trustees and Medical Staff

SYSTEM DESCRIPTION

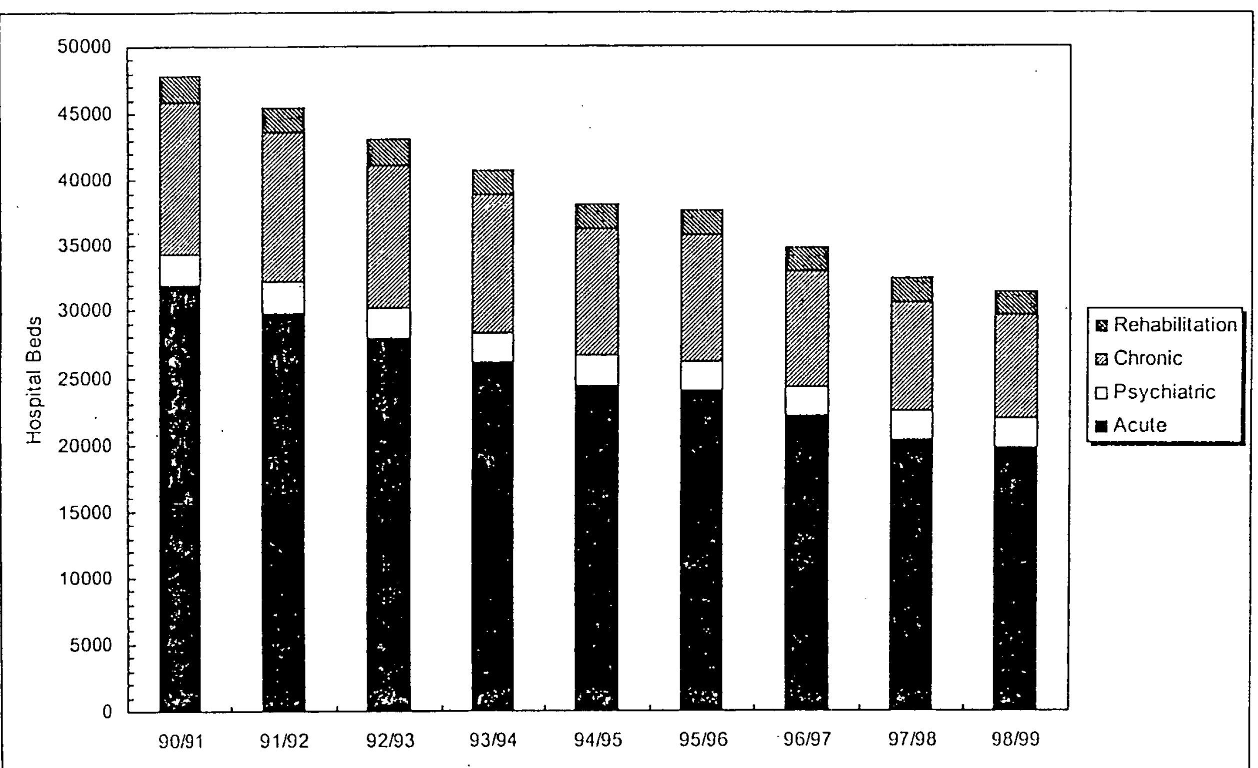
159 public hospitals
- 144 acute care
- 11 chronic care
- 4 rehabilitation

4 specialty psychiatric hospitals

FTEs employed in Hospital System
- 119,489 in 1995/96
- 114,673 in 1996/97
- 108,366 in 1997/98
- 108,295 in 1998/99
- 115,906 in 1999/00 (targeted funding for Nurses)

Data Source: Ontario Hospital Reporting System

System Description Hospital Beds



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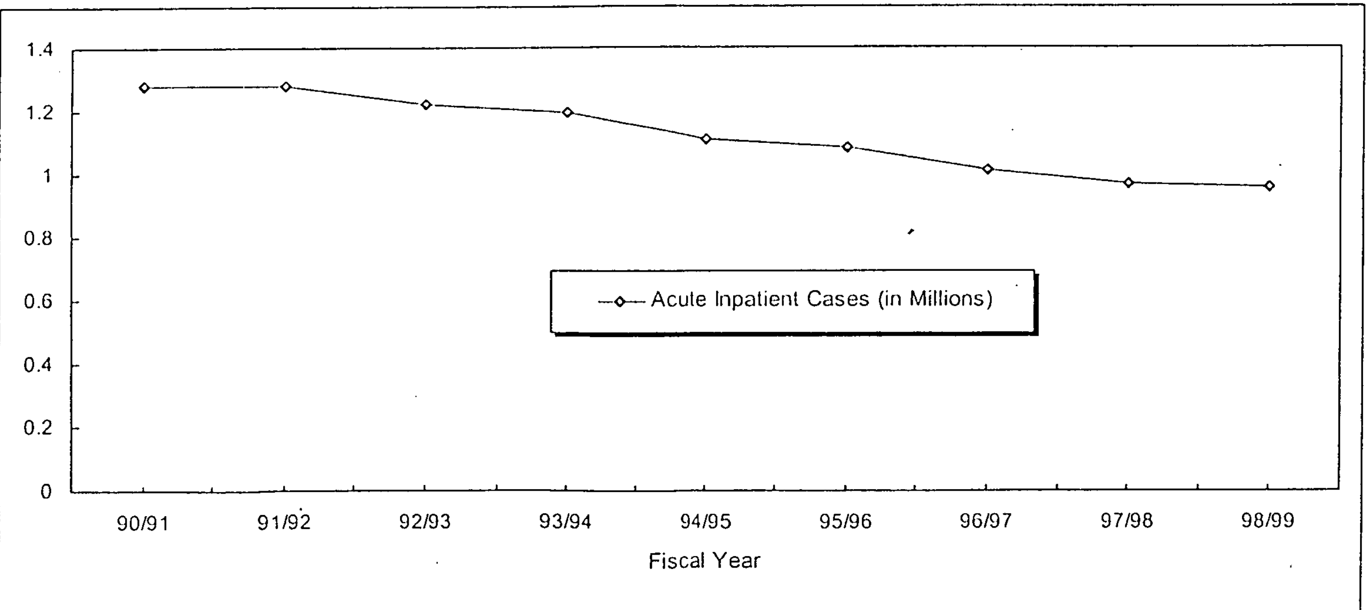
Hospital Activity Indicators
Acute Inpatient Cases



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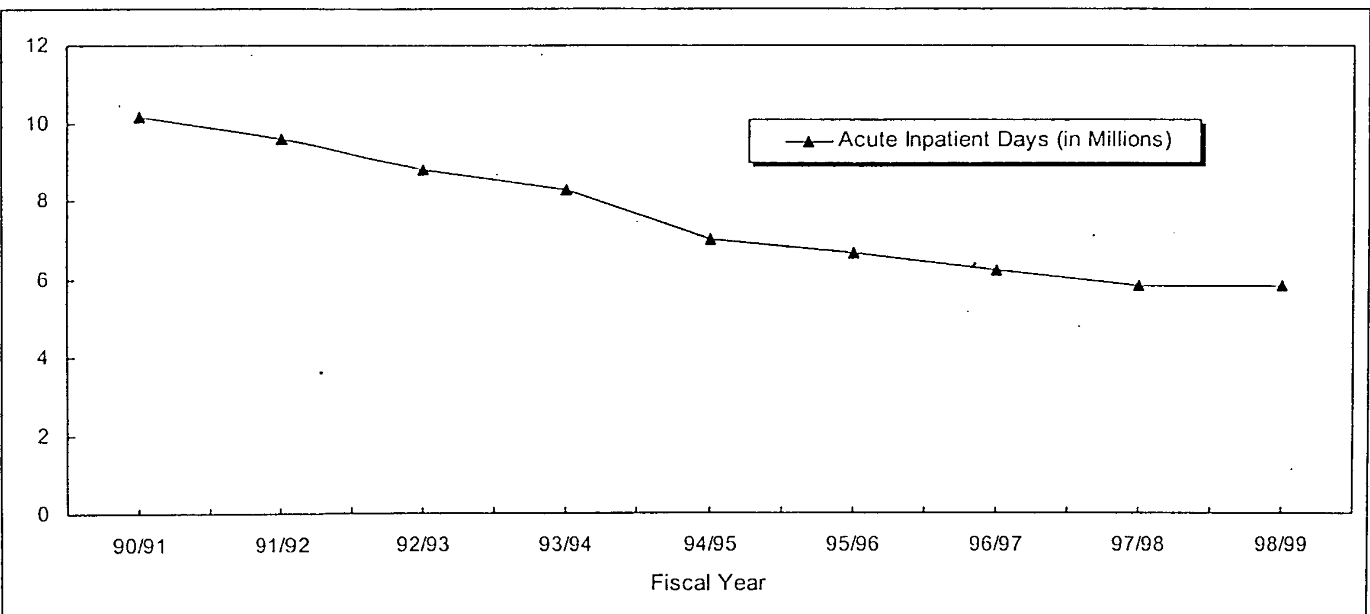
Hospital Activity Indicators
Acute Inpatient Days (in Millions)



home-care technology

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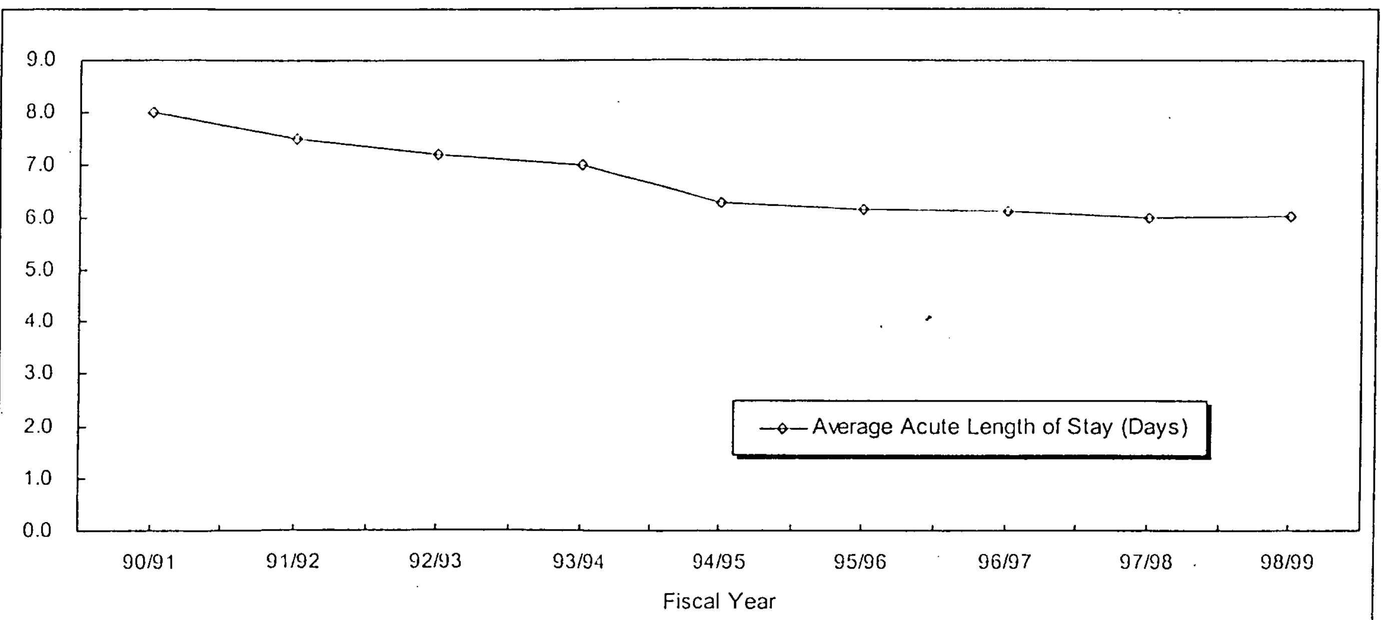
Hospital Activity Indicators
Average Acute Length of Stay (Days)



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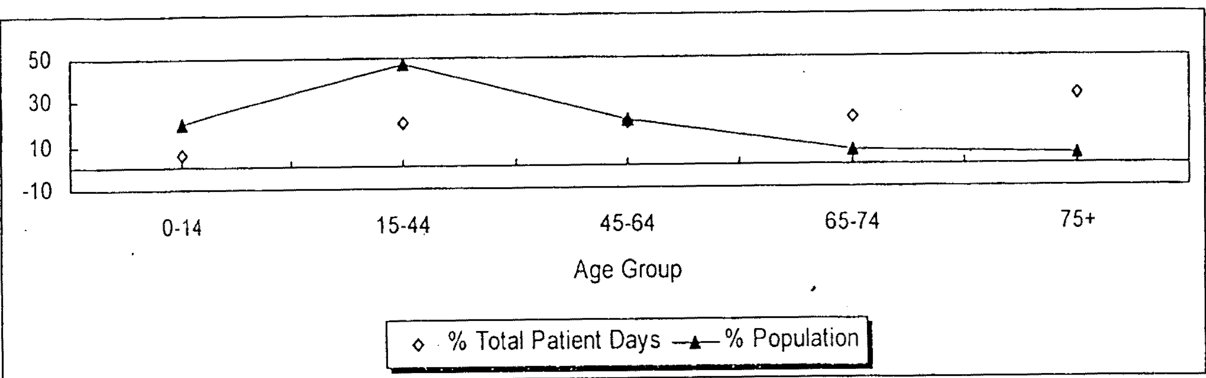
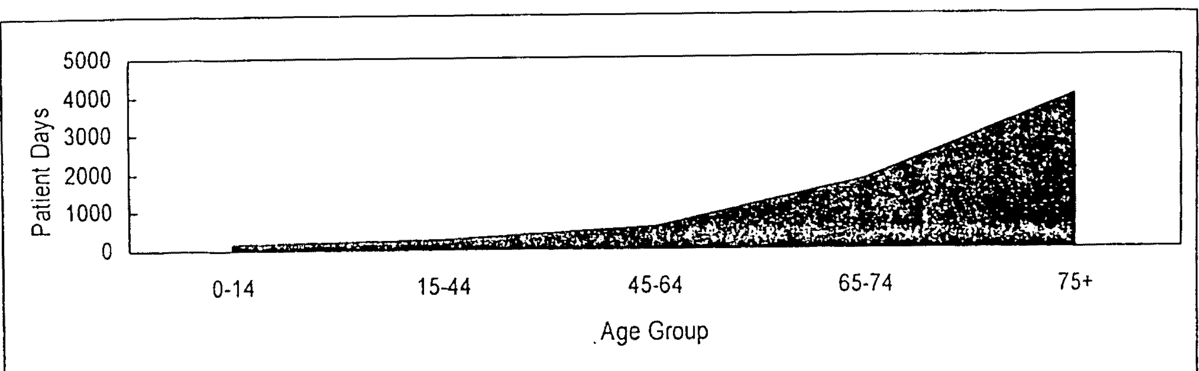
Utilization Rates by Age Group





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WHAT HAS CHANGED?

Inpatient cases ↓

hospital Day Surgery cases ↑

Day Surgery as a percentage of total surgery ↑

The number of acute care beds ↓

The average length of stay in acute care ↓

POLICY CONTEXT
Operating Plan Guidelines

Since 92/93 hospitals have been required to develop annual operating plans on their programs and services, finances and human resources in consultation within internal and external groups.

DHCs review each hospital plan for consistency with local needs.

Ministry approval is required before a hospital can implement its plan.

The Operating Plan is the principal tool used by the Ministry to monitor hospital operations; basis for the accountability mechanisms.

Prior to 1992/93 hospitals were monitored primarily through their annual budget and activity reports.

FUNDING ENVIRONMENT

Public Hospitals:

- Capital Projects:
  - 50% of the approved project costs for new approved construction
  - 70% of approved project costs for facilities undergoing restructuring
- Operating: 75% — remote location
  - Base global budget
  - One-time funding
  - Priority Programs

COMPREHENSIVE HOSPITAL FUNDING MODEL

Integrated Population-Based Allocation (IPBA)

Current Approach to Hospital Funding
Global Budget + add-ons

Largely built upon a historical base (global budgets) that has been incrementally adjusted over time

In-year adjustments to the base or as one-time modifications

Established mechanisms to identify and deal with high growth, high cost, high tech demands on the system.

Current Approach to Hospital Funding (contd.)

Priority Programs:

Special program funding is available for new/expanded programs and specialized high costs services such as

- Cancer
- Cardiac (catheters angioplasty, stents, pacemakers)
- Cleft Lip
- End Stage Renal Disease (ESRD)
- Genetics (cancer)
- MRI
- Orthopaedic (hip/Knee)
- Transplants (bone marrow)
- Transplants (organs)
- Trauma

Current Context and Perceptions about the current funding process

- Fragmentation of funding to hospitals
  - multiple formulae with many one-time funding initiatives
  - conflict between perceived financial incentives and best clinical practice
  - confusing (not only to hospitals)
- Hard to define accountability
- Difficult to develop long range plans
- An aging and growing population of more educated health care consumers
- Inequitable

Integrated Population-Based Allocation (IPBA)

"Ideal or Eventual"

Integrated=

- Applicable across health sectors (Acute, Long-Term, Chronic, Ambulatory, Mental health, etc...)
- Applicable across hospital types

Population Based=

- Does account for population factors

Allocation=

- model is not meant to determine the size of the pot of funds, but to take a predetermined pot and to allocate it equitably

PROPOSED APPROACH

Integrated Population-Based Allocation (IPBA)

$ MOHLTC Hospital Funding $

HOSPITAL ACTIVITY

- Acute Inpatient
- Same Day Surgery
- Complex Continuing Care
- Outpatient component of Emergency*
- Eldcap *
- Rehabilitation *
- Palliative *

Model being considered for 2001/2002

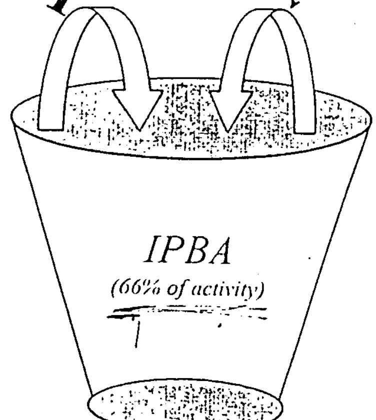
ADJUSTMENT FACTORS

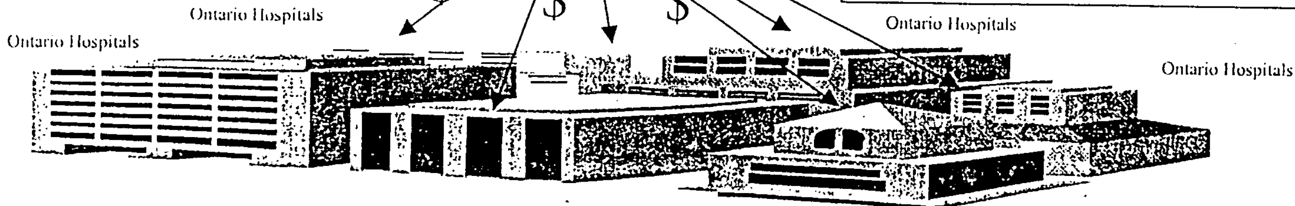
Rate Model:

- Isolation
- Size
- Teaching Activity
- Levels of Care (Chronic)
- Tertiary (Neonate and Adult)

Medical / Surgical Volumes:

- Age / Sex
- Excess mortality
- Socio-Economic Status (average income)
- Aboriginal Percentage
- Rural
- Fertility Rate
- Low Birth Weight

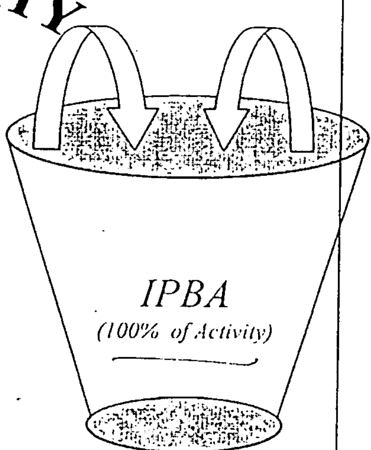




* For Small hospitals only

PROPOSED APPROACH

Integrated Population-Based Allocation (IPBA)



HOSPITAL ACTIVITY

- Acute Inpatient
- Same Day Surgery
- Complex Continuing Care
- Emergency
- Eldcap
- Outpatient Clinics *
- Rehabilitation *
- Priority Programs *
- Revenue *
- Palliative

ADJUSTMENT FACTORS

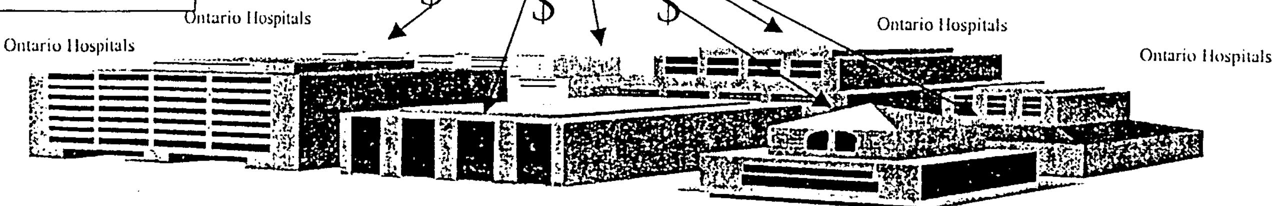
Rate Model:

- Isolation
- Size
- Teaching Activity
- Levels of Care (Chronic)
- Tertiary (Neonate and Adult)

Medical / Surgical Volumes:

- Age / Sex
- Excess mortality
- Socio-Economic Status (average income)
- Aboriginal Percentage
- Rural
- Fertility Rate
- Low Birth Weight

Future Years



* Some of these components already exist for small hospitals; Some components plan to be added in future Years

Integrated Population-Based Allocation (IPBA)

The Volumes component:

Predicts hospital volume based on the relative need of the population the hospital serves. (Expected Volume)

The Rate or Cost component:

Determines what the hospital's cost to provide care for the population served is expected to be. (Expected cost)

(The Actual Rates and Volumes are based on Provincial Averages.)

Rate Implications

High cost Hospitals (relative to peers) have a financial incentive to become more efficient and reduce actual cost per weighted case by:

- managing expenses holding volumes constant
- increasing volumes without increasing expenses

Low cost hospitals will receive an equity adjustment which will allow them to increase per case spending for patient care while holding volume constant

Alternatively, low cost hospitals could increase volumes at the same unit cost

Volume Implications

High volume Hospitals have a financial incentive to become more efficient and reduce actual volume per weighted case by:

- maximizing volumes without increasing expenses

Low volume hospitals will receive an equity adjustment which will allow them to increase volumes while holding costs constant

Shared Accountability

Hospitals are responsible for providing a set level of care at appropriate quality at a set rate

MoHLTC is responsible for determining the level of funding and setting the volume and rate expectations

MoHLTC measures and monitors volume and rate compliance

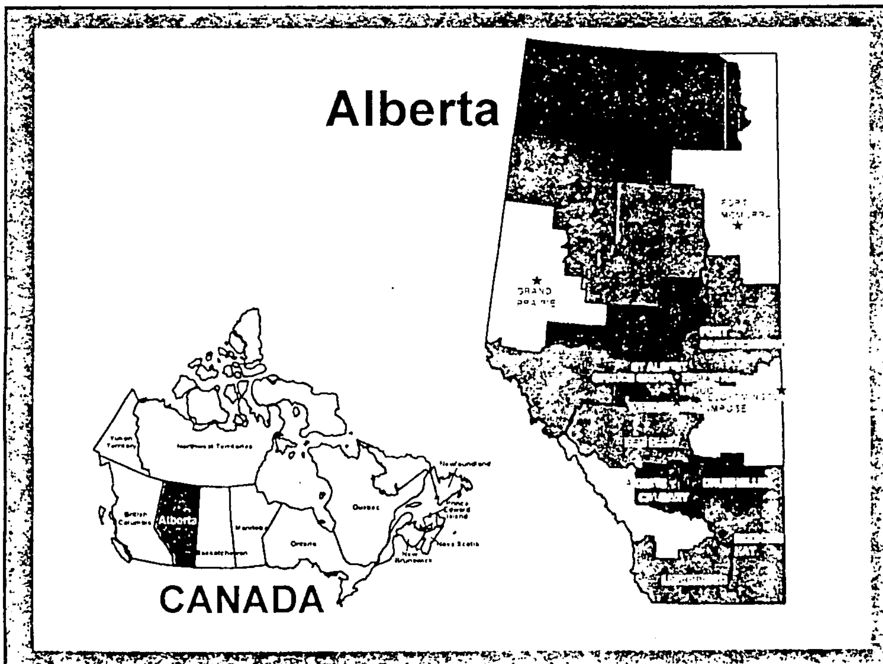
附 錄 二

An Overview of Health Services in Alberta

Organization & Funding

Taiwanese Delegates

Health Resourcing and Economics Branch
Finance and Corporate Services
Alberta Health and Wellness
June 2001

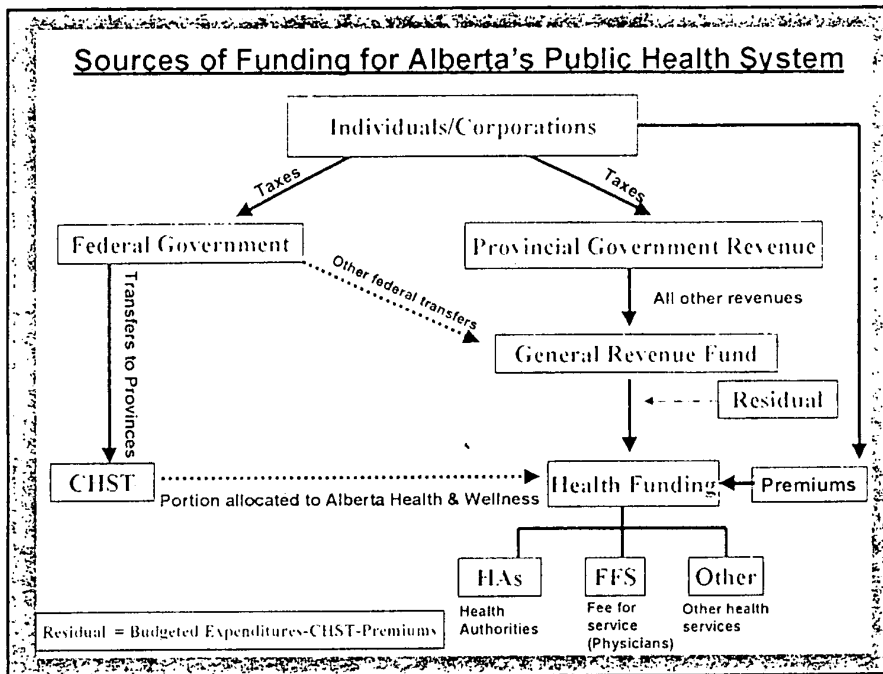


Alberta's Health System

- **17 Regional Health Authorities are responsible for:**
  - ➤ Hospital/Acute Care Services
  - ➤ Continuing Care Facilities
  - ➤ Community Health Services
  - ➤ Public Health Programs: Promotion of Health and Prevention of Illness
- **2 Provincial Health Authorities are responsible for:**
  - ➤ Cancer Services - Alberta Cancer Board
  - ➤ Mental Health - Alberta Mental Health Board
- **Health Professionals in Fee-for-Service Practice**
- **Others Who Provide Equipment, Supplies & Services**
- **Services Administered/Delivered by Alberta Ministry of Health & Wellness**
  - ➤ Alberta Health Care Insurance Plan
  - ➤ Alberta Blue Cross Non-Group Program
  - ➤ Ground & Air Ambulance Services
  - ➤ Alberta Aids to Daily Living Program
  - ➤ Communicable Diseases Control/Monitoring
  - ➤ Persons with Development Disabilities
  - ➤ Alberta Alcohol & Drug Abuse Commission

Alberta's Health System

- ✔ Almost 3 million registered under the Alberta Health Care Insurance Plan
- ✔ In 2000, total health expenditures (public & private) is estimated to be at 7.8% of provincial GDP- $3,299 per capita
- ✔ 2001/02 provincial government budgeted expenditure:
  - $6.3 billion
  - 4.7% of provincial GDP
  - approximately 1/3 of provincial program expenditure
  - $17.3 million a day
  - $2,027 per Albertan
- ✔ Significant contributor to economic and social well-being



Canada Health Act

The *Canada Health Act* covers only insured physician and hospital services.

✔Five principles:

- ✔publicly administered
- ✔comprehensive
- ✔universal
- ✔portable
- ✔accessible

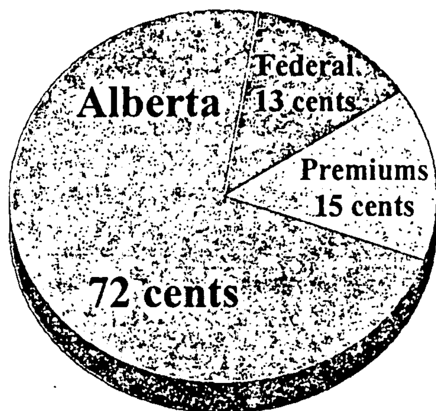
The Canada Health and Social Transfer (CHST) - 1995

- ✔ Consolidated Federal Government contribution to health, social services and post-secondary education
- ✔ Block Transfer – gives provinces flexibility
- ✔ Satisfy conditions of the Canada Health Act
- ✔ Consists of tax points and cash transfers
- ✔ By 2001-02, all provinces will be on an equal per capita basis

Alberta Health Care Insurance Plan (AHCIP) Premium Revenue

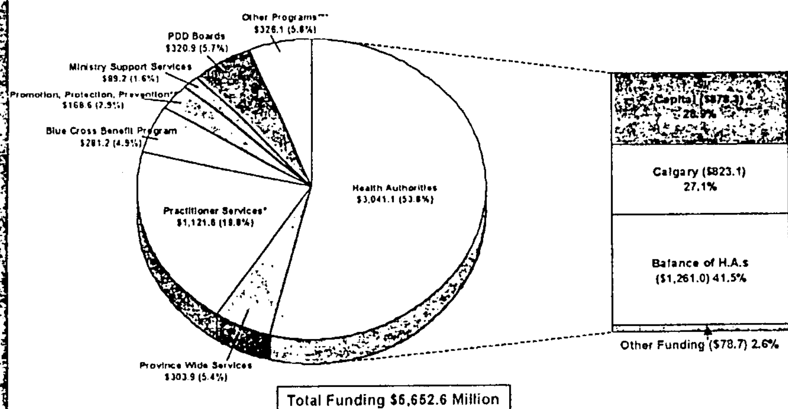
- ✔ Health care insurance premiums cover about 13% of cost of health services provided in Alberta
- ✔ The current AHCIP premium rates are $34 per month for single coverage and $68 per month for family coverage (two or more persons). These rates have not increased since July 1, 1995
- ✔ An estimated $20 million will also be received from Alberta Blue Cross premiums in 1999-2000
- ✔ Subsidies are available for those unable to pay full premiums

Share of Contributions
Towards Alberta Public Health Care Funding
1999/2000



Prepared by Finance & Health Plan Administration Alberta Health & Wellness

Alberta Health & Wellness
2000/01 Budget Allocation



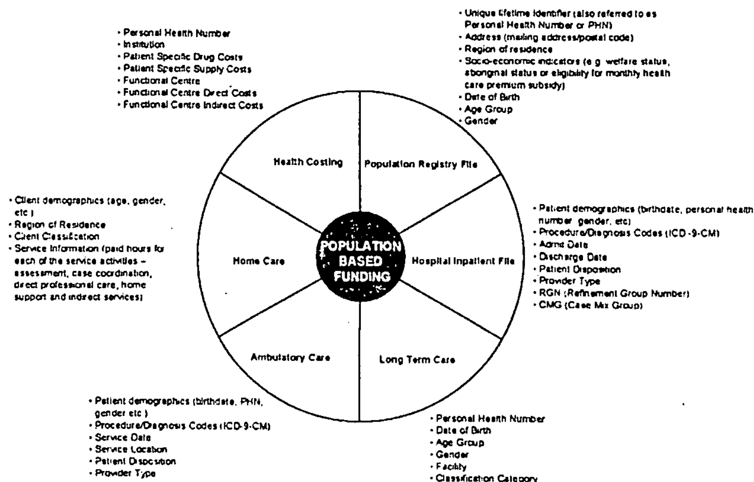
Total Funding $6,652.6 Million

* Includes Medical Services, Alternate Compensation Strategies, Rural Initiatives, Medical Education Allowance, Allied Health Services, and Extended Health Benefits
** Includes Purchase of Vaccines and Sera, Provincial Labs of Public Health, Alberta Aids to Daily Living, Aboriginal Health Strategies, Alberta Wellness, AADAC, ACB - Detection of Breast Cancer Screening, Community Support
*** Includes Systems Development, Human Tissue and Blood Services, Equity Agreements, Ambulance Services, Out of Province Health Care Costs, Health Services, Federal Nursing Stations, Community Support, Dedicated Program Funding, Innovation Fund, Health Care Insurance Premium Revenue Write-offs, and Valuation Adjustments

Hospital Funding in Alberta
A Chronology

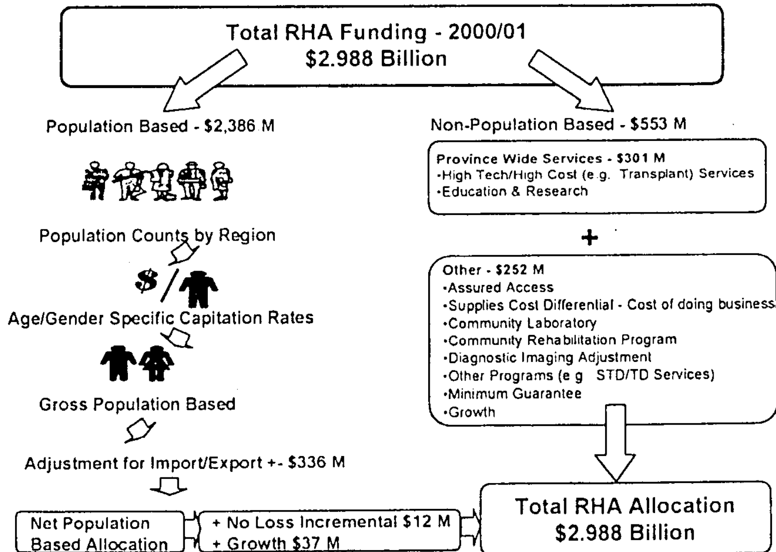
1980s	• Global Plus Line by Line Funding $\$_t = \$_{t-1}$ (± Adjustments)
1990/91 to 1994/95*	• Acute Care Funding Plan (Hospital Performance Index) • Adjustment for Bed Size • Scope - Teachingness
1993/94	• A Major Overall Funding Reduction Happened in 1993/94 of $132M and further reduction of $95M in 1994/95. • Hospital Funding - Shifting of $ from Hospital to Community Care
1995/96 1996/97	• Transition to the Population Funding Acute Care Funding Continued as Part of Population Funding
Between 1997/98 and Now	• Population Funding for All Health Services • No Separate Hospital Funding

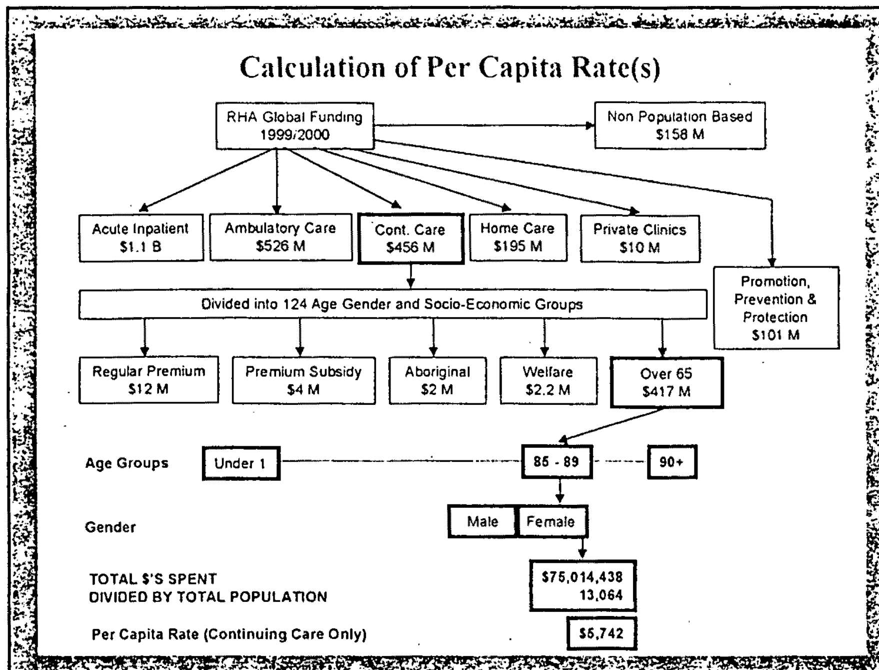
Population Based Funding & Health Information in Alberta



Population-Based Funding

- In the past, funding was directed to specific facilities, agencies or programs, largely based on previous year funding allocations
- ✓In 1997-98, Alberta adopted new method of funding RHAs to ensure each region receives fair share of available health dollars
- ✓Regions now operate on more level playing field than in past
- ✓Funds allocated according to region's population and estimated relative health care expenditure requirements:
  - total population base
  - age and gender of population base
  - socio-economic composition of population
  - services provided by region to residents of other regions





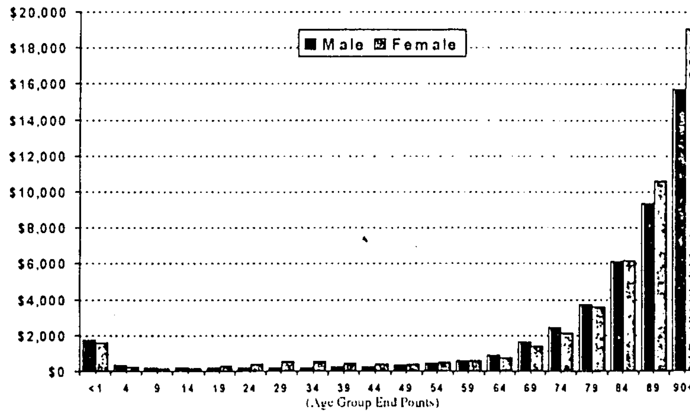
Risk-Adjusted Capitation Payments

- Age and sex are considered when allocating the population based funding to the regional health authorities

- Currently in the process of studying the implementation of risk adjusters that also contain diagnoses and previous utilization.

Consumption of Regional Health Resources

Per Capita Rates By Gender and Age Groups
1999/2000 (1998/99 activity)
Full premium paying population plus all over 65



Per capita rates as calculated for RHA Global Funding (excludes Province-Wide Services, Cancer Board and Mental Health)
Prepared by: Health Resourcing, Finance & Health Plan Administration, Alberta Health & Wellness

Rural Adjustment One

Assured Access (Remote Population)

1. <u>Assured Access</u>

- About 99,000 Albertans live in remote areas where it would be difficult to access health services. These people live 50 km. or more from a population centre of 5,000 people. 52% of these people live in the five Northern Regions of the province.
- Regions with people living in remote areas receive a 25% adjustment on their per capita funding for persons living 50-80 km from a population centre and an additional 25% for persons living more than 80 km.

<u>Revisions for 2000-01 Funding</u>:

- Non enumerated reserves were added in Lakeland, Peace, and Keeweetinok Lakes.

Rural Adjustment Two

Cost of Doing Business
(Very Remote Geographical Location)

2. Cost of Doing Business

Because of the high cost of travel, supplies and utilities, Regional Health Authorities located more than 300 km. from the nearest major city receive funding adjustment.

- This applies to five Regional Health Authorities in the northern half of the province.
- The five northern Regional Health Authorities receive a 25% increase on their supplies budget (20% of total budget) to address the additional costs of supplies.

Revisions for 2000/01 Funding

- An allowance for the Jasper area of WestView was included.

Other Adjustment (Third)
Teaching & Research Indirect Costs

✔ The Teaching and Research funding adjustment is intended to compensate Edmonton & Calgary for their additional costs per in-patient and out-patient case (non-PWS) resulting from teaching function indirect costs.

✔ The indirect costs of medical education are assumed to be 7% of CHA/CRHA's acute care budget portion that has teaching units attached to it.

✔ The $30M is approximately split into:
- Edmonton $18M: 7% of 260M
- Calgary $13M: 7% of 187M

Province-Wide Services Funding

- ✔ Provides small range of high-cost, high-tech, life-sustaining services funded separately from basic health services, such as angioplasties, coronary bypasses, bone-marrow transplants, craniotomies, cardiac valve procedures and kidney dialysis treatments
- ✔ Planning, delivery and standard-setting is collaborative effort between ministry and health authorities
- ✔ Ensures availability of centrally funded services to all Albertans regardless of where they live

Province Wide Services List

Inpatient Services

- Organ and Bone Marrow Transplants
- Selected Tertiary Services for:
  - Trauma and Burns
  - Neurosurgery
  - Cardiovascular Procedures
  - Neonatology
  - Oncology

Clinics and Home Services

- Dialysis and Renal Program
- Pre and Post Transplant Activities
- Medical and Cancer Genetics
- HIV Clinics
- Poison and Drug Information Services
- Home Enteral Nutritional Therapy
- Perinatal Outreach
- Craniofacial Osseointegration (COMPRU)
- Children with Complex Health Care Needs
- Pediatric Transport
- Advanced Diagnosis of Sleep Disorders
- Pediatric and Neonatal Extra-Corporeal Life Support

High-Cost Drugs

- Transplant: Cyclosporine, Tacrolimus, Mycophenolate, Azathioprine, OKT-3, and ATGAM (Immunosuppressants); Ondansetron and Neupogen
- HIV Drugs: Zidovudine (AZT), Lamivudine (3TC), Stavudine (d4T), Zalcitabine (ddC), Didanosine (ddI), Indinavir, Saquinavir, Ritonavir, Nelfinavir, Abacavir, Efavirenz, Nevirapine, Delavirdine, Fortovase, and Protease Inhibitors (HIV)
- Human Growth Hormone (Chronic Renal Failure and Growth Hormone Deficiency)
- Pulmozyme (Cystic Fibrosis)
- Flolan (Primary Pulmonary Hypertension)

High-Cost Devices

- Implanted Cardiac Defibrillators
- Cranioplasty
- Cochlear Implants
- CPAP devices

Teaching and Research

- Compensation for indirect costs associated with teaching hospitals

Equipment

- Equipment required for Province Wide Services

Forces of Change and Challenges

Demographics

- ✔ Alberta's population is increasing and aging
- ✔ Health system usage increases and intensifies as people age
- ✔ As population ages, skill shortages will occur in key health professions

Forces of Change and Challenges

Technology: changing what, when, where, how and for whom

- ✔ procedures (e.g. laproscopic surgery)
- ✔ drugs (e.g. HIV, migraine)
- ✔ diagnostic and treatment equipment (e.g. MRI, lazers)
- ✔ communication (e.g. telehealth)

Forces of Change and Challenges

Rising Expectations

- ✔ New high-profile technology improves the capacity to meet needs and raises public expectations for access to supports and services
- ✔ Realigning priorities and reallocating resources is a constant challenge

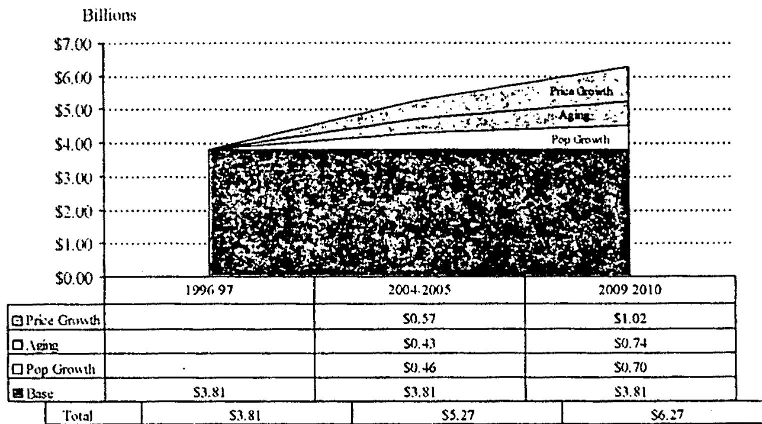
Forces of Change and Challenges

Sustainability

- ✔ Expenditures on drugs, technology, salaries and utilization are increasing in excess of growth in the economy
- ✔ Health is a large and growing portion of provincial budgets
- ✔ Continuing reform is necessary to keep costs within capacity of public funding while ensuring accessibility, quality and accountability

Health Fiscal Resource Projections

Due to Population and Inflation
For Alberta 2004/2005 and 2009/2010



	1996/97	2004-2005	2009 2010
Price Growth		$0.57	$1.02
Aging		$0.43	$0.74
Pop Growth		$0.46	$0.70
Base	$3.81	$3.81	$3.81
Total	$3.81	$5.27	$6.27

CPI is assumed at 2% per year during the projection period.
No provision for increase in level of utilization of resources. No provision for technological advancements & productivity gains
Based on 1996/97 consumption pattern for regionalized health services & assumed to stay constant during the projection period.

Finance & Health Plan Administration, Alberta Health & Wellness (HXROJPIM)

Albertans' Ratings of Service: Quality

Measure	1995	1996	1997	1998	1999	Provincial Target
Quality of health services in the community (% responding good or excellent)	78%	79%	78%	78%	75%	80%
Quality of care personally received (% responding good or excellent)	87%	86%	86%	86%	78%	90%
Effect of care personally received (% responding good or excellent)	N/A	N/A	83%	84%	83%	85%

Source: Alberta Health Survey, 1995, 1996, 1997, 1998, 1999

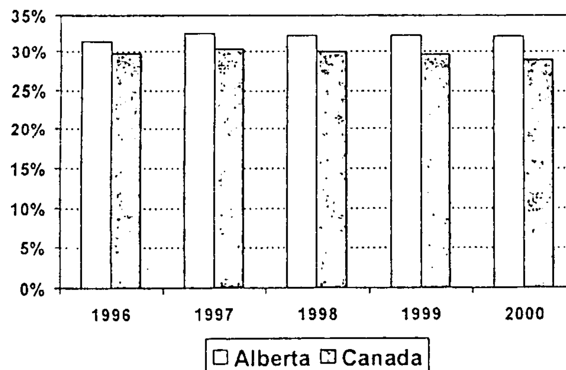
Albertans' Ratings of Service: Access

Measure	1995	1996	1997	1998	1999	Provincial Target
Availability of health services in the community (% responding good or excellent)	74%	75%	71%	71%	74%	80%
Ease of access to health services (% responding good or excellent)	80%	76%	74%	73%	73%	80%
Failure to receive needed care (% responding good or excellent)	6%	7%	7%	8%	9%	3%

Source: Alberta Health Survey 1995, 1996, 1997, 1998, 1999

Private Sector Health Expenditures as a Proportion of Total Health Expenditures:

Alberta & Canada



Source: Canadian Institute of Health Information - National Health Expenditure Trends, 1975-2000

Alberta

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THIS AGREEMENT DATED FOR REFERENCE
THE 20th DAY OF APRIL, 1998

BETWEEN:

HER MAJESTY THE QUEEN
IN RIGHT OF ALBERTA
as represented by the
Minister of Health

- and -

THE ALBERTA MEDICAL ASSOCIATION
(C.M.A. Alberta Division)

THIS AGREEMENT DATED FOR REFERENCE THE 20th DAY OF APRIL, 1998

BETWEEN:

HER MAJESTY THE QUEEN
IN RIGHT OF ALBERTA
as represented by the
Minister of Health

- and -

THE ALBERTA MEDICAL ASSOCIATION
(C.M.A. Alberta Division)

WHEREAS:

A The parties wish to ensure that residents of Alberta will continue to have reasonable access to quality health care services, that fair and equitable compensation will be provided to Physicians for the provision of Insured Services, and that the cost to government for the provision of quality care and Physician services will be affordable and sustainable;

B The provision of quality health care services to Albertans requires the co-operation and combined efforts of patients, RHAs, Physicians, other health care providers, the Association and government; and

C The parties hereto will fulfill their respective obligations under this Agreement in good faith.

NOW THEREFORE THIS AGREEMENT WITNESSETH that, in consideration of the mutual premises, and of the terms, conditions and agreements hereinafter contained, it is agreed by and between the parties hereto as follows:

ARTICLE 1. DEFINITIONS

1.1 In this Agreement, unless there is something in the subject matter or context inconsistent therewith:

(a) **"Act"** means the *Alberta Health Care Insurance Act*, being Chapter A-24 of the Revised Statutes of Alberta, 1980;

(b) **"Actual Expenditure"** means the actual amount paid during a Fiscal Year, to Physicians from the aggregate of the Alternate Payment Stream, the Benefit Stream, and the Fee For Service Stream;

(c) **"Agreement" or "this Agreement"** means this Agreement dated for reference the 20th day of April, 1998 and all appendices attached hereto as either might be amended from time to time in accordance with the provisions hereof;

(d) **"Alternate Payment Plan"** means a plan to compensate Physicians, directly or indirectly, for providing Insured Services to Residents covered by the Plan, other than through fee for service billing, and includes, for the purposes of this Agreement, funding agreements or services agreements as appropriate;

(e) **"Alternate Payment Stream"** means monies from the Medical Services Budget utilized, subsequent to the Effective Date, for the provision of Insured Services to Residents covered by the Plan through Alternate Payment Plans;

(f) **"Association"** means The Alberta Medical Association (C.M.A. Alberta Division), a society formed under the *Societies Act* of Alberta;

(g) **"Benefit Agreements"** means those agreements pertaining to existing Benefit Plans specified in Appendix "A" attached hereto;

(h) **"Benefit Plans"** means those benefit plans the objectives of which are more particularly described in Appendix "B" attached hereto;

(i) **"Benefit Stream"** means monies from the Medical Services Budget to the maximum amount agreed to between the Association and the Department to be utilized in a Fiscal Year for Benefit Plans;

(j) **"College"** means the College of Physicians and Surgeons of the Province of Alberta;

(k) **"Cost Neutral"** means in respect of the relative value recommendations of the RVG Commission, the determination of a unit value which, when applied to the units allocated to each of the Insured Services referred to in the Schedule, will not result in an increase in the aggregate amount being paid from the Fee For Service Stream in a Fiscal Year;

(l) **"De-Insure"** or **"De-Insurance"** means, in respect of an Insured Service, the decision of the Minister that such Insured Service is no longer an Insured Service and no longer payable under the Plan;

(m) **"De-List"** or **"De-Listing"** means the removal of an Insured Service from the Schedule, with a corresponding reduction to the Medical Services Budget in respect of the removal of such Insured Service, without the De-Insurance of such Insured Service;

(n) **"Department"** means the department designated under the *Government Organization Act* to deal with health care for Albertans, and initially means the Department of Health;

(o) **"Effective Date"** means 12:01 a.m. April 1, 1998;

(p) **"Expenditure Variance"** means the difference in a Fiscal Year between the Hard Cap and the Actual Expenditure;

(q) **"Fee For Service Stream"** means monies from the Medical Services Budget to be utilized for fee for service payments to Physicians pursuant to the Schedule for the provision of Insured Services to Residents covered by the Plan;

(r) **"Finance Committee"** means the Finance Committee continued by clause 11.1;

(s) **"Fiscal Year"** means a period of time occurring during the term of this Agreement commencing April 1 on any calendar year and ending March 31 in the next ensuing calendar year;

(t) **"Hard Cap"** means:

(i). in the first Fiscal Year of the term of this Agreement, the aggregate amount of the Fee For Service Stream, the Alternate Payment Stream, and the Benefit Stream;

(ii) and in each subsequent Fiscal Year, the aggregate amount of the Fee For Service Stream, the Alternate Payment Stream, and the Benefit Stream for that Fiscal Year, plus or minus:

i) the prior Fiscal Year's Expenditure Variance;

ii) any prior Fiscal Year's Expenditure Variance which has not otherwise been included in the operation of the Default Price Adjustment Mechanism (as hereinafter defined) because of the provisions of clause 4.10(e); and

iii) any amount arising from clause 4.6, 4.13, or 4.14;

(u) **"Initial Expiry Date"** means 12:00 p.m. March 31, 2003;

(v) **"Initial Term"** means the period commencing on the Effective Date and ending on the Initial Expiry Date;

(w) **"Innovation Fund"** means that portion of the Medical Services Budget referred to in Article 4 plus drug savings pursuant to clause 6.6 both to be utilized, directly or indirectly, in each Fiscal Year of the term of

this Agreement for, or to enhance, the provision of Insured Services, and includes, without limitation, costs and expenses associated with:

(i) Physician recruitment and retention initiatives;

(ii) initiatives designed to enhance primary care; and

(iii) the activities of the RVG Commission;

(x) **"Insured Services"** means an insured service, as defined in the Act, provided by a Physician to a Resident;

(y) **"Medical Services Budget"** means the aggregate annual amount established pursuant to Article 4 to fund the Fee For Service Stream, the Alternate Payment Stream, the Benefit Stream, and the Innovation Fund in any given Fiscal Year;

(z) **"Minister"** means the member of Executive Council charged with the administration of the Act from time to time, and initially means the Minister of Health, and any person authorized to act in his behalf;

(aa) **"Physician"** means, with reference to medical services provided in Alberta to a Resident, a person who is registered as a medical practitioner or an osteopathic practitioner under the *Medical Profession Act*, being Chapter M-12 of the Revised Statutes of Alberta, 1980;

(bb) **"Plan"** means the Alberta Health Care Insurance Plan as referred to in the Act;

(cc) **"Prior Agreements"** means the agreements between Alberta and the Association identified in Appendix "C" attached hereto;

(dd) **"Regulation"** means the Medical Benefits Regulation (Alta. Reg. 173/93) made pursuant to the Act;

(ee) **"Resident"** means a resident as defined in the Act;

(ff) **"RVG Commission"** means the commission established pursuant to clause 10.1; and

(gg) **"Schedule"** means the Schedule of Medical Benefits used in the operation of the Plan and prepared and published by the Department and approved by the Minister in accordance with the Act.

ARTICLE 2.
INTERPRETATION

2.1 In this Agreement, except where expressly otherwise provided or where the fact or context does not permit:

(a) wherever the singular, plural, masculine, feminine, neuter, body politic or body corporate is used the same shall be construed as meaning the plural, singular, feminine, masculine, neuter, body politic or body corporate as the case might be;

(b) a reference to an individual by his or her name of office means the individual appointed as the person holding that office from time to time or the successor of that office;

(c) a reference to a statute or regulation or a provision thereof means the statute or regulation or provision as amended or superseded from time to time, except where otherwise expressly stated;

(d) a reference to a person includes a body corporate and the Province;

(e) a reference to dollars or amounts of money means lawful money of Canada;

(f) "herein" or "hereof" or "hereunder" and similar expressions when used in a section shall be construed as referring to the whole of this Agreement and not to that section only, unless otherwise provided; and

(g) provisions expressed disjunctively shall be construed as including any combination of two or more of them as well as each of them separately.

2.2 Except as otherwise provided herein or by law, the Minister may from time to time perform, exercise, enforce or waive on behalf of the Department any of the rights, powers and privileges conferred on or enjoyed by the Department at law, in equity, by statute or pursuant to this Agreement and the instruments made and agreements entered into pursuant to this Agreement.

2.3 This Agreement shall be interpreted and governed by the laws in force in Canada and the Province of Alberta from time to time applicable hereto.

2.4 The headings of the articles, sections or clauses of this Agreement are for reference purposes only and do not bear on the interpretation of the articles, sections or clauses to which they relate.

2.5 The contra proferentum rule shall not apply to the interpretation of this Agreement.

2.6 The preamble and the following appendices are incorporated into and form part of this Agreement:

APPENDIX	DESCRIPTION
"A"	Benefit Agreements
"B"	Benefit Plans
"C"	Prior Agreements

ARTICLE 3.
TERM OF AGREEMENT

3.1 This Agreement shall take effect as of the Effective Date and shall, subject to clause 3.3, remain in full force and effect until the Initial Expiry Date.

3.2 Either party may reopen negotiations on any part of this Agreement only pursuant to the provisions of Article 16.

3.3 Where notice is served by either party pursuant to Article 16, provisions of this Agreement shall continue until a new agreement is signed.

ARTICLE 4.
BUDGET MANAGEMENT

4.1 On or before the Effective Date:

(a) the Department will apply the entire balance of the Fee Stabilization Fund (as defined in the Prior Agreements); and

(b) the Association will apply all monies then remaining in the Reserve Pool (as defined in the Prior Agreements);

to reduce the overexpenditure in the Fee For Service Pool (referred to in the Prior Agreements) for the 1996/97 and 1997/98 Fiscal Years.

4.2 The Association confirms that, since August 31, 1997, it has not applied any monies from the Reserve Pool, without the consent of the Department.

4.3 The parties agree that the Medical Services Budget will be:

(a) For the 1998/99 Fiscal Year, the aggregate amount of $848,300,000 of which:

(i) $5,000,000 will, at the outset of the Fiscal Year, comprise the Innovation Fund; and

(ii) $843,300,000 will, at the outset of the Fiscal Year, comprise the Hard Cap;

(b) For the 1999/00 Fiscal Year the aggregate amount of $879,500,000 of which:

(i) $5,000,000 will, at the outset of the Fiscal Year, comprise the Innovation Fund; and

(ii) $874,500,000 will, at the outset of the Fiscal Year, comprise the Hard Cap;

(c) For the 2000/01 Fiscal Year the aggregate amount of $919,000,000 of which:

(i) $5,000,000 will, at the outset of the Fiscal Year, comprise the Innovation Fund; and

(ii) $914,000,000 will, at the outset of the Fiscal Year, comprise the Hard Cap.

4.4 The Hard Cap shall be automatically reduced in the event of the De-Insurance of an Insured Service:

(a) in the Fiscal Year in which the De-Insurance occurs by an amount equal to the amount paid by the Plan, in respect of the Insured Service to be De-Insured, and attributable to the immediately preceding Fiscal Year divided by 365 and multiplied by the number of days remaining in the Fiscal Year in which the De-Insurance occurs; and

(b) in each subsequent Fiscal Year throughout the Initial Term of this Agreement by an amount equal to the amount paid by the Plan in respect of that Insured Service and attributable to the Fiscal Year immediately preceding the Fiscal Year in which the De-Insurance occurred.

4.5 In the event that, during the Initial Term of this Agreement, an Insured Service is De-Insured and then re-insured the Hard Cap shall be automatically increased:

(a) in the Fiscal Year in which the reinsurance occurs by an amount equal to the amount paid by the Plan in respect of that Insured Service and attributable to the Fiscal Year immediately preceding the year of De-Insurance divided by 365 and multiplied by the number of days following the re-insurance remaining in the Fiscal Year of the re-insurance; and

(b) in each subsequent Fiscal Year throughout the Initial Term of this Agreement by an amount equal to the amount paid by the Plan in respect of that Insured Service and attributable to the Fiscal Year immediately preceding the Fiscal Year in which the De-Insurance occurred.

4.6 The Hard Cap, excluding the amount of the Liability Insurance Premium Assistance Program forming a portion of the Benefit Stream (in this clause called the "Adjustable Hard Cap"), shall be adjusted during each Fiscal Year of the term of this Agreement to account for increases or decreases in population in Alberta. The population adjustments shall be based upon Alberta Treasury (Statistics Branch) calculations, consistently applied. The Association acknowledges that the amount of the Hard Cap in clause 4.3 includes estimated increases in population as follows:

(a) the 1998/99 Fiscal Year - 1.7%;

(b) the 1999/00 Fiscal Year - 1.6%; and

(c) the 2000/01 Fiscal Year - 1.6%;

The adjustment of the Adjustable Hard Cap to reflect actual population increases or decreases shall occur on October 1 of each year, commencing October 1, 1999. The Adjustable Hard Cap will be increased or decreased as the case might be by the difference, if any, between the projected and actual population figures. Any adjustment shall be applied in the year calculated and in each subsequent Fiscal Year.

4.7 Notwithstanding the provisions of clauses 4.3(b) and 4.3(c) above, the Department's obligation to increase the Medical Services Budget in the 1999/00 and 2000/01 Fiscal Years is conditional upon the Department receiving each of the following in a timely manner, namely:

(a) the report of the co-chairs on the delivery of diagnostic imaging services referred to in clause 9.4; and

(b) the report of the co-chairs referred to in clause 14.4(c);

The Association's obligations under this clause shall be considered fulfilled if the reports referred to above are received within the later of:

(c) the initial or extended time referred to in clause 9.4 or 14.4(c); and

(d) receipt of an arbitrator's report pursuant to Article 17.

4.8 The Association acknowledges and agrees that the amount of the Medical Services Budget shall include, without limitation, amounts paid by the Department in respect of:

(a) Physician charges respecting Insured Services provided by Physicians to Residents in conjunction with other health providers or otherwise permitted pursuant to the Schedule or an Alternate Payment Plan;

(b) Insured Services provided to non eligible persons in good faith; and

(c) Insured Services provided to Residents by physicians licensed to practise in the Province of Saskatchewan and practising in Lloydminster.

4.9 The parties shall, through the Finance Committee, develop a model to forecast the expenditures in the Hard Cap during each Fiscal Year. If the parties fail to agree on such a model by June 30, 1998, then the Department shall appoint an independent third party to develop a model and the model so developed shall be utilized for the purpose of forecasting the Actual Expenditure unless and until the parties agree that an alternate forecasting model should be utilized.

4.10 In order to maintain and manage an effective Hard Cap and notwithstanding anything else in this Agreement to the contrary but subject always to the provisions of clause 4.11 the Schedule shall, if required, be adjusted automatically (such automatic adjustment mechanism to be referred to as the "Default Price Adjustment Mechanism") as follows:

(a) Adjustments to the Schedule shall be implemented through:

(i) across the board fee increases or decreases as the case might be; or

(ii) in accordance with recommendations made by the Finance Committee, having had due regard for utilization, or such other factors as considered appropriate; provided that such recommendations are received from the Finance Committee on or before the first day of February or August immediately preceding the calculation date to which the recommendations are intended to relate.

(b) Adjustments shall, if required, occur on October 1, 1998 and on the first day of each of April and October next following throughout the term of this Agreement.

(c) Each adjustment shall be determined utilizing the forecasting model and be based on the most current data available to the Department

immediately preceding the date of each adjustment, given the time required to make any required changes to the Schedule to implement the adjustment.

(d) Adjustments shall be implemented so as to eliminate the Expenditure Variance by the end of the Fiscal Year in which the adjustment is made.

(e) Adjustments shall only be made if the forecasted Expenditure Variance at the April or October calculation date exceeds or is less than the Hard Cap for the relevant Fiscal Year by 0.5%.

4.11 The operation of the Default Price Adjustment Mechanism shall not, in any Fiscal Year:

(a) reduce the fees in the Schedule below the lesser of:

(i) the amount of such fees on March 31, 1998; and

(ii) the amount of such fees at March 31, 1998 after application of any adjustments arising out of the recommendations of the RVG Commission, when implemented; or

(b) increase the fees in the Schedule by an aggregate amount of more than 6% in the 1998/99 Fiscal Year, 5% in the 1999/00 Fiscal Year, or 6% in the 2000/01 Fiscal Year, inclusive of any other adjustment referred to in this Agreement increasing such fees.

4.12 The Association specifically acknowledges and agrees that the Department's ability to adjust the Schedule through the Default Price Adjustment Mechanism shall survive the termination of this Agreement to the extent required to ensure that the Hard Cap in the 2000/01 Fiscal Year continues.

4.13 The Finance Commmittee shall, no later than December 31 in each year of the term of this Agreement, provide the Department with a calculation of the budgetary impact, if any, of changes in the rates for medical liability insurance charged by the Canadian Medical Protective Association and paid to Physicians under the Liability Insurance Premium Assistance Program (in this clause the "CMPA Rate").

The budgetary impact for the 1999/00 and 2000/01 Fiscal Years shall comprise the difference between the amount set out in clause 7.2(b) or (c) relating to the CMPA Rate for that Fiscal Year and the projected payment respecting the CMPA Rate for that Fiscal Year calculated by multiplying the CMPA premium rate per risk category by the number of Physicians in that risk category and summed over all categories. The Hard Cap for the Fiscal Year to which the calculation relates shall be increased by the increase, if any, so determined.

4.14 Changes in Physician supply affects the Medical Services Budget. The effect is a very complex issue and has numerous associated factors. Funding has already been added to the Medical Services Budget covering projected increases in population, some of which will be to cover the cost of additional medical services delivered by an increase in Physician supply.

As a result of the implementation of the Physician resource plan to be developed pursuant to Article 14, the Finance Committee may, with due regard to the complexities involved, recommend that the Minister make an adjustment to the Medical Services Budget. The adjustment, if any, shall be designed to account for the net change in Physician services as defined in the said plan.

ARTICLE 5.
FLOW OF FUNDS FROM THE MEDICAL SERVICES BUDGET

5.1 The Department shall, in accordance with the provisions of this Agreement, negotiate only with the Association, as the sole and exclusive representative of Physicians in the Province of Alberta, in respect of the amount of, and flow of money from, the Medical Services Budget.

5.2 Where the Department and the Association have agreed to funding flows respecting Alternate Payment Plans, Physicians shall have a choice in the method of compensation for the provision of Insured Services.

5.3 Physicians who desire to be compensated for the provision of Insured Services from:

(a) the Fee For Service Stream shall be compensated in accordance with the provisions of the Schedule; and

(b) the Alternate Payment Stream shall be compensated in accordance with the provisions of an Alternate Payment Plan.

5.4 The Department and the Association shall be entitled to approve the terms and conditions under which funds shall flow from the Medical Services Budget to an Alternate Payment Plan to ensure that such funding is fair and equitable in the circumstances. The parties shall consider the following criteria in determining the amount of funding to flow to an Alternate Payment Plan, namely:

(a) the Physician's professional autonomy and clinical independence should be protected;

(b) the funding formula shall consider the population covered, rates of payment, adjustment processes, including negation;

(c) services provided must be evaluated and relate to stated goals and objectives;

(d) such other funding considerations as the parties mutually agree; and

(e) the right of a Physician to be compensated for the provision of Insured Services through the Fee For Service Stream should a Physician no longer be involved in an Alternate Payment Plan.

5.5 For greater clarity the provisions of clause 5.4 shall not apply to monies allocated to agreements between Physicians and other persons existing before the Effective Date.

5.6 The parties shall, after the Effective Date, discuss with the regional health authorities how the tripartite process (established under the Prior Agreements) should be continued.

5.7 The parties have established the Innovation Fund to provide additional flexibility to deal with emerging issues involving the provision of Insured Services. Monies in the Innovation Fund may be utilized to encourage and assist in the provision of Insured Services, whether flowed to a Physician or other entity, or for such other purposes as the parties may agree. The Department and the Association shall agree on the terms and conditions under which monies shall flow from the Innovation Fund having due regard for the provisions of clause 5.4 and the need for additional flexibility giving rise to the Innovation Fund.

5.8 Notwithstanding any other provision of this Agreement, no portion of the Innovation Fund shall be included in the calculation of the Hard Cap. Any monies in the Innovation Fund that are unallocated and unexpended at the end of a Fiscal Year shall lapse.

5.9 The Association acknowledges that the decision of a Physician or a regional health authority to involve the Association respecting the services component of an Alternate Payment Plan is voluntary.

5.10 The Department acknowledges that a Physician may request or authorize the Association to represent their interests when negotiating the delivery of Insured Services to be provided under an Alternate Payment Plan. The Department covenants to encourage regional health authorities to involve the Association, as the representative of the said Physicians in such instances; provided always that the Department's obligation shall not include or require the Minister to issue any directive to a regional health authority whether under the provisions of the *Regional Health Authorities Act*, or otherwise.

ARTICLE 6.
DRUG SAVINGS

6.1 The Department and the Association are committed to working with pharmacists, the regional health authorities, and others to find ways to reduce drug costs, through drug funding, utilization and management initiatives, while maintaining or enhancing quality of care.

6.2 The Department and the Association will within thirty (30) days from the signing of this Agreement undertake a process to review and respond to the recommendations presented by the "Drug Initiatives Review Committee" in October, 1997.

6.3 This review will identify those recommendations which will reduce expenditures to the drug budget in the short term. The Department and the Association will identify appropriate implementation plans for the selected recommendations.

6.4 The Department and the Association will agree in writing to the implementation plan developed in 6.3 above and will implement the process forthwith.

6.5 The agreement in 6.4 above will include, with respect to each initiative selected, the:

(a) projected savings;

(b) method for measuring actual savings against projected savings; and

(c) methods for evaluating quality of care.

6.6 Fifty (50%) percent of the actual savings from initiatives selected under clause 6.5 will form part of the Innovation Fund.

6.7 Savings which result from the use of co-pays, deductibles or other mechanisms which result in a transfer of funding, rather than a true cost saving in drug expenditures, shall not be a component of the committee's recommendations or included in the calculation of drug savings.

6.8 Subject to the matters agreed to herein, no provision of this Article will affect the ability of the Minister to pursue other options or to manage the drug program by means other than as described above.

ARTICLE 7.
BENEFIT PLANS

7.1 Administration of the Benefit Plans is hereby transferred to the Association, such transfer to be effective, without more, on the Effective Date.

7.2 The parties agree that the maximum aggregate amount of the Benefit Stream for each Fiscal Year referred to in clause 4.3 shall be the amounts set out below, namely:

(a) for the 1998/99 Fiscal Year, $21,023,000 of which $15,100,000 shall comprise that portion of the CMPA rates provided to Physicians under the Liability Insurance Premium Assistance Program;

(b) for the 1999/00 Fiscal Year, $22,523,000 of which $16,500,000 shall comprise that portion of the CMPA rates provided to Physicians under the Liability Insurance Premium Assistance Program; and

(c) for the 2000/01 Fiscal Year, $22,523,000 of which $16,500,000 shall comprise that portion of the CMPA rates provided to Physicians under the Liability Insurance Premium Assistance Program;

as increased by the amounts set out in clause 7.5 below.

7.3 For the purposes of this Article "Eligible Physician" means a Physician who, throughout the program year applicable to the Benefit Plan in respect of which an application for benefits is made, meets all of the following criteria, namely:

(a) is a resident of Alberta; and

(b) has carried on the practice of medicine in Alberta, while opted into the Plan;

but excludes:

(c) a Physician who is:

(i) an intern or resident in a hospital; or

(ii) subject to the *Public Service Act*.

7.4 The Department shall pay the maximum aggregate amount of the Benefit Stream to the Association in quarterly installments commencing April 1, 1998 based on cash flow requirements of the Benefit Plans established by the Association and agreed to by the Department.

7.5 The Association shall provide the Department with a statement, certified to be complete and accurate in all respects by the Chief Financial Officer of the Association, no later than thirty (30) days after the end of each quarter of each Fiscal Year during the term of this Agreement. The statement shall set out the amount paid by the Association in the preceding quarter:

(a) in respect of each Benefit Plan to Eligible Physicians who are not members of the Association;

(b) to Eligible Physicians entitled to practise medicine in Alberta as of the Effective Date and who, after the Effective Date, become members of the Association in respect of benefits paid to such Eligible Physicians after the date of their membership in the Association; and

(c) the increases occurring after the Effective Date, if any, in payments to Eligible Physicians arising directly as a result of increased expenditures under the Liability Insurance Premium Assistance Program and resulting directly from premium increases imposed by the Canadian Medical Protective Association;

Upon receipt of the statement, in satisfactory form and content, the Department shall transfer the amount indicated in the statement from the Medical Services Budget to the Association for addition to the Benefit Stream.

7.6 As of March 31, 1997 the Association holds the sum of $6,502,807, as a reserve against future claims arising under the Benefit Plans.

7.7 All monies received by the Association pursuant to clause 7.2 or 7.5, clause 15.6, or held by the Association pursuant to clause 7.6 shall be kept separate and apart from any other monies of the Association in an account established and maintained with a financial institution satisfactory to the Department. The Association may invest surplus monies, if any, not required for the payment of benefits from time to time. In making any investments the Association shall adhere to investment and lending policies, standards and procedures that a reasonable and prudent person would apply in respect of a portfolio of investments to avoid undue risk of loss and obtain a reasonable return. Any investment gains or earnings shall only be used for the purposes of providing the benefits contemplated by the Benefit Plans or for the payment of the costs of administering the Benefit Plans.

7.8 The Association shall make the Benefit Plans equally available to all Eligible Physicians who desire to take part in same and shall advertise the availability of, and administer, the Benefit Plans in a fair and equitable manner so as to ensure, to the greatest extent reasonably possible, that administrative differences between members and non-members of the Association in respect of participation in such Benefit Plans are minimized.

7.9 The Association shall administer the Benefit Plans in such a manner that no benefits are to be paid to Physicians in respect of any period of time when the said Physician is not an Eligible Physician. The Association shall use its best efforts to recover from any Physician who, during a Benefit Plan program year ceases to be an Eligible Physician, any amounts paid to that Physician in respect of a benefit applicable to a period of time when that Physician is not an Eligible Physician.

7.10 The Department acknowledges that the Association intends to charge non-members an administration fee as a condition of participation in the Benefit Plans. The Association covenants that such administration fee shall not exceed

the annual cost of membership charged by the Association to its members for full membership in the Association.

7.11 The Association shall not be entitled to initiate a new, or discontinue an existing, Benefit Plan without the prior written consent of the Department.

7.12 The Association shall have the authority to:

(a) transfer or change the allocation of funding between Benefit Plans; provided that the aggregate payments and costs to administer the Benefit Plans will not exceed the amount of the Benefit Stream in any Fiscal Year; and

(b) allocate a reasonable amount for administration costs; provided that such costs shall not exceed 3% of the amount of the Benefit Stream plus $250,000 in any Fiscal Year.

7.13 The Association shall:

(a) within ninety (90) days immediately following the end of a Fiscal Year provide to the Department:

(i) audited financial statements in respect of the benefits paid, reserves maintained and administrative costs incurred or accrued respecting the Association's administration of the Benefit Stream;

(ii) an evaluation of the Benefit Plans assessing the overall performance and management of the Benefit Plans; and

(iii) forward copies of the financial statements referred to in clause 7.13(a)(i) to all Physicians who are members of the Association or who have participated in a Benefit Plan during the Fiscal Year to which the financial statements relate. The Association may satisfy its obligations under this clause by making electronic copies of the said audited financial statements available through the Internet; provided that the Association notifies its members and all non-member Physicians who participate in a Benefit Plan in writing that the said financial statements are so available and that paper copies will be provided to any Physician so requesting; and

(b) provide, forthwith upon request, any other information pertaining to Benefit Plans and the Benefit Stream at such time and in such manner as the Department may reasonably require.

7.14 With respect to the Liability Insurance Premium Assistance Program, the Department shall provide to the Association a list of Physicians deemed to be eligible to receive benefits; provided that the Department shall bear no liability

for errors or omissions in respect of Physicians whose services are charged to the Fee For Service Stream through a common billing number or similar joint arrangement.

7.15 The Association shall use its best efforts to ensure that any dividend, premium rebate, refund, or surplus arising in respect of assistance provided to Physicians under the Liability Insurance Premium Assistance Program shall be paid to the Association, form part of the Benefit Stream, and be utilized only as contemplated under the provisions of this Article.

7.16 The parties agree that the Incentive Payments Agreement established on January 3, 1985, and amended as of January 1, 1991 (the "IPP"), shall be terminated effective March 31, 1998 and that the Department shall thereafter be at liberty to use an amount equal to $1,206,357 for the purposes of a rural Physician on-call program to be developed by the Department.

7.17 The Association shall administer the Benefit Plans in such a manner as to fulfill the goals, objectives, criteria and transitional arrangements (if any), set out in Schedule "B" attached hereto. The Benefit Agreements are terminated and superceded by this Agreement on the Effective Date.

7.18 The parties acknowledge that the Transition Adjustment Program implemented by letter agreement dated July 4, 1996 has terminated, in accordance with its terms, on March 31, 1998.

7.19 A Physician's ability to access a Benefit Plan shall not be affected solely depending on whether the Physician is being compensated through the Fee For Service Stream or the Alternate Payment Stream.

ARTICLE 8.
ACADEMIC MEDICINE

8.1 The Department and the Association agree that sustainable and predictable funding is an important ingredient in the continued development of academic medicine.

8.2 The Department and the Association shall, forthwith after the execution of this Agreement form a committee to be co-chaired by a representative of each of the Department and the Association. The co-chairs shall forthwith invite a representative of each of the academic medical centres in Edmonton and Calgary, a representative of each of the Calgary Regional Health Authority and the Capital Health Authority, together with such other involved stakeholders as the parties might mutually agree to participate on the committee. The committee so established shall, within one hundred and eighty (180) days from the Effective Date develop:

(a) a definition of an academic Physician; and

(b) a methodology to determine the amount being billed to the Medical Services Budget by academic Physicians, as defined in clause 8.2(a), and other funding being provided directly by the Department to academic Physicians.

ARTICLE 9.
FUNDING AND RESPONSIBILITY FOR SERVICES

9.1 The Department and the Association are committed to an affordable and sustainable health system. As part of this commitment a consultation process into the delivery of diagnostic imaging services will be conducted.

9.2 The parties will establish a committee forthwith after the signing of this agreement to determine the principles and mechanisms under which diagnostic imaging services may be delivered. Committee membership will be comprised of two representatives from each of the Department, the Association, regional health authorities and the Alberta Society of Radiologists. The Department and the Association will each appoint a co-chair.

9.3 The committee shall investigate and report on such aspects of diagnostic imaging service delivery as they think reasonable but shall consider the advantages, if any, of such service delivery through Alternate Payment Plans. The committee shall include in their determinations such other reports and investigations as might assist them.

9.4 The co-chairs of the committee will report to the Department and the Association on the results of the committee's investigations and deliberations under clause 9.3 above no later than one hundred and eighty (180) days after its establishment. Should the co-chairs decide that, for factors outside of their control, the reporting date set out above should be extended they may request the Minister to extend the reporting date for such period of time as the Minister determines is reasonable in the circumstances.

9.5 Should the co-chairs be unable to reach a consensus concerning the content of the report either party shall be entitled to submit such dispute to arbitration pursuant to Article 17 on or before the expiry of the original or extended term specified in clause 9.4.

9.6 During the life of this Agreement the parties shall, in good faith, consider and investigate the delivery of medical care services so as to enhance the quality of care or provide more cost effective treatment or delivery.

9.7 The Department agrees that it will not De-List one or more Insured Services without the agreement of the Association for the Initial Term of the Agreement. De-Insurance cannot be used in substitution for De-Listing.

ARTICLE 10.
EQUITABLE FEES FOR PHYSICIANS

10.1 Within thirty (30) days of the parties signing this Agreement the Minister shall establish a committee to be known as the RVG Commission. The RVG Commission shall be composed of five (5) persons, two (2) appointed by each of the Department and the Association and an independent chairperson recommended jointly by the appointees. In the event that the appointees fail to agree on an independent chairperson within twenty (20) days of the signing of this Agreement either party may utilize the dispute resolution mechanism, set out in Article 17 to cause the appointment of an independent chairperson.

10.2 The costs and expenses of the RVG Commission shall be funded from the Innovation Fund. Monies presently held by the Association and designated for RVG activity shall be deposited into the Innovation Fund within thirty (30) days of the parties signing this Agreement.

10.3 The RVG Commission shall be responsible to develop a report respecting the principles, processes and methodologies necessary or desirable to develop and implement Cost Neutral relative value changes to the Schedule for the purpose of ensuring equitable fees for Physicians and to ensure that the Schedule reflects the relative value of medical services in the current medical environment and given present technology.

10.4 The report of the RVG Commission shall be delivered to the Department and the Association on or before December 31, 1998 or such later date as the parties mutually agree.

10.5 The report of the RVG Commission shall be made public upon receipt and implemented as quickly as possible.

10.6 In the event that the RVG Commission does not report as required by clause 10.4 above, the Minister shall be at liberty within twelve (12) months of the initial or alternate date the report was to be delivered to take such steps as might be reasonably necessary or required to make any changes to the Schedule as the Minister might deem appropriate in order to implement fair and equitable fees for Physicians. In the event the Minister does take such action, it shall be deemed to be the report of the RVG Commission.

ARTICLE 11.
FINANCE COMMITTEE

11.1 The Subcommittee on Finance is hereby continued as the Finance Committee.

11.2 The Finance Committee shall be composed of six members, three of whom shall be appointed by each of the Department and the Association. All decisions shall, where possible, be by consensus. In the event that there is no consensus, decisions of the Finance Committee shall require the agreement of

at least two members appointed by each of the Department and the Association.

11.3 The Finance Committee shall meet at least quarterly unless otherwise agreed to by the parties.

11.4 The Finance Committee shall establish its own process which may include collaboration, joint action, establishment of and references to subcommittees, research studies, or any other means which the Finance Committee may agree upon to deal with issues, including but not limited to:

(a) expenditures and utilization respecting the Fee For Service Stream and the Benefit Stream;

(b) the payment rates, and conditions of payment, that may be included as part of an Alternate Payment Plan;

(c) an application to vary the flow of funding from the Medical Services Budget, excluding the Innovation Fund, to the Benefit Stream;

(d) the allocation of fees payable for existing items in the Schedule; provided that:

(i) such allocation shall not offend the principles and practices recommended by the RVG Commission, when implemented; and

(ii) the financial impact of such allocation shall not affect the operation of the Default Price Adjustment Mechanism set out in clause 4.10;

(e) the addition of, and fees payable for, new items in the Schedule; provided always that:

(i) the Department has the final right to determine services to be insured, which right shall not be exercised until ninety (90) days after the Department has notified the Association of its intention to add a new item to the Schedule; and

(ii) that such fee shall not offend the principles and practices recommended by the RVG Commission, when implemented;

(f) changes to general rules and assessments in the Schedule.

11.5 The Finance Committee may refer any matter to a subcommittee formed by it. Any subcommittee so formed need not be composed of members of the Finance Committee, but shall consist of equal numbers of members appointed by each of the Department and the Association. All decisions shall, where possible, be by consensus. In the event that there is no consensus the

subcommittee may report its inability to reach a consensus to the Finance Committee which may:

(a) refer the matter to the same or a new subcommittee;

(b) make a decision in respect of the matter, with or without further consideration in accordance with the provisions of clause 11.2; or

(c) proceed no further.

11.6 The Department shall notify the Association of any proposal to De-Insure an Insured Service and such matter shall be discussed in the Finance Committee. If agreement cannot be reached no such De-Insurance may occur until three (3) months after the date that the Department has notified the Finance Committee of the intended De-Insurance.

11.7 The Finance Committee shall establish a subcommittee forthwith after the signing of this Agreement to determine the mechanisms under which services provided by Physicians related to the provision of home care services can be reimbursed. Representatives of the regional health authorities will be invited to participate on the subcommittee as full participants.

The subcommittee so established shall develop a report, which includes recommendations regarding the service description, value of the service and rules of application, and an estimate of service utilization. The report will be provided to the Finance Committee for introduction of a benefit item into the Schedule by no later than November 1, 1998.

Funding for the home care service benefit item will be provided from the Innovation Fund and the Department shall be at liberty to transfer the amount paid in respect of such benefit item from the Innovation Fund to the Hard Cap.

ARTICLE 12.
INFORMATION SHARING

12.1 Each party will, upon request, in a timely manner, and to the extent permitted by law, provide all information and data in its possession that may be reasonably required by the requesting party to assist the requesting party to perform its responsibilities and obligations hereunder. The party providing such information shall use reasonable efforts to put such information and data into such form as may be reasonably required by the requesting party.

12.2 Either party shall be entitled to require the other to enter into a confidentiality agreement respecting information provided under clause 12.1; provided always that this obligation shall not apply to information that is already in the public domain, other than through the operation of clause 12.1.

ARTICLE 13.
ALBERTA WE*LLNET*

13.1 The Department and Association are committed to enhancing the availability of better health information for better health, and as part of that commitment agree to support the continued development of the alberta we*llnet* initiative.

13.2 The Department agrees that computer software developed or acquired through the alberta we*llnet* initiative, which may be used by Physicians to improve the delivery of medical services, will be provided to Physicians without charge except charges respecting transactions fees, if any, required to utilize such software. Nothing in this clause pertains to commercial use of such software by Physicians outside the direct scope of their medical practice.

13.3 The Department agrees that Physician's participation in alberta we*llnet* initiatives is voluntary and will be based on a business case beneficial to both parties.

ARTICLE 14.
PHYSICIAN RESOURCE PLANNING

14.1 Within thirty (30) days of the parties signing this Agreement the Minister shall form a committee entitled the Physician Resource Planning Committee (the "PRP Committee"). The PRP Committee shall be comprised of a representative of each of the following, namely:

(a) the Department;

(b) the Association;

(c) the College;

(d) the regional health authorities;

(e) the Faculties of Medicine;

(f) the Professional Association of Internes and Residents of Alberta;

(g) the Medical Students Associations; and

(h) a non-Physician representative appointed by each of the Department and the Association to represent the interests of the Alberta public.

14.2 The PRP Committee shall be co-chaired by the representative of each of the Department and the Association and shall develop a Physician resource plan for the Province of Alberta, which plan shall:

(a) include objective criteria to define regional requirements for physicians, including number, types and location, based on criteria including, but not limited to:

(i) the definition of a full time Physician;

(ii) Physician to population ratios;

(iii) population density;

(iv) population demographics, including socio-economic risk factors;

(v) Physician demographics, including the mix of primary care Physicians to specialists and distribution of Physicians;

(vi) distance to major centres or facilities; and

(vii) patient import/export flows;

(b) include methods to continue the development of needs based regional planning templates for Physician resource planning;

(c) include recommendations for formalizing a reporting relationship between the PRP Committee and:

(i) the Physician Database Working Group;

(ii) the Post Graduate Medical Education Working Group; and

(iii) the Rural Physician Action Plan Coordinating Committee;

so as to build the PRP Committee and the forgoing into a coherent and coordinated structure for Physician resource planning;

(d) include recommendations for ongoing governance to ensure clear expectations and accountabilities;

(e) include recommendations to the Minister regarding initiatives which will address particular issues of Physician recruitment and retention and medical care in rural and remote areas of Alberta; and

(f) include structures and processes to continuously update Alberta's Physician resource plan and monitor on an ongoing basis that Physician supply, mix and distribution are in accordance with the plan.

14.3 The PRP Committee shall deliver the plan referred to in clause 14.2 addressing each of the matters referred to therein and any other matters that the committee determines advisable with respect to the issues of Physician resource planning to the Minister and the Association no later than December 30, 1998.

14.4 The Department and the Association further agree that:

(a) the Department shall identify not more than ten (10) communities experiencing pressure regarding Physician supply, within thirty (30) days of the parties signing this Agreement;

(b) the Department and the Association will each appoint a co-chair who will invite a representative of each of the College, and the appropriate regional health authorities; and

(c) the co-chairs shall be responsible to develop, by August 21, 1998, a report setting out a short term action plan addressing the issues. Should the co-chairs decide that, for factors outside of their control, the reporting date set out above should be extended they may request the Minister to extend the reporting date for such period of time as the Minister determines is reasonable in the circumstances.

14.5 Should the co-chairs be unable to reach a consensus concerning the content of the report either party shall be entitled to submit such dispute to arbitration pursuant to Article 17 on or before the expiry of the original or extended term specified in clause 14.4(c).

ARTICLE 15.
CLINICAL PRACTICE GUIDELINES:

15.1 The Department and the Association are committed to enhancing the development of evidence based medicine and, as part of this commitment, hereby agree to undertake to support the continued development or acquisition of clinical practice guidelines ("CPG's) designed to support effective and appropriate quality medical care in Alberta.

15.2 The parties will, within thirty (30) days of the signing of this Agreement:

(a) form a committee to be called the CPG Executive Committee, which shall consist of a representative of each of the Department and the Association together with the person jointly nominated by the parties to serve as the chair of the CPG Steering Committee referred to in clause 15.2(b); and

(b) form a committee to be called the CPG Steering Committee which shall report to the CPG Executive Committee and which shall consist of a representative of each of the Department and the Association and the parties further agree that they will invite the participation of a representative of each of the following, namely:

(i) Physicians;

(ii) health services stakeholders;

(iii) each of the academic medical centres; and

(iv) the public at large.

15.3 The CPG Executive Committee shall provide direction to the CPG Steering Committee and shall be responsible to:

(a) establish mandate for approval by the parties hereto;

(b) determine performance measures;

(c) select appropriate project topics and priorities;

(d) allocate resources;

(e) evaluate program effectiveness;

(f) approve overall project timelines; and

(g) integrate CPG program with other initiatives.

15.4 The CPG Steering Committee shall be responsible to:

(a) establish program standards;

(b) oversee the development and approval process of projects;

(c) facilitate grassroots input;

(d) implement projects as directed by the CPG Executive Committee;

(e) advise on approaches;

(f) establish working groups;

(g) approve guidelines produced;

(h) oversee dissemination strategies and process;

(i) oversee implementation strategies and process; and

(j) advise on continued quality improvement process.

15.5 The CPG Executive Committee shall prepare an action plan by June 30, 1998 to accelerate and streamline the development of CPGs, which action plan shall include the number of CPGs to be produced or acquired during each Fiscal Year of the term of this Agreement; provided that this commitment shall not obligate the Department to increase its financial support as set out in clause 15.6.

15.6 The Department and the Association shall equally share the costs and expenses related to the development of CPGs under the provisions of this Article up to a maximum aggregate of $550,000 per Fiscal Year.

15.7 The Association's share of the amount referred to in clause 15.6 shall be transferred from the Fee For Service Stream to the Benefit Stream and the Department's share shall be paid to the Association for deposit into the account referred to in clause 7.7.

15.8 The Association shall administer and account for all costs and expenses related to the administration of the funds referred to in clause 15.6

ARTICLE 16.
REOPENING THE AGREEMENT

16.1 This Agreement may be reopened in respect of:

(a) the term of this Agreement; and

(b) the amount of the Medical Services Budget in respect of a Fiscal Year occurring after the 2000/01 Fiscal Year;

by using the process set out in clause 16.2.

16.2 The parties may reopen negotiations only after July 31, 2000, by using the following process:

(a) on or before August 31, 2000, or August 31, 2001 in the event that negotiations in 2000 did not result in a two (2) year agreement, either party may deliver to the other a written submission which shall contain a list of items for which negotiation is required, which shall only include:

(i) the amount of the Medical Services Budget in either or both of Fiscal Years 2001/02 and 2002/03;

(ii) the term of this Agreement, if it is desired to extend the term beyond the Initial Expiry Date;

(iii) the amount of the Medical Services Budget for each Fiscal Year beyond the Initial Expiry Date.

16.3 The written submission delivered under clause 16.2 shall, in addition to the list of items to be negotiated, contain the names of a maximum of five (5) persons authorized to represent the initiating party in the negotiation process. Upon receipt of the written submission, the other party shall within seven (7) days of receipt provide a written response setting out a maximum of five (5) persons authorized to represent it in the negotiation process. The response may also contain a list of any additional issues permitted to be negotiated that the

responding party wishes be addressed.

16.4 The respective representatives of each party shall meet forthwith and endeavour to resolve the issues raised by the submissions no later than November 30 in the same year.

16.5 In the event that the parties or their authorized representatives are unable to reach agreement on any issue permitted to be raised by them within the time set out in clause 16.4 either party may submit the issues remaining in dispute resolution pursuant to Article 17.

ARTICLE 17.
DISPUTE RESOLUTION

17.1 Any difference submitted under Article 16 or arising as to the interpretation, application, operation or any contravention or alleged contravention of this Agreement or as to whether any such difference can be the subject of arbitration. The parties agree to meet and endeavour to resolve such matter in accordance with the provisions of this Article.

17.2 The following items are not subject to dispute resolution under this Agreement:

(a) the Preamble;

(b) Article 3, except to the extent that the term of this Agreement may be the subject of reopened negotiations under clause 16.1;

(c) Article 4, except to the extent that the amount of the Medical Services Budget for:

(i) the 2001/02 and 2002/03 Fiscal Years; and

(ii) Fiscal Years beyond the Initial Expiry Date

may be the subject of reopened negotiations under clause 16.1;

(d) Article 5, except with respect to a dispute concerning:

(i) the amount of money to flow from the Medical Services Budget to an Alternate Payment Plan under clause 5.4; and

(ii) the amount of money to flow from the Innovation Fund under clause 5.7;

(e) the addition of a new Insured Service to the Schedule; except to the extent of the fee to be allocated to that Insured Service in the Schedule;

(f) the De-Insurance of an Insured Service; or

(g) the De-Listing of an Insured Service.

17.3 A submission for dispute resolution shall list the permitted issues in dispute or claimed to be in dispute and be forwarded to the other party. Upon receipt the receiving party may add any permitted issues in dispute or claimed to be in dispute. If no response is received within seven (7) days from the date that the initial submission is received it shall be deemed that no additional issues are in dispute.

17.4 Upon receipt of the earlier of the responding submission or the expiration of the seven (7) day period the Executive Director of the Association and the Deputy Minister of the Department shall arrange to meet within a further seven (7) days to discuss and attempt, in good faith, to resolve the issues in dispute or claimed to be in dispute.

17.5 If the issues in dispute or claimed to be in dispute are not resolved the party raising an issue may submit the matter to arbitration as set out below.

17.6 All submissions to arbitration shall be in writing and contain a list of the permitted issues in dispute or claimed to be in dispute and the name and address of the initiating party's nominee to the arbitration board.

17.7 Within seven (7) days of receipt or deemed receipt of a submission to arbitration the responding party shall prepare a written response setting out any additional permitted issues in dispute or claimed to be in dispute and the name and address of the responding party's nominee to the arbitration board.

17.8 The arbitration board shall consist of three persons, one nominated by each party as set out above and a chair who is agreed to by the two nominees. The two nominees shall within seven (7) days of their appointment agree upon a chairman.

17.9 In the event that one party fails to appoint a nominee within seven (7) days of receipt of notice of the submission, or the two nominees fail to agree on the chair of the arbitration board within seven (7) days of their appointment the other party or either party as the case might be may request the Chief Justice, or Associate Chief Justice, of the Court of Queen's Bench of Alberta to make the appointment.

17.10 Nothing in clause 17.8 prevents the parties, except in respect of a matter arising under Article 16, from agreeing to have the matter resolved by a single arbitrator selected by the parties.

17.11 The arbitration board shall hear and determine the issues in dispute or claimed to be in dispute, in private, and in determining the amount of the Medical Services Budget for any Fiscal Year following the 2000/01 Fiscal Year shall consider fair and reasonable compensation for Physicians and prevailing and anticipated economic conditions in Alberta.

17.12 The arbitration board shall render a decision in writing within sixty (60) days of the hearing. The decision of the arbitration board shall be final and binding on the parties and shall be implemented in the manner provided for in the arbitration decision; provided that the arbitration board shall be entitled to reserve jurisdiction to hear and resolve any disputes arising as a result of the award.

17.13 The decision of the arbitration board shall, within sixty (60) days of the issuance of the award be incorporated into an agreement which shall be signed by the parties forthwith.

17.14 Each party shall pay the fees and expenses of its nominee to the arbitration board and shall pay one half of the expenses of the chair.

ARTICLE 18.
GENERAL

18.1 This Agreement may be altered or amended in any of its provisions when such changes are reduced to writing and signed by the parties hereto, but not otherwise.

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

18.3 This Agreement contains the entire agreement between the parties hereto relating to the subject matter hereof and there are no oral agreements, statements, representations, warranties, collateral agreements, undertakings, conditions or agreements whatsoever respecting the subject matter hereof other than expressed herein.

18.4 Any notice required to be given hereunder by any party shall be in writing and shall be deemed to have been well and sufficiently given if:

(a) personally delivered to the party to whom it is intended or if such party is a society to an officer of that society;

(b) mailed by prepaid registered mail, to the address of the party to whom it is intended as hereinafter set forth; or

(c) sent by facsimile, to the facsimile number of the party to whom it is intended as hereinafter set forth; namely

if to **The Department**

Alberta Health
10025 Jasper Avenue
P.O. Box 1360 Station Main
Edmonton, Alberta
T5J 2N3

Attn: Deputy Minister

Facsimile Number: (403) - 427-1016

and if to

The Association

The Alberta Medical Association
(C.M.A. Alberta House)
12230 - 106th Avenue N.W.
Edmonton, Alberta
T5N 3Z1

Attn: Executive Director

Facsimile Number: (403) - 482-5445

or to such other address or facsimile number as a party may from time to time direct in writing.

Any notice:

(d) personally delivered as aforesaid shall be deemed to have been received on the date of delivery;

(e) mailed shall be deemed to have been received seventy two (72) hours after the date it is postmarked. If normal mail service is interrupted by strike, slow-down, force majeure or other cause after the notice has been sent the notice will not be deemed to be received until actually received; or

(f) forwarded by facsimile shall be deemed to have been received on the business day next following dispatch and acknowledgment of receipt by the sender's facsimile machine.

In the event any of such means of communication is impaired at the time of sending the notice, the party sending the notice shall utilize any other service which has not been so impaired so as to ensure prompt receipt thereof.

18.5 No provision of this Agreement shall be deemed to be waived unless such waiver is in writing. Any waiver of any default committed by any of the parties hereto in the observance or performance of this Agreement shall not extend nor be deemed to extend to or affect any other default.

18.6 Any covenant or provision hereof determined to be void or unenforceable in whole or in part shall not be deemed to affect or impair the validity of this Agreement or any other covenant or provision hereof and the covenants and provisions hereof are declared to be separate and distinct.

18.7 Time is and shall remain of the essence of this Agreement.

18.8 The Prior Agreements are terminated and superseded by this Agreement on the Effective Date.

IN WITNESS WHEREOF the Alberta Medical Association (C.M.A. Alberta Division) has affixed its corporate seal, attested by the hands of its duly authorized officers in that behalf on the 22 day of June, 1998, and this Agreement has been signed on behalf of Her Majesty the Queen in right of Alberta as represented by the Minister of Health on the 29 day of June, 1998, all such execution to be effective as of the Effective Date.

THE ALBERTA MEDICAL ASSOCIATION (C.M.A. Alberta Division)

Per:

HER MAJESTY THE QUEEN IN RIGHT OF ALBERTA
as represented by the
Minister of Health

By:

BENEFIT PROGRAM OBJECTIVES

1. LIABILITY INSURANCE PREMIUM ASSISTANCE PROGRAM

To reimburse Eligible Physicians for costs incurred in respect of medical liability insurance premiums. The annual deductible for the 1998, 1999 and 2000 calendar years will be $1,000 per Eligible Physician. Reimbursement to Eligible Physicians above the deductible for the 1998 calendar year shall be 100% for rural Eligible Physicians and 85% for urban Eligible Physicians and for the 1999 and 2000 calendar years 100% for rural and urban Eligible Physicians.

2. CONTINUING MEDICAL EDUCATION

To reimburse eligible Physicians for costs incurred with regard to the maintenance and enhancement of knowledge, skills and competency with due regard to providing the best value and meeting the health service needs of Albertans in the most efficient manner.

3. PHYSICIAN DISABILITY INSURANCE PROGRAM

To provide an approved level of long term disability insurance for all Eligible Physicians.

4. COMPASSIONATE EXPENSE PROGRAM

To assist, on compassionate grounds, Eligible Physicians in need of temporary support who have been referred by either the College or the Physicians Assistance Committee of the Association.

5. CLINICAL PRACTICE GUIDELINES PROGRAM

To support the development, dissemination and use of Clinical Practice Guidelines in Alberta.

6. RURAL LOCAL PROGRAM

To ensure that Residents living in communities with 4 or fewer Physicians will have access to continuous medical coverage if a Physician is unable to provide Physician services due to short term absences. Any initiatives through the Rural Locum Program should be consistent with Rural Physician Action Plan initiatives.

7. PHYSICIAN SUPPORT INITIATIVE

To provide Eligible Physicians, and their qualified dependents (as defined in that agreement made between Humanacare Counselling, Inc and the Association made effective December 12, 1996), with assistance in dealing with life management issues.

Appendix "A"
To that Agreement Dated for Reference the 20th day of April, 1998 and made between Her Majesty the Queen in right of Alberta as represented by the Minister of Health and The Alberta Medical Association (C.M.A. Alberta Division)

DESCRIPTION OF BENEFIT AGREEMENTS

The Text of Appendix "A" starts on the immediately following page.

1. Liability Insurance Premium Assistance Program Agreement made December 31, 1990;

2. Continuing Medical Education Program Agreement made effective January 31, 1993;

3. Physician Disability Insurance Program Agreement made effective January 31, 1993

4. Compassionate Expense Program Agreement dated April 1, 1991;

5. Clinical Practice Guidelines Program made as of July 1, 1994;

6. Rural Locum Program Agreement made December 31, 1991; and

7. Physician Support Initiative established by letter agreement dated January 22, 1997

all as amended from time to time.

Appendix "B"
To that Agreement Dated for Reference the 20th day of April, 1998 and made between Her Majesty the Queen in right of Alberta as represented by the Minister of Health and The Alberta Medical Association (C.M.A. Alberta Division)

DESCRIPTION OF BENEFIT PLANS

The Text of Appendix "B" starts on the immediately following page.

Appendix "C"
To that Agreement Dated for Reference the 20th day of April, 1998 and made between Her Majesty the Queen in right of Alberta as represented by the Minister of Health and The Alberta Medical Association (C.M.A. Alberta Division)

DESCRIPTION OF PRIOR AGREEMENTS

The Text of Appendix "C" starts on the immediately following page.

1. Memorandum of Agreement made as of the 23rd day of July, 1986;
2. Memorandum of Agreement signed and dated the 2nd day of December, 1991;
3. Memorandum of Agreement re 1994/95 Fiscal Year dated April 27, 1994;
4. Letter of Understanding dated December 8, 1995;
5. Principles of Budget Management attached to letter dated February 20, 1997;
6. Administrative Council Program Agreement made as of April 1, 1992.