ALBERTA MEDICAL ASSOCIATION

AMA AGREEMENT 2011-2018
OVERVIEW AND ANALYSIS

"Alberta Medical Association (AMA) and Alberta Health (AH) now wish to create, through the provisions of this AMA Agreement, the principles, processes and agreement which will apply to and which will govern a long term financial and working relationship between AH and Alberta's physicians, as represented by the AMA."

Overview Elements

Element 1. Two-Party Agreement

What/How

The agreement shall be between Alberta Medical Association (AMA) and Alberta Health (AH).

AMA Agreement Document Reference

Page 1 Preamble.

You Might Ask

Q1.1 *Is Alberta Health Services (AHS) a party to the AMA Agreement?*

- No. AHS is not a party to the AMA Agreement, but AHS is a party to one of the Consultation Agreements (see Element 12 Consultation Agreements) and will have a role to play in the other two Consultation Agreements.

Element 2. Term

What/How

The initial financial term of the AMA Agreement is April 1, 2011 to March 31, 2018.

AMA Agreement Document Reference

Page 6 Section 6.

You Might Ask

Q2.1 *Do all provisions of the AMA Agreement expire in 2018?*

- No. Unlike the previous agreement, certain elements of the agreement are “evergreen” in nature; they survive the initial term of the AMA Agreement (see Element 6 Evergreen Term).

Element 3. Scope and Purpose

What/How

The AMA Agreement is intended to govern a long-term financial working relationship between AH and Alberta’s physicians, as represented by the AMA. The scope of the agreement includes:

- Physician compensation for insured medical services paid directly by AH, no matter where the service is provided.
- Payment rates for the Schedule of Medical Benefits (SOMB) and alternative relationship plans (ARPs), including the clinical insured medical services component of academic ARPs (AARPs).
- All programs and benefits currently available to physicians:
  - Continuing Medical Education.
  - Medical Liability Insurance.
  - Parental Leave.
  - Physician and Family Support.
  - Compassionate Expense.
  - Physician Locums (Regular and Specialist).
  - Practice Management.

Physician Support Programs

- Physician On-Call.
- Physician Learning.
- Program Management Offices.
- Towards Optimized Practice.
- Business Costs.
- Retention Benefit.
- Rural, Remote, Northern.

Physician Assistance Programs

AMA Agreement Document Reference

Pages 2-3 Section 3.

You Might Ask

Q3.1 *Are the Business Costs Program and Retention Benefit continuing?*

- Yes. Both programs continue, as well as all others that physicians have had access to through the previous agreement.

Q3.2 *Why are programs divided into two categories in the AMA Agreement: Physician Support Programs and Physician Assistance Programs?*

- The separate lists are to distinguish between those programs which are part of the evergreen term (Physician Support Programs) and those programs (Physician Assistance Programs) which are continued through the basic term of this AMA Agreement (to March 31, 2018), and whose future beyond March 31, 2018 will be decided prior to the end of the term.

Q3.3 *Does this agreement cover compensation for insured medical services paid through AHS?*

- No. This AMA Agreement covers only payments for clinical services paid directly by AH. Where AHS is the payer (e.g., hospitalists under direct contract with AHS), those rates are not covered by the AMA Agreement. As always, the AMA will support physicians in negotiating these separate contractual arrangements when requested.

Q3.4 *Does the main AMA Agreement cover Primary Care Networks (PCNs) and their funding?*

- No. The main AMA Agreement does not cover PCNs and PCN funding, although they are referenced therein. These matters are directly addressed in the Primary Medical Care/Primary Care Networks Consultation Agreement (see Element 12B Primary Medical Care/Primary Care Networks Consultation Agreement).

Q3.5 *Does the AMA Agreement cover Family Care Clinics (FCCs)?*

- The type of compensation model that each FCC uses for physician services will determine whether or not it is covered by the agreement. The AMA Agreement covers compensation for insured medical services when paid directly by AH. Physician compensation within FCCs, when paid directly by AH, will be covered by this AMA agreement.

Q3.6 *How are clinical ARPs and AARPs affected by this agreement?*

- Clinical ARP service rates are covered under the AMA Agreement.
- AARPs have two major components.
  - Clinical insured medical services.
    - These are covered by the agreement.
  - Academic services (teaching, research, leadership/administration).
    - These are not covered by the agreement since they are paid through other sources including conditional grant funding from AH to the universities.
- New provisions in the AMA Agreement that involve the AMA in consultation on matters that touch and concern physicians may create more opportunity to be involved in supporting academic physicians.

Element 4. AMA Recognition

What/How

The AMA Agreement recognizes the AMA as the sole and exclusive representative of Alberta physicians with regard to the term, scope and purposes (see Element 2 Term and Element 3 Scope and Purpose).

The AMA Agreement also requires that, for health matters which touch and concern physicians but are not within the stated scope and purposes of the agreement, AH will consult with and seek the advice of AMA.

AMA Agreement Document Reference

Page 2 Section 2, Page 4 Section 4.

You Might Ask

Q4.1 *Is the AMA recognized specifically as the representative of physicians for matters outside of the agreement?*

- While not specifically recognized, as noted, AH is required to consult with AMA on all health matters which "touch and concern physicians." The AMA will also assist upon request with specific negotiations with other entities, e.g., AHS physicians always have the right to request that the AMA act as their representative.

Q4.2 *Why does the agreement include a provision for AH to entrench recognition in legislation?*

- While this AMA Agreement provides for ongoing recognition of the AMA (see Element 6 Evergreen Term), entrenching recognition in legislation could give added comfort to physicians that the AMA will be recognized by government in an ongoing fashion as the representative of Alberta physicians. Other provinces have taken the legislative route with respect to medical association recognition.

Element 5. Financial

What/How

The AMA Agreement provides specific financial provisions for the initial financial term of the arrangement. The following "agreed increases" will be applied to the SOMB and ARPs, and as well as to all Physician Support Programs and Physician Assistance Programs (see Element 3 Scope and Purpose):

- 2011–12: 0%.
- 2012–13: 0%.
- 2013–14: 0%.
- 2014–15: 2.5%.
- 2015–16: 2.5%.
- 2016–17: Cost of living adjustment (COLA).
- 2017–18: COLA.

These increases are effective April 1 of each fiscal year:

- Increases will be allocated according to a process managed by the Physician Compensation Committee (PCC) (see Element 9 Physician Compensation Committee).
- COLA is derived from the previous calendar year's increase in the Alberta All Items Consumer Price Index.
- Any additional costs above these rates that arise from utilization will be the responsibility of AH (e.g., increased population in Alberta and other factors that physicians do not control).

In addition to the above, the AMA Agreement provides for AH to make a payment of $68 million to be distributed to physicians by the AMA after consulting with AH. Best efforts will be made to distribute within 90 days of ratification of the AMA Agreement.

AMA Agreement Document Reference

Page 5 Section 5(b)-(e).

You Might Ask

Q5.1 *What happens if utilization exceeds the rate increase applied in a given year? Will my fees be clawed back?*

- No. Utilization increases, which are the responsibility of AH, are on top of any rate/price increase in a given year. There will be no claw back of fees arising from utilization.

Q5.2 *Is my compensation guaranteed to increase by the same rate increase applied for each year, e.g., 2.5% in a year where 2.5% applies?*

- Rate increases will be determined through the allocation process identified by the PCC. The allocation will determine how increases impact each physician.

Element 6. Evergreen Term

What/How

Several matters within this AMA Agreement survive the initial financial term (April 1, 2011 – March 31, 2018). These include:

- AMA recognition.
- The agreement governance structure (see Element 7 Governance).
- Dispute resolution processes (see Element 10 Dispute Resolution).
- Rates and prices for the SOMB, ARPs and programs (identified in the agreement as Physician Support Programs):
  - Continuing Medical Education.
  - Medical Liability Reimbursement.
  - Parental Leave.
  - Physician and Family Support.
  - Compassionate Expense.
  - Physician Locums (Regular and Specialist).
  - Practice Management.

Not only are the above programs guaranteed to exist past March 31, 2018, a process is established to renegotiate the rates and prices for these programs at the end of the initial financial term, with a binding arbitration process for resolution in the event that the parties cannot reach agreement.

Programs that are not subject to the Evergreen Term (identified in the AMA Agreement as Physician Assistance Programs) are guaranteed to exist until at least March 31, 2018. Processes have been established to negotiate their future after March 2018, including a non-binding dispute resolution process. These are:

- Physician On-Call.
- Physician Learning.
- Program Management Offices.
- Towards Optimized Practice.
- Business Cost.
- Retention Benefit.
- Rural Remote Northern.

Where program future is in question at the end of term, the processes are designed to resolve issues before the end of term.

AMA Agreement Document Reference

Page 6 Section 6, Page 11 Schedule 1, Page 12 Schedule 2, Page 18 Schedule 5.

You Might Ask

Q6.1 *Will this evergreen provision put an end to long periods of time without a negotiated agreement?*

- It is expected that this AMA Agreement will allow for a smooth transition period between one agreement term and the next. Evergreen elements of the AMA Agreement continue, i.e., will always be in place.

Q6.2 *Can government end these evergreen provisions unilaterally?*

- Notwithstanding that government always retains certain legislative powers, these evergreen matters are to remain in place until ended by mutual written agreement of the parties.

Element 7. Governance

What/How

This AMA Agreement has a more streamlined governance approach than the previous agreement, with only two formalized committees: the Management Committee and the Physician Compensation Committee.

AMA Agreement Document Reference

Pages 6-7 Sections 7 and 8, Page 14 Schedule 3, Page 15 Schedule 4.

You Might Ask

Q7.1 *How are these committees set up?*

See Element 8 Management Committee and Element 9 Physician Compensation Committee.

Element 8. Management Committee

What/How

The Management Committee (MC) has overall authority to manage the agreement. The MC is comprised of the Deputy Minister of Health and the AMA Executive Director or their designates. The specific roles, responsibilities and duties of the MC are laid out in Schedule 3 of the AMA Agreement. Generally, these include:

- Ensuring the scope and purposes of the AMA Agreement are followed and implemented.
- Providing general direction to the Physician Compensation Committee (PCC).
- Recommending potential PCC chair candidates to the Minister and President.
- Managing the terms and conditions of the contract for the chair of the PCC.

AMA Agreement Document Reference

Page 6 Section 7, Page 14 Schedule 3.

You Might Ask

Q8.1 *Are there any decisions the MC cannot make?*

The MC does not have the authority to overrule or set aside a properly made decision/recommendation of the PCC.

Element 9. Physician Compensation Committee

What/How

The Physician Compensation Committee (PCC) has specific and focused authority in the AMA Agreement regarding physician compensation matters. The PCC will be comprised of not more than seven members and not less than three:

- Up to three members each from AH and AMA.
- An independent chair selected jointly by the Minister and the President.
- In the event that the Minister and President cannot agree on a chair, there are provisions within Schedule 5 for the appointment of the chair by the Court of Queen's Bench of Alberta.
- Voting of the PCC is by majority. The AMA will have one vote, AH will have one vote and the chair will have one vote.

The specific roles, responsibilities and duties of the PCC are laid out in Schedule 4 of the AMA Agreement. Generally, these include:

- Managing the compensation aspects of the AMA Agreement, including:
  - Allocation of negotiated increases.
  - Reviewing and adjusting fees.
  - Reviewing and determining prices for the Rural Remote Northern, Physician On-Call and Business Costs programs.
  - Reviewing and managing the distribution of funding among insured medical services, plans and programs.

The PCC does not have jurisdiction or responsibility for any program managed by the AMA through grant agreements with AH (see Element 11 Grant Agreements).

Each party will be responsible for the costs of their own PCC members and will share the costs of the chair.

AMA Agreement Document Reference

Page 7 Section 8, Page 15 Schedule 4.

You Might Ask

Q9.1 *Is there a risk of allowing majority voting with an independent chair?*

- Best results will always occur when the parties work together and reach decisions together on matters brought before the PCC. But, in the case of disagreement, the chair will have the deciding vote and there are no guarantees of outcome. In this environment, the parties need to work together, with best information available to support their decisions.

Q9.2 *How will three AMA representatives present a position for the whole AMA?*

- Up to three members will be responsible for bringing forward the views of the medical profession at the PCC. The PCC can also establish working committees and physicians will be involved in these. The AMA will be responsible for setting its own internal support and providing guidance to those representing the profession.

Q9.3 *What processes will the PCC use to make its decisions, e.g., related to fee review, fee relativity, etc.*

- The PCC will determine its own procedures. The AMA has had a long-standing view that any fee review process must:
  - Be fair.
  - Be transparent.
  - Be based on best information available.
  - Allow for the appropriate input from affected parties, e.g., sections.

Q9.4 *Will there be a new process for allocation*?

- Yes. This process will be established by the PCC. It is likely that greater emphasis will have to be applied to system objectives such as improving access, quality and productivity. Other factors that would influence allocation would include fee relativity and overhead recovery.

Q9.5 *How will the PCC determine its priorities, e.g., for future allocations?*

- The PCC mandate will be determined by the provincial strategic requirements for physician compensation, programs and plans established by AH in consultation with the AMA. The Management Committee (MC) will consult with AH and AMA on these strategic requirements and give broad general direction to PCC on priorities. The Consultation Agreements provide another channel for this system-level input.

Q9.6 *What is the term of the PCC chair?*

- The term has not yet been established. The MC will work out details of the term and contract of the PCC chair.

Element 10. Dispute Resolution

What/How

As noted in other sections of this summary, the AMA Agreement establishes ways to resolve future disputes about financial terms. Some of these processes are binding on the parties and some are not. As noted also, processes have been established for the situation where the parties cannot agree on a Physician Compensation Committee chair.

Finally, there may be instances where the parties disagree on interpretation and/or scope of the AMA Agreement. If such situations arise, the parties have agreed on a non-binding process (i.e., facilitation/mediation) to resolve the matter through the Management Committee and, as necessary, the Minister and President. Ultimately, if the parties cannot agree, each party is at liberty to pursue remedies through the courts.

AMA Agreement Document Reference

Page 18 Schedule 5.

You Might Ask

Q10.1 *What is new in these provisions for dispute resolution?*

In past agreements, the AMA has had provisions for the resolution of disputes within the term of the agreement. What is new in the AMA Agreement is that some some aspects are evergreened, i.e., there is no term and the provisions simply continue.

Most importantly, for the payments for clinical services (SOMB, ARPs and the clinical component of AARPs) and the Physician Support Programs, the recognition of the AMA, continuance and binding arbitration on rates are evergreened and survive past the date of the initial financial term of March 31, 2018. This evergreening is a major change from past agreements.

For the Physician Assistance Programs, these are subject to negotiation and non-binding faciliation and mediation. Their continuance past March 31, 2018 is subject to the agreement of both parties, otherwise they will end.

Element 11. Grant Agreements

What/How

Historically, the AMA has managed a number of programs on behalf of physicians. This has occurred under the terms of grant agreements between AH and AMA. The concept of grant agreements will continue under the terms of this AMA Agreement. Included within the grant agreements are the following programs:

- Compassionate Expense.
- Parental Leave.
- Physician and Family Support.
- Continuing Medical Education.
- Medical Liability Insurance.
- Locum Programs (Regular and Specialist).
- Physician Learning.
- Practice Management.
- Towards Optimized Practice.
- Retention Benefit.
- ARP Program Management Office.
- PCN Program Management Office.

The details of these programs including eligibility requirements are included in Schedule 6 of the AMA Agreement. Schedule 6 also provides for the AMA to use a portion of the grants for program operations, and acknowledges the ability of the AMA to charge non-members an administration fee as a condition of participation in the programs.

In general, physicians providing insured medical services are eligible for benefits and programs regardless of their source of payment.

AMA Agreement Document Reference

Page 23 Schedule 6.

You Might Ask

Q11.1 *Will I continue to receive my Retention Benefit directly from the AMA?*

- Yes. The Retention Benefit as well as funding for the other programs listed above will be paid through the AMA. The AMA will manage these programs whether they provide a service to physicians or a specific financial benefit.

Q11.2 *I don't see the Business Costs Program (BCP) on this list. Is it still part of the AMA agreement?*

- Yes. But, the BCP is not covered under a grant agreement as are the programs listed above. You will find the BCP under Physician Assistance Programs (see Element 3 Scope and Purpose).

Element 12. Consultation Agreements

What/How

The AMA Agreement generally focuses on physician compensation for the provision of insured medical services. However, physicians and the AMA have a broader role to play in the health care system. The AMA Agreement recognizes this in stating that:

"For health matters which touch and concern physicians but which are not within the stated scope and purposes of this AMA Agreement… AH will consult with and will seek the advice of AMA, from time to time."

As a step forward in this commitment to consultation, the parties have negotiated three independent Consultation Agreements that are referenced in the main AMA Agreement, each focused on a particular area of interest and importance to physicians:

- Electronic medical records (EMRs).
- Primary medical care.
- Achieving efficiencies in the health care system.

AMA Agreement Document Reference

Page 4 Section 4, Provincial Electronic Medical Records Strategy Consultation Agreement, Primary Medical Care/Primary Care Networks Consultation Agreement, System-Wide Efficiencies and Savings Consultation Agreement.

You Might Ask

Q12.1 *When do the three Consultation Agreements come into effect?*

- While they have been signed, the three Consultation Agreements each contain a clause which makes them subject to the ratification of the AMA Agreement. Hence, the ratification vote for the AMA Agreement is for the entire package of agreements: i.e., the AMA Agreement and three Consultation Agreements.

Element 12A Provincial EMR Strategy Consultation Agreement

What/How

In 2010, before the end of the previous agreement, the parties agreed to an EMR acceleration plan for which AH committed funding through March 31, 2014. As such, physician support for the implementation of EMRs, currently provided through the Physician Office System Program (POSP), will end on March 31, 2014.

The Provincial Electronic Medical Records Strategy Consultation Agreement commits the parties to develop a provincial EMR strategy that will define the future approach to EMR use in Alberta. While not a signatory to this Consultation Agreement, AHS will play a role in the strategy development, participating in a working group for the EMR strategy that will develop a report by February 15, 2014. The report will be presented to the provincial Health Information Executive Committee, for recommendation to the Minister of Health prior to March 31, 2014.

AMA Agreement Document Reference

Provincial Electronic Medical Records Strategy (following the main AMA Agreement and Schedules 1-6).

You Might Ask

Q12A.1 *What is happening to my EMR funding after March 31, 2014?*

- Physician EMR funding through the POSP will end after March 31, 2014. The EMR strategy development will identify any future support structures.

Element 12B Primary Medical Care/Primary Care Networks Consultation Agreement

What/How

The AMA Agreement does not speak directly to the future of primary medical care and Primary Care Networks (PCNs). These items are addressed in the Primary Medical Care/Primary Care Networks Consultation Agreement.

This Primary Medical Care/Primary Care Networks Consultation Agreement commits the parties to develop a framework for PCN evolution, including consideration of how this evolution will link with the broader provincial primary care strategy.

The primary care Consultation Agreement deals directly with existing PCNs by:

- Establishing a PCN Committee to provide ongoing advice on policy and issues relating to PCNs. The PCN Committee is an advisory body reporting to the Minister of Health.
- Tasking the PCN Committee with review and provision of advice on changes to the PCN per capita funding amount on an annual basis. This review process contains provisions for non-binding dispute resolution.

While AHS is not a signatory to the Consultation Agreement, AHS representation is included on the PCN Committee.

AMA Agreement Document Reference

Primary Medical Care/Primary Care Networks Consultation Agreement (following the EMR Consultation Agreement).

You Might Ask

12B.1 *What roles do established primary care structures within the AMA play in this Consultation Agreement?*

- The Primary Care Alliance is directly involved in leading the PCN evolution project, generally known as PCN 2.0.
- The AMA's PCN Physician Leads Executive will comprise the AMA's membership on the PCN Committee.

12B.2 *Why is the PCN per capita funding rate not included in the main AMA Agreement?*

- The AMA Agreement is essentially limited to compensation for insured medical services. PCN per capita funding is generally provided for non-insured services and so falls outside of the AMA Agreement.

Element 12C System-Wide Efficiencies and Savings Consultation Agreement

What/How

This System-Wide Efficiencies and Savings Consultation Agreement is a three-party agreement between AH, AMA and AHS. The parties are all interested in identifying opportunities for system-wide efficiency and savings. This Consultation Agreement brings the parties together to identify a prioritized list of proposals for system-wide efficiency and savings that are within a common sphere of the three parties. A working group will be established to identify the list of proposals. The Consultation Agreement includes an appendix of possible initiatives developed in a one-day session in early April. The list is not intended to limit the discussions of the working group, but rather is intended to be illustrative.

AMA Agreement Document Reference

System-Wide Efficiencies and Savings Consultation Agreement (following the primary care Consultation Agreement).

You might ask

12C.1 *What will be done with the list of proposals that the working group develops?*

- The working group will report to the Minister, who will consult with the Chair, AHS and President, AMA on the impact of the recommendations. Following that, the Minister may direct which, if any, of the recommendations are to be pursued.

Element 13 Table:
AMA Agreement Structure and Consultation Agreements Overview

Type	Program	Governance	Established Within	Dispute Resolution Sched 5	What Happens 2018
Insured Medical Services	Fee for Service – SOMB	PCC	Regulation	Binding Arbitration	Programs continue after March 31, 2018 with the rates being subject to negotiation and binding arbitration. Recognition, continuance and binding arbitration on the rates for these programs is an evergreen provision and survives the initial financial term of the AMA Agreement.
	ARP, clinical portion of AARP				
Physician Support Programs	Continuing Medical Education	AH / AMA Grant	AMA Grant Funded Programs		
	Medical Liability Insurance				
	Parental Leave				
	Physician and Family Support				
	Compassionate Expense				
	Physician Locums (Reg. and Sp.)				
	Practice Management				
Physician Assistance Programs	Physician Learning			Non-binding Facilitation / Mediation	Subject to negotiations, including provision for non-binding facilitation and mediation. If there is no agreement to continue the program past March 31, 2018 the program ends.
	Towards Optimized Practice				
	Retention Benefit				
	Program Management Offices				
	Business Cost	PCC	AMA Agreement		
	Physician On-Call				
	Rural Remote Northern				
Consultation Agreements	Primary Medical Care / PCN	AH	Separate Agreements		To be determined by the parties
	System-Wide Efficiencies	AMA/AH/AHS		None	
	Electronic Medical Records	AH			N/A

Analysis of the AMA Agreement vs. AMA Negotiations Objectives

Objective	Comparison
Fair and equitable settlement that recognizes the economic challenges of government and physicians.	No rate adjustments to April 1 of 2011, 2012 and 2013 is recognized as a significant challenge for physicians and a major contribution to the needs of the province. Mitigating factors: • Government has accepted responsibility for all service growth from population and other factors. • All services and programs see price and volume increases commencing April 1, 2014. • Threat has been removed to major programs (e.g., Retention Benefit, Business Costs Program).
A place at the table: Physicians have the knowledge and skill to provide advice and have a say on major issues.	AMA Agreement has a general clause requiring consultation on all matters affecting physicians. AMA Agreement provides physicians with significant input on key services and programs: • Recognition. • Grant agreements. • Physician Compensation Committee. Three Consultation Agreements provide for input on key issues: • EMRs. • Primary medical care and PCNs. • System-wide efficiencies and savings.
A more stable process with clear roles and responsibilities that is longstanding: • Recognition. • Continuance. • Dispute resolution.	Simplified, clear governance structure for clinical service payments and programs. AMA recognition and binding arbitration of rates survive the initial financial term through the evergreen provisions. These apply to: • Insured services paid by Alberta Health. • Physician Support Programs: Continuing Medical Education; Medical Liability Insurance, Physician and Family Support; Parental Leave; Physician Locums; Practice Management and Compassionate Expense. ALL physicians providing insured services, regardless of payer, are eligible for physician benefits.

Element 15. In Conclusion

The preceding table "Analysis of the AMA Agreement vs. AMA Negotiations Objectives" illustrates that many objectives the AMA established for a new agreement with government have been met. How well the AMA Agreement (if ratified) will perform against those targets depends on various factors, some of which are controlled by the AMA and some by others.

One consideration is the lengthy and often tortuous road these negotiations travelled. Events have tested the relationship between the parties. The AMA Agreement and three Consultation Agreements now provide a vehicle to begin rebuilding the relationship, but it will take time. In the end, it is not the group of agreements that will restore confidence; it is the parties themselves who have to make it happen.

Fundamentally the AMA Agreement and three Consultation Agreements do two things. They (i) form a strong consultative framework and (ii) provide processes for managing rates and programs. The opportunity and value arise from the way these two building blocks work together. Can we help to identify clear strategic requirements and objectives for the system? Can we align our programs with those of AHS and AH towards these objectives?

AHS is a signatory to only one of the Consultation Agreements (System-Wide Efficiencies and Savings). That being said, it is critical that AHS be viewed as a full partner. The overlap of AHS' mandate with that of physicians is large and affects all levels of care. Note that AHS is involved in other aspects of the AMA Agreement and Consultation Agreements. We will need to take full advantage of this.

The AMA has had its own challenges and the agreement provides a means to begin addressing them. Issues include:

- Fee relativity (both within and among sections).
- Measurement and recognition of overhead.
- Accountability for and measurement of output and performance across all payment methods.
- Allocation of new funds not only to physician requirements, but also to system objectives of access, quality and productivity.

The agreement does not determine whether we will stand up and face these or, alternatively, allow them to divide and weaken us. We must make that choice on our own.

Finally, the AMA Agreement and three Consultation Agreements are different than the previous Trilateral Master Agreement in terms of decision-making methods and the way roles and responsibilities are allocated. The AMA will have to look at our own structure to get optimal value from the agreements. For example:

- What roles and responsibilities should the Board of Directors assume? The Representative Forum? Sections? Zone Medical Staff Associations?
- How might we work differently with physicians in primary care? Secondary and tertiary? Academic centers?

Patients will be the most important partners for the medical profession in all these matters. Physicians work with patients every day; increasingly the AMA is working with the public, getting their input through surveys and initiatives like the Primary Care Summit Series. Advocating for and with patients is a direction that will flow into our work with AH and AHS.

A ratified AMA Agreement would not only conclude a lengthy period of negotiations. We hope it can mark the beginning of a productive and longstanding relationship with government and AHS that will allow us to put Patients First® in new and positive ways.