IN THE MATTER OF AN INTEREST ARBITRATION ESTABLISHED PURSUANT TO THE BINDING ARBITRATION FAMEWORK:

HIS MAJESTY THE KING IN RIGHT OF ONTARIO
(as represented by the Ministry of Health)

(the "Ministry")

- and –

THE ONTARIO MEDICAL ASSOCIATION

("the OMA")

BEFORE THE BOARD OF ARBITRATION:

Arbitrator: William Kaplan
Ministry Nominee: Dr. Kevin Smith
OMA Nominee: Michael Wright

July 2 and 3, 2025

INTEREST ARBITRATION BRIEF OF THE MINISTRY OF HEALTH

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1. INTRODUCTION

1.1 Overview and Value of Physician Services

1. The Ministry of Health (the "MOH" or the "Ministry") recognizes and values the vital health services that physicians provide to the residents of Ontario. Physicians are the most highly educated and highly skilled providers of health care services in the province. It is the government which pays for these services through our single payer Ontario Health Insurance Plan (the "OHIP"). As set out in the Health Insurance Act (Ontario) (the "HIA"), all medically necessary services are compensated through the provincially administered health insurance program in order to qualify for funding from the federal government under the Canada Health Act (the "CHA").

2. One of the key objectives of the relationship between the MOH and the physicians represented by the Ontario Medial Association (the "OMA") is to determine the terms and conditions for the payment of physician services in a manner that ensures patient care and patient access within a sustainable and publicly funded health care system. This focus is captured in the first criteria of the Binding Arbitration Framework (the "BAF") (Exhibit 1) which is reproduced below:

> *(a) The achievement of a high quality, patient-centered sustainable publicly funded health care system*

3. As such, the Award of this Board of Arbitration is of importance to Ontarians. The Board must ensure that any compensation increases awarded to physicians encourages the delivery of high-quality, accessible and convenient care. Further, that such compensation increases are considered in light of total health care spending on physician compensation, and the need to ensure a sustainable health care system.

1.2 Ministry Position

4. This Interest Arbitration Board is required to determine the price increase for Years 2, 3 and 4 of the 2024-28 Physician Services Agreement (the "PSA") under the BAF.

5. On September 12, 2024, an award for the price increase for Year 1 (April 1, 2024 to March 31, 2025) of the PSA was issued. That award is filed as Exhibit 2. This Interest Arbitration Board is also convened to decide any unresolved issues with respect to the allocation of targeted price increases for Year 1 of the PSA.

6. Both parties filed complete briefs, exhibits and rebuttals for the Year 1 arbitration. The MOH materials are filed at Exhibit 3. The OMA materials are filed at Exhibit 4.

7. This is the same Board of Arbitration that heard and decided the Year 1 arbitration. Accordingly, the Ministry will only update and expand upon the material in its submissions for the first year where appropriate and will rely on the Boards knowledge and understanding of the material already filed rather than completely replicate it here.

8. The materials filed at Exhibit 3 are part of the Ministry's presentation. The Ministry welcomes any questions from the Board on the previous submissions filed, as well as the submissions in this Brief.

9. Notwithstanding, for easy reference, the Ministry repeats the criteria set out in Section 25 of the BAF below:

> *25. In making a decision or award on any matters falling within the scope of arbitration, the arbitration board shall take into consideration the following factors and any other factors it considers relevant:*
>
> *(a) The achievement of a high quality, patient-centered sustainable publicly funded health care system;*

(b) The principle that compensation for physicians should be fair (in the context of such comparators and other factors that the arbitration board considers relevant) and reasonable;
(c) Such comparators as the arbitration board considers to be relevant, including but not limited to, physician compensation;
(d) The economic situation in Ontario;
(e) Economic indicators that the arbitration board considers relevant, including, but not limited to, the cost of physician practice;
(f) Evidence-based relativity and appropriateness considerations; and
(g) *Data sources agreed to by the parties to be reliable, or otherwise the most reliable data available*.

10. It is the Ministry's submission that the Board ought to award:

I. A Year 2 compensation increase equal to 2.25% for the "normative" increase from April 1, 2025 to March 31, 2026.

II. A Year 3 compensation increase equal to 2.0% for the "normative" increase from April 1, 2026 to March 31, 2027.

III. A Year 4 compensation increase equal to 2.0% for the "normative" increase from April 1, 2027 to March 31, 2028.

IV. The Ministry position that the above compensation increases in Years 2, 3, and 4 be split between price increases and "targeted" increases on the basis of a 90% fee increase and a 10% targeted increase.

V. The Ministry's position with respect to the very few remaining outstanding issues on the Family Health Organization (the "FHO") funding model. The parties have agreed to allocate significant targeted investments in Primary Care Physician compensation. Particularly, the parties have agreed to a modernized FHO funding model that aligns with the Governments announced objectives to improve access to Primary Care for Ontarians. While the majority of the components of a modernized FHO funding model have been agreed, there are two outstanding issues to be determined by this Arbitration Board. The

Ministry's position and submissions with respect to the outstanding issues are found in Section 8.

1.3 Context of Ministry Submissions

11. Prior to making submissions on the issues in dispute before this Arbitration Board, the Ministry respectfully submits that it is important to reflect on the point in time that this hearing is taking place. There is unprecedented change occurring as a result of the uncertainty of U.S. imposed tariffs which has an unknowable and perhaps significant impact on Ontario's economy. Inflation has plummeted to an annual rate of 1.7% (parenthetically we note that the Year 1 award referenced inflation 68 times in its reasons).

12. The Ministry takes seriously the OMA's proposals with respect to physician compensation. As will be submitted below, the parties have been working together and have largely agreed to a modernized compensation model for Primary Care physicians that will increase access to family medicine. It is the Ministry's view that while this is a time to be thoughtful and respectful of physicians and their compensation proposals, it is also a time to be prudent about the level of expenditures in these particularly uncertain times.

13. Ontario's publicly funded health care system requires tax expenditures, and the size of revenue received by Government is highly dependent on changes in the economy. In order to protect and preserve Ontario's valuable publicly funded health care system, this may well be a time where a measured and cautious approach for the next three years is warranted.

14. That notwithstanding, the Ministry's proposals before this Board identifies a commitment to a significant expenditure of public funds to support Ontario's physicians who are an integral provider within the publicly funded health care system. **The investment of new funds for physician increases attributable to the Ministry's proposal will total of $2.7 billion additional funding over the**

remaining 3 years of the PSA. The table below illustrates the accumulated new expenditures:

	$Millions
Year 2 of PSA - 2.25%	$436
Year 3 of PSA - 2.25% and 2.0%	$1,030
Year 4 of PSA - 2.25% and 2.0% and 2.0%	$1,236
Total new $ over 3 years	**$2,701**

15. The Ministry proposes that 10% of those funds be focused on targeted investments. While not matching the OMA proposals, in the context of the award for the first year, wherein the Chair noted that the substantial increase in that year addressed an OMA proposal for catch up, we respectfully submit that the government expenditure is both warranted and appropriately prudent in these uncertain times.

16. We note further that the Ministry's proposal exceeds the current inflation level of 1.7% and as such does no harm to the relative compensation levels arising out of the first year award.

17. This Ministry will provide detailed submissions to the following considerations in this brief:

    I. The Award for Year 1 of this PSA has already made observations and conclusions that must guide the Board in the determination of the remaining outstanding issues and Year 2, 3 and 4 physician compensation increases.

    II. That 10% of the normative compensation adjustment being directed to targeted investments is an appropriate allocation to targeted investments, particularly in

light of the significant targeted investments awarded in Year 1 of this PSA. Further, that any determination on OMA proposed targeted investments and changes to physician compensation are complex and best left to the parties to decide.

III. That Arbitral precedent shows that significant consideration should be taken of the economic climate, including the climate at the time of the hearing, when deciding matters of compensation.

IV. The evidence presented will show that:

(i) inflation at 1.7% is significantly lower and well below the level of increase proposed by the Ministry;
(ii) the Canadian economy has softened and economic risks to the economic outlook have increased considerably;
(iii) there is a rising unemployment rate and
(iv) GDP Per Capita is on the decline. Economic growth has been modest in recent quarters. In the near term, economic growth remains uncertain and could easily moderate further depending on the impact of U.S. tariffs.

V. The arbitrable precedents would support deviation from settlement trends given the significance of the change to the current economic climate. Notwithstanding this, a significant number of settlements in 2025 and following fall in the low 2% range.

VI. Sustainability of the publicly funded health care system is a criteria this Arbitration Board is to take into consideration. The expenditure of health services coupled with low rates of productivity in the Canadian economy resulting is sub par Nominal GDP growth has meant that the share of income devoted to healthcare has increased substantially.

18. The Ministry submissions are focused on these above identified considerations.

2. ARGUMENTS, OBSERVATIONS AND CONCLUSIONS IN THE YEAR 1 AWARD

2.1 Conclusions of the Year 1 Award

19. This Interest Arbitration is being argued and decided in the context of an already determined Year 1 of a four year agreement.

20. In February 2024, the parties agreed in their "Implementation and Procedural Agreement" (Exhibit 5) to address the issue of price increases for the 2024-28 PSA in two phases. The parties agreed that in Phase One, the Board would hear and decide the appropriate price increase for Year 1 (April 1, 2024 to March 31, 2025).

21. Thus, many of the arguments with respect to the appropriate four year PSA have already been heard and conclusions have been drawn by this Board of Arbitration. The Ministry first reviews the conclusions of this Board in the Year 1 award, which must necessarily have direct application to Years 2,3,4 of this same agreement as well as the resolution of any Year 1 issues. This Ministry submits that the Board must necessarily adhere or "stand by" those conclusions reached in its previous award. Further, the Ministry will review the award's articulation of the arguments of the parties and the Chair's discussion of that advocacy in the Year 1 award. The Ministry submits this Board should be very cautious of any inconsistent arguments the OMA now attempts to advance that contravenes their earlier arguments. Finally, the Ministry will conclude with the overall objective of the decision with respect to the 2024-2028 PSA, as articulated by the Chair in the award for Year 1.

22. In the overall conclusion for the award at page 70, this Chair stated:

> *In our view, in addition to the targeted investments that the Ministry identified in its submissions, the Government needs to invest in targeted spending on physician services, about which we express the following views (in anticipation of the next phase of these proceedings). Targeted*

> *investments must be directed at ensuring that currently attached patients, and patients who become attached, have ready and timely access to their primary care physicians. Targeted investments must be directing at attaching more patients to a primary care doctor. As well, given the evidence of the decline in the number of patients seen – and while the parties did not agree on the explanation for this phenomenon – it is extremely concerning and is, in any event, not sustainable. As a result, targeted investments should be structured in such a manner that rewards or recognizes improving the number of patients seen in a timely way. Moreover, while the focus of targeted spending should certainly include primary care (as noted above, particularly attaching the unattached) there is also a physician distribution problem requiring urgent attention through targeted spending or otherwise, including the servicing of underserviced communities. As well, the administrative burden must be promptly addressed so that doctors can prioritize clinical care over administrative duties. In addition, there should also be some degree of targeted support for emergency medicine, the restructured HOCC program, and certain APPs. As for other targeted investments, the parties are obviously in the best position to attempt to reach agreement on remaining areas which may include the various matters referred to in the parties' Procedural and Implementation Agreement.*
>
> *We understand that our award – both the normative amount and the redress/catch-up amount – will satisfy neither party. Those redress/catch-up claims result from the unprecedented inflation that arose contemporaneously with the previous PSA compounded by Bill 124 bargaining distortions. In any event, redress/catch-up is now resolved. Intensive negotiations and mediation will now take place over compensation increases in Years 2, 3 and 4 (including, where appropriate, specific targeted amounts), together with the allocation of the Year 1 targeted increases, with arbitration to follow where agreement cannot be reached.*

23. The conclusions reached in the Year 1 award have, in our submission, guided the work that the parties have done bilaterally to resolve many significant issues between them and ought necessarily to guide the Ministry's submissions for Years 2, 3 and 4 of this PSA. In other words, these conclusions should clearly inform the resolution of disputes related to unresolved Year 1 targeted investments.

24. The Chair of the Arbitration Board made it clear that any issues with respect to redress/catch up is now resolved. While it is tempting for the Ministry to reargue

the historical context and what the level of increase could or should have been given the OMA's arguments for redress/catch up, such argument can have no weight when made in the context of this four year agreement. The first year has been determined to have taken the historical context into account and resolved this OMA argument on redress/catch up.

25. If either party is pursuing an argument that asks the Arbitration Board to revisit the overall conclusion in Year 1 of this award, that very significant onus rests with the party arguing a departure from the conclusions.

26. With respect to conclusions made on targeted investments, the award for Year 1 states definitively that:

> *Targeted investments must be directed at* ***ensuring that currently attached patients, and patients who become attached, have ready and timely access to their primary care physicians.*** *Targeted investments must be directing at attaching more patients to a primary care doctor. As well, given the evidence of the decline in the number of patients seen – and while the parties did not agree on the explanation for this phenomenon – it* ***is extremely concerning and is, in any event, not sustainable. As a result, targeted investments should be structured in such a manner that rewards or recognizes improving the number of patients seen*** *in a timely way.*

27. The Ministry's arbitration position on targeted investments for FHOs captures this focus. The award continues in that same vein, stating:

> *Moreover, while the focus of targeted spending should certainly include primary care (as noted above, particularly attaching the unattached) there is also a* ***physician distribution problem requiring urgent attention through targeted spending or otherwise, including the servicing of underserviced communities****. As well, the* ***administrative burden*** *must be promptly addressed so that doctors can prioritize clinical care over administrative duties.*

28. The distribution problem and underserviced areas are addressed comprehensively in the Year 1 targeted investment award for Rural and Northern communities, which itself recognized that many of the issues in dispute were

resolved consensually prior to the Board having to resolve a small set of outstanding issues.

29. On the question of resolving targeted investments the award notes:

> *As for other targeted investments, the parties are obviously in the best position to attempt to reach agreement on remaining areas which may include the various matters referred to in the parties' Procedural and Implementation Agreement.*

30. With respect to catch-up or redress, the conclusions of the award are clear where it stated:

> *In any event, redress/catch-up is now resolved. Intensive negotiations and mediation will now take place over compensation increases in Years 2, 3 and 4 (including, where appropriate, specific targeted amounts), together with the allocation of the Year 1 targeted increases, with arbitration to follow where agreement cannot be reached.*

31. The Ministry's position at this arbitration hearing is made within the context of the above conclusions and comments.

3. TARGETED INVESTMENTS

3.1 Ministry Proposal for a "90/10" Split

32. The Ministry proposes that the price increase be split between a "targeted" increase and price increases on the basis of a 90% fee increase (which will go through the targeted fee increase process described below) and a 10% targeted increase.

33. As they did in their Year 1 Brief, the Ministry is concerned that the OMA will argue that the general price increase should be attributable to the basis for their economic adjustment proposal and the targeted increase should be attributable to their many special additional proposals beyond price adjustments. **The Ministry disagrees completely.**

34. Respectfully, the Board should decide what price increase is appropriate, taking all factors into account and establish the overall percentage increase first. Then the split is automatic. This is the "top down", not "bottom up", analysis that the Ministry agreed to when entering into the 2023 Physician Services Agreement for Year 3/Year 1.

35. The history of bargaining favours entirely the "top down" approach to this matter. First, the prior voluntarily reached settlement (the 2021 PSA) provided that the Year 3 compensation increase would be first spent on targeted areas. The parties agreed that Hospital On Call Coverage ("HOCC") and the Alternative Payment Plans ("APPs") would be the first to receive available funding stemming from any increases. We provide below the excerpt from paragraph 8 of the 2021 PSA:

> *8. A prospective compounded adjustment to physician payments in the amount as determined pursuant to paragraph 6 (a) and (b) will be permanently allocated on the following basis:*
>
> *Step 1*

a) 1/5th of the year 3 increase, up to $75 million, will be added to the existing HOCC funding to fund the new burden-based Hospital On-Call Program, as described in paragraph 14 below, and in Appendix B;

b) 1/10th of the year 3 increase, up to $50 million, will be allocated to fund Alternate Payment Programs, as described in paragraph 16 below, and in Appendix C.

Step 2

c) 1/4 of the year 3 increase, after the provisions made in a) and b), will be allocated to each section or physician grouping on an equal percentage amount; and

d) 3/4 of the year 3 increase, after the provisions made in a) and b), will be allocated to each section or physician grouping, based on the hybrid CANDI-RAANI score, using updated fiscal 2022/23 data, and any methodological or other changes to the relativity tool as agreed by the parties.

36. As noted earlier, even the price increases in the previous settlement were split between general price increases and targeted fee increases. The settlement provided a 1% increase in Year 1, a 1% increase in Year 2, and a potential further increase in Year 3. The parties agreed that the increases from Year 1, 2 and potential Year 3 (after the targeted increases into HOCC and APP), that ¼ of the increases were allotted as general increases. The remaining ¾ of the increases were allocated to sections based on the RAANI-CANDI formula. The RAANI-CANDI formula allocates more funds to some physician sections and less to others. After that exercise the sections allocate their allotment enabling special adjustments to individual fee codes where the MOH and Section agree it is needed through a process called the Physician Payment Committee ("PPC").

37. As a result of the 2021 agreement, the parties agreed to establish an ongoing PPC which replaced previous bilateral committees that reviewed and made recommendations on the implementation of price increases. The mandate of the PPC is, among others, to make recommendations on an annual basis to PSC regarding:

> *Addition, revision and deletion of fee codes in the Schedule of Benefits based on the allocation to each section of the normative fee increases, having regard to such factors as time, intensity, complexity, risk, technical skills and communication skills required to provide each service, as well as flow-through and any other financial changes to non-fee for service contracts and to other programs…*

38. Historically, there have been fees which, in the opinion of the OMA, were not deserving of a fee increase. In these instances, the fees have achieved no increases or increases below the general ATB for these fees. The funds which were not applied to these fees (the fees excluded from the ATBs) were instead redirected to enhance other fees at levels above the average ATB.

39. To further explain, we take the example of the Year 2 permanent increase of 2.01% under the 2021 PSA. The allotment to certain sections were as low as 0.52% and some allotments were above 2.01%, with the overall increase being 2.01%. Furthermore, within a section, the parties agreed to allocate the increases such that some fees/compensation items would receive NO increase, while other would receive an adjustment above that sections allotment.

40. The table on the following page illustrates the allotment to sections for the 2.01% permanent adjustment in physician payments in Years 1 and 2 of the 2021 PSA. This is based on the RAANI CANDI methodology for relativity as agreed to by the parties in the 2021 PSA:

Group	Description	April 1, 2023 (%)	ALLOCATION
23	Ophthalmology	0.5186%	$1,815,872
41	Gastroenterology	0.8916%	$1,531,711
33	Diagnostic Radiology	1.0826%	$8,681,280
1	Anaesthesiology	1.1899%	$6,267,541
9	Cardiac Surgery	1.2089%	$494,096
34	Radiation Oncology	1.2089%	$913,533
60	Cardiology	1.5257%	$6,181,942
44	Medical Oncology	1.5736%	$133,073
35	Urology	1.5982%	$2,105,090
28	Laboratory Medicine group	1.6231%	$1,060,798
16	Nephrology	1.7005%	$1,863,195
4	Neurosurgery	1.7271%	$758,583
6	Orthopaedic Surgery	1.7271%	$4,461,646
00_1	GP-1	1.7817%	$7,285,702
24	Otolaryngology	1.7817%	$2,022,491
15	Endocrinology	1.8383%	$1,654,452
62	Clinical Immunology	1.8673%	$322,970
8	Plastic Surgery	1.8967%	$1,567,368
2	Dermatology	2.0202%	$2,086,989
12	Emergency Medicine group	2.0524%	$4,088,273
5	Community Medicine	2.0742%	$11,966
11	Critical Care	2.0751%	$3,460,517
63	Nuclear Medicine	2.1187%	$434,021
17	Vascular Surgery	2.1527%	$811,451
48	Rheumatology	2.1527%	$1,533,306
3	General Surgery	2.1876%	$6,862,183
61	Haematology	2.3334%	$687,124
64	General Thoracic Surgery	2.3716%	$511,632
13	Internal and Occupational Medicine	2.4107%	$12,206,524
22	Genetics	2.4107%	$69,788
26	Paediatrics	2.4107%	$7,286,743
31	Physical Medicine & Rehabilitation	2.5753%	$1,468,001
47	Respiratory Disease	2.5753%	$2,583,650
00_2	GP-2	2.6186%	$26,484,033
7	Geriatrics	2.7081%	$811,861
20	Obstetrics & Gynaecology	2.7081%	$9,510,104

Group	Description	April 1, 2023 (%)	ALLOCATION
18	Neurology	2.8012%	$3,390,280
46	Infectious Disease	2.8012%	$920,385
19	Psychiatry	3.0540%	$15,271,787
00_3	GP-3	3.3385%	$25,979,543

41. The increases are then allotted to each section and split between the fees/compensation elements of the section. The Ministry provides below how the parties agreed to allocate the Year 1 and 2 permanent 2.01% increase for Primary Care fee codes:

Fee Code	Descriptor	2021 Fee Value	New Fee Value	Fee Increase	Percent Increase
A003	GP/FP - General assessment	$84.45	**$87.35**	$2.90	3.43%
C003	GP/FP - Non-emergency hospital in-patient services - General assessment	$84.45	**$87.35**	$2.90	3.43%
A005	GP/FP - Consultation	$84.45	**$87.90**	$3.45	4.09%
C005	GP/FP - Non-emergency hospital in-patient services - Consultation	$84.45	**$87.90**	$3.45	4.09%
W105	GP/FP - Non-emergency LTC in-patient Services - Consultation	$77.20	**$87.75**	$10.55	13.67%
A007	GP/FP - Intermediate assessment/well baby care	$36.85	**$37.95**	$1.10	2.99%
A917	GP/FP - Focused Practice Assessment (FPA)- Sport medicine FPA	$36.85	**$37.95**	$1.10	2.99%
A927	GP/FP - Focused Practice Assessment (FPA) - Allergy FPA	$36.85	**$37.95**	$1.10	2.99%
A937	GP/FP - Focused Practice Assessment (FPA) - Pain management FPA	$36.85	**$37.95**	$1.10	2.99%
A947	GP/FP - Focused Practice Assessment (FPA) - Sleep medicine FPA	$36.85	**$37.95**	$1.10	2.99%
A957	GP/FP - Focused Practice Assessment (FPA) - Addiction medicine FPA	$36.85	**$37.95**	$1.10	2.99%
A967	GP/FP - Care of the elderly FPA	$36.85	**$37.95**	$1.10	2.99%
A888	GP/FP - ED equivalent - Partial assessment	$36.85	**$37.95**	$1.10	2.99%
A777	GP/FP - Intermediate assessment - Pronouncement of death	$36.85	**$37.95**	$1.10	2.99%

C777	GP/FP - Non-emergency hospital in-patient services - Intermediate assessment - Pronouncement of death	$36.85	**$37.95**	$1.10	2.99%
Fee Code	**Descriptor**	**2021 Fee Value**	**New Fee Value**	**Fee Increase**	**Percent Increase**
W777	GP/FP - Non-emergency LTC in-patient Services - Admission assessment - Intermediate assessment - Pronouncement of death	$36.85	**$37.95**	$1.10	2.99%
A900	GP/FP - Complex house call assessment	$45.15	**$54.50**	$9.35	20.71%
A902	GP/FP - House call assessment - Pronouncement of death in the home	$45.15	**$54.50**	$9.35	20.71%
A905	GP/FP - Limited consultation	$72.10	**$73.25**	$1.15	1.60%
C905	GP/FP - Limited consultation	$72.10	**$74.25**	$2.15	2.98%
A911	GP/FP - Special family and general practice consultation	$144.75	**$150.70**	$5.95	4.11%
C911	GP/FP - Non-emergency hospital in-patient services - Special family and general practice consultation	$144.75	**$150.70**	$5.95	4.11%
W911	GP/FP - Non-emergency LTC in-patient Services - Special family and general practice consultation	$144.75	**$150.70**	$5.95	4.11%
A912	GP/FP - Comprehensive family and general practice consultation	$217.15	**$226.05**	$8.90	4.10%
C912	GP/FP - Non-emergency hospital in-patient services - Comprehensive family and general practice consultation	$217.15	**$226.05**	$8.90	4.10%
W912	GP/FP - Non-emergency LTC in-patient Services - Comprehensive family and general practice consultation	$217.15	**$226.05**	$8.90	4.10%
G010	Laboratory Medicine - Miscellaneous - one or more parts of above without microscopy	$2.14	**$2.64**	$0.50	23.36%
G365	Gynaecology - Papanicolaou Smear - Periodic	$8.65	**$12.00**	$3.35	38.73%
G420	Otolaryngology - Ear syringing and/or extensive curetting or debridement unilateral or bilateral	$11.35	**$13.15**	$1.80	15.86%
G538	Injections and Infusions - Immunization - Other immunizing agents not listed above	$4.95	**$5.80**	$0.85	17.17%
G590	Injections and Infusions - Immunization - Influenza agent	$4.95	**$5.65**	$0.70	14.14%
G841	Injections and Infusions - Immunization - Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus, Haemophilus influenza type b (DTaP- IPV- Hib) - Paediatric	$5.40	**$6.35**	$0.95	17.59%
K017	GP/FP - Periodic health visit - Child	$43.60	**$45.25**	$1.65	3.78%

K131	GP/FP - Periodic health visit - Adult age 18 to 64 inclusive	$54.00	**$56.95**	$2.95	5.46%
K132	GP/FP - Periodic health visit - Adult 65 years of age and older	$77.20	**$80.95**	$3.75	4.86%
P003	Obstetrics - Prenatal care - General assessment (major prenatal visit)	$77.20	**$80.35**	$3.15	4.08%
Fee Code	**Descriptor**	**2021 Fee Value**	**New Fee Value**	**Fee Increase**	**Percent Increase**
P004	Obstetrics - Prenatal care - Minor prenatal assessment	$36.85	**$38.15**	$1.30	3.53%
P005	Obstetrics - Prenatal care - Antenatal Preventative Health Assessment	$45.15	**$47.70**	$2.55	5.65%

42. As can be seen from the above, the parties chose to increase some of the primary care fee codes as much as 38%, whereas approximately 200 other primary care fee codes received **zero** increases.

43. As can be established from the above, physician fee changes are unlike any traditional bargaining increase that are negotiated or awarded, where there is a general increase for all classifications and occasionally special adjustments for classifications that have fallen behind market. The determination of fee changes for physicians is virtually all special adjustments.

44. The Ministry also notes that this method of allocation of increases is not unique to the last settlement. It has applied generally to physicians pre BAF and post BAF. Fee increases have traditionally been negotiated as “across the board” but have traditionally not been implemented “across the board”.

45. As an example, we excerpt below from *Ministry of Health and Long Term Care and Ontario Medical Association* award (unreported) for the April 1, 2017 to March 30, 2021 PSA (**Exhibit 6**):

> *Except as specifically noted above, the distribution of the fee increases we have awarded is subject to relativity adjustments. The parties have agreed that in years one and two the PSA settled by this*

> *award that this distribution is governed by the terms of the parties' interim relativity agreement. The board remains seized in respect of years three and four should the parties be unable to agree, and this matter can proceed in the next phase of these proceedings.*

46. The Year 1 Award by this Board of Arbitration for these parties completely reinforces this history. As the Chair states at page 69 of his award:

> *The Normative Amount*
>
> *We award 3% for Year 1. We have not, as the OMA proposed, increased the normative increase in Year 1 beyond 3% to reflect what the OMA has asserted as the need for further targeted compensation increases. We recognize that for years 2, 3 and 4, the issue of targeted investments will be open for the parties to negotiate and failing resolution referred to and determined by arbitration.*
>
> *The Redress/Catch-up Amount*
>
> *We award an additional redress/catch-up amount of 6.95%. We do so for the reasons set out above, including acknowledgement that unlike hospital healthcare, this amount is not retroactive, and that there is a pattern of settlements in the public and broader public sectors; notably the specific ONA, CUPE/SEIU and OPSEU hospital healthcare awards referred to above. Those awards specifically address both inflation during the period of the previous PSA and remediate the impact of Bill 124 that directly influenced and constrained the previous outcomes. We note, as well, that we have specifically taken into account the 4.8% already agreed to including the 2.8% for Year 3.*

47. It is clear that the Chair decided what price increase is appropriate taking all factors into account and established the overall percentage increase first.

48. The Ministry submits that a 90/10 split is a justified departure from the previous agreement to split normative increases by 70/30 in the Year 1 award. This Arbitration Board's Award in Year 1 of a 9.95% price increase resulted in a targeted investment of $488 million dollars. A portion of this significant investment has already been allocated by the parties in the priority areas of Emergency Departments, Rural and Northern Communities (including Kenora and Sioux

Lookout, the underserviced areas programs and RNPGA) and the Pregnancy and Parental Leave Benefit program (totaling $126.4M in targeted investments). Further, while the parties have a few outstanding matters on the model, they are mostly agreed on the allocation of $209M of targeted investments in Primary Care, the areas particularly emphasized by this Chair in the Year 1 award as needing further targeted investments.

49. As such, there is still $152.6M to be allocated to targeted investments. This significant remaining allocation, along with the Ministry's proposal for 10% of normative adjustments in Years 2, 3 and 4 to be directed to targeted investments is reasonable for addressing those areas of the health system requiring targeted funding in this PSA.

3.2 The Complexity of Targeted Investments

50. The Ministry expects the OMA to continue to advance those targeted investment proposals pursued in the Year 1 arbitration brief. It is the Ministry's submission that the negotiations of the targeted investments pursuant to the Year 1 award of this Board is best left to the Parties to determine. Such an approach is critically important and arguably necessary for the Arbitration result to reflect logical and defensible changes to the compensation elements and proposals pursued by the parties. The compensation system for physicians is, to say the least, complicated. The expertise needed to resolve these complicated issues resides with the parties. The risk of unintended consequences is high. The spill over effect of a given change on other specialties is real.

51. The OMA recognizes that it is the parties, not this Board of Arbitration, that are best suited to determining any areas of targeted investments, how they are implemented and the amount needed to be allocated. In the OMA's May 1, 2024 Year 1 Brief at Page 163 (paragraph 442) they state:

> *The parties are not asking that the issue of targeted increases being addressed in the initial phase of the Year 1 arbitration, and indeed they have agreed that they will not be so determined. Once the amount of the Year 1 increase has been determined, the parties will attempt to agree on the specific targeted increases that are to be implemented and the amount to be allocated to each of them. Any disputes with respect to these issues will be submitted to the Board of Arbitration for final and binding determination. As is apparent from the following, however, the OMA has identified some areas which can be and should be addressed immediately.*

52. The parties agreed that the Board should not address the targeted increases in Year 1 arbitration. That is because both the Ministry and OMA recognized that the funding mechanisms for physician compensation are diverse and complex, each with its own strengths and weaknesses in incentivizing efficient and equitable care and ensuring access to quality healthcare. It is the parties, and the not the Board of Arbitration, that are best positioned to review and agree to where and how such investments are implemented.

53. Interest arbitrators have consistently declined to make awards on matters that are more complex, require major changes, and where further discussions were needed between the parties. It is well recognized that interest arbitration is not designed or equipped to address such complex issues. As per Arbitrator Hayes in *York University and Canadian Union of Public Employees Local 3903*:

> *19. It is important to be clear about what interest arbitration is not designed to do. An Interest Arbitrator is not a Task Force charged with exploring and recommending a range of solutions to complex issues. An intrinsically adversarial interest arbitration for a single publicly funded university is certainly not equipped to get to the root of job security issues presented in post-secondary institutions across North America.*
>
> *20. In this respect, the Union's perspective as recorded in the Kaplan Report is not misconceived. It presaged genuine concern that third party adjudication could not possibly meet member expectations. It squarely recognized that it is the parties who are best suited for such a task:*

> *Indeed, in Local 3903's submission, the complicated Unit 2 job security proposals require detailed and nuanced discussion between the parties – discussions that necessarily engage institutional principles and fundamental academic goals, not to mention the needs of the union members as both educators and, in some cases, students. These matters, along with the other issues in dispute, were reviewed by the union and the point made that the only possible solution, in the union's estimation, was for the parties to return to the table and achieve a bargained outcome. Interest arbitration was a blunt instrument only to be used in the most extreme cases, and it was one, in any event, that was particularly poorly suited to the resolution of a difficult and challenging problem – one requiring complex and creative solutions.*
>
> *21. This Award can only reflect an informed opinion as to a rational result having regard to the specific local circumstances presented at this one point in time*

54. The Ministry submits for the same reason the parties agreed that the Board should not address the targeted increases in the Year 1 arbitration, the Board should be cautious in making any determinations on not only the areas requiring targeting investments in Years 2,3,4, but the level of targeted investments required. The OMA's submissions on targeted investments reflect their advocacy position, as they did in their Year 1 brief as well.

55. The two areas where the parties agreed upon targeted investments in Year 1 are prime examples of the complexities of physician renumeration that are best left to the parties to resolve. While the OMA has made proposals in their Year 1 brief with respect to targeted investments in Emergency Departments and RNPGAs, respectfully, their proposals lacked the complex and creative solution that was ultimately awarded after several days of direct negotiation and mediation which focused the Ministry and OMA on these issues.

56. For example, the April 21 2025 award with respect to targeted funding for Emergency Departments, primarily reflecting agreement between the parties, is a nuanced and tailored approach to addressing physician staffing across the various sites and the regions they operate within. Physician renumeration for

emergency clinical services are particularly complex, with multiple different models for payment for physician services depending on the region, number of patients and volume of service, and the group of physicians desires working in that particular emergency department. The parties were able to reach agreement on premiums to incent physicians to take on more Emergency Department Shifts, increase base funding at a greater rate for Northern sites in order to attract to these geographical areas, as well as provisions that instituted greater rigor for physicians groups to ensure they had a plan to cover the emergency department for the year.

57. The Chair of this Arbitration Board would know that many of the targeted investments which the OMA pursued in their Year 1 brief, and which the Ministry expects the OMA will continue to pursue, are incredibly complex. This Chair mediated and issued the awards with respect to Emergency Departments and Underserviced areas. This Chair was also involved with the mediation of further targeted investment proposals of the OMA and as such, the complexity of the compensation structures of those areas of targeted investments. Clearly, physician compensation is multifaceted and any targeted investments require extensive discussions between the parties. Respectfully, it is the parties, and not this interest arbitration board, that are best positioned to make determinations on target investments in a manner which will incentivizing efficient, equitable and accessible health care delivery to Ontario.

4. CHANGED ECONOMIC AND FISCAL CLIMATE

4.1 Impact of Changed Economic and Fiscal Climate on Interest Arbitration

58. Historically, the normal economic cycles have created fiscal problems and retrenchment in the past and the interest arbitration process has responded accordingly. The Ministry reviews the awards of an extensive list of highly respected arbitrators who clearly modified previously established bargained or arbitrated patterns because the economic environment had changed.

59. It will be noted from a review of awards from earlier times of "changed circumstances" that in such times, arbitrators have dramatically diverted from the pre-existing trends. Arbitral precedent and common sense would support the proposition that dramatic changes in the economic climate must compel the decision of interest arbitration boards**.**

60. The BAF criteria for this Board to consider includes **(d) the economic situation in Ontario.**

61. Arbitrations Boards have historically placed significant weight on the economic conditions when rendering decisions. In the strike/lockout environment, wage settlement levels in the public sector are driven by the economic realities. We submit that any appropriate application of replication requires such a result in interest arbitration.

62. We review on the following pages how interest arbitration has addressed similar changed circumstances in the past. A summary table highlights the Arbitration results in Ontario in meaningful and comparable years:

Year	Award	Awarded Increase (Annual)	Award Below Trends (Annual)	MoL Private Sector Increase [1]	Industry Sector Increase
2012	Unifor & Extendicare	0.0%	1.2%	1.2%	**
2012	SEIU & Participating LTC	0.0%	1.2%	1.2%	**
2011	ONA & Hospitals	0.9%	1.1%	1.9%	2.0%
2011	OPSEU & Hospitals	0.9%	1.1%	1.9%	2.0%
2011	ONA & Nursing Homes	0.9%	0.8%	1.9%	1.7%
2009	OPSEU & Hospitals	2.5%	0.5%	1.3%	3.0%
1993	U of T & UTFA	0%	1.9%*	1.9%	*
1991	Brantford & Police	5.3%	1.2%	4.6%	6.5%
1991	Metro & Teachers	3.6%	2.4%	4.6%	6.0%
1992	Orillia & Police	2.0%	1.56%	2.7%	3.5%
1992	Leamington & Police	2.0%	1.56%	2.7%	3.5%
1993	Edward Street Manor	1.7%	2.5%	1.9%	4.2%
1993	Mennonite Home	3.0%	3.0%	1.9%	6.0%
1993	Versa-Care Center	1.5%	4.75%	1.9%	6.25%
1993	ONA & Nursing Homes	1.5%	11.5%	1.9%	13.0%
1996	Marycrest Home	0%	1.9%*	2.2%	*
1996	Guelph & Police	0%	3.05%	2.2%	3.05%
1996	SEIU Master	0%	2.2%*	2.2%	**
1997	SEIU Master	1.0%	2.3%*	3.3%	**
1998	SEIU Master	1.0%	2.1%*	3.1%	**

* No sector trend established. Comparison based on private sector settlement trends.
** Leading Award for the Sector

[1] Ontario Ministry of Labour Dispute Resolution Services Collective Bargaining Information Services, Ontario Collective Bargaining Reviews 1998-2012

4.2 Case Review – Changed Economic Climate

2012 (Teplitsky and Kaplan)

63. The September 2012 Teplitsky award for Participating Nursing Homes and SEIU and the subsequent 2012 Kaplan Award for Extendicare Nursing Homes and UNIFOR represent significant awards for the health care sector, as both awards reflected the impact of the drastically changed economic climate. In both decisions, the Arbitrators awarded wage freezes for the two years of the agreement. These awards reflected the extraordinary toll that the uncertain economic climate took on the Ontario Economy and the financial health of the Ontario Government.

64. In Mr. Kaplan's decision for Extendicare and UNIFOR he specifically referenced funding and the economy and it's influence on his award:

> *In determining the outstanding issues, I have been guided by the legislative criteria. They are set out in the Hospital Labour Disputes Arbitration Act. Both parties referred to them in their written materials, and those materials have been carefully reviewed. There is no doubt, for example, that the economic situation in Ontario is very troubled. In 2012, the government increased funding to the nursing envelope by only 1%. A significant portion of the employees in these bargaining units have their wages and compensation funded through the nursing envelope. While this point is elaborated below, it is quite clear that the economic situation in Ontario has influenced both collective bargaining settlements and interest arbitrators and thus appropriately informs the disposition in this award.*[2]

65. In his award for the SEIU Master group, Mr. Teplitsky recognized the link between the economy and collective bargaining results:

> *Re: 9.(1)(1.3) Judging by the size of the deficit in Ontario, and the results of collective bargaining generally, the economic situation is not robust.*[3]

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[2] *Extendicare v CAW, Local 302*, 2012 CanLII 58551 (ON LA), <https://canlii.ca/t/ft3jn>

[3] *Participating Nursing Homes and Service Employees International Union Local 1 Canada*, September 27, 2012

66. He also referenced the influence of collective bargaining results and Government initiatives in a difficult economic environment on his award:

> *Since 2000, these employees have bargained or been awarded increases which follow public sector results. For the relevant period of this award, or at least two years thereof, "0" increases will be the norm. The results of recent settlements coupled with aggressive Government initiatives, makes this conclusion a certainty. The private sector has its own share of "0" increases. The recent settlements with Ford, GM and Chrysler and CAW illustrate this fact. In the result, I award a "0" increase in year one and year two; a wage reopener in year 3 and following the Red Cross settlement, supra¸ a lump sum of .15 cents per hour worked payable in the final week of each of the first 2 years of the agreement.*

67. The Ministry of Labour reported the trends in the public sector for those years 1.4%.

	Date	Ontario Deficit in $ billions	Ontario Net Debt in $ billions	Ontario Debt as % of GDP	MoL Public Sector Increases	MoL Private Sector Increases
Year Before Previous Agreements Expiry Date	2011	$15.0	$214.5	37.2%	1.6%	1.9%
Year of Release Date of Award	2012				1.4%	1.2%

2011 (Devlin, Kaplan, Stanley)

68. The June 2011 interest arbitration awards of Arbitrators Devlin (ONA)[4] and Kaplan (OPSEU)[5] and the Participating Hospitals for the Hospital sector represent significant awards for the health care sector in their reflection of the drastically changed economic climate. In awarding net wage freezes to the base in two of the three years of the renewal terms, these awards reflect the extraordinary toll that the recession took on the Ontario economy and the financial health of the Ontario government.

69. These central ONA Hospital and OPSEU Hospital awards reflected the considered recognition of two seasoned and respected arbitrators that economic realities would not sustain the rates of increase negotiated or awarded previously within the health care sector.

70. Arbitrator Devlin's and Arbitrator Kaplan's awards clearly and compellingly overturned the 2%/annum hospital service worker wage pattern that was entrenched in the August 2009 CUPE and CAW central hospital settlements for terms extending into 2013 and 2012 respectively. The awards provide 0% increase in 2011 and 2012 and 2.75% in 2013. The average increase over the three years was 0.9%.

71. The Devlin (ONA) and Kaplan (OPSEU) awards were 2% below the existing CUPE Hospital trend.

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[4] *The Participating Hospitals and Ontario Nurses' Association,* June 2, 2011

[5] *The Participating Hospitals and Ontario Public Service Employees Union*, June 17, 2011

	Date	Ontario Deficit in $ billions	Ontario Net Debt in $ billions	Ontario Debt as % of GDP	MoL Public Sector Increases	MoL Private Sector Increases
Year Before Previous Agreements Expiry Date	2010	$14.0	$193.6	35.0%	2.0%	2.1%
Year of Release Date of Award	2011	$15.0	$214.5	37.2%	1.6%	1.9%

The Bargaining Context in the Hospital Sector Prior to Arbitrator Devlin's Award

72. In rounds of negotiations prior to the Devlin Award, RNs within the central ONA Hospital bargaining process had generally commanded a higher rate of wage and compensation adjustment relative to other Hospital Unions due to the market realities occasioned by a shortage of nurses.

73. In his November 2009 interest award for the central Hospitals and OPSEU[6] for the two year term of April 1, 2009 – March 31, 2011, Arbitrator Gray awarded a modestly lower rate of increase in recognition of the changed economic climate, awarding a 2.5% in each of 2009 and 2010. Historically, the ONA Hospital central bargaining outcomes had established the pattern for the OPSEU Hospital central process, but Arbitrator Grey awarded a modestly lower rate of increase.

74. During the summer of 2009, CUPE and CAW bargained settlements in their central bargaining processes with the Hospitals. CUPE negotiated a four year term, September 29, 2009 – September 28, 2013, with 2% general wage increases in each of the four years. CAW negotiated a three year settlement,

[6] *Participating Hospitals and Ontario Public Service Employees Union and its participating locals,* November 4, 2009

October 11, 2009 – October 12, 2012 with 2% general wage increases in each of the three years.

75. SEIU did not achieve a settlement in its central hospital process and proceeded to arbitration for a two year term, October 11, 2009 to October 10, 2011. In his November 2010 award[7], Arbitrator Burkett awarded a 2% wage increase in each of the two years.

Arbitrator Devlin's 2011 Award for the Central Hospital/ONA Agreements

76. Arbitrator Devlin's award applies to 137 Hospitals and 45,000 Registered Nurses and covered a three year term from April 1, 2011 – March 31, 2014.

77. In the first two years of the term, Arbitrator Devlin awarded no net increase to the total compensation base. Arbitrator Devlin did not provide for any wage rate increases for these first two years. However, she did award lump sum payments valued at 1% of wages in each of the first two years. These payments are not imbedded in salary rates or the compensation base. This is a significant cost containment in view of the economic climate.

78. Arbitrator Devlin did award benefit, shift premium and vacation improvements in the first two years of the term. However, the cost of these compensation increases in these two years is entirely offset by the cost savings resulting from two compensation rollbacks that Arbitrator Devlin awarded. Arbitrator Devlin reduced sick pay benefit entitlement for the 6th and subsequent periods of sickness. Arbitrator Devlin also awarded a substantial reduction in the early retirement allowance. [Reference Page 9 of the Award.]

79. The third year of the term provides for a wage increase of 2.75%. This represents an average annual increase over the three year term 0.9% per year.

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[7] *Participating Hospitals and Service Employees International Union,* November 5, 2010

80. This award was a major change in settlement trends for public sector employees particularly given the significant and continuing shortage of nurses.

81. Arbitrator Kaplan's June 17, 2011 Award for the Central Hospital/OPSEU Agreements.

82. Arbitrator Devlin's award heralded a major change in settlement trends for public sector employees as was immediately evidenced by the release of Arbitrator Kaplan's June 17, 2011 award for the central Hospital and OPSEU bargaining process.

83. Arbitrator Kaplan's award applies directly to 46 Hospitals and approximately 9,000 employees and covers a three year term from April 1, 2011 – March 31, 2014.

84. Arbitrator Kaplan does not provide for any wage rate increases for the first two years of this three year renewal. However, he does award lump sum payments valued at 1% of wages in each of the first two years. These payments are not imbedded in salary rates or the compensation base.

85. Arbitrator Kaplan recognized the importance of the net zero impact of Devlin ONA award on non-wage items.

86. Although Arbitrator Kaplan did award some improvements to early retiree benefits in the second year, he also awarded a significant cost containment to the sick pay benefit. Arbitrator Kaplan's award provides fewer improvements than Arbitrator Devlin's award for ONA (for example, no improvements in shift premium, vision, care, vacations, etc.) and also provides fewer cost containments.

87. The third year of the term provides for a wage increase of 2.75%. This represents an average annual wage increase over the three year term 0.9% per year.

88. The circumstances surrounding the expired OPSEU agreement were such that if the ONA award was seen as a floor, OPSEU could have readily argued for a higher increase. The relevant history is set out below:

I. OPSEU was awarded the Registered Technologists parity with Hospital RN wages by Richard Verity in his 1982 Award for the Participating Hospitals and OPSEU.

II. Although OPSEU subsequently saw their wage rates fall below parity, the issue of RN parity was always at the forefront of their central negotiations in each round of bargaining with the Hospitals.

III. Owen Gray was the arbitrator who awarded the OPSEU Hospital agreements in the round prior to the above-referenced Kaplan decision. As referenced in an earlier section of this brief entitled The Relevance of the Changed Economic Climate, Gray not only did not provide any catch-up to RN parity for OPSEU, but because of the changed economic climate he actually provided for a lesser increase than that freely negotiated by ONA in its corresponding central bargaining round. He discounted ONA's increases by ½ of 1% each year.

IV. Therefore OPSEU had already endured some pain as a result of the difficult economic climate and could have argued that its 2001 – 2014 award should have at least reflected that earlier discounting.

V. The Kaplan Award did not reflect any recognition that OPSEU had participated in restraint already.

The award (November 4, 2009) of Owen Gray states[8]:

[56] Without necessarily accepting that the comparison warrants equal pay rates ("parity") in the long term, we accept that RN's are the paramedical employees' closest and strongest comparator for purpose of assessing rates

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[8] *Participating Hospitals and Ontario Public Service Employees Union and its participating locals,* November 4, 2009

of increase of pay. ***If the economic situation had not changed in the meantime, we would have been inclined to award these workers the rates of wage increase that in February 2008 the RN's negotiated centrally with hospitals for the same two years.***
[emphasis added]
…

[58] The recession that began in the fall of 2008 has clearly had an impact on collective bargaining outcomes. The impact has not been uniform across all sectors of the economy, however, nor across all occupations within a sector. The challenge for this board has been to determine what the impact would have been on bargaining for paramedical employees of hospitals had that bargaining continued to a conclusion. Perhaps surprisingly, the evidence is clear that within the funding system in which hospitals and health care providers must function, some workers have received post-downturn increases at or very near 3% per annum for the period with which we are concerned: although there are other examples, the most notable are nurses at York Central Hospital, nurses under the central nursing homes agreement, workers at the Central Community Care Access Centre and radiation therapists at UHN. The fact that one of the participating hospitals, Collingwood General & Marine Hospital, could and would give a 3% increase effective April 1, 2009 to the unrepresented portion of its paramedical staff underscores this point. Although this involved a small number of employees and is unaccompanied by any commitment to any later increase, it is some measure of its significance nevertheless that when the OHA's presenters sought information about it someone felt it necessary to dissemble about whether there had been, in essence, an across the board increase.

[59] ***Although those matters weigh strongly in the balance, the recession cannot be ignored. One of the reasons for wages increases is to offset inflation. The wage increases needed to counter the effects of inflation over the course of an agreement for the period April 2009 to March 2011 would certainly be more modest than might have been thought in February 2008, when the hospitals agreed with ONA to increases of 3% for each of those years.*** *Put another way, the economic value of wage increases awarded in these proceedings will be greater in real dollar terms than they would have seemed in February 2008. This consideration weighs in favour of an outcome in which wage increases are more modest than they might have been if the period in question had been the subject of agreement between these parties in February 2008. Lower wage increases would increase the gap between RTs and RNs at the end of the contract period, however, which OPSEU would have continued to strongly resist in bargaining. The fact is, though, that if the intervening event had been an economic surge accompanied by increases in inflation not anticipated at the time of the nurses' settlement, OPSEU would undoubtedly have sought*

wage increases higher than those achieved by nurses earlier, arguing that that changed economic situation had to be taken into account.
[emphasis added]

[60] Having weighed the competing considerations on this item, including our disposition of the other items in dispute and the cost implications of each, we award:
• As of April 1, 2009 - 2.5% across the board wage increase

• As of April 1, 2010 - 2.5% across the board wage increase

89. In conclusion, for the two years beginning April 2009, Grey awarded wage increases to the paramedical employees of a total of 5%. For the same period, the hospitals and ONA negotiated a 6% increase for the nurses – a true comparator to the paramedical employees. He clearly reduced his award by at least ½ of 1% per year relative to the prior ONA Hospital settlement simply because of a changed **economic climate.**

	Date	Ontario Deficit in $ billions	Ontario Net Debt in $ billions	Ontario Debt as % of GDP	MoL Public Sector Increases	MoL Private Sector Increases
Year Before Previous Agreements Expiry Date	2008	$6.4	$169.6	28.9%	3.1%	2.0%
Year of Release Date of Award	2009	$19.3	$193.6	33.3%	2.4%	1.3%

1976 (Dubin) - Teachers and School Boards of Metropolitan Toronto[9]

90. The Ministry refers the Board to one of Ontario's most respected arbitrators (the late Mr. Justice Dubin) and his often-quoted decision for the Teachers and School Boards of Metropolitan Toronto (1974-75). The full award will be provided upon request, but we have excerpted specific sections to illustrate the fact that the

[9] *The Metropolitan Toronto Boards of Education and Associations,* March 3, 1976

arbitrator came to the conclusion that the economic climate was a more influential factor than other salary levels and increases already established.

91. A review of the Dubin Decision in a variety of contexts is set out below:

I. Other teacher salaries across Ontario had been negotiated at higher levels than Metro was offering. At Page 36 of the Award:

It is when a comparison is made with the salaries paid to secondary school teachers in other municipalities in this province that the teachers make out their strongest case for a substantial increase in salary."

"It does appear from an examination of those Appendices that the relative position of the Metro secondary school teachers suffered in comparison with others in the schedule even when the amendment made to the salary scales in Metro in June, of 1974, which is not reflected in that schedule, is taken into consideration*.*

At Page 38 of the Award:

What has transpired, however, is that certain municipalities, particularly Carleton and Ottawa, have agreed to pay, in the case of Ottawa for the period January 1 to August 31, 1976, and in the case of Carleton for the period January 1 to December 31, 1976, salaries at a higher scale than is proposed by the Boards for Metro for those periods.

What is now being sought by the teachers is a salary scale which is said by them to be higher than all other teachers in Ontario, save for Nipissing, and in some categories higher than Nipissing, and substantially higher than what is being paid by the other municipalities in the above schedule.

On that basis and on the same premises, the average increase in salaries for all those in the bargaining unit as of January 31, 1975 would have increased by 42.3% in the first year and 57.6% in the second year. In my respectful opinion, such an increase is completely unrealistic having regard to the present economic climate, and is so even when it is calculated in the manner submitted by the teachers.

92. Although the arbitration followed the Anti-Inflation legislation, Mr. Justice Dubin did not feel bound by the Act. At Page 16 it is stated:

> *I have concluded that the proper course for me is to limit myself to the mandate that I have been given and to decide the matter within the framework of Bill 1 without any specific regard to the Anti-Inflation Act and its Regulations.*

93. Although the arbitration followed the Anti-Inflation legislation, Mr. Justice Dubin did not feel bound by the Act. The following was stated:

> ***One cannot ignore the timing of this arbitration. Every award of an arbitrator must have regard for the economic climate of the day [Page 16]***
>
> ***I have concluded that, with a few exceptions, nothing has been put before me which would warrant any increases in the monetary items beyond those which were proposed by the Boards****. I have arrived at that conclusion only after carefully and anxiously considering the mass of material presented and the extensive arguments submitted by counsel, and after weighing all of them against the criteria which I have set forth above.* (emphasis added) [Page 18]

94. In conclusion, Dubin awarded a 24.6% increase in the first year of the agreement and 11.7% increase in the second year for a combined increase of 39.2% over two years.

95. This 1976 Award was significantly lower than the trends of 1975-1976 wage increases for other teachers in other municipalities and clearly considered the economic environment of the time.

<u>1993 (Munro) – University of Toronto and the Faculty Association[10]</u>

96. The University of Toronto and the Faculty Association have an interest arbitration dispute resolution procedure. The Faculty Association pursued a substantial adjustment based on the principle of following the reasoning and comments on

[10] *The Governing Council of The University of Toronto and The University of Toronto Faculty Association,* June 18, 1993

Arbitrator Burkett in an interest arbitration award for the same parties in the early 1980s.

97. The University argued the changed economic climate. These hearings occurred before the Social Contract process began. The award for the 1993-94 School Year was for a 0% adjustment.

98. The argument regarding the impact of the changed economic climate was central to that decision as the following quote will reveal from pages 12 - 15 of the award of Arbitrator Munro will reveal:

> ***As we have already commented, the prevailing economic climate in Ontario has lately been savagely recessionary. The oppressive character of the recession can be measured both in terms of its depth and its duration. Among other consequences of the recession has been a dampening of both private and public sector pay demands and bargaining outcomes. Harkening back to the replication model, we are of the view that these economic realities of the day would have profoundly influenced the eventual product of the parties' direct negotiations according to the normal processes of collective bargaining - including the threat or actuality of a strike or lockout."***

Term of Agreement: September 1993- August 1994

Percentage Award was Below Established Trends: Not identified in Award

	Date	Ontario Deficit in $ billions	Ontario Net Debt in $ billions	Ontario Debt as % of GDP	MoL Public Sector Increases	MoL Private Sector Increases
Year Before Previous Agreements Expiry Date	1992	$12.4	$61.8	21.6%	2.6%	2.7%
Year of Release Date of Award	June 18, 1993	$11.2	$80.6	27.5%	0.5%	1.9%

1982 (Teplitsky) – Group of 46 Hospitals and SEIU[11]

99. The following quote from the 1982 HLDAA Arbitrator for 46 Hospitals and SEIU confirms that economic change is a significant fact in interest arbitrations.

> ***I have no hesitation in stating that had I been arbitrating this matter 3 or 4 months ago, an appropriate increase would have been approximately 12-1/2%.*** *There are any number of different settlements within the hospital sector and in the public sector generally which reflect wage increases at that level. Indeed, the settlements in the health sector in the first quarter of 1982 averaged 13.8% in Ontario.*
>
> ***On the other hand, the most recent statistical data released by Labour Canada with reference to wage settlements in the second quarter of 1982 show a continuing decline in the level of settlements from the first quarter of 1982 and the last quarter of 1981.*** *At the present time, the average increase is 11.3%. Further, the most recent data in the Consumer Price Index indicates the rate of inflation has slowed to an annual rate of 10.8%.*
>
> ***If I were to award 12-1/2% at the present time, it seems to me that I would be ignoring entirely the fact that economic conditions have worsened and that this worsening has been reflected in the level of settlements which are currently being negotiated both in the private and the public sector.*** *Whether this trend will continue over the next 12 months is impossible to know with any degree of certainty although the likelihood is that it will. An increase of 11% will provide adequate protection against inflation over the term of the agreement and represents a significant recognition compared with prior settlements in 1982 in the hospital sector, of restraint.*

Conclusion

Health Care Sector Settlement Averages 1st Quarter 1982 (Ontario):	13.8%
Teplitsky Award August 31, 1982:	11.0%

[11] *A Group of 46 Hospitals and Service Employees International Union, A.F. of L., C.I.O., C.L.C., LOCALS 183, 204, 268, 478, 532 and 777,* October 6, 1982

As shown by this award Arbitrator Teplitsky took into account the economic climate and awarded wage increases at a level 2.8% below the average at the time of the award.

Overall Conclusion:

100. The Ministry respectfully submits that arbitral precedent shows that significant consideration should be taken of the economic climate, including the climate at the time of the hearing and the particularly low annual rate of inflation, when deciding matters of compensation. To do otherwise ignores the normal factors which govern bargaining in a strike/lockout environment and is inconsistent with the Replication Principle.

5. THE UNCERTAINTY OF TODAY'S ECONOMIC CONDITIONS

5.1 The State of the Economy

101. The annual rate of inflation has dropped dramatically to a level where the proposed increases exceed the level of inflation. The Canadian economy has softened and economic risks to the economic outlook have increased considerably. Between falling GDP per capita and rising unemployment rates, red flags are present as the economy faces unprecedented trade policy uncertainty.

102. On March 3, 2025, President Trump announced that 25% tariffs on Canadian and Mexican goods would take effect the following day. Subsequent annoucements excellerating and reversing economic tarriffs have led to signficant uncertainty. In a speech in late February, Bank of Canada Governor Tiff Macklem warned

> The economic consequences of a protracted trade conflict would be severe. In the pandemic, we had a steep recession followed by a rapid recovery as the economy reopened. This time, if tariffs are long-lasting and broad-based, there won't be a bounce-back. It's more than a shock – it's a structural change[12].

103. Following this comment, the central bank cut the target for its overnight interest rate by an additional 0.25%, citing economic uncertainty caused by increased trade tensions and tariffs imposed by the U.S.

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[12] "Trump confirms he will impose 25% tariff on Canadian goods Tuesday", CBC News, Mar. 3, 2025, at https://ici.radio-canada.ca/rci/en/news/2145091/trump-confirms-he-will-impose-25-tariff-on-canadian-goods-tuesday

5.2 Ontario Budget 2025: Economic Performance & Outlook

104. The following excerpts from the newly released Ontario Budget highlight the potential impacts of U.S. trade tensions on the Ontario and global economies

105. The follow exerpt is from Chapter 2, Page 133 of the Ontario Budget:

Ontario's economy proved to be resilient in 2024, continuing to grow and add jobs as inflationary pressures eased throughout the year. In 2024, real gross domestic product (GDP) increased by 1.5 per cent and employment rose by 140,000 (+1.7 per cent). Although there were solid gains in 2024, the uncertain economic environment is expected to weigh on the economy over the projection period.

Ontario is among the Canadian provinces and territories most exposed to U.S. trade policy and related uncertainty, and its real and nominal GDP forecasts have therefore come down significantly. Real GDP is projected to rise by 0.8 per cent in 2025 and 1.0 per cent in 2026. For the purposes of prudent fiscal planning, these projections are set slightly below the average of private-sector forecasts.

Table 2.1

Summary of Ontario's Economic Outlook

(Per Cent)

	2024	**2025p**	**2026p**	**2027p**	**2028p**
Real GDP Growth	1.5	0.8	1.0	1.9	1.9
Nominal GDP Growth	5.2	3.1	3.0	4.0	4.0
Employment Growth	1.7	0.9	0.4	0.9	0.9
CPI Inflation	2.4	2.3	2.0	2.0	2.0

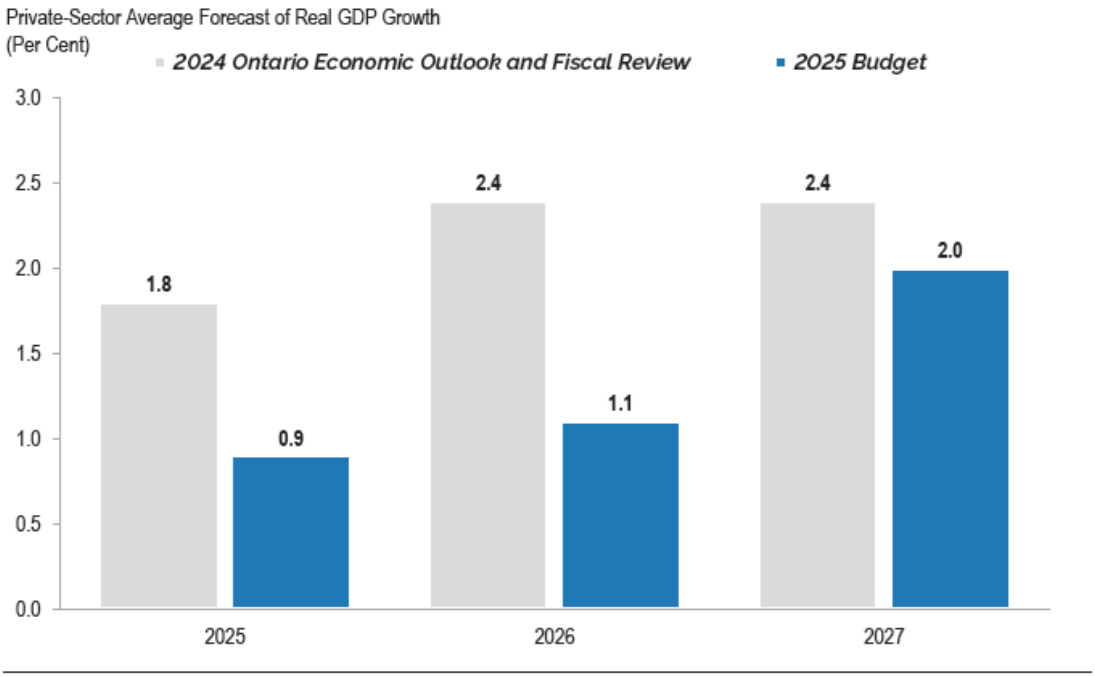
p = Ontario Ministry of Finance planning projection based on external sources as of April 3, 2025.

Sources: Statistics Canada and Ontario Ministry of Finance.

106. The follow exerpt is from Chapter 2, Page 141 of the Ontario Budget:

The U.S. tariffs as well as heightened uncertainty around trade policy have contributed to a significant deterioration in the private-sector economic outlook. Compared to the 2024 Ontario Economic Outlook and Fiscal Review, the private-sector average of real GDP growth forecasts has declined from 1.8 per cent to 0.9 per cent in 2025, from 2.4 per cent to 1.1 per cent in 2026, and from 2.4 per cent to 2.0 per cent in 2027.

Chart 2.5
Tariffs Weighing on Ontario Real GDP Growth Outlook



Sources: Ontario Ministry of Finance Survey of Forecasters (September 19, 2024 and April 3, 2025).

While tariffs have contributed significantly to the deterioration in private-sector forecasts since the fall, there are a wide range of views and assumptions incorporated in private-sector economic forecasts. At the higher end of the private-sector range, forecasts have generally incorporated fewer tariff impacts over a shorter period of time. At the lower end of the private-sector range, forecasts have generally incorporated more significant tariffs and over a longer period. The uncertainty around U.S. trade policy is reflected in the historically wide range of Ontario real GDP forecasts.

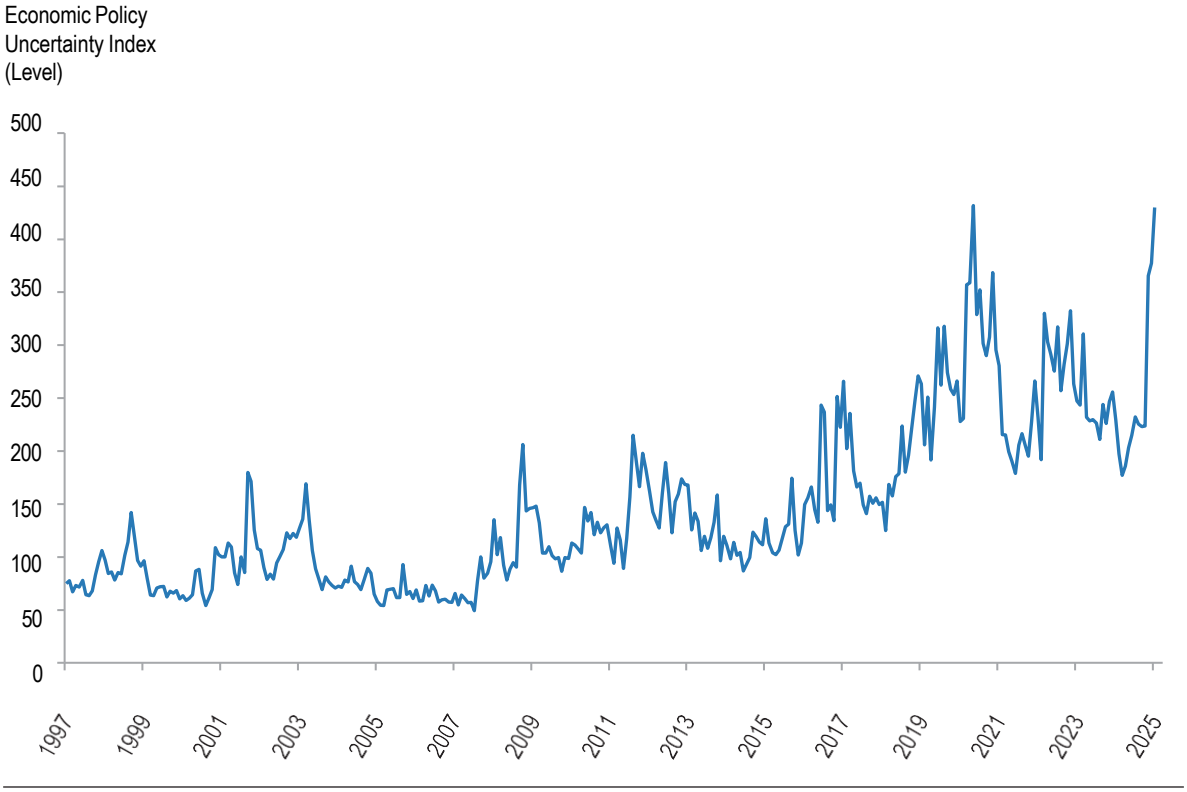
107. The follow exerpt is from Chapter 2, Page 143 of the Ontario Budget:

Global Economic Environment

Increased trade tensions emanating from the United States are leading to greater uncertainty and contributing to a weaker global economic outlook. The rapidly evolving trade policy landscape is weighing on businesses and consumers across the world. Trade tensions have also contributed to global economic policy uncertainty, which is at its highest level since 1997.

Chart 2.7

Heightened Global Economic Policy Uncertainty



Notes: Latest data point is January 2025.

Economic Policy Uncertainty Index reflects the frequency of newspaper articles that contain terms pertaining to the economy, policy and uncertainty.

Source: www.policyuncertainty.com

On April 2, 2025, the Trump administration announced "reciprocal" tariffs on a large set of countries. Subsequently, on April 9, 2025, the administration announced that it was pausing these tariffs for 90 days on all affected countries with the exception of China, where the tariffs were being raised to significantly higher levels. These announcements as well as continued, unexpected policy

shifts have resulted in significant financial market volatility and are expected to negatively impact the economy.

108. The follow exerpt is from Chapter 2, Page 151 of the Ontario Budget:

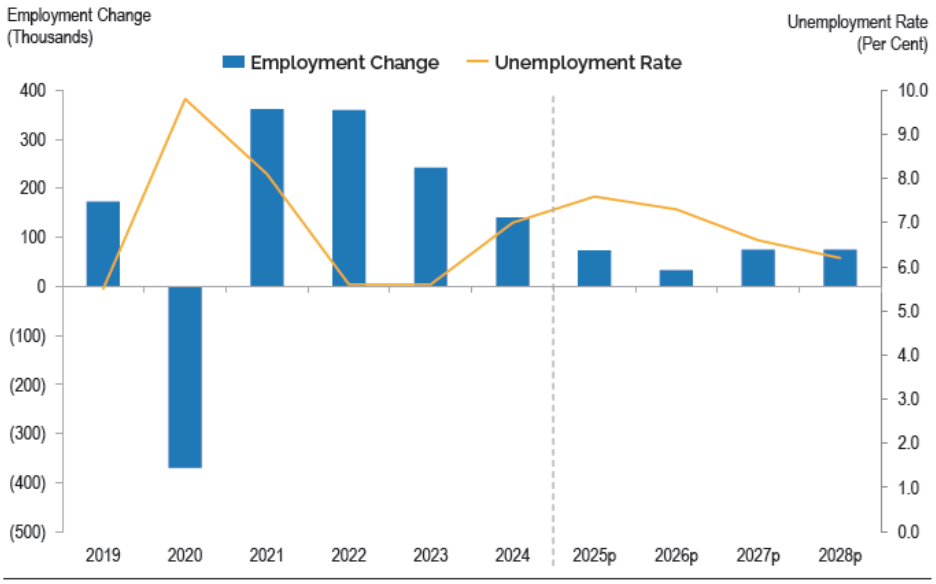
Employment

Increased uncertainty and reduced business confidence from trade tensions with the United States are expected to weaken business activity and hiring in Ontario. In addition, slowing population growth due to federal immigration plan changes will moderate employment gains.

Ontario employment increased by 140,000 or 1.7 per cent in 2024. Although there were solid employment gains early in 2025, the uncertain economic environment is projected to weigh on employment growth over the rest of the year. The annual gains for 2025 are projected to slow to 73,000 or 0.9 per cent. Population and labour force growth are projected to continue to outpace employment growth in 2025, raising the unemployment rate to 7.6 per cent.

Impacts from the trade conflict and economic uncertainty are expected to continue to weigh on employment in 2026, with growth projected to slow further to 0.4 per cent. These impacts are expected to wane in 2027 and 2028, resulting in employment growth improving to 0.9 per cent in both years. As population growth slows significantly over the 2026 to 2028 period and economic growth picks up, employment growth is projected to outpace labour force growth, resulting in a gradual decline in the unemployment rate to 6.2 per cent in 2028.

Chart 2.12
Employment Gains Projected to Slow



p = Ontario Ministry of Finance planning projection based on external sources as of April 3, 2025.
Sources: Statistics Canada and Ontario Ministry of Finance.

109. The follow exerpt is from Chapter 2, Page 157 of the Ontario Budget:

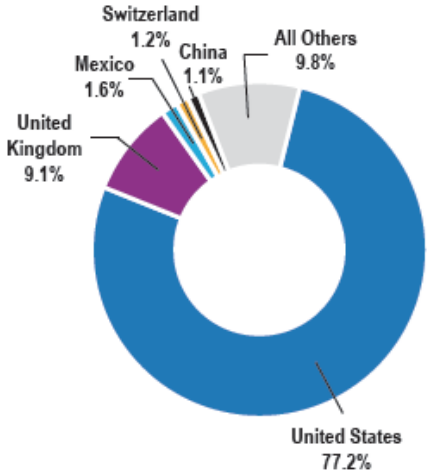
Potential Impact of U.S. Tariffs on Ontario's Economy
Ontario's Trade Profile

International trade is a key driver of Ontario's economy. In 2024, the province's exports of goods and services reached $593 billion, equalling 50 per cent of Ontario's gross domestic product (GDP). Total trade activity — including both exports and imports — amounted to $1.2 trillion, nearly matching Ontario's total GDP. Trade with other provinces also plays a significant role, with interprovincial exports totalling $196 billion and imports reaching $144 billion.

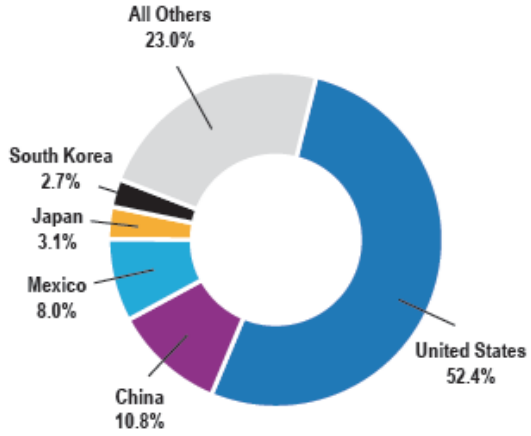
The United States remains Ontario's largest trading partner due to geographic proximity and highly integrated supply chains. In 2024, Ontario's domestic merchandise exports to the United States totalled $194.9 billion, accounting for 77.2 per cent of the province's total merchandise exports. The United Kingdom was Ontario's second-largest export market at $23.1 billion, representing 9.1 per cent of total exports. Mexico, another treaty partner in the Canada–United States–Mexico Agreement (CUSMA), ranked third at $4.1 billion, or 1.6 per cent of total exports. On the import side, Ontario sourced $243.3 billion in merchandise from the United States, representing 52.4 per cent of total merchandise imports. China followed at $50.3 billion, making up 10.8 per cent of total imports, while Mexico ranked third at $37.2 billion with a share of 8.0 per cent.

Chart 2.16
United States Is Ontario's Top Merchandise Trading Partner

Share of Ontario Exports by Destination Country
(Per cent)



Share of Ontario Imports by Source Country
(Per cent)



Source: Statistics Canada.

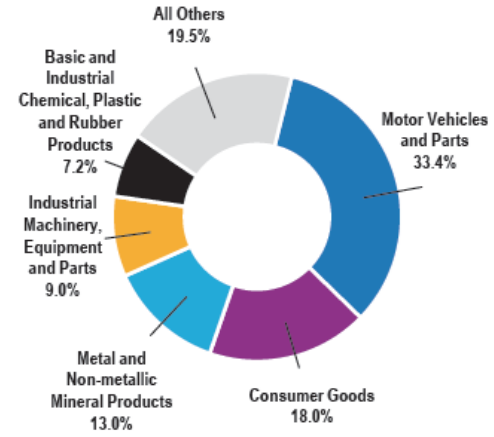
110. The follow exerpt is from Chapter 2, Page 158 of the Ontario Budget:

Ontario's merchandise trade with the United States is heavily concentrated in the auto sector due to North America's integrated supply chains in auto production. In 2024, motor vehicles and parts accounted for $65.0 billion, or 33.4 per cent of Ontario's total merchandise exports to the United States. Consumer goods followed at $35.1 billion, making up 18.0 per cent, while metal and non- metallic mineral products totalled $25.4 billion, representing 13.0 per cent.

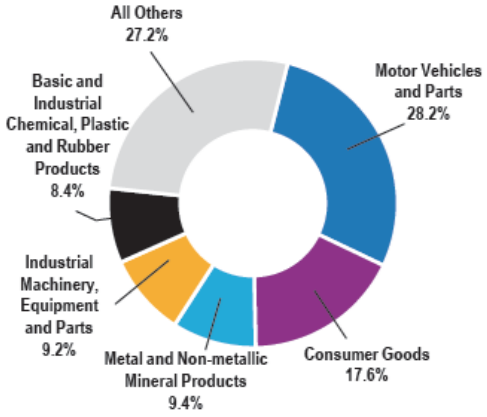
Ontario's merchandise imports from the United States followed a similar pattern. In 2024, motor vehicles and parts led at $68.5 billion, accounting for 28.2 per cent of total U.S. merchandise imports. Consumer goods ranked second at $42.9 billion, or 17.6 per cent, while metal and non-metallic mineral products totalled $22.9 billion, representing 9.4 per cent.

Chart 2.17
U.S.–Ontario Trade Concentrated in Autos and Consumer Goods

Ontario Merchandise Exports to U.S. by Product
(Per cent)



Ontario Merchandise Imports from U.S. by Product
(Per cent)



Source: Statistics Canada.

5.3 Ontario's Debt Trajectory

111. Ontario received two credit rating upgrades in 2024. Morningstar DBRS upgraded Ontario's rating to AA from AA (low) on June 6, 2024, and S&P raised its credit rating to AA− from A+ on December 3, 2024.

112. The credit rating upgrades took place before the tariffs imposed by the United States which has since resulted in a significant risk to Ontario's economy and has limited Ontario's overall fiscal capacity.

113. Moody's removed the positive outlook on Ontario's credit rating on May 26, 2025. The change in outlook from positive to stable reflects Moody's view that the balance of risks that previously supported the positive outlook have reverted to a balanced position as a result of "uncertainty caused by the US tariff announcements, both in terms of direct impacts between Ontario and the US as well as the slowing of global economic growth, will dampen economic activity in Ontario in 2025 and 2026, leading to lower revenue levels than we previously projected. We expect that Ontario's real GDP will be close to that of Canada, which we forecast will be 0.9% in 2025 and 0.8% in 2026. Roughly 70% of the province's revenue are derived from taxes, which are influenced by economic activity."

5.4 Inflation

114. To bring high inflation back down to target levels, the Bank of Canada initiated a series of cuts to its benchmark interest rate in 2022 and 2023. Inflation has eased substantially since its June 2022 peak.

115. On September 17, 2024, Canada's annual inflation rate (August 2024 data published by Statistics Canada) returned to the Bank of Canada's 2% target for the first time since 2021, a significant milestone following the worst inflation surge in a generation.

116. According to the Bank of Canada, inflation is expected to hover around the 2% target for the next couple of years:

> *CPI inflation has been about 2% since the summer, and is expected to average close to the 2% target over the next couple of years. Since October, the upward pressure on inflation from shelter and the downward pressure from goods prices have both moderated as expected. Looking ahead, the GST holiday will temporarily lower inflation but that will be unwound once the GST break ends. Measures of core inflation will help us assess the trend in CPI inflation.*[13]

Inflation Since October 2022

Inflation[14]	Ontario			Canada		
Month	CPI	M-o-M % change	Y-o-Y % change	CPI	M-o-M % change	Y-o-Y % change
May-25	165.9	0.7	1.7	164.3	0.6	1.7
Apr-25	164.8	-0.2	1.6	163.4	-0.1	1.7
Mar-25	165.1	0.3	2.3	163.5	0.3	2.3
Feb-25	164.6	1.2	2.7	163.0	1.1	2.6
Jan-25	162.6	-0.1	1.7	161.3	0.1	1.9
Dec-24	162.7	-0.5	1.7	161.2	-0.4	1.8
Nov-24	163.5	0.0	1.8	161.8	0.0	1.9

[13] "Bank of Canada reduces policy rate by 50 basis points to 3¼%", Bank of Canada, Dec. 11, 2024, at https://www.bankofcanada.ca/2024/12/fad-press-release-2024-12-11/

[14] Statistics Canada

Inflation[14]	Ontario			Canada		
Month	**CPI**	**M-o-M % change**	**Y-o-Y % change**	**CPI**	**M-o-M % change**	**Y-o-Y % change**
Oct-24	163.5	0.4	2.0	161.8	0.4	2.0
Sep-24	162.8	-0.3	1.9	161.1	-0.4	1.6
Aug-24	163.3	-0.4	2.1	161.8	-0.2	2.0
Jul-24	163.9	0.5	2.7	162.1	0.4	2.5
Jun-24	163.1	-0.1	3.0	161.4	-0.1	2.7
May-24	163.2	0.6	3.0	161.5	0.6	2.9
Apr-24	162.2	0.5	2.7	160.6	0.5	2.7
Mar-24	161.4	0.7	2.6	159.8	0.6	2.9
Feb-24	160.2	0.2	2.4	158.8	0.3	2.8
Jan-24	159.9	-0.1	2.7	158.3	0.0	2.9
Dec-23	160.0	-0.4	3.4	158.3	-0.3	3.4
Nov-23	160.6	0.2	3.3	158.8	0.1	3.1
Oct-23	160.3	0.4	3.3	158.6	0.1	3.1
Sep-23	159.7	-0.1	3.6	158.5	-0.1	3.8
Aug-23	159.9	0.2	3.8	158.7	0.4	4.0
Jul-23	159.6	0.8	3.2	158.1	0.6	3.3
Jun-23	158.4	-0.1	2.6	157.2	0.1	2.8
May-23	158.5	0.4	3.1	157.0	0.4	3.4
Apr-23	157.9	0.4	4.2	156.4	0.7	4.4
Feb-23	156.4	0.4	5.1	154.5	0.4	5.2
Jan-23	155.7	0.6	5.6	153.9	0.5	5.9
Dec-22	154.8	-0.4	6.0	153.1	-0.6	6.3
Nov-22	155.4	0.1	6.4	154.0	0.1	6.8
Oct-22	155.2	0.7	6.5	153.8	0.7	6.9

5.5 Unemployment Rate

117. Canada's unemployment rate reached a historic low of 4.9% in July 2022, the lowest level observed since comparable data become available in 1976.

118. Since that time, however, the unemployment rate has been steadily increasing. Ontario's unemployment rate has increased to 7.9%, while Canada's unemployment rate has increased to 7.0% as of May 2025.

119. The rise in the unemployment rate reflects a cooling labour market amidst ongoing economic pressures, and this trend is expected to continue through 2025.

Unemployment Rate Since October 2022

Unemployment Rate (%)[15]	Ontario		Canada	
Month	Unemployment Rate (%)	Monthly Change (% pts)	Unemployment Rate	Monthly Change (% pts)
May-25	7.9	+0.1	7.0	+0.1
Apr-25	7.8	+0.3	6.9	+0.2
Mar-25	7.5	+0.2	6.7	+0.1
Feb-25	7.3	-0.3	6.6	0.0
Jan-25	7.6	0.1	6.6	-0.1
Dec-24	7.5	-0.2	6.7	-0.2
Nov-24	7.7	0.6	6.9	0.3
Oct-24	7.1	0.0	6.6	0.0
Sep-24	7.1	-0.2	6.6	-0.1
Aug-24	7.3	0.4	6.7	0.3
Jul-24	6.9	-0.1	6.4	0.0
Jun-24	7.0	0.2	6.4	0.1
May-24	6.8	0.0	6.3	0.1
Apr-24	6.8	0.1	6.2	0.1
Mar-24	6.7	0.1	6.1	0.2

[15] Statistics Canada, Table 14-10-0287-01

Unemployment Rate (%)[15]	Ontario		Canada	
Month	**Unemployment Rate (%)**	**Monthly Change (% pts)**	**Unemployment Rate**	**Monthly Change (% pts)**
Feb-24	6.6	0.5	5.9	0.2
Jan-24	6.1	-0.2	5.7	-0.1
Dec-23	6.3	0.3	5.8	0.1
Nov-23	6	-0.2	5.7	0.0
Oct-23	6.2	0.3	5.7	0.2
Sep-23	5.9	0.1	5.5	0.0
Aug-23	5.8	0.2	5.5	0.0
Jul-23	5.6	0.0	5.5	0.1
Jun-23	5.6	0.1	5.4	0.2
May-23	5.5	0.5	5.2	0.1
Apr-23	5	-0.2	5.1	0.1
Mar-23	5.2	0.1	5	-0.1
Feb-23	5.1	-0.2	5.1	0.0
Jan-23	5.3	0.0	5.1	0.1
Dec-22	5.3	-0.3	5	0.0
Nov-22	5.6	0.1	5	-0.1
Oct-22	5.5		5.1	

5.6 GDP Per Capita

120. After reaching a record level of $61,032 in 2022Q2, Ontario real GDP per capita declined every quarter except for slight increases in 2023q1 and 2024q4. GDP figures were helped significantly by a surge in population growth, which added millions of new consumers and workers to the economy.

121. GDP per capita reflects the average economic output per person and is a key indicator of economic performance and living standards. In Canada, per capita GDP fell in six consecutive quarters as of 2024Q3, a decline that is larger than that which has occurred in previous times of technical recession. Most recently, Canadian GDP per capita rose by 0.6% in 2024Q4.

122. Over the past couple years, Ontario GDP per capita has fallen in almost every quarter (see table below). From 2022 Q2 to Q4 of 2024, it has fallen by a cumulative 3.4%. When coupled with the steep rise in unemployment, these GDP per capita figures suggests a high degree of uncertainty for the future direction of the economy.

Ontario GDP Per Capita Since 2022 Q2

Quarter	GDP ($M)[16]	Population[17]	GDP/Million Pop.	Quarterly Growth	Yearly Growth	2022Q1= 100
2022Q2	$918,074	15,042,458	$61,032			100
2022Q3	$920,728	15,141,455	$60,808	-0.37%		99.6
2022Q4	$918,889	15,289,550	$60,099	-1.17%		98.5
2023Q1	$927,945	15,402,095	$60,248	0.25%		98.7
2023Q2	$931,811	15,478,287	$60,201	-0.08%	-1.36%	98.6
2023Q3	$934,815	15,623,207	$59,835	-0.61%	-1.60%	98.0
2023Q4	$936,457	15,818,465	$59,200	-1.06%	-1.50%	97.0
2024Q1	$940,988	15,944,379	$59,017	-0.31%	-2.04%	96.7
2024Q2	$944,513	16,033,583	$58,908	-0.18%	-2.15%	96.5
2024Q3	$948,226	16,124,116	$58,808	-0.17%	-1.72%	96.3
2024Q4	$954,297	16,171,802	$59,010	0.34%	-0.32%	96.6

[16] Ontario Economic Accounts (OEA)

[17] Statistics Canada

5.7 Real GDP

123. Economic growth in both Canada and Ontario has been moderate in recent quarters, with fluctuations due to a variety of economic challenges (see table below).

124. The Canadian economy grew more than expected in 2024Q4 (2.6% annualized), but this momentum occurred before U.S. President Trump began threatening to impose tariffs on Canada.

125. In April 2025, the Canadian economy fell by 0.1% from a month earlier, and the direct impact of tariffs adds clear downside risks to the outlook.

126. In the near term, economic growth remains uncertain and will likely moderate further.

GDP Growth Since 2022 Q4

Real Gross Domestic Product, Expenditure-Based (Quarterly)	Ontario[18] (% change)	Canada[19] (% change)
2022 Q4	-0.2	-0.1
2023 Q1	1.0	1.0
2023 Q2	0.4	0.2
2023 Q3	0.3	-0.1
2023 Q4	0.2	0.2
2024 Q1	0.5	0.5
2024 Q2	0.4	0.7
2024 Q3	0.4	0.5
2024 Q4	0.6	0.6

[18] Ontario Ministry of Finance

[19] Statistics Canada

5.8 Summary

127. Overall, the Canadian and Ontario economies are showing levels of uncertainty.

1. Trump Tariffs & Potential Impacts - U.S.-Canada trade tensions have intensified, with significant economic implications unfolding. A trade war with the U.S. poses serious risks to the Canadian economy, which could significantly slow economic growth, increase recession risk, and push inflation higher.

2. Ontario Budget 2025 - Escalating U.S. trade tensions, new tariffs, and growing policy uncertainty are projected to significantly dampen the economy in the coming years. Given Ontario's heavy reliance on U.S. trade—especially in the auto sector—its economic outlook has weakened notably, with slower GDP and job growth expected through 2026.

3. Inflation – Inflation has eased considerably since its peak in June 2022. In both Canada and Ontario, inflation hovers within the Bank of Canada's target range (currently between 2% and 3%) and is expected to remain around the 2% target into 2025. The annual inflation rate today is 1.7%.

4. Unemployment Rate – A significant sign of economic downturn is the rising unemployment rate. A sustained deterioration of the labour market is typically only seen during recessions.

5. GDP Per Capita – Per Capita GDP reflects the average economic output per person and is a key indicator of economic performance and living, one that shows a "little bit more truth" than Real GDP on its own. This measure has fallen in 8 of the past 10 quarters, a decline that is larger than that which has occurred in previous times of recession.

6. Real GDP – Economic growth has been modest in recent quarters. In the near term, economic growth remains uncertain and could easily moderate further depending on the impact of U.S. tariffs.

6. MAJOR SETTLEMENTS REFLECTING A CHANGE IN TREND

6.1 When is the Impact of the Changed Economic Climate Reflected in Interest Arbitration

128. The Ministry has proved an extensive list of Interest Arbitration awards where the decision makes a material change in direction from existing settlement trends and determines an increase that is materially lower.

129. Given that the Economy is a specific criteria for the Board and the severity of the change to the current economic climate, it is respectfully submitted that these precedents should be followed.

130. The Ministry expects that the OMA will advocate for this Board to follow the reasoning articulated by this Chair in Toronto Transit Commission and ATU, 113, 2022 CanLII 9 (ON LA). The Ministry disagrees. This reasoning in the award is set out below followed by the rationale as to why the circumstances are different from those in TTC:

> ***In terms of the economic increases that have been awarded, they follow the now established pattern of looking to previously identified comparators and their freely bargained settlements.*** *The employer urged that these comparators be reconsidered with attention paid to (the much lower) negotiated settlements, in particular at the City of Toronto, among other suggestions. This submission is, again, rejected. As was earlier determined (TTC & ATU (2018) 137 CLAS 118 at 6, 9):*
>
> *… the most appropriate comparators … are … other transit services ….*
>
> *… By any measure, the most appropriate comparators, are Metrolinx… and Mississauga… and Brampton Transit …. The bargaining results at GO Transit are also instructive.*
>
> *… The union agreed that these were the appropriate comparators, and these comparators have been followed for the three years at issue.* ***Nevertheless, the union took the position that these results, bargained prior to the upward and dramatic escalation in inflation and the Consumer Price Index, had to be substantially increased – doubled in***

> ***fact – to reflect the enormous growth in the cost of living****. This submission is also rejected (while noting that the awarded increases do not dramatically deviate from what the employer proposed at the hearing, albeit in a collective agreement with a longer term).*
>
> ***To date, there are no bargained settlements – at least none brought forward in this proceeding – where inflation adjustments, over and above normative economic increases, have been negotiated, and no interest arbitration awards – at least none brought forward in this proceeding – where inflation adjustments, over and above normative economic increases, have been awarded. There are, therefore, no outcomes with an inflation adjustment to replicate. Accordingly, there are no outcomes – negotiated or awarded – that support an inflation adjustment over and above the normative increases. Notwithstanding the temptation to adjust across-the-board increases to reflect current inflation – of which there is demonstratable uncontradicted evidence – there is no outcome with an inflation adjustment – negotiated or awarded – to replicate.***
>
> ***Interest arbitrators are not leaders but followers –*** *followers, preferably and whenever they are available, of freely negotiated settlements especially sectoral comparators. This is the best evidence of what the parties would have achieved in free collective bargaining, and that is why interest arbitrators rely upon them.*
>
> *Occasionally there are situations where the demonstrated need is so compelling that it must be immediately addressed; but this is not that case as the parties will, soon enough, given that the union's request for a three-year deal has been awarded, be back at the bargaining table and able to negotiate fair and contextual outcomes, for example addressing inflation should it prove persistent. It must also be noted that the wage increase cannot be considered in isolation.*

131. The view expressed in the Kaplan TTC award was made in an interesting time of the inflation cycle. Many prognosticators were saying the inflation was a transient event and an anomaly which would soon pass. In soon became apparent that the inflation was deep rooted and continuing, but at the time of the TTC award that was not the case.

132. No one is describing the current slowdown as temporary. While the layoffs and closures make it clear that the economy is in trouble, many are saying the

complete impacts of the slowdown are not yet reflected in the economic data which has an embedded time lag.

6.2 Settlements/Awards which extend in 2026/2027

133. Even recognizing the reluctance of Interest Arbitrators to be the first to establish a new level of increase, that is not the case here. There have been a significant number of settlements in 2025 and following that fall in the low 2% range.

134. Not many settlements or awards extend into 2026 and even fewer into 2027, but the increases in those years are lower than current trends established in 2024.

Major Settlements or Awards	2021	2022	2023	2024	2025	2026	2027
PARO & Ontario Teaching Hospitals	3.00%	4.75%	3.50%	3.00%	**2.65%**		
PEGO & Government (OPS)	2.00%	2.00%	3.50%	3.00%	3.00%	**2.00%**	
OSSTF (Teachers) & School Boards	3.75%	3.00%	3.00%	2.75%	**2.50%**	-	
ETFO (Teachers) & School Boards	3.75%	3.00%	3.00%	2.75%	**2.50%**	-	
OPSEU & LCBO	3.00%	3.00%	3.50%	3.00%	**2.75%**	**2.25%**	
Dockyard Trades & Federal TB			4.75%	3.50%	**2.25%**		
Electrical Trade Bargaining Agency					**2.26%**	**2.28%**	**2.29%**
Waterloo University and Faculty	1.00%	1,00%	4.00%	4.70%	**3.60%**	**2.20%**	
Ottawa University & Faculty	2.25%	3.00%	3.25%	2.50%	**2.50%**		
Western University and Faculty	1.75%	1.00%	3.00%	2.00%	**2.00%**		
Western University & L&A	1.00%	1,50%	3.00%	2.00%	**2.00%**	**2.00%**	
York University & Faculty	2.00%	3.00%	4.00%	3.10%	**2.85%**	**2.85%**	
McMaster University & Faculty	1.94%	1.00%	1,60%	1.70%	**5.00%**	**2.00%**	**2.00%**

135. This is an award that looks 3 years into the future. As submitted by the Ministry earlier in this brief, the inflation forecast over the next three year time horizon is lower than the Ministry proposal.

136. Physicians are among the highest compensated citizens in Ontario. Truly physicians are compensated at a level which falls into the top 1% of society. The Ministry refers the Board to Exhibit 7 where it has updated the previous submission with respect to physician renumeration compared to the average Ontarian.

137. While economic restraint is no fun for anyone, it has been often recognized by Interest Arbitrators that it is the individuals at the lower income levels who are hurt the most.

138. Mr. Teplitsky reviewed the CPI in his 1978 award for 43 Participating Hospitals & SEIU, where he quoted Justice Dubin as follows:

> *Employees whose incomes are relatively modest are most affected by the impact of increases in the cost of living. Mr. Justice Dubin accepted the validity of his observation in The Metropolitan Toronto Secondary School Teachers dispute, Award dated March 3, 1976 at page 45 where he stated:*
>
> *'By applying the percentage increase in the CPI against the salary, those in the higher salary brackets receive more than those in the lower salary brackets. In my opinion, it is an inaccurate reflection of the cost of living to apply it in this way. The impact of the increased cost of living is felt most by those who earn less. (emphasis mine -Teplitsky)*
>
> *In a period when compensation increases lag behind cost of living increases, one should avoid becoming mesmerized by percentage increases. These percentage increases should be translated into the actual dollars generated. Accordingly settlements even in the same industry are less weighty as comparables if the employees affected by those settlements earn substantially higher than the employees covered by this collective agreement.'*

139. Employees whose incomes are relatively modest are most affected by the impact of increases in the cost of living. Mr. Justice Dubin accepted the validity of his observation in The Metropolitan Toronto Secondary School Teachers dispute, Award dated March 3, 1976 at page 45 where he stated:

> *To award 8 1/2% for the rise in the cost of living is to ignore economic restraint, which as I have mentioned, is being reflected in both the private and public sector settlements.*

6.3 Certainty of Payment

140. Physicians do not face risk that their invoices will not be paid because their clients go out of business or a put in receivership. Physicians are not paid by their patients. They are paid by Government. This risk of Government defaulting is very low. This risk for employees and others whose employer or client may default is higher in a good economic environment and the risk increases geometrically in a bad economic climate.

141. Again, this in sharp contrast to the significant increased risk of insolvencies in Canada and the many employees who risk losing income and any contractors providing services will fall behind the creditors (often banks) in terms of not payments for work already performed. The most credible indicia of increased insolvency risks are the load loss provisions of the Publicly owned Canadian Banks. It is the fiduciary obligations of these banks to report accurately and objectively as to potential losses.

142. The Ministry provides the recent publicly released reports of Canada's big six banks. The Board will note that the increased insolvency risks, relative to the previous year total totals by $2.012 billion dollars a 46.2% increase over the prior year. The data by bank is set out below.

BIG CANADIAN BANKS' PROVISIONS FOR CREDIT LOSSES (PCL) IN Q2 2025
BMO – PCL of $1,054 million, compared to $705 million in Q2 2024
CIBC – PCL of $605 million, compared to $514 million in Q2 2024
National Bank – PCL of $545 million, compared to $138 million in Q2 of 2024
RBC – PCL of $1,424 million, compared to $920 million in Q2 of 2024
Scotiabank – PCL of $1,398 million, compared to $1,007 million in Q2 of 2024
TD Bank – PCL of $1,341 million, compared to $1,071 million in Q2 of 2024

7. SUSTAINABILITY

7.1 Sustainability in the Context of the Framework

143. The Framework Appendix for Negotiation, Mediation and Arbitration ("the Framework") defines a quasi labour relations model of dispute resolution with one very unique and important criterion which enables a dispute resolution process designed for an employment relationship to work for the unique and atypical contractor relationship with physicians.

144. Therefore, from the Ministry's perspective, sustainability of the publicly funded health care system is the most important factor which allows the "square peg" (determination of physician compensation) to fit into the "round hole" of a labour relations dispute resolution process intended for employer/employee relations.

145. Indeed, both parties agree that sustainability is a fundamental principle of any Physician Services Agreement. The Framework is part of a larger agreement between the parties: the 2012 Representation Rights Agreement (Exhibit 8). That agreement provides the context within which the Framework must be interpreted and applied. The principle of sustainability is at the forefront of the Representation Rights Agreement to achieve a PSA. Most notably, section 3 of the Representation Rights Agreement, which incorporates the Framework, states (emphasis added):

> *3. The Minister and the OMA will consult and negotiate in good faith with each for the purpose of entering into Physician Services Agreements to establish physician compensation for physician services and related accountabilities in the publicly funded health care system. The Parties anticipate that any Physician Services Agreement would be based on shared objectives* ***including a patient-centered sustainable health care system****. The Parties will use the [Framework Appendix] set out in Appendix "A" to negotiate Physician Services Agreement or any periodic re-openers of such an agreement.*

146. The Ministry notes two points from the above:

I. Any PSA (whether negotiated by the parties or determined by the arbitration board) must have a patient-centered sustainable health care system as its objective.

II. The OMA and the Ministry have placed the principle of a patient-centered sustainable health care system at the heart of each PSA. This is a shared objective, not just an objective of government.

147. The Ministry references *the Framework* agreement at paragraph 25 which captures the criteria for the arbitration decision:

> *Criteria for Arbitration*
>
> *25. In making a decision or award on any matters falling within the scope of arbitration, the arbitration board shall take into consideration the following factors and any other factors it considers relevant:*
>
> *(a) The achievement of a high quality, patient-centred sustainable publicly funded health care system;*

148. Further, the Ministry again references the Framework agreement at paragraph 21 which captures the scope of issues appropriate for the arbitration decision:

> *Scope of Arbitration*
>
> *21. The following issues fall within the jurisdiction of the arbitration board for inclusion in a PSA:*
>
> *…*
>
> *(d) With respect to the PSB:*
>
> *(i) what components are to be included in the PSB, with the condition that all of the following components must be included in the PSB:*
>
> *1. the detailed list of the payments currently made by the MOHLTC to physicians attached as Appendix A, including those payments made to physicians known as fee-for-service (FFS) payments, alternate payment plans (APPs) and alternate funding plans (AFPs), primary health care (including physician compensation in FHTs such as the blended salary model and FHT sessional fees), hospital on-call coverage (HOCC) and*

sexually transmitted disease (STD) services, compensation for CHC and AHAC physicians, and flow-through top up for public health physicians, and physicians in divested psychiatric hospitals and assertive community treatment teams;

2. Payments for clinical services paid by other ministries;

(ii) the "baseline" of the PSB, or of separate components of the PSB;

(iii) any changes to the PSB in each year of the agreement (in addition to any changes in physician payments as set out above) based on change in population number, ageing and other demographic changes including chronic disease prevalence, technological change, change in the numbers of physicians, change to the cost of new or changing programs/services/fees, impact of allied health professionals, and any other factors relevant to changes in expenditures for physician services. The parties recognize that these factors may be interrelated and these interrelationships must be considered in determining the overall change to the PSB, rather than considering each factor individually; and

(iv) determination of the consequences (if any) and of the extent to which either party should bear responsibility, if expenditures on physician services exceed the PSB or a component of the PSB (if any) in a given year.

149. From the Ministry's standpoint, the references in the Framework are material and significant components of the Framework, which cannot be overlooked or read out of this governing document.

150. There would be no purpose to define the "baseline of the PSB" as is referenced in 21. (d) (ii) unless the Board of Arbitration considers in their deliberations the growth of the PSB. Simply determining the "baseline of the PSB" would have no impact on the outcome unless the Board makes some determination under 21.(d) (iv).

> *(iv) determination of the consequences (if any) and of the extent to which either party should bear responsibility, if expenditures on physician services exceed the PSB or a component of the PSB (if any) in a given year.*

151. Similarly, there would be no purpose to determine " any changes to the PSB in each year of the agreement" as is referenced in 21. (d) (iii) unless the Board of Arbitration considers the impact of the growth of the PSB.

7.2 Sustainability is Not a New Concept

152. Sustainability is not a new or novel concept. Below are a few significant and recent examples. In the ciliation report issued by Hon. Warren K. Winkler on December 11, 2014, sustainability was referred to extensively by retired Chief Justice Warren Winkler in his Conciliation recommendation to the parties (Exhibit 9). At page 1 of the conciliator's report, the Honourable Warren Winkler states:

> *The MOHLTC is the primary funder of Ontario's publicly funded health care system. The mandate of the MOH is to establish, manage and maintain a patient-focused, results-driven, integrated and sustainable publicly funded health system.*

153. At page 6 of the conciliator's report, the Honourable Warren Winkler states:

> *It is apparent that these positions are irreconcilable in the longer term. Absent some rationalization, the system may not be sustainable.*

154. At pages 6 and 7 of the conciliator's report, the Honourable Warren Winkler states:

> *Both the Task Force and the Minister's Roundtable would include representatives of important stakeholders in the health care system, especially the public. The purpose of the Task Force would be to conduct a long-term study and analysis of the sustainability of Ontario's health- care system with the mandate of advising and making recommendations for systemic changes to the delivery and funding of physician services.*

155. At page 7 of the conciliator's report, the Honourable Warren Winkler states:

> *The Parties' agreement to embark on these initiatives was an important development as it enabled them to focus their discussions on the pressing matters required to agree on the 2014 PSA, with the comfort that the broader systemic issues impacting the sustainability of health care in Ontario would be appropriately and collaboratively addressed in a larger forum. I tabled language that reflected the substance of the consensus reached in these two important areas.*

156. At page 8 of the conciliator's report, the Honourable Warren Winkler states:

> *During the Conciliation, much progress was made towards achieving a three-year PSA. A three-year PSA would be a significant win for the public, the health system and the Parties. The third year is a cost- neutral year that offers a meaningful payment toward physicians' cost of practice. It would afford the Parties the time required to focus on the Task Force, the goal of which is to collaboratively address the systemic issues threatening the sustainability of Ontario's publicly funded health system. If the Parties can take advantage of the opportunity that the Task Force provides to them, they will have provided an invaluable service to the citizens of our province.*

157. Sustainability was also referred to by the Alberta Medical Association (AMA), Alberta's Minister of Health (AH) and the CEO of Alberta Health Services (AHS) when the AMA, AH and AHS achieved a settlement in 2016 to reopen their existing agreement and achieve substantial savings. The Ministry refers below to the public pronouncements at the time of signing the final agreement by the Minister of Health, the AMA President and the CEO of AHS:

> *"This agreement marks a renewed relationship based on trust and collaboration between government and the AMA as we work together to deliver high-quality health care that is affordable and sustainable. The Physician Resource Plan is an example of the commitment to patient care and innovation that we share with the AMA and all of its members as stewards of our health system."*
>
> *Sarah Hoffman, Minister of Health*
>
> *"The physicians of Alberta are committed to quality care for patients. We also recognize that we need to be part of making the health-care system fiscally sustainable. That is why we entered into negotiations for an amending agreement. We are pleased that what we have achieved moderates health-care expenditure growth and provides for collaboration and shared responsibility in needs-based physician resource planning, savings initiatives and other things. The AMA looks forward to working with the minister, her team, and AHS to implement this agreement. We are optimistic regarding all that we can accomplish together."*
>
> *Dr. Padraic Carr, President, Alberta Medical Association*
>
> *"As an organization, and as a province, we're making great strides in delivering health care that's both high-quality and financially sustainable, and this agreement with the AMA represents further progress on both these*

> *goals. Albertans will continue to receive outstanding physician care as we continue to build a sustainable health-care system for all Albertans."*
>
> *Dr. Verna Yiu, President and CEO, Alberta Health Services*

158. The OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement is another example where the concept of sustainability is embedded. The 2012 Representation Rights Agreement governs the relationship between the parties. The BAF, which governs the dispute resolution process, is an appendix to the Representation Rights Agreement. The concept of sustainability is throughout the Representation Rights Agreement. In the preamble the parties agree as follows:

> *AND WHEREAS the Parties acknowledge that physicians are independent professionals who practice within a publicly funded health care system and that the services that physicians provide are integral to the achievement of a high-quality patient-centred sustainable system;*

159. Further, in paragraph 3 the parties further agree that:

> *3. The Minister and the OMA will consult and negotiate in good faith with each other for the purpose of entering into Physician Services Agreements to establish physician compensation for physician services and related accountability in the publicly funded health care system. The Parties anticipate that any Physician Services Agreement would be based on shared objectives including a patient-centred sustainable health care system. The Parties will use the Joint Process set out in Appendix "A" to negotiate Physician Services Agreements or any periodic re-openers of such an agreement.*

160. The concept of sustainability of the health care is integral to the recognition rights of the OMA and the bargaining and arbitration framework that is the foundation of the current process.

161. The Ministry submits that the Arbitration Board can look to the history of the bargaining of these parties as an indicator of the importance of sustainability of the Physician Services Budget. The parties agreed that "the economic structure of this PSA is entered into without prejudice to either party's position in any future

bargaining, mediation or arbitration respecting the relationship between price/other compensation adjustments and PSB expenditures." However, the Ministry notes the following pertinent part of the 2021 agreement with respect to the Year 3 increase. In year 3 the parties agreed to a methodology for increases based on the expenditure of the PSB. It is outlined in the agreement under Section A, "Year 3. Year Compensation Increases and Gain Sharing". If the expenditure for the PSB in Year 3 was between $16.1759 Billion and $15.8587 Billion, the difference was allocated entirely to physicians as compensation adjustments. If the PSB expenditure was less than $15.8587, the difference between the actual PSB expenditure and $15.8587 was gainshared with government, with 75% of the difference being allocated to physician compensation adjustments. There was no financial liability for physicians if the PSB expenditure exceeded $16.1759 billion.

162. These are the more recent examples of acknowledgement of the issues of growth in physician service utilization and sustainability. However, it is an issue that has been reviewed historically throughout the relationship between the Ministry and the OMA, which is further detailed in Exhibit 10.

163. The consequences of an "open-ended" health system without budgetary restraint on the costs of physician's services is not sustainable. The Ministry reviews in details below the growth of the Physician Services Budget over the last year and compares it to the growth in the number of physicians in Ontario and the population growth in Ontario.

7.3 Physician Expenditure Increases over the Last Year

164. Without counting the cost and benefit of the CMPA subsidy, based on very accurate projections of the PSA for 2024/2025, the increase over 2023/24 will be 15.95%. That number includes a 9.95% price increase which when removed from the costs leaves a 5.46% PSA increase absent any increase.

Year	PSA (BAF) without CMPA	PSA without 9.95% Price Increase (% increase over prior year actual)
2023-24	16,746,500,000	
2024-25	19,417,700,000	17,660,482,037
23/24 to 24/25	15.951%	5.458%

165. Certainty this number is impacted by the population increase (1.49%). Factoring out the population increase, the 5.46% reduces to 3.91%. Therefore, the PSA costs, assuming no price increase and factoring out the population increase, was 3.91%.

Year	PSA (BAF) without CMPA	PSA without 9.95% Price Increase (% increase over prior year actual)	PSA without 9.95% and without pop increase (% increase over actual)	Ontario Population
2023-24	16,746,500,000			15,944,379
2024-25	19,417,700,000	17,660,482,037	17,401,204,096	16,182,641
23/24 to 24/25	15.951%	5.458%	3.909%	1.494%

166. The number of physicians increased at a faster rate that the population (3.48%). Factoring out the physician number increase, the 5.46% reduces to 1.91%. Therefore, the per physician PSA costs assuming no price increase was 1.91%.

Year	PSA (BAF) without CMPA	PSA without 9.95% Price Increase (% increase over prior year actual)	PSA without 9.95% and physician increase (% increase over actual)	PSA with 9.95% and utilization factoring out physician growth (3.48%)	Number of Physicians
2023-24	16,746,500,000				36,204
2024-25	19,417,700,000	17,660,482,037	17,066,565,556	18,764,688,829	37,463
23/24 to 24/25	15.951%	5.458%	1.911%	12.051%	3.478%

167. Phrased differently, the average physicians would have billed 1.91% more in 2024/25 with no fee increase. Compounding the awarded 9.95% increase on top of the per physician utilization increase results in a total billing increase per physicians of 12.05%, moving the average compensation per physician from $462k to $518k. We note that there in need to factor in population increase here because the increase in physicians exceeded the increase in population.

PSA Increase with CMPA

168. Adding in the CMPA subsidy, based on very accurate projections of the PSA for 2024/205, the increase over 2023/23 will be 16.66%. That number includes a 9.95% price increase which when removed from the costs leaves a 6.25% PSA increase absent any increase.

Year	PSA (BAF) without CMPA	CMPA Subsidies	PSA including CMPA	PSA Including CMPA without 9.95% Price Increase (% increase over prior year actual)
2023-24	16,746,500,000	130,280,000	16,876,780,000	
2024-25	19,417,700,000	271,300,000	19,689,000,000	17,931,782,037
23/24 to 24/25	15.951%		16.663%	6.251%

169. Certainty this number is impacted by the population increase (1.49%). Factoring out the population increase, the 6.25% reduces to 4.69%. Therefore, the PSA costs, assuming no price increase and factoring out the population increase, was 4.69%.

Year	PSA including CMPA	PSA Including CMPA without 9.95% Price Increase (% increase over prior year actual)	PSA including CMPA without 9.95% and without pop increase (% increase over actual)[2]	Ontario Population
2023-24	16,876,780,000			15,944,379
2024-25	19,689,000,000	17,931,782,037	17,668,521,073	16,182,641
23/24 to 24/25	16.663%	6.251%	4.691%	1.494%

170. The number of physicians increased at a faster rate that the population (3.48%). Factoring out the physician number increase, the 6.25% reduces to 2.68%. Therefore, the per physician PSA costs assuming no price increase was 2.68%.

Year	PSA including CMPA	PSA Including CMPA without 9.95% Price Increase (% increase over prior year actual)	PSA including CMPA without 9.95% and physician increase (% increase over actual)[2]	PSA including CMPA with 9.95% and utilization factoring out physician growth (3.48%)	Number of Physicians
2023-24	16,876,780,000				36,204
2024-25	19,689,000,000	17,931,782,037	17,328,741,822	19,026,865,095	37,463
23/24 to 24/25	16.663%	6.251%	2.678%	12.740%	3.478%

171. Phrased differently, the average physicians would have billed and enjoyed the benefit of CMPA to the extent of a 2.68% increase in 2024/25 with no fee increase. Compounding the awarded 9.95% increase on top of the per physician utilization increase results in a total billing and CMPA increase per physicians of 12.74%, moving the average compensation per physician from $466k to $526k. We note that there in need to factor in population increase here because the increase in physicians exceeded the increase in population. The full excel table with respect to the above figures is provided at Exhibit 11.

172. The consequences of inexorable increases on physician services at a higher rate than every other public service would inevitably cause the elimination of our treasured public services or cause irrefutable harms to the other components of the health care system.

7.4 Productivity Growth – GDP Per Capita

173. After reaching a record level of $61,032 in 2022Q2, Ontario real GDP per capita declined every quarter except for slight increases in 2023q1 and 2024q4.

174. GDP figures were helped significantly by a surge in population growth, which added millions of new consumers and workers to the economy.

175. GDP per capita reflects the average economic output per person and is a key indicator of economic performance and living standards.

176. In Canada, per capita GDP fell in six consecutive quarters as of 2024Q3, a decline that is larger than that which has occurred in previous times of technical recession. Most recently, Canadian GDP per capita rose by 0.6% in 2024Q4.

177. Over the past couple years, Ontario GDP per capita has fallen in almost every quarter (see Table below). From 2022 Q2 to Q4 of 2024, it has fallen by a cumulative 3.4%.

178. When coupled with the steep rise in unemployment, these GDP per capita figures suggest that the risk of recession lingers.

Ontario GDP Per Capita Since 2022 Q2

Quarter	GDP ($M)[20]	Population[21]	GDP/Million Pop.	Quarterly Growth	Yearly Growth	2022Q1= 100
2022Q2	$918,074	15,042,458	$61,032			100
2022Q3	$920,728	15,141,455	$60,808	-0.37%		99.6
2022Q4	$918,889	15,289,550	$60,099	-1.17%		98.5
2023Q1	$927,945	15,402,095	$60,248	0.25%		98.7
2023Q2	$931,811	15,478,287	$60,201	-0.08%	-1.36%	98.6
2023Q3	$934,815	15,623,207	$59,835	-0.61%	-1.60%	98.0
2023Q4	$936,457	15,818,465	$59,200	-1.06%	-1.50%	97.0
2024Q1	$940,988	15,944,379	$59,017	-0.31%	-2.04%	96.7
2024Q2	$944,513	16,033,583	$58,908	-0.18%	-2.15%	96.5
2024Q3	$948,226	16,124,116	$58,808	-0.17%	-1.72%	96.3
2024Q4	$954,297	16,171,802	$59,010	0.34%	-0.32%	96.6

179. The implications of weak GDP per capita figures are highlighted in the following news articles.

180. Globe & Mail Article September 21, 2024

> *Canada's living standards set to worsen without productivity bump: TD report*[22]
>
> *"Canada risks a further deterioration in living standards if its lacklustre performance in productivity does not improve, economists at Toronto-Dominion Bank warn in a new report.*
>
> *Business sector productivity – output per hour worked, adjusted for inflation – grew by a 'respectable' annual average of 1.2 per cent over*

[20] Ontario Economic Accounts (OEA)

[21] Statistics Canada

[22] "Canada's living standards set to worsen without productivity bump: TD report", the Globe and Mail, Sept 12 2024, at https://www.theglobeandmail.com/business/article-canadas-living-standards-will-worsen-without-productivity-bump-td/

the decade before the pandemic, TD chief economist Beata Caranci and senior economist James Marple write in their report, published Thursday.

But since then, productivity growth has ground to a halt. The slowdown has been driven by a contraction in the goods sector, the report notes, and the decline is especially bad in the construction industry, where productivity has tumbled to levels last seen in the 1990s.

'Canada has seen its productivity go from bad to worse since the pandemic,' the TD report says. 'Without improved productivity growth, workers will face stagnating wages and government revenues will not keep pace with spending commitments, requiring higher taxes or reduced public services.'

Canada's productivity woes have become a hot topic of discussion over the past couple years. In March, Bank of Canada senior deputy governor Carolyn Rogers said the country was facing a productivity 'emergency.'

Several weeks after her speech, Statistics Canada published a report that said national per capita output had fallen 7 per cent below its long-term trend – a decline of roughly $4,200 a person.

In aggregate, gross domestic product (GDP) is continuing to grow, in large part because the population is expanding at decades-high rates. But on a per capita basis, real GDP has dropped to levels seen in 2014.

Real GDP per capita is often used as an indicator of living standards. Residents of countries with higher per capita output tend to enjoy higher wages and live longer. Even so, it's not a flawless measure: While Canada's per capita output lags well behind that of the United States, average life expectancies are higher in Canada."

181. Fraser Institute Article - Jul. 29, 2024

Canada living standards falling behind rest of developed world[23]

"Economists often measure living standards by real gross domestic product (GDP) per person—in other words, the inflation-adjusted monetary value of what a country produces in goods and services divided by its population.

As noted in a new study published by the Fraser Institute, from 2002 to 2014, Canada's GDP per-person growth roughly kept pace with the rest of

[23] "Canada living standards falling behind rest of developed world", Fraser Institute, July 29 2024, at https://www.fraserinstitute.org/commentary/canada-living-standards-falling-behind-rest-developed-world

the OECD. But from 2014 to 2022, the latest year of available comparable data, Canada's annual average growth rate declined sharply, ranking third-lowest among 30 countries over the period. Consequently, in dollar terms, Canada's GDP per person increased only $1,325 during this time period, compared to the OECD average increase of $5,070 (all values in 2015 U.S. dollars).

Moreover, between 2014 and 2022, Canada's GDP per person declined from 80.4 per cent of the U.S. level to 72.3 per cent, and lost substantial ground to key allies and trading partners such as the United Kingdom, New Zealand and Australia.

And according to OECD projections, Canada will have the lowest projected average annual growth rate of GDP per person (at 0.78 per cent) from 2030 to 2060 when our GDP per person will be below the OECD average by $8,617. This represents a swing of more than $11,000 from where it was in 2002.

Why is this happening?

Several reasons, including historically weak business investment over the past decade, a substantial shift in the composition of permanent and temporary immigrants towards those with less education and fewer skills, and subdued technological innovation and adoption. These factors have combined to produce very low or negative labour productivity growth due to weak growth in the education and skills of the average worker and the amount of capital (namely plant, machinery and equipment) per worker."

182. Financial Post Article Jul. 25, 2024

Both GDP and GDP-per-capita important to consider as population grows, says Macklem[24]

*"Canada may not technically be in a recession**, but some economists argue the country's declining per-capita output mimics trends of prior downturns,** so there's a need for policymakers to look beyond the overall positive economic numbers the country has posted in recent quarters.*

[24] "Both GDP and GDP-per-capita important to consider as population grows, says Macklem", Financial Post, July 25, 2024, at https://financialpost.com/news/economy/both-gdp-and-gdp-per-capita-important-to-consider-as-population-grows-says-macklem

Bank of Canada governor Tiff Macklem touched upon this on Wednesday when he announced a second consecutive cut in interest rates and said the central bank will "have to look at both" the total economic growth and the output per person to analyze the state of the economy while making interest rate decisions.

'Households have actually been cutting back on spending,' he said during the press conference. 'But with high rates of immigration, there are more households, so that's boosting the GDP (gross domestic product).'

…

GDP measures the total output created through the production of goods and services in a country during a certain period. It also measures the income earned from that production. GDP per capita is calculated by dividing the country's total GDP by its total population.

Canada's GDP per capita has declined in six of the past seven quarters.

The kind of situation where GDP is on the rise, but per-capita GDP is on the decline isn't sustainable, said Benjamin Tal, an economist at the Canadian Imperial Bank of Commerce, since it means the economy is growing mainly due to population growth as opposed to being productive. Canada's productivity numbers have also been declining in recent quarters.

'I think population growth is entering (policymakers') psyche,' he said.

*BMO Capital Markets economist Robert Kavcic said **the per-capita numbers show a 'little bit more truth,**' such as the scaling back of spending, than the overall numbers show." (Emphasis added)*

183. RBC Thought Leadership - Jul. 17, 2024

Canada's economy might not be in recession but it feels like one[25]

"The total size of the Canadian economy has continued to grow—narrowly avoiding the consecutive headline GDP declines that would normally qualify as a "recession" in the aftermath of surging inflation and aggressive interest rate hikes by the BoC in 2022-23. But, that's only due to a wave of new consumers arriving from abroad. Canada's population grew by 6% from Q2 2022 to Q1 of this year, adding 2.1 million new consumers to the economy.

[25] "Canada's economy might not be in recession but it feels like one", RBC, July 17, 2024, at https://www.rbc.com/en/thought-leadership/canadas-economy-might-not-be-in-recession-but-it-feels-like-one/

Consumer spending accounts for more than half of GDP, and many of those new arrivals (a larger share than the Canadian-born population) are also workers that added to the economy's productive capacity.

***Without higher population boosting demand, the Canadian economy almost certainly would have contracted outright over last two years**. Per person after inflation household spending is 2.6% below its post-pandemic peak and down 2% from pre-pandemic 2019 levels as higher prices and interest rates cut into purchasing power. Per capita GDP has declined in six of the past seven quarters to 3.1% below 2019 levels.*

*The 1.6 percentage point uptick in the unemployment rate is smaller than in those seen in larger recessions, and that increase is from half-century post-pandemic lows. **But since the 1970s, Canada has never had a trough to peak increase in the unemployment rate of that size without the economy going through a recession.** An increase following the dot-com bubble burst in 2000 maxed out at 1.5 percentage points.*

About half the increase in the unemployment rate from its post-pandemic lows has come from layoffs, which are up 20% from a year ago as of June. About 40% of the uptick in unemployment is coming from students and new graduates having a harder time finding a job.

*The per capita GDP decline in Canada has been milder than in more recent downturns. In 2008, real per capita output fell 5% from peak to trough, similar to the contraction in the early 90s. The drop in the 1980s was a larger 7%. **But the current per capita GDP decline is larger than in earlier periods that were considered recessions."** (Emphasis added)*

184. Statistics Canada - Economic & Social Reports - Apr. 24, 2024

Canada's gross domestic product per capita: Perspectives on the return to trend[26]

*"Slower economic growth over the past year and near-record population increases fuelled by temporary and permanent immigration have put the spotlight on recent trends in Canada's gross domestic product (GDP) per capita. Real GDP per capita has now declined in five of the past six quarters and is currently near levels observed in 2017. Recent reports by Porter (2024), Ercolao (2023), and Marion and Ducharme (2024) have all stressed **the trend towards weaker per capita growth, highlighting its negative***

[26] https://www150.statcan.gc.ca/n1/pub/36-28-0001/2024004/article/00001-eng.htm

***implications for living standards and wage growth**. Recent declines in per capita output have also brought concerns over Canada's weak productivity performance to the fore, since historically, much of the long-term growth in GDP per capita has reflected sustained improvements in labour productivity.*

***Economic activity has slowed markedly during the past year** as businesses and households continued to adjust to higher interest rates. Real GDP grew 1.1% in 2023, its slowest annual pace since lower oil prices weighed on growth in 2016, excluding the COVID-19 pandemic-related decline in 2020. Growth in 2023 was driven primarily by increases in exports and household spending, while lower business investment and declines in residential construction weighed on gains. As of late 2023, real output was 4.4% above pre-pandemic levels observed in the fourth quarter of 2019.*

While the pace of economic activity has slowed, Canada's population continued to expand rapidly. During 2023, Canada's population grew 3.2%, an increase of over 1,271,000 people, roughly equivalent to the size of Calgary (Statistics Canada, 2022). With population growth outpacing output growth, GDP per capita has trended lower and is now 2.5% below pre-pandemic levels." (Emphasis added)

7.5 Considerations of Growth in the Economy versus Physician Expenditure

185. As submitted above, the PSA increased from $16.7 Billion in 2023-24 to $19.4 Billion in 2024-35. The represented an increase of 15.9%. When you add the MOH contribution of CMPA, in both years, the increase becomes 16.7%.

186. Over the same period the Ontario Nominal GDP (which includes inflation and population increases) grew only 5.2%.

Year	PSA (BAF) without CMPA	PSA including CMPA	Nominal GDP - Calendar Year - $Millions
2023-24	16,746,500,000	16,876,780,000	1,119,545
2024-25	19,417,700,000	19,689,000,000	1,178,092
23/24 to 24/25	15.951%	16.663%	5.23%

187. Respectfully, a one year Gap of between 10.7% or 11.4% between GDP growth and Physician Compensation is completely unsustainable.

188. Growth in the Ontario Nominal GDP (which includes inflation and population increases) and the Growth in Physician Compensation must eventually run at the same level or the concept of a publicly funded is not sustainable.

189. The funding to sustain our tremendous health care system can only be found in GDP growth.

190. Increasing the rate of taxation in the absence of an equilibrium between Costs (Physician Compensation) and Economic Growth (Nominal GDP) is not a viable long term solution.

191. Increasing Government Debt in the absence of an equilibrium between Costs (Physician Compensation) and Economic Growth (Nominal GDP) is not a viable long term solution.

192. The Ministry reminds the Board that long term consequences are simply the result of consecutive short term results. This is not the time to push the solution off to another day.

8. PRIMARY CARE

8.1 Modernized Primary Care Compensation

193. It is clear that both parties have a shared goal for the health care system. All Ontario residents should have access to a Primary Care provider.

194. The Arbitration Board awarded the following:

> *In our view, in addition to the targeted investments that the Ministry identified in its submissions, the Government needs to invest in targeted spending on physician services, about which we express the following views (in anticipation of the next phase of these proceedings).* ***Targeted investments must be directed at ensuring that currently attached patients, and patients who become attached, have ready and timely access to their primary care physicians****.* ***Targeted investments must be directing at attaching more patients to a primary care doctor.*** *As well, given the evidence of the decline in the number of patients seen – and while the parties did not agree on the explanation for this phenomenon – it is extremely concerning and is, in any event, not sustainable.* ***As a result, targeted investments should be structured in such a manner that rewards or recognizes improving the number of patients seen in a timely way.***

195. Both parties are agreed that changes can and should be made to the predominate Primary Care compensation model, the FHO funding model, with the objective of enhancing access to longitudinal comprehensive family medicine. And while a significant investment is being made into Primary Care in order to make the FHO funding model particularly attractive to physicians, such compensation changes must also be designed to prioritize patient access (which is foundational to a high-performing healthcare system). The Ministry's proposals should be viewed in this light.

196. The parties have achieved consensus on a significant number of issues:

I. To introduce an hourly rate into the FHO funding model that compensates physicians for both direct patient care provided to rostered patients, as well as time spent on indirect patient care and administration. Paying primary care

physicians for hours worked is intended to appeal to physicians who value compensation that is aligned with time and effort, which is directly responsive to the previous submissions of the OMA on primary care physician burnout and amount of administrative work. And while the hourly rate is also intended to encourage a focus on efficient and quality care, it should also be balanced with compensation structures which motivate physicians to provide access to rostered patients (including attaching more patients) and the provision of ready and timely access to care.

II. The hourly rate will be partially funded by the removal of the current compensation elements called the “comprehensive care capitation payment” and “access bonus.” This was particularly of interest to the OMA, who argued in their 2024 brief that negation is unfair and a significant source of frustration to Ontario FHO physicians.

III. To increase the FHO funding model Shadow Billing rate for in-basket services from 19.41% to 30%. Further, that the shadow billing rate for certain in-basket procedures should be incentivized to 50%. This is intended to enhance patient access by motivating physicians to provide services to enrolled patients.

IV. The after-hours premium for FHO Physicians providing services to enrolled patients will be increased from 30% to 50% for all services and procedures performed after hours. Again, this is another change intended to enhance timely and ready access for patients by encouraging greater availability on evenings and weekends.

V. An additional Enhanced Group Management Leadership Payment (GMLP) for the FHOs, FHNs, and RNPGA physician groups to provide funding to support a leader that will ensure the new FHO contract arrangements with government are successfully implemented, including appropriate after-hours availability and care specifically.

VI. Health Care Connect payment enhancements to encourage physicians to attach those on the waitlist, aligned with the government's initiative to connect all individuals registered on the waitlist to a primary care provider.

VII. Increasing the number of available entry positions in the FHO funding model and amendments to the colocation guidelines to work alongside the range of new initiatives in the FHO model to attract more primary care physicians to enter into the FHO funding model and attach more patients.

8.2 Ministry Position

198. The parties have reached agreement on a substantial number of items in this major and complex transformation to substantially change the FHO funding model.

199. The following represents the Ministry's proposal with respect to the FHO funding model. Some of the proposals also enhance funding for other primary care enrollment models in addition to the FHO funding model (for example, the patient attachment bonus proposal). Most of this proposal represents an agreement between the parties. The Ministry submits that with the exception of patient attachment bonuses, the modernized FHO funding model become effective April 1, 2026. The Ministry proposes, given the agreement of the parties, that the patient attachment bonus become effective July 1, 2025.

200. Where there are differences between the parties on the modernized FHO funding model, these are highlighted in yellow. The Ministry asks the Board to reflect upon and consider the significant degree of agreement achieved by the parties.

> *The parties acknowledge that Ontario is experiencing a growing number of unattached patients and that they have a shared objective of enhancing access to longitudinal comprehensive family medicine. To this end, the parties have worked cooperatively to develop a modernized Family Health Organization model ("mFHO") which is intended to retain current physicians and attract new physicians to the provision of this model of care, increase patient enrollment and improve patient access to primary care.*
>
> *Overall, the combined effect of the changes set out below – which include investing additional funding in the FHO model, reintroducing unattached patient fees, repurposing the CC payment and the access bonus, increasing the shadow billing component, and introducing a rate where compensation is tied to time spent providing overall care including indirect patient care – is intended to increase the proportion of physician payments which results from rostering patients and providing accessible care, while at the same time maintaining the widely acknowledged health system benefits of capitated primary care payments.*
>
> *In order to achieve the changes required to implement the transformative mFHO model, the parties agree that $240 million of the FHO allocation of the*

awarded Year 3 – 2.8% price increase and Year 1 - 6.95% price increase being allocated to fund this proposal (and not allocated through PPC).

l. ***Hourly Payment:*** *Introduce an hourly payment of $80.00 for the time a FHO physician spends providing care, including time spent on direct care and indirect care (including clinical administration). The hourly rate for total physician time recognizes the full scope of insured activities and services that FHO physicians provide to rostered patients, direct and indirect care and clinical administrative work. The new fee code will also incent physicians to provide care in their clinics/offices. The hourly rate will apply to all insured services provided to rostered patients. For greater clarity, the hourly rate applies to virtual care services provided in Ontario in accordance with the virtual care payment rules, and to services provided by FHO-Contracted Physicians. However, the hourly rate for direct care related to telephone-based virtual care services provided when the physician is not physically present in the clinic will be $68.00. The parties mutually recognize and agree that this hourly rate arrangement is without prejudice to the parties' respective position about the price of virtual care delivered by phone elsewhere in the Schedule of Benefits.*

The hourly rate does not apply to services provided outside the usual family medicine clinical practice setting. In particular, the hourly rate does not apply to services provided while in emergency departments, in-hospital (i.e. admitted patients/hospitalist work as well as obstetrical labour and delivery care), anesthesia, surgical assist, IHF, and long-term care homes, or to services provided to non-rostered patients or uninsured services.

The maximum daily limits for payment of the hourly rate to be set at fourteen (14) hours in a single day, with a twenty-eight (28) consecutive day limit of 240 hours. No more than 25% of the total physician's hours billed (averaged over a twenty-eight (28) consecutive days) can be for indirect patient care and clinical administrative work. Clinical administration time (CAT) will be no more than five (5) percent of the total amount of time claimed by the physician for direct and indirect patient care, measured over twenty-eight (28) consecutive days.

The compensation will be for the cumulative time the physician spends providing services in each of the following three categories: Direct Patient Care, Indirect Patient Care, and/or Clinical Administration in a calendar day. Time codes are billed and paid in 15 minute units for each category, which will be calculated on a cumulative basis across the calendar day. The cumulative number of minutes in each category will be divided by fifteen (with any remainder of 8 minutes or more counting as a full 15-minute unit). Time codes will not be calculated for each individual patient but will be calculated on a cumulative basis for all patients. Schedule A sets out additional payment rules regarding the hourly rate.

II. ***Schedule A – Hourly Rate Payment Rules***

Direct and indirect patient care and Clinical Administration Reporting: *Direct and indirect patient care and clinical administration reporting is an all-inclusive service conducted for the purposes of reporting cumulative physician time rendered providing Direct Patient Care, Indirect Patient Care, and/or Clinical Administration in a calendar day*

Definitions/Required elements of service. *For the purposes of this section of the Schedule only, the following Definitions apply:*

(i) ***Direct Patient Care (Fee QXXX)*** *is payable for time spent personally providing clinical services to rostered patients of the FHO group for in-person care and synchronous virtual care, subject to the limitations of B including clinical teaching provided concurrently with patient care*

(ii) ***Direct Telephone-based Patient Care -*** *Not in Office (Fee QZZZ) is payable for time spent personally providing telephone based virtual care services to rostered patients of the FHO group when the physician is not physically present in the usual family medicine clinical practice setting;*

(iii) ***Indirect Patient Care (Fee QYYY)*** *is payable for time spent personally providing the services listed below that are associated with patient-specific insured services provided to rostered patients of the FHO group where there is no direct patient contact, whether in-person or virtually:*

(A) Documentation of patient interactions and charting.

(B) Review of results: labs, imaging, consultations, and other reports.

(C) Preparing referrals and requisitions.

(D) Chart review.

(E) Discussion with, and providing advice and information to the patient or the patient's representative, via synchronous or asynchronous care communication, that is directly related to pre or post direct patient care

(F) Care coordination and care planning

(G) Conferencing, consulting, and meeting with other physicians and/or other health professionals for a specific patient or patients.

(H) Conferencing and meeting with family members and/or patient medical representatives.

(I) Reviewing and analyzing clinically related information/research directly related to the needs of a particular patient (e.g.: investigating particular diagnostic and therapeutic interventions).

(J) Completion of clinically required forms, reports and medical certificates of death (excluding services requested or required by a third party for other than medical requirements and for which the physician can bill the patient directly, such as insurance forms and reports, medical-legal letters and reports, insurance/industrial examinations, and physical fitness examinations for school/camp).]

(K) Patient-specific clinical teaching arising from Direct Patient Care. Teaching that is unrelated to Direct Patient Care is not payable as Indirect Patient Care Time.

(iv) ***Clinical Administration (Fee QZZZ)*** *is payable for time spent on activities that are not described in A B or C above and are not patient-specific but require the professional expertise of a physician for management of the patient panel and practice. Clinical administration includes:*

(A) Proactive patient management and review for screening interventions, disease management, and provision of care (e.g., mammograms, colon cancer screening, immunizations, diabetes management).

(B) Electronic Medical Record (EMR) updating and management that requires physician expertise.

(C) Quality improvement planning and implementation (e.g. patient access/equity and digital solution initiatives).

Clinical administration does not include time spent on non-clinical administration related to clinic management. Non-clinical administration includes management of employees, finance and accounting responsibilities, ordering supplies and equipment, and clinic infrastructure services such as leasing and insurance.

III. ***Hourly Payment - Records:*** *Physicians shall maintain such records as may be necessary to establish the total time spent providing Direct Patient Care,*

Indirect Patient Care, and/or Clinical Administration. Such records of time spent providing Indirect Patient Care and Clinical Administration on a given day shall include a summary description of the activities associated with the time-based fee code. Upon Request, physicians shall provide the Minister or her agents with such records or other information to demonstrate the direct, indirect and clinical administrative work that the physician has billed for a given day.

IV. ***Access Bonus:*** *Remove and reinvest the Access Bonus and all related provisions.*

V. ***Comprehensive Care Capitation Payment****: Remove and reinvest the CC Cap and all related provisions.*

VI. ***Shadow Billing:*** *The Shadow Billing rate for in-basket services will be increased to 30%. The shadow billing rate for all in-basket procedures set out* ***in Exhibit 12*** *will increase to 50%.*

VII. ***After hours premium:*** *The after-hours premium for FHO Physicians providing services to enrolled patients will be increased from 30% to 50% for all services and procedures performed afterhours. In return, the Ministry expects that FHO physicians meet their after-hour compliance obligations (current contractual requirements).*

VIII. ***Group Management Leadership Payment****: The current Group Management Leadership Payment (GMLP) provides the FHOs, FHNs, and RNPGA physician groups with an administrative payment of one dollar per patient per fiscal year, prorated daily for each patient enrolled to a maximum of $25,000 (prorated based on the commencement date). The current GMLP will be maintained. In addition, there will be an additional Enhanced GMLP to a maximum of $100,000 (prorated) annually, for group leadership activities. This Enhanced GMLP will be provided in return for the group lead or leads providing leadership to ensure FHO contract compliance generally, including appropriate after-hours availability and care specifically. The Enhanced GMLP will be calculated as an administrative payment of four dollars per patient per fiscal year, prorated daily for each patient enrolled to a maximum of $100,000 per group (prorated based on commencement date). However, in no event will the sum of the current GMLP and the new Enhanced GMLP payment to the group be less than $25,000. Payment for the existing GMLP program will remain status quo. Payment for the Enhanced GMLP to be issued at fiscal year-end.*

IX. ***Patient Attachment Bonus:*** *Introduce a Patient Attachment Bonus which applies to all Patient Enrollment Models (PEM) physicians, in addition to any capitation rate.*

Established Doctors

Newly Enrolled Patient	*RIO < 40*	*RIO >= 40*
Age 0 – 64	*$100*	*$150*
Age 65+	*$120*	*$180*

New Grads (New Grads are defined as physicians who have completed family medicine residency within three years prior to joining a PEM, or an IMG who has completed family medicine postgraduate training and has received an independent practice license within three years of joining a PEM). New Graduate eligibility will be determined as of the date of joining the PEM and will continue for a 12-month period. Eligible New Grads will receive the New Grad attachment bonus rate, as follows:

Newly Enrolled Patient	*RIO < 40*	*RIO >= 40*
Age 0 – 64	*$150*	*$225*
Age 65+	*$180*	*$270*

X. Criteria for Payment of the Bonus: The following criteria must be met for the physician to receive the patient attachment bonus:

(i) All PEM groups are eligible to bill the new fee.

(ii) The fees applicable to newly enrolled patients may only be billed once by the same group enrolling the same patient.

(iii) Payment of the fee requires the patient be enrolled to the FHO group.

(iv) The patient attachment bonus code can only be billed for a newly enrolled patient at the time of the first billable service. The first billable service does not include services provided outside of the usual family medicine clinical practice setting prior to enrolment.

(v) If the group chooses to de-enroll a new patient within 12 months of formal enrolment, the fee paid to the group will be recovered.

(vi) The patient attachment bonus cannot be billed in addition to the Health Care Connect Payment, New Code: Mother Newborn New Patient Fee and New Code: Multiple/Newborn Fee.

William Kaplan will be seized to resolve any dispute. Notwithstanding that the targeted investment funding will cease to be allocated to the Primary Care Attachment Bonus upon the expiry of the 2024-28 PSA, such targeted funding

allocated per this proposal will continue to be committed to permanent additional targeted funding, with payment to be negotiated between the parties in the 2028-2032 PSA.

XI. Additional Payments to Enhance Attachment:

(i) Increase the Health Care Connect payment (Q053) from $350 to $500 for attaching complex patients.

(ii) Provide Q054 Mother Newborn New Patient Fee $350

A one-time payment of $350.00 for physicians enrolling both an unattached mother and newborn within two weeks of giving birth or an unattached woman after 30 weeks of pregnancy.

(iii) Provide Q055 Multiple/Newborn Fee $150

In the case of multiple births, physicians may bill a Multiple Newborn Q055A fee code of $150.00 per newborn in addition to the Q054A Mother Newborn New Patient code for each additional newborn of an unattached mother.

(iv) Q056 Health Care Connect (HCC) Upgrade Patient Status $500

Where a physician accepts an HCC referred as a non-complex/vulnerable patient that the physician in his/her clinical opinion, assesses to be complex and/or vulnerable, the physician is eligible to bill the HCC Upgrade Patient Status Q056A fee code. When billing this code, physicians will receive a total one-time payment of $500.00 (the equivalent of Q053).

XII. ***Accountability - Base Capitation Rate/Adjustment to Base Capitation rate:*** *The Capitation Rate will be subject to an "at risk" reduction should an individual FHO physician's continuity of care fall below the minimum indicator as set out below:*

In-Basket Continuity of Care:	***Expected Patient Access***
Percentage of All In-Basket Primary Care Visits Provided to the FHO physician's rostered patients by (i) the FHO physician, or (ii) any physician within the FHO Group (including by a locum registered to the FHO group), or (iii) any other Acceptable Provider, as defined in (d) below.	*80% or greater, to be measured over the previous quarter.*

XIII. ***Measurement of the Accountability:*** *For the purposes of measuring quarterly in-basket continuity of care, the indicator will be calculated in each quarter, based on service date, on the following basis:*

(i) *If the Continuity of Care Indicator in a quarter (Q1 is not met such that the capitation rate is at risk of being adjusted, the physician will be notified by the Ministry in Q3, allowing for the completion of Q1 billing by the end of Q2 Notification must be provided within xxx days of the completion of Q2. Note: The Ministry proposes the number of days upon which notification is provided be referred back to the parties with arbitrator Kaplan to remain seized.*

(ii) *If in the quarter following Ministry notification (Q4 but assessed at the end of Q5 to allow for the completion of Q4 billings), the physician has not met the Continuity of Care indicator, the capitation rate paid for Q1 will be reduced in the next quarter's capitation payments (Q6), by 20% the amount of Q1 capitation payments.*

(iii) *This process will be applied on a rolling basis for each quarter following the initial Q1.*

(iv) *For the purposes of measuring in-basket continuity of care, the average % of Primary Care Visits provided by Group or Other Acceptable Provider is determined to be:*

Numerator: Primary Care Visits provided by FHO Group or Other Acceptable Provider	*In-basket visits provided by the FHO Group or Other Acceptable Provider, defined as follows:* ***Provided by Group*** *– in-basket services provided by the FHO group to whom the patient is enrolled, including by locums registered to the FHO group* ***Provided by Other Acceptable Provider*** *– A designated in-basket visit provided by an FP, who is not in the FHO group to which the patient is enrolled, as defined below:* *GP Focus Practice in-basket Visits by FP designated physicians billing fee codes or diagnostic codes identified for their area of practice* *Emergency Department and Hospital Visits: in-basket visits that take place in the Emergency Department or*

	elsewhere in a Hospital identified by a master hospital number (including special visits to an emergency department: In-basket visits claimed with these codes: K990 to K999 series codes and H980 to H981; H984 to H989) *HIV or COE Physicians: In-basket HIV or COE physicians billing select fee codes identified for their area of practice* *Oculo-visual Claims: In-basket visits provided by physicians who provide oculo-visual services (fee code A110A and A112A)*
ALL Primary Care Visits (Denominator)	*Primary Care Visits are defined as in-basket FHO services provided by physicians with an FP specialty (Classification Code = 00) to patients enrolled to the FHO model, excluding long-term care patients*

(v) *The Ministry proposes a separate standalone report to be provided to each physician monthly via the existing Medical Claims Electronic Data Transfer (MCEDT) account.*

XIV. ***FHO complement/managed entry:*** *The FHO complement will be increased by an additional 240 total spots for April 1, 2024, to March 31, 2025, on the same terms as under the 2021-24 PSA, including the following.*

(i) *Registration of the 240 new physicians into the FHO models, prioritizing those seeking practice in an area with a RIO score of 30 or above, for FHOs with less than 6 physicians, or involved in Ministry supported activities such as Ontario Health Teams subject to ministry discretion;*

(ii) *Any unused spots can be rolled over to the subsequent year (including unused spots from the prior 2021-24 PSA)*

(iii) *Replacement physicians will be permitted and processed outside the Managed Entry process;*

(iv) *Physicians in a different practice model will have the opportunity to enter into the FHO model without having to de-roster and then re-roster;*

(v) *The Ministry will report quarterly to the OMA on the filling of the entry of physicians into the model pursuant to these provisions.*

XV. ***FHO co-location guidelines:*** *The FHO co-location guidelines will be broadened as follows:*

(i) *If all physicians in a group cannot be in the same location, there should be no less than 2 physicians in each location.*

(ii) *In areas where the RIO score is 0, close proximity to be defined as the FHO's locations being within a 5 km radius of one another.*

(iii) *In areas with a RIO score of 1 to 5, close proximity to be defined as being within a 10 km radius.*

(iv) *In areas with a RIO score of greater than 5, close proximity to be defined as being with a 30 km radius.*

(v) *Where physicians fall outside of these proximity parameters, applications from groups will be considered based on a consideration of infrastructure limitations or any other relevant factors having regard to the health care needs of the community. Any application not granted can be referred to PSC co-chairs for resolution, failing which the matter will be referred to the referee for final determination.*

(vi) *For clarity, these guidelines do not apply to existing FHOs adding physicians to their pre-existing group locations.*

XVI. ***Location of Services within the FHN/FHO:*** *The FHO/FHN contract to be amended such that in-patient services provided in-hospital are considered out of basket and paid the full fee for service amounts. The Ministry confirms that these services are out of basket and will not impact the FFS limit with respect to enrolled patients.*

XVII. ***Updated FHO Boilerplate:*** *The parties will agree on an updated FHO boilerplate agreement, reflecting the changes above. These proposals and any settlement are contingent on the agreement of the parties to an updated FHO boilerplate agreement which the Ministry will require each FHO physician to sign. Every effort will be made to complete the updated agreement within 90 days of the effective implementation of the above. Arbitrator Kaplan to remain seized on any issue related to the updated boilerplate language.*

XVIII. ***FHO Declaration Amendments:*** *The parties agree to add the following as new paragraph 8 to the FHO Physician Declaration:*

The undersigned confirms:

a. *I will support the Family Health Organization's ongoing efforts to enable patients to receive a response from the group with respect to administrative matters during regular business hours, including via email, text, phone or other combination.*

b. *I will support the Family Health Organization's efforts to provide appropriate access that meets the needs of the practice's patients including meeting contractually required after-hours coverage.*

c. *I will not direct patients to attend at an Emergency Department during regular business hours, and contractually required after hours, for conditions which can be appropriately assessed by a FHO physician.*

d. *I will make best efforts to arrange clinically appropriate coverage when away from the practice which may include arranging cross-coverage by other physicians in the Family Health Organization.*

XIX. ***Effective date:*** *the effective date of the above model will be April 1, 2026.*

XX. ***Group Limit:*** *The shift to individual fee for service billing limits for FHO/FHN agreed to in the 2021-24 PSA will not apply, and the Group Limit will continue to apply.*

XXI. ***Dispute Resolution:*** *Any dispute with respect to the interpretation or application of the provisions of this Agreement may be referred by the OMA to the Physician Services Committee (PSC) for consideration. Any matter that is not resolved by the PSC may be referred by either the OMA or the Ministry to the Referee in accordance with the provisions of Section 39 of the Binding Arbitration Framework.*

8.3 Ensuring Patient Access

201. Improving access to primary care lies at the bedrock of the Ministry's primary care proposals. It is critically important to the Ministry that a revised compensation model for primary care physicians aligns with the province's objectives for Ontario's publicly funded primary care system[27]. Investments to primary care physician compensation must be structured and targeted at the goal of ensuring that the people of Ontario have improved access to primary care clinicians and teams, including access to timely, convenient and coordinated primary care. Together, the Ministry and the OMA have found significant alignment on many shared priorities. Below are our submissions to support the very few issues that remain outstanding between the parties.

[27] https://news.ontario.ca/en/release/1005885/ontario-taking-next-steps-to-protect-primary-care

8.4 Continuity of Care as a Measure of Access

a. The Importance of Continuity of Care

202. Along with monthly notice of a practice's level of continuity of care agreed to by the parties (a report that will, unto itself, enhance awareness of this performance metric), the Ministry advances a proposal that is designed to add a reasonable measure of accountability to complement the investment that is being made in this new primary care model. Accordingly, the Ministry proposes an 80% continuity of care threshold. As will be submitted below, currently primary care physicians are, on average, well above this threshold. The Ministry is not suggesting that 80% is an appropriate level of continuity of care, and would in fact suggest that continuity of care expectations for primary care physicians should be greater than 80%. However, the Ministry is willing to use 80% as the benchmark that informs a mechanism to encourage care levels at or above that level for the benefit of their patients.

203. What is continuity of care? It means receiving care from the same dedicated provider over time[28]. Continuity of Care can be measured by tracking how often a patient's care is provided by the same physician, or in the case of FHOs, by the same group of physicians, over time. It means having access to and seeing your physician (or a another member of the care team) rather than going to a walk-in clinic for episodic care, for example.

204. The theory that longitudinal comprehensive family medicine provided by a group or team of physicians is superior to episodic care from a wide variety of unconnected physicians has a compelling logic and is why the parties share a common agreement that keeping track of a group's continuity of care can be an important piece of information to support a successful practice. It is recognized that stronger continuity leads to better health outcomes for patients, enhanced

[28] https://www.cfpc.ca/CFPC/media/Resources/Health-Care-Delivery/Continuity-of-Care-one-pager-ENG-Final.pdf

patient quality of life as well as improved health system costs and efficiency[29]. Continuity of care is consistently associated with lower risk of hospitalizations, emergency department use, and/or rehospitalization[30].

205. Given the above, not surprisingly, the OMA itself argued in its 2024 brief on the importance of continuity stating:

> 507. As well, as discussed above, the practice of comprehensive longitudinal family medicine is on the decline. Comprehensive longitudinal family practice is "the provision of a broad range of services on a longitudinal basis to a defined panel of patients of all ages, backgrounds, and health conditions."[320] ***The true value of primary care is realized through a continuous relationship between a patient and their family physician, coordination of care, being the first point of contact in the health system, and the comprehensiveness of services***.[321] Despite the fact that comprehensive longitudinal care is associated with better health outcomes, the overall proportion of Ontario family physicians providing this type of care has dropped from 77.2% in 2008 to 70.7% in 2019 to 65.1% in 2022.322

206. The Ministry also cites below the award of Kaplan (Year 1) wherein he references the study referred to by the OMA in their Year 1 presentation:

> *That doctor shortage, to state the obvious, the OMA observed, led to serious and entirely predictable consequences to the unattached patient: in obtaining initial diagnosis and follow-up care when ill, and in receiving regular preventive care. The academic literature was conclusive: continuity of care with a primary care professional or team was associated with decreased utilization, decreased health care costs, and decreased mortality.*

207. What causes these benefits for the patient and the health system? In a comprehensive care model, the physician is very familiar with the patient and the patient medical history. The patient has a sustained relationship with the physician over time, not just episodic visits. Over this time, the physician obtains a broader knowledge of the patient's history, preferences and social context,

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[29] https://www.cfpc.ca/CFPC/media/Resources/Health-Care-Delivery/Continuity-of-Care-one-pager-ENG-Final.pdf

[30] https://www.cfpc.ca/CFPC/media/Resources/Health-Care-Delivery/Continuity-of-Care-one-pager-ENG-Final.pdf

leading to more personalize decisions[31]. This could include knowledge of the family, interests, habits and other non medical facts that could have an indirect impact on the health of the patient. Further, the physician has easy and immediate access to all the medical records of the individual. It also results in improved care coordination, with a continuous provider ensuring that all aspects of the patients care is coordinated, and that there are fewer gaps in care. These would be a few of the obvious advantages of continuity of care between the patient and physician(s).

207 The physicians in the current FHO funding model have an average continuity of care of approximately 84.8%. Those FHO physicians in Family Heath Teams have an average continuity of care of 87.5%. As such, the Ministry proposal for a Continuity of Care accountability measure at the 80% level is well within a reasonable range of expectation, given the current averages of groups, particularly those with the support of a Family Health Team. The Ministry also notes that with announced investments into primary health care teams, it is reasonable to expect that the average continuity of care will only increase.

[31] https://patientsmedicalhome.ca/files/uploads/PMH_VISION2019_ENG_WEB_2.pdf

Comparing Continuity of Care Among FHT and Non-FHT FHO Groups[32]

FHT Affiliated Physicians			
Time Period	**Inside Primary Care Visits by Enrolled Patients**	**Total Primary Care Visits by Enrolled Patients**	**% Continuity of Care**
Q1	1,543,010	1,752,001	88.1%
Q2	1,430,907	1,641,560	87.2%
Q3	1,515,157	1,739,477	87.1%
Q4	1,583,622	1,809,744	87.5%
Entire Fiscal Year	**6,072,696**	**6,942,782**	**87.5%**

Non-FHT Affiliated Physicians			
Time Period	**Inside Primary Care Visits by Enrolled Patients**	**Total Primary Care Visits by Enrolled Patients**	**% Continuity of Care**
Q1	2,636,279	3,157,761	83.5%
Q2	2,473,498	2,974,454	83.2%
Q3	2,584,445	3,112,640	83.0%
Q4	2,629,446	3,145,545	83.6%
Entire Fiscal Year	**10,323,668**	**12,390,400**	**83.3%**

Aggregate	**16,396,364**	**19,333,182**	**84.8%**

[32] Ministry claims data (FY23/24)

b. The "Appropriate Level" for Continuity of Care

208. A review of the academic literature identifies that there are different ways of measuring continuity of care. However, all the literature reviewed by the Ministry measures continuity to the individual provider, whereas the Ministry's proposed Continuity of Care accountability measures continuity to the group. In other words, the Ministry's measurement counts visits to both the individual physicians AND their colleagues/other acceptable providers in the numerator, which makes it much easier to achieve a higher continuity percentage, whereas the literature only counts visits that the individual enrolling physician is doing. If awarded, a group-based measurement is, in the Ministry's view, the most reasonable and appropriate approach to take as we introduce this concept to support improved access to care.

209. One measurement cited in literature is the ""Usual Provider of Care" (UPC) methodology. It's measurement formula is as follows:

I. Numerator = visits to enrolling physician only

II. Denominator = all primary care visits

210. Again, the Ministry proposed accountability measure:

I. Numerator = visits to enrolling physician + visits to colleagues + visits to locum + visits to acceptable providers (e.g. GPFP)

II. Denominator = all primary care visits

211. Using the UPC measurement of continuity of care (i.e. only looking at the measurement of visits to an individual enrolling physician), here is what the continuity of care would look like in the FHO funding model:

Continuity of Care Measurement	UPC Methodology
No. (%) Of Physicians Impacted at 80% CoC Threshold	3,356 (50.1%)[33]
No. (%) Of Physicians Impacted at 75% CoC Threshold	2,407 (35.9%)
No. (%) Of Physicians Impacted at 70% CoC Threshold	1,711 (25.5%)
No. (%) Of Physicians Impacted at 60% CoC Threshold	9624.4%)

212. Using the UPC measurement of continuity of care, only 3,356 (50.1%) of FHO physicians reach a continuity of care threshold of 80%. The Ministry's current proposed measurement (which is dramatically different from the UPC methodology), only impacts 1,410 physicians at an 80% Continuity of Care level. Further, as will be described below, though throughout the year 1,410 FHO physicians may be risk adjusted, this is a much lower number when it is netted out against the Ministry's agreement to eliminate the Access Bonus "negation". In other words, under the current Access Bonus, the vast majority of FHO physicians in the province receive some sort of "negation". In the Ministry's proposed model, only a small minority of physicians will experience the equivalent of "negation".

[33] Total of 6,699 FHO physicians in the 2023/24 Fiscal Year

c. Literature Review

213. Health Quality Ontario did a literature review of the studies assessing the UPC methodology. Across 8 studies assessing continuity of care using the UPC methodology, the threshold for high continuity of care in these studies was identified within the range of 75% to 86%.

214. It is important to note, as seen above, a 70% level of Continuity of Care using the UPC methodology is equivalent to an 80% level of Continuity of Care level using the methodology proposed by the Ministry. The Ministry submits that a Continuity of Care threshold at 80%, using the methodology proposed by the Ministry, is supported by literature as an appropriate threshold and a reasonable accountability measure.

Study	Continuity cut-off	Additional Notes
Cheng et al, 2011 (1) (Taiwan)	No cut-off values – divided into three equal tertiles based on data - Average UPC of all patients = 55%	For patients with any condition
Ionescu-Ittu et al, 2007 (2) (Canada)	- Low: <=50% - Medium: 50-80% - High: >80%	For patients with any condition
Menec et al, 2006 (3) (Canada)	- Low: <=75% - High: >75%	For patients with any condition
Menec et al, 2005 (4) (Canada)	- Low: <=75% or <=50% (for comparison) - High: >75% or >50% (for comparison)	For patients with any condition
Chen &Cheng, 2011 (5) (Taiwan)	- Low: 47% - Medium: 47-86% - High: >=86%	For patients with Diabetes
Worrall & Knight, 2011 (6) (Canada)	- Low: <75% - High: >=75%	For patients with Diabetes
Lin et al, 2010 (7) (Taiwan)	- Low: 47% - Medium: 47-75% - High: >=75%	For patients with Diabetes
Knight et al, 2009 (8) (Canada)	- Low: <75% - High: >=75%	For patients with Diabetes

215. There is one further methodology used in research for continuity of care called the “Bice-Boxerman Continuity of Care Index”. However, there are two major fundamental issues that would prevent any objective assessment of the use of this method.

216. Firstly, the Bice-Boxerman Continuity of Care Index has no knowledge of who the patient is SUPPOSED to see. A patient who sees their own FHO physician once, and a walk-in clinic twenty (20) times in a quarter, would be considered to have excellent continuity. This would be entirely contrary to what the parties are attempting to measure and would in fact reward those FHO physicians with the worst continuity of care for their enrolled patients.

217. The Bice-Boxerman Continuity of Care Index can not be calculated when the patient sees only one provider in the period. In other words, a FHO physician who is the only physician for a given patient (a very good result) is not counted at all. The Bice-Boxerman formula will result in a division by zero in the case where a patient saw only one physician and division by zero is of course, not a mathematical possibility. Hence, this perfect physician/patient relationship would be ignored. This formula could not be reliably used as a measure of continuity of care for a FHO Physicians enrolled patients because it ignores those FHO physicians with the best continuity of care for their enrolled patients.

218. The Ministry therefore respectfully submits that this method provides no assistance in determining the appropriate level or threshold for the measure of Continuity of Care as these parties define and understand that term.

8.5 The Level of Adjustment proposed at 20% is modest

219. As the Ministry has noted above, it proposes an accountability model to support improving the level of continuation of care in this primary care model. This model would work on the understanding that a physician would receive a monthly report regarding their continuation of care. If, in a given quarter, a physician does not meet the continuity of care measure of 80%, the physician would be provided a further 3 months to first take steps to improve their level of continuation of care to their patients. If the physician does not bring the continuity of care level to 80% or greater in the 2nd quarter, a 20% discount would be applied to the physician's capitation rate only for one quarter and that discount would continue until the physician improves the continuity of care level to 80% or above.

220. This new method replaces entirely, the Access Bonus/Negation model which automatically penalized a physicians on each and every occasion and each and every month where a patient enrolled to that physician went to a walk-in clinic, for example, and which did not include any advance notice or period of time to remedy the situation.

8.6 Remaining Outstanding Primary Care Issues

221. The OMA has proposed that the FHO complement be increased by an additional 240 total for each year of the PSA. The Ministry has proposed, without prejudice to the issue of the arbitrability of managed entry pursuant to the BAF, to increase the FHO complement by 240 in the first year of the agreement. Further, the Ministry proposes that the registration of Family Health Group (FHG) physicians will not count towards this total. As such, for the purposes of this PSA, the Ministry submits this represents a sufficient capacity for entry to the FHO model.

222. The OMA also has a proposal with respect to the exemption for hospital on call counting for after hours coverage. The parties have been engaged in

discussions to resolve this issue. The Ministry respectfully submits that this is an issue that should be referred back to the parties to resolve, on the understanding that the parties reserve all their rights with respect to this issue.

8.7 Conclusion with Respect to Primary Care Investments

223. The Ministry has worked constructively with the OMA to establish a transformative new primary care funding model that elevates Ontario primary care compensation from best in class (i.e. the best in Canada) to an even more superior level in a mutually recognized effort to allocate the Board's Year 1 award to a shared interest priority of the parties.

224. In consideration for this materially enhanced compensation model, the Ministry seeks to measure and track the success of this investment to ensure that it achieves one it its desired goals – improving access to primary care. In doing so, the Ministry acknowledges the toxicity that was associated with the prior model's negation model which was not particularly focused at those physicians with low patient access, and therefore not appropriate in all circumstances. Instead, by working with a mutually recognized interest of the parties – continuity of care, the Ministry has proposed a reasonable accountability tool that runs alongside a monthly notice process and an advance notice system that provides a physician with time to address any issues in the group's practice regarding continuity of care. With the support of a practice leader, something these parties have agreed to fund, the Ministry is confident that the current averages of 84 and 87 percent continuity of care can be further improved. It is also why the Ministry submits that an 80% threshold is a fair and achievable number for new or existing physicians practicing in this model.

225. Ontario is already making a significant investment of over $1.8 billion to connect two million more people to a family doctor or primary care team within four years. With this investment, the Ontario Government will add 305 new primary care

teams across the province[34]. In primary health care teams, patients benefit from the care provided by a variety of health care professionals (nurses, dieticians, social workers, etc.) working collaboratively to address their needs. Through this investment, Ontario is building a primary care system that is comprehensive, convenient and accessible to Ontario residents. The Ministry submits that further investments into primary care, and particularly FHO physician compensation, should also support these government objectives. The Ministry's proposal for changes to the FHO compensation model accomplishes this.

226. The Ministry is recognizing and fairly compensating its FHO physicians in order to acknowledge their important contribution to Ontario's health care system and to materially improve the patient experience for Ontario's citizens, particularly remunerating those FHO physicians who provide excellent continuity of care and access for their patients.

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[34] https://news.ontario.ca/en/release/1005770/ontario-connecting-300000-more-people-to-a-family-doctor-and-primary-care-teams-this-year

9. TARGETED INVESTMENTS TO PEDIATRIC HOSPITALS

9.1 The Hospital for Sick Kids and Children's Hospital of Eastern Ontario

227. The Government has made tremendous investments in pediatric health services to connect children and youth to more convenient and high-quality care at health care facilities across Ontario[35][36]. In alignment with the Ministry's investments in pediatric funding, the Ministry is in agreement that this is an area where targeted investments should be allocated to the Alternative Funding Plans (the "AFPs") for physicians services at the Hospital for Sick Kids ("sick kids") and the Children's Hospital of Easter Ontario ("CHEO"). Targeted investments are warranted in the unique circumstances of the pediatric agreements of these two hospitals, where these AFPs have received flow-through, but have not been strategically reassessed in a significant number of years.

228. However, the Ministry does not agree with the level of targeted investments as proposed by the OMA. The Ministry submits that the Arbitration Board should issue an award with respect to the targeted adjustments as submitted earlier, and leave it to the parties who are best positioned to determine the allocation of targeted adjustments which would include these pediatric agreements. Further, the Ministry submits that the additional allocation of funds into these pediatric AFPs should be focussed, with the goal of supporting faster access to emergency department care and reduced wait times for children and youth. The Ministry propose that the AFPs should provide the Ministry with a targeted plan and accounting to demonstrate how these goals are being realized.

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[35] https://news.ontario.ca/en/release/1003298/ontario-connecting-children-and-youth-to-care-close-to-home

[36] https://news.ontario.ca/en/release/1003910/ontario-connecting-children-and-youth-in-the-greater-toronto-area-to-care-close-to-home

10. TECHNICAL FEES

10.1 Position of the Parties on Technical Fees

230. As noted above, the Ministry supports targeted investment into certain areas of the health care system where there is a demonstrated system need and will enhance access to health service for Ontarians. The Ministry has identified specific areas of priority above. However, in contrast to the Ministry's position with respect to pediatric physician compensation, the Ministry does not agree that further targeted investments are required in the area of physician technical fees. As these parties have consistently agreed, the Technical Fee issue applies only to Physician Technical Fees and Integrated Community Health Service Centra Fees and not Hospital Technical Fees. If there is a dispute in this regard the Ministry will raise a jurisdictional issue.

231. The OMA is pursuing substantial targeted investments to be allocated to Technical Fees as reproduced below:

(i) In each year of the 2024-2028 PSA, beginning in Year 1, the OMA proposes a 10% increase to the OHIP technical fee pool, including hospital Emergency Department and Out Patient Department technical fees, physician technical fees and ICHSC facility costs, to be implemented through the Physician Services Committee ("PSC") based on recommendations provided by the Physician Payment Committee ("PPC").

(ii) OMA proposes 25% of funds will be applied to new technologies and 75% of funds will support an adjustment of existing diagnostic services and procedures, taking into consideration advances in technology and overall cost increases.

(iii) Establish Bilateral Technical Fee Committee

(iv) The OMA proposes that the parties established a joint MOH-OMA technical fee committee ("TFC") under the auspices of PPC. The TFC would be responsible for developing a framework to ensure that there is an appropriate level of technical and facility fees in order to cover the cost of providing diagnostic services and procedures.

(v) *The committee's mandate would include determining and recommending to PPC appropriate compensation for the provision of the technical component (including facility costs) of diagnostic and procedural services. In addition, the committee would address system issues such as a planning, quality and service standards, appropriateness, the introduction of new services and technologies and the acquisition and replacement of capital equipment.*

232. The term “Technical Fees” commonly applies to fees that are payments for the additional overhead required to perform certain diagnostic tests. Overhead costs include the provision of the premises, equipment, supplies, materials and personnel required to perform the insured service.

233. There are three types of fees payable in relation to the provision of insured Physician services, (I) Physician Technical Fees, (II) Hospital Technical Fees, and (III) Integrated Community Health Services Centres (ICHSC fees).

234. While the Ministry submits that additional targeted investments to technical fees are not appropriate, it does submit that the following proposal would be appropriate to address the issue of technical fee compensation:

I. Establishing a pool of funds derived from the “flow-through” funds arising from the awarded price increase for Years 2, 3 and 4. The Ministry proposes applying 50% of the flow through increases to all technical fees. Assign the remaining 50% of the flow through for Fund for special allocation of Technical Fees.

II. Establish a Technical Fee Working Group as a Sub-Committee of PPC to determine an agreed allocation of the Fund. PPC would work to establish criteria for determination of the allocation of funds and establish terms of reference for the Technical Fee Working Group. The focus of the criteria would be establishing new Technical Fees for new equipment or other allocations as appropriate. Any disputes in that regard would be referred to Arbitrator Kaplan.

235. The Ministry submits that Technical Fees have already received substantial adjustments. The current expenditure on Technical Fees is approximately $965 million dollars. The flow through increases pursuant to Year 3 of the prior settlement and Year 1 of this PSA (the Year 1 Award) to Technical Fees amounted to a 10% increase of approximately $85 million dollars to bring the total to approximately $965 million.

236. The flow through increases pursuant to Year 2 of this Award based on the Ministry position of a 2.25% increase would amount to approximately $22 million dollars, based on FY24/25 base of approximately $1 billion dollars.

237. The flow through increases pursuant to Year 3 of this award based on the Ministry position of a 2.0% increase would amount to approximately $19 million dollars, based on FY24/25 base of approximately $1 billion dollars.

238. Similarly, the flow through increases pursuant to Year 4 of this award based on the Ministry position 2.0% increase would amount to approximately $19 million dollars, based on FY24/25 base of approximately $1 billion dollars.

239. In total over Years 2, 3 and 4 of this PSA, based on the Ministry position, the flow though dollars to Technical Fees will have increased by approximately $60 million. With the increase from Year 3 of the previous settlement and the Year 1 award, the Technical Fees will be adjusted by a total of approximately $145 million.

240. The average Technical compensation received by a Cardiologists who billed in Technical Fees in 2024/2025 is $422,000 with the Year 3 and Year 1 awarded increases included. These will increase to at least $449,000 with the Award for Years 2, 3 and 4. The average Professional Fee for a Cardiologist, including the Year 3 and Year 1 Award will be $873,000 wiill be higher following the Year 2, 3 and 4 Award).

241. The average Technical Fee compensation received by a Radiologists who bill Technical Fees is $640,000 with the Year 3 and Year 1 awarded increases

included. These will increase to at least $680,000 with the Award for Years 2, 3 and 4. The average professional fee for a Radiologist including the Year 3 and Year 1 awards will be $1,015,000 and will be higher following the Year 2, 3 and 4 award.

10.2 Business Case Analysis (based on FY22/23 data)

242. In order to place the compensation derived from Technical Fees into context, the Ministry presents the following business case analysis.

243. First, the Ministry submits the following facts related to the trends in Physician Office Technical Fee Billings:

I. Physician office technical fee billings were $241.3M in 2022/23 (as of March 31st, 2023)

II. Physician office technical fee billings have been growing at a rate of 7.44% per year over the past ten years

III. Approximately 90% of all technical fee billings in physician offices are associated with cardiology

With the trends in mind, the Ministry performed a business case analysis to understand Technical Fee billings and their associated costs.

244. The stress echocardiogram (G582) and the routine echocardiogram (G570) were selected for the analysis as these two services and bundled fee codes make up the majority (61%) of all physician office technical fee billings in 2022/23.

245. When co-billed services (i.e. more than one technical fee code is billed during the same visit) are factored in, the average revenue physicians earn for G570 and G582 services are $162.48 and $235.81 respectively. Co-billed fee codes account for 30% of revenue earned by physicians for these two services.

246. The estimated cost to provide echocardiography services is $134k per year. This estimate includes incremental staffing, leasing, and equipment costs incurred to provide echocardiography services.

247. Given the average revenue generated from G570 and G582, the minimum threshold for a business case to provide Echocardiogram services is 3.04 echocardiograms per day. Approximately 95% of clinics meet this threshold in 2022/23. In other words, this case analysis demonstrates the cost to provide technical services does not exceed current technical fees. The complete business case analysis is provided at Exhibit 13.

248. The Ministry again submits that no adjustment beyond the flow through increase are justified for Technical Fees. For the reasons above, the Ministry respectfully submits that its proposal with respect to a pooling of funds to enable a focused allocation of funds where it is best suited should be awarded.

11. MINISTRY POSITION ON OTHER OUTSTANDING ISSUES

249. As previously submitted, there is still a substantial remaining allocation ($152.6M) to be direct to targeted investments arising from the Year 1 award, as well as a significant allocation under the Ministry's proposal for 10% of normative adjustments in Years 2, 3 and 4 to be directed to targeted investments. The Ministry submits that such allocation is reasonable for addressing those areas of the health system requiring targeted investments in this PSA. For example, the OMA has proposals with respect to Hospital On Call Coverage Program. The parties have been working bilaterally on a revised burden-based HOCC payment and accountability structure to replace the outdated payment model for physician on-call coverage in hospitals. This is an area both parties have historically agreed is in need of updating. The OMA also has proposals with respect to incenting anesthesiologists to in-hospital work availability and proposals for a Hospitalists funding model. The Ministry is aligned with investments into those areas which is necessary to enable better access to care, reduce surgical backlog, and reduce wait time for Ontarians. As such, the Ministry does submit there are some of the OMA's pursued targeted investments which the Ministry is aligned with providing targeted system investments (unlike technical fees and some of the other OMA pursued targeted investments). However, the Ministry does not agree with the level of targeted investments as proposed by the OMA. Further, these are clearly areas of considerable complexity in determining the appropriate compensation structures which should be applied. The Ministry submits that their proposed targeted investment on a 90/10 split should be awarded, with the allocation of targeted investments referred back to the parties. It is the parties who are best placed to determine the system investments that will address discrete complex issues which are unique to the myriad of physician compensation models in the health care system.

250. The Ministry also notes that the OMA had a proposal for the establishment of an Academic Medicine Steering Committee to address ongoing issues with

academic physician funding arrangements. It is the Ministry position that there is a sufficient degree of bilateral engagement between the parties that does not necessitate the creation of a committee at this time.

251. Finally, the OMA has a proposal with respect to physicians practicing under Divested Provincial Psychiatric Hospitals (**“DPPH”**), and the application of a targeted adjustment to DPPH physicians who are receiving total compensation that is above the new target rate. The OMA proposes that in those instances where the physician is receiving total compensation that is above the new target rate should receive the psychiatry increase applied on their current total compensation. The Ministry respectfully submits that the OMA’s proposal in this regard are outside the jurisdiction of this Board of Arbitration under Section 21 of the BAF.

252. Finally, though not an issue in dispute, the Ministry notes the parties further agreement to continue the Appropriateness Working Group as amended by the parties' 2021 agreement.

12. CONCLUSION

253. The Ministry thanks the Board for the time and consideration that it will devote to this extremely important matter. If further information relevant to this arbitration is required, the Ministry remains available to the Board. All of which is respectfully submitted.