

In the Matter of an Arbitration

BETWEEN:

ONTARIO MEDICAL ASSOCIATION

(the “OMA”)

- AND -

MINISTRY OF HEALTH

(the “MOH”)

(together, “the PARTIES”)

**YEAR 2, 3 and 4 BRIEF OF THE
ONTARIO MEDICAL ASSOCIATION**

GOLDBLATT PARTNERS LLP

Barristers and Solicitors
20 Dundas Street West, Suite 1039
Toronto, ON M5G 2C2
Tel.: 416-977-6070

Howard Goldblatt

hgoldblatt@goldblattpartners.com

Steven Barrett

sbarrett@goldblattpartners.com

Colleen Bauman

cbauman@goldblattpartners.com

Counsel for OMA

TO: **BOARD OF ARBITRATION**
William Kaplan
william@williamkaplan.com

Michael Wright
mwright@wrichthenry.ca

Kevin Smith
kevin.smith@uhn.ca

AND TO: **HICKS MORLEY HAMILTON**
Barristers and Solicitors
77 King Street West, 39th Floor
Toronto, ON M5K 1K8
Tel.: 416-362-1011

Craig Rix
craig-rix@hicksmorley.com

BASS ASSOCIATES
16 Edmund Avenue
Toronto, ON M4V1H4
Tel.: 416-962-2277

Bob Bass
bbass@bassassociates.com

Michele White
mwhite@bassassociates.com

Counsel for MOH

TABLE OF CONTENTS

PART I -OVERVIEW	1
A. The Ontario Medical Association and its Members.....	7
B. The Ongoing Challenges Facing the Profession	10
(i) Delayed Care and Wait Times.....	10
(ii) Family Medicine in Crisis.....	12
(iii) Increasing Patient Complexity	19
(iv) Administrative Burden and Increasing Workload	19
(v) Physician Burnout	21
(vi) Physician Recruitment and Retention.....	22
C. The Binding Arbitration Framework and Criteria for Interest Arbitration:.....	40
D. Overview of the Year 1 Award, Bargaining and Subsequent Awards:	44
 PART II -	
ECONOMY, ONTARIO'S FISCAL POSITION, AND HEALTH CARE	
SPENDING	48
A. Ontario's Economy in 2024 and the First Quarter of 2025 Performed Well	49
B. Measures of Economic Health	50
(i) Real GDP	50
(ii) Net-debt-to-GDP ratio.....	52
(iii) Interest on Debt.....	53
(iv) Employment Rate.....	55
(v) Return to Surplus by 2027	56
C. Inflation.....	57
D. US Tariff Policy Should Not be a Basis for Determining Physician Increases.....	57
E. Health Care Spending by the Ontario Government	60
 PART III -	
PROPOSAL FOR GLOBAL INCREASES FOR YEARS 2, 3, 4.....	67
A. Background to OMA's Global Increase Proposal	67
B. Bargaining Trends in 2024-25 in the Broader Public Sector	67
(i) Hospital Sector Increases.....	68
(ii) Municipal Sector Increases	77
(iii) Police and Fire Sector Increases.....	82
(iv) Post-Secondary Sector Increases	86
(v) Increases in the Ontario Public Service (OPS) and Other Groups Paid from the Public Purse	88
C. Bargaining and Wage Trends in 2024-25 Generally.....	90
D. Comparison to Physicians in Other Provinces.....	93
 PART IV -	
TARGETED PROPOSALS	103
A. Family Medicine Proposal	103
(i) The Crisis in Family Medicine.....	104
(ii) Problems with the Current FHO Model	107
(iii) The Family Medicine Proposal – Areas of Agreement.....	108

	(iv) The Family Medicine Proposal – Areas of Disagreement.....	121
B.	Anesthesia	133
	(i) Background to Anesthesiology Proposal	133
	(ii) A Shortage of Anesthesiologists.....	134
	(iii) The OMA's Proposal to Respond to the Crisis.....	139
C.	HOCC - Burden-Based On-Call Program Proposal	145
	(i) Background to On-Call Coverage	145
	(ii) Problems with the Current Program.....	147
	(iii) The OMA's Burden-Based On-Call Coverage Proposal.....	149
D.	Repair and Modernization of Existing Alternative Payment Programs (APPs)..	157
	(i) Background to APPs	157
	(ii) Proposal to Repair and Modernize APPS	158
E.	Introducing New APP Agreements and Expanding Existing APPs	160
	(i) Proposal for New and Expanding APPs	160
F.	Amend Current Oncology APP Agreements.....	162
	(i) Background for Oncology Proposals	162
	(ii) Radiation Oncology – Funding for Peer Review	162
	(iii) Gynecology Oncology	165
	(iv) Neuro-Oncology	166
	(v) The OMA's Oncology APPs Proposal.....	167
G.	Hospitalist APP	168
H.	New Infectious Diseases, Genetics and Geriatrics APPs	170
	(i) Infectious Diseases	171
	(ii) Genetics.....	172
	(iii) Geriatrics.....	173
I.	Physicians Practicing under Divested Provincial Psychiatric Hospitals ("DPPHS").....	174
J.	Laboratory Medicine	176
K.	Academic Health Science Centres ("AHSC") Alternative Funding Plans ("AFPs")	178
	(i) Background to AHSCs in Ontario	178
	(ii) Challenges Facing AHSCs in Ontario.....	187
	(iii) The OMA's AHSC Proposal.....	193
L.	Northern Ontario Academic Medicine Association ("NOAMA") AFP Proposal ..	196
M.	The Hospital for Sick Children (SickKids) AFP	200
	(i) Background to SickKids.....	200
	(ii) SickKids Current Reality – Underfunding Leading to Physician Shortages.....	202
	(iii) The SickKids AFP Renewal Proposal.....	207
N.	Children's Hospital Academic Medical Organization ") AFP	211
	(i) Background to CHEO and CHAMO	211
	(ii) CHEO's Current Reality – Underfunding Leading to Physician Shortages.....	213
	(iii) The Effects of Physician Shortages on Care	218
	(iv) CHAMO's Proposed Solution	220
O.	Virtual Care Proposal.....	224

	(i)	Background to Virtual Care	225
	(ii)	Proposal for Virtual Care Consultation by Telephone	226
	(iii)	Proposal to Enable Physicians Practicing in Shared Care Models to Bill Comprehensive Virtual Care Codes.....	227
	(iv)	Proposal Regarding Long-Term Care Virtual Care Services.....	229
P.		Manual Review Proposal	233
	(i)	Background to Manual Review Concerns	233
	(ii)	The OMA's Manual Review Proposal	234
Q.		Good Faith Payment Proposal	238
	(i)	Background to Good Faith Concerns.....	238
	(ii)	Newborn Rejections and Neonatal Death.....	239
	(iii)	OHIP Eligible without Valid Coverage or Documentation.....	241
	(iv)	Uninsured Patients Requiring Non-Deferrable Care	242
	(v)	The OMA's Good Faith Proposal.....	243
R.		Technical Fees Proposal.....	245
	(i)	Background to Technical Fees Proposal	245
	(ii)	Developments since 2017	256
	(iii)	2021 Beltzner Study on costs associated with technical fees	260
	(iv)	OMA Technical Fees Proposal	265
S.		Physician Health Benefit Program (PHBP) Proposal.....	268
T.		OHIP SCHEDULE OF BENEFITS IMPROVEMENTS	271
	(i)	Gender Pay Gap Schedule of Benefits Proposal	271
	(ii)	New Services Resulting From Medical Innovation/Technological Advances Schedule of Benefits Proposal	275
	(iii)	Complexity Of Patient Care Schedule of Benefits Proposal.....	278
	(iv)	Fee Schedule Modernization Proposal	280
	(v)	Medical Specialties Consultation Time-Based/Complexity Proposal.....	285
	(vi)	Surgical Unbundling Pre- and Post-Operative Care Proposal	290
U.		Community Physicians Overhead Support Proposal	294
V.		Canadian Medical Protective Association	298
W.		Payment Delay and Ministry Payment Infrastructure: The Need to ensure proper and timely implementation of negotiated and awarded compensation increases	298

PART I - OVERVIEW

1. Ontario's health care system is under significant strain and at a crossroads. In the face of increasingly complex patients, growing delays and rising demands, Ontario's physicians are feeling the pressure daily.
2. As recognized in the Year 1 Arbitration Award, Ontario is facing a worsening physician human resources crisis, with an acknowledged need for more family doctors, emergency medicine specialists, anesthesiologists, psychiatrists, pediatricians, and physicians in rural, northern, and remote regions, together with various other specialists.
3. Despite increasing demand, Ontario has seen the slowest growth in physician supply in Canada since 1971, falling from the second highest physician-to-population ratio in the country to the fourth lowest by 2023. Ontario's growing population and demographic changes are adding to this strain. Notably, the proportion of the population over 65 years old has increased from 13.7 percent in 2009 to 18.3 percent in 2023, increasing the demand on health care needs and greater resource intensity per patient.
4. Compensation remains a critical tool in addressing these challenges and there can be no dispute that compensation can incent physician behaviour, including physician decisions about when to retire or whether to remain in Ontario and in what areas to practice. Compensation, while not the only solution, remains a powerful and essential tool to address Ontario's physician workforce crisis.
5. The OMA's proposals are summarized in brief below and discussed in further detail in the brief:

Global Increases for Years 2, 3, and 4:

The OMA proposes normative increases of 3.75% in each of Years 2, 3 and 4. This proposal is supported by comparability, including normative increases bargained and awarded to other groups in the broader public sector, and in the health sector in particular, which Arbitrator Kaplan recognized as compelling comparators in the Year 1 Award. The proposal is also supported by the significant investments other provinces have made in their physicians, as seen in

their most recent Physician Services Agreements, which have left Ontario doctors at the bottom nationally in terms of compensation.

Targeted Funding Proposals

Family Medicine:

This comprehensive proposal, much of which has been agreed, aims to modernize the Family Health Organization (FHO) model and improve primary care delivery in Ontario by retaining existing FHO physicians, attracting new ones, boosting patient enrollment, and enhancing patient access to care. Building on the strengths of the current capitation-based system, the new model better captures the time physicians spend on both direct and indirect patient care.

Key elements of the model agreed to over many months of negotiation and mediation include reinvesting the Comprehensive Care Capitation payment and access bonus related to negotiations, in addition to new targeted funding, to fund a new \$80 hourly rate for time spent on all patient care activities, including indirect care and clinical administration as well as additional enhancements including increasing the shadow billing rate for in-basket services from 19.4% to 30%, and from 19.4% to 50% for certain in-basket procedures, as well as increasing the after-hours premium for certain services provided to enrolled patients from 30% to 50%.

To support leadership within FHO groups, a new Enhanced Group Management Leadership Payment (GMLP) of up to \$100,000 annually will be introduced. The proposal also introduces a Patient Attachment Bonus for all physicians in Patient Enrollment Models and includes new or increased payments aimed at improving patient attachment.

These changes are intended to enhance both patient attachment and access to care.

The OMA has also proposed to increase the FHG premium from 10% to 20%.

There are other changes agreed to which are outlined below but which include expanding the FHO complement by 240 new spots in 2024–25, with the OMA advocating for continued annual expansions thereafter, amongst other changes.

The parties do not agree on whether there should be any “accountability measure” with respect to the performance of FHO physicians, and, if so what that measure should be and the consequences, if any, for physicians falling below that measure.

Anesthesia:

This proposal seeks to address Ontario's anesthesiologist shortage through two key initiatives: a \$500 daily in-hospital sessional stipend (ISS) and an expansion of the Anesthesia Care Team (ACT) model under a new ACT-2025 framework. The ISS would supplement existing fee-for-service payments to incentivize anesthesiologists to maintain in-hospital availability for perioperative and non-operating room anesthesia (NORA) work.

The ACT-2025 proposal updates Ontario's long-standing ACT model by allowing anesthesiologists to bill for supervising allied health professionals who provide delegated care. This change would enable anesthesiologists to oversee more than one procedure simultaneously, boosting surgical throughput by up to 50%.

Virtual Care:

This proposal aims to improve access to virtual health services across Ontario by addressing barriers in technology, care delivery models, and long-term care settings.

The first component proposes funding for telephone consultations by specialists when video or in-person visits are impractical due to technological, cognitive, or socio-economic barriers. These telephone consultations would be reimbursed at 85% of the in-person fee, or 95% for mental health services. However, such calls would not count toward establishing a physician-patient relationship for the purposes of comprehensive care billing.

The second part of the proposal seeks to enable physicians in shared care models to bill comprehensive virtual care codes. This would be permitted where there is an established physician/patient relationship with any physician in the group, and where the group shares access to medical records and can offer in-person care when needed.

Finally, the proposal includes a provision for virtual care in long-term care (LTC) settings. It recommends that comprehensive virtual care codes be allowed for acute, non-elective virtual encounters initiated by patients, families, or LTC staff, provided a physician conducts the service with the support of an LTC-affiliated nurse.

Hospital On-Call Coverage:

The OMA's Burden-Based On-Call Program Proposal aims to modernize and improve the Hospital On-Call Coverage (HOCC) program by introducing a burden-based compensation structure which would provide a more nuanced, data-driven, and equitable system for determining on-call compensation. The proposal introduces three new levels to the current program and shifts payments from an annual to a per diem basis, allowing more accurate reflection of the actual burden of on-call duties. Compensation levels would now be determined based

on three main criteria: the volume of hospital-based after-hours billings, the expected in-person response time for on-call physicians, and whether the physician serves as the Most Responsible Physician (MRP).

Alternative Payment Plans (APPs):

The OMA proposes a comprehensive plan aimed at repairing, modernizing, and expanding Alternate Payment Plans (APPs), as well as addressing long-standing funding problems in various physician groups.

Repair, Modernization, and Compensation Adjustments for APPs

The OMA is seeking targeted investments to repair and modernize existing APPs. A bilateral APP Repair Working Group would be created under the oversight of the Physician Services Committee (PSC). This group would be tasked with developing a standardized evaluation framework to identify APPs in need of reform, determining the associated costs using an agreed methodology, and recommending specific implementation strategies to the PSC throughout the PSA period.

Expansion of Existing APPs and Introduction of New Models

Building on the 2021 PSA, the OMA proposes using a bilateral joint review process to apply evaluation criteria for the expansion and establishment of APPs. This includes implementing commitments for the establishment of a Hospitalist Medicine APP and an APP for Laboratory Medicine. This funding would be used to grow existing APPs and establish new ones.

Amendments to Existing Oncology APPs

The OMA has proposed targeted investments to address identified gaps in oncology compensation models. For the Radiation Oncology APP, funding must be increased to compensate these physicians who are performing the essential service of peer review of the treatments being provided to patients. As well, the OMA proposes increasing the shadow billing premium for gynecologic oncology from 33% to 50% due to the increasing complexity of systemic therapies, and providing additional funding for fellows, clinical associates, and non-APP oncologists. The OMA also proposes integrating neuro-oncologists either into the existing Medical Oncology APP or developing a new APP that ensures parity with Medical Oncology compensation.

APPs Infectious Diseases, Genetics, and Geriatrics

The OMA is also seeking to resolve long-standing temporary funding arrangements for Infectious Diseases (ID), Genetics, and Geriatrics by establishing permanent APPs.

Sick Kids and Childrens' Hospital Academic Medical Organization (CHAMO) physicians

The OMA is seeking targeted funding to improve compensation for physicians practicing at The Hospital for Sick Children (SickKids) and for the Children's Hospital of Eastern Ontario (CHEO) reflecting the increased complexity and demands on pediatric academic physicians, and ensuring funding is restored to the 75th percentile level of community physicians. This funding is necessary to ensure improved access for the children served by physicians at both hospitals, and in order to improve recruitment and retention of physicians with advanced training and highly specialized expertise, who provide critical services to the vulnerable population served by their hospitals.

Academic Health Science Centres (AHSCs) AFP

The OMA is calling for a targeted funding investment to right-size academic physician funding across Ontario. This initiative aims to align physician compensation with the increased responsibilities in teaching, research, and complex patient care.

Divested Provincial Psychiatric Hospital (DPPH) Physicians

For physicians working in former Provincial Psychiatric Hospitals, the OMA proposes adjusting compensation to reflect psychiatry-specific PSA increases. Physicians earning below the new target rate would receive a top-up, while those above it would receive the same percentage increase on their current income.

Technical Fee Increase Proposal

The OMA proposes targeted funding for the technical fee pool to fund diagnostic services, new equipment investments, and adoption of new technologies. Seventy-five percent of the funds would be allocated to enhance existing services and 25% to support new technologies. A joint Ministry of Health (MOH)-OMA Technical Fee Committee (TFC) would be formed under the Physician Payment Committee (PPC) to manage fee recommendations and policy planning.

Community Overhead Support

The OMA is proposing a new \$5 overhead fee per in-person community visit (up to 40 visits/day/physician) to help cover overhead costs in community practices. The fee would exclude hospital, contract-based, and Family Health Organization (FHO) services.

Physician Health Benefit Program (PHBP) Proposal

The OMA is proposing increased funding for the PHBP to address continued growth in participation in the program, rising medical costs, and escalating drug prices. Without increased funding, the program is projected to run a \$5.7 million deficit by 2027/28, and Ministry contributions would fall to covering just 35% of total expenditures, down from 82% in 2018.

Fee Schedule Modernization

The OMA proposes a dedicated funding pool to modernize and update the OHIP Schedule of Benefits.

The OMA also proposes that a three-member Schedule Modernization and Review Expert Panel be established to develop a new, comprehensive Schedule of Benefits for delivery by October 1, 2027. The panel will coordinate with PPC and specialty groups to update, simplify, and bring fee codes into relativity, with changes subject to future PSA negotiations.

Medical Specialties – Consultation Time Extension Fees

OMA proposes eliminating outdated specialty time-based consult codes and introducing a standardized add-on fee for extended consultations. The PPC would determine base consultation times and additional billing thresholds for each specialty.

Surgical Pre- and Post-Operative Care Unbundling

This proposal unbundles pre- and post-operative care from the surgical fee schedule to better reflect the complexity of in-hospital patient management and modern surgical care practices.

Gender Pay Gap

The OMA proposes that funding be allocated to address gender pay disparities through PPC-reviewed submissions.

Medical Innovation and Technology

The OMA proposes that the PPC receive annual funding to evaluate and respond to new technologies and innovations in medical practice.

Complexity of Patient Care

The OMA proposes funding to address the increased workload and time demands associated with complex patient care.

PART II: BACKGROUND

A. The Ontario Medical Association and its Members

6. As of June 1, 2025, the OMA represents Ontario's 49,045 physicians, medical students, and retired physicians of whom 36,768 are actively practicing.¹ Of the active OMA members, approximately 16.5% of OMA members are just starting their careers, 56.6% are established in their careers, and 26.9% are late career. 55.8% are men and 44.2% are women. The OMA's members can be found throughout all regions of the province including in urban, rural and Northern communities.

7. The OMA members practice in all areas and specialties. OMA members belong to sections with a member's primary section being the section most relevant to their area of practice, while the secondary section is a secondary or an additional area of practice. The breakdown of OMA by primary section is set out in the following table:

As of June 1, 2025

Section	Number
Addiction Medicine	213
Allergy and Clinical Immunology	210
Cardiac Surgery	102
Cardiology	896
Chronic Pain	318
Critical Care Medicine	425
Dermatology	328
Diagnostic Imaging	1358
Emergency Medicine	2082
Endocrinology and Metabolism	360

¹ OMA, [Membership Data as of June 1, 2025](#), Book of Documents ("BOD") VOL 1 TAB 1.

Eye Physicians and Surgeons of Ontario	597
Gastroenterology	489
General & Family Practice	16,640
General Internal Medicine	1584
General Surgery	1019
General Thoracic Surgery	71
Genetics	70
Geriatric Medicine	195
Hematology & Medical Oncology	658
Hospital Medicine	479
Infectious Diseases	241
Laboratory Medicine	801
Long Term Care/Care of the Elderly	166
Medical Students	1740
Nephrology	337
Neurology	661
Neuroradiology	94
Neurosurgery	140
Nuclear Medicine	79
Obstetrics & Gynecology	1116
Occupational & Environmental Medicine	112
Ontario's Anesthesiologists	1834
Orthopedic Surgery	728
Otolaryngology - Head and Neck Surgery	358
Palliative Medicine	347
Pediatrics Section OMA	1875
Physical Medicine & Rehabilitation	319

Plastic Surgery	302
Primary Care Mental Health	282
Psychiatry	2899
Public Health Physicians	193
Radiation Oncology	282
Reproductive Biology	61
Residents	2041
Respiratory Disease	404
Rheumatology	336
Sport and Exercise Medicine	176
Urology	391
Vascular Surgery	127
No Primary Section	2503
Grand Total	49045

8. OMA members are the most highly trained and skilled medical professionals in the province. The path to becoming a doctor in Ontario is long and arduous and requires many years of intensive study, attracting some of the very best and brightest learners.

9. The majority of applicants to Canadian medical schools have, at a minimum, a bachelor's degree with some even holding advanced degrees. Students attend medical school for four years (three years at McMaster). The first two years are typically spent in classrooms and laboratories and the final two years are spent in practicums working with patients while being supervised by senior physicians within clinic and hospital settings. During this time, student physicians rotate through psychiatry, family practice, internal medicine, pediatrics, surgery, obstetrics and gynecology.

10. Following medical school, graduates participate in residency programs, which can last between 2 to 8 years depending on the specialty. In some cases, additional fellowships or subspecialty training is needed for physicians to obtain even more

specialized training. As well, following their residency, all physicians must pass a standardized licensure examination. For internationally trained physicians, there are different but equally, if not more rigorous, pathways to licensure.

11. As set out in detail in the OMA's Year 1 brief and summarized again below, physicians in Ontario must work in stressful and difficult circumstances amidst a health care system under pressure.

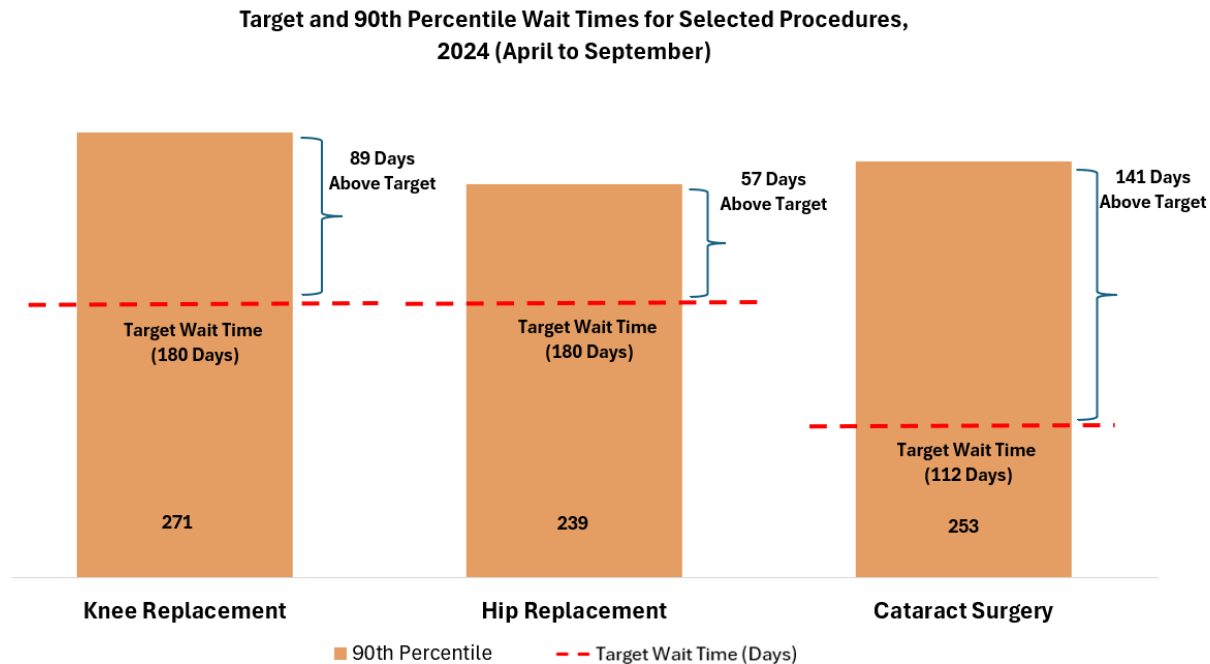
B. The Ongoing Challenges Facing the Profession

12. As discussed at length in pages 8-27 of the OMA's Year 1 brief [which the OMA is providing to the Board again for its reference alongside this brief], Ontario physicians are facing increased and unprecedented job pressures. They work in a health care system under tremendous stress, where, notwithstanding their best efforts, patients, who are ageing and present with increasing medical and mental complexity, are facing delays in receiving care and experiencing extended wait times for many diagnostic, surgical and other procedures due to increased demand and the lack of human and capital resources. Significantly, millions of patients are without family doctors. In this context, physician burnout is a real and ever-present problem, and recruitment and retention issues are growing. As a result, it is important that physician compensation keep pace with normative increases being provided to others in the health sector and that significant funds be specifically invested in the health care system as proposed by the OMA in its "targeted proposals." Some of the challenges facing the system are addressed more fully below.

(i) Delayed Care and Wait Times

13. Delays and long-wait times remain a problem throughout the system. Delays "expose patients to higher risks of poorer health-related quality of life, progression of

underlying conditions and worse surgical outcomes.”² Since 2019, wait times have been increasing greatly for a number of priority surgical procedures. As of 2023, the majority of knee, hip, and cataract procedures were all above the government’s own target wait times:³



14. Wait times in emergency departments (“ED”) are also longer. According to Ontario Health Quality reports, as of April 2025, patients spent an average of 18.2 hours in the emergency department (“ED”) before being admitted and getting a bed, and only 28% of admitted patients get a bed within the target time of 8 hours. This in turn makes it harder for doctors to see new patients, slowing workflow for emergency physicians, increasing the time needed to complete an assessment for a given patient, and, in turn,

² N. Jaworska, Emma Schalm et al. “[The impact of delayed nonurgent surgery during the COVID-19 pandemic on surgeons in Alberta: a qualitative interview study](#)” CMAJ Open, Jul 2023, 11 (4) E587-E596; DOI: 10.9778/cmajo.20220188, BOD VOL 1 TAB 2.

³ Source: Canadian Institute for Health Information. *Wait Times for Priority Procedures in Canada — Data Tables*. Ottawa, ON: CIHI; 2024, BOD VOL 1 TAB 3.

generating further increases in wait times. As well, emergency physicians end up being responsible for the care and management of patients over an extended period of time leading to even more stress and burnout.⁴

(ii) Family Medicine in Crisis

15. The crisis in family medicine remains particularly severe.⁵

16. Not having a family physician can have very serious health consequences for patients in obtaining initial diagnosis and follow-up care when ill and in receiving regular preventative care. This, in turn, results in increased pressures on physicians and the health care system generally.⁶

17. As demonstrated by the table below, the percentage of attached patients has continued to steadily decrease since 2017.

Year	Attached (%)	Attached (#)	Uncertainly Attached (%)	Uncertainly Attached (#)
March 2017	89.1	12,399,025	10.9	1,516,828
March 2018	89.0	12,545,529	11.0	1,550,571
March 2019	89.0	12,737,955	11.0	1,574,354
March 2020	87.9	12,862,033	12.1	1,770,542

⁴ From Health Quality Ontario, "[Time Spent in Emergency Departments: Provincial](#)" (April 2025), BOD VOL. 1 TAB 4.

⁵ Stuart Foxman, Colleges of Physicians and Surgeons Ontario, "[Family Medicine in Crisis](#)," *Dialogue* (June 15, 2023) ["Foxman"], BOD VOL 1 TAB 5.

⁶ Danielle Martin, "[The Primacy of Primary Care](#)," Temerty Medicine, University of Toronto (April 11, 2023), BOD VOL 1 TAB 6.

March 2021	87.4	12,863,444	12.6	1,854,455
BOMarch 2022	85.3	12,758,757	14.7	2,198,754
March 2023	84.7	13,062,948	15.3	2,359,659

18. According to INSPIRE, as of September 2023, about 2,531,626 patients in Ontario were unattached, an increase of about 1 million since 2017, an increase from 11 to 16 percent of the population.

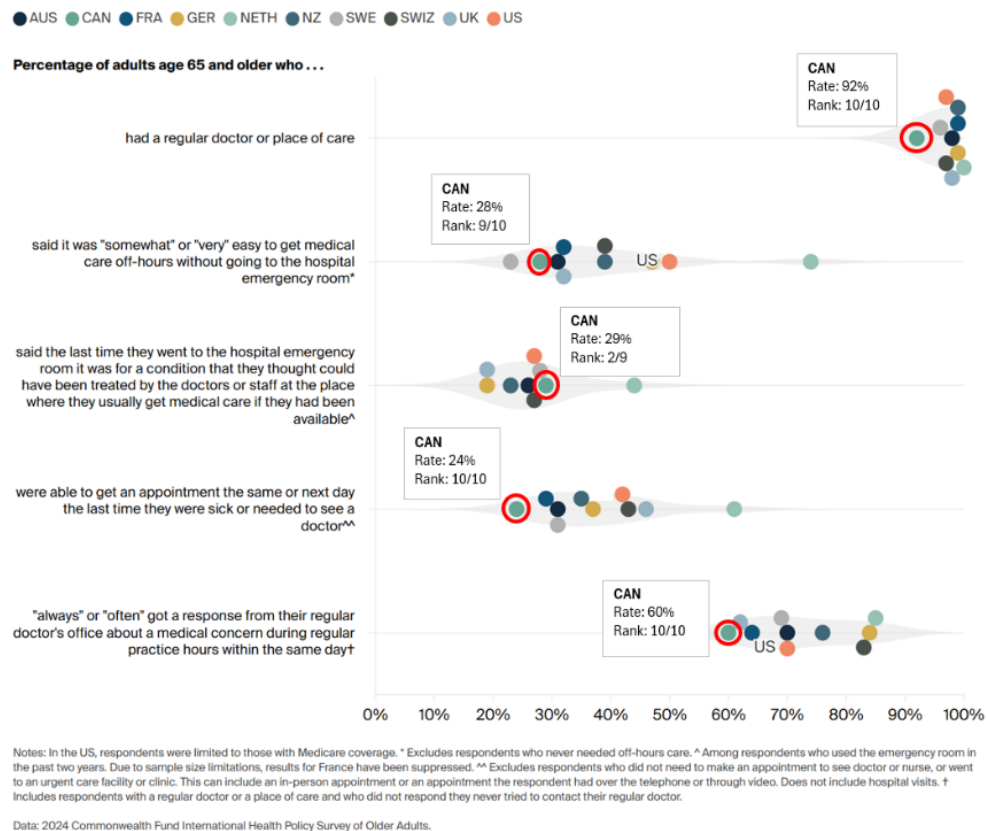
19. In the absence of any policy changes, it is predicted that as many as 25 percent of the population (about 4.4 million) may become unattached by 2026⁷, as physicians retire or scale back their practices.

20. Further, according to the 2023 Commonwealth Fund, Canadians have the worst access to primary care among all OECD countries.⁸ As well, according to the 2024 Commonwealth Fund International Health Policy Survey of Older Adults, only 92% of Canadian adults aged 65 and older reported having a regular doctor or place of care, the lowest rate among the 10 surveyed countries⁹. This has resulted in significant barriers in access to timely care:

⁷ OCFP, “More Than Four Million Ontarians Will Be Without a Family Doctor by 2026,” (November 7, 2023) [“OCFP Nov. 7 2023”] BOD. VOL 1 TAB 7.

⁸ CIHI, “Primary health care: International survey shows Canada lags behind peer countries in access to primary health care” (March 21, 2024), BOD VOL 1 TAB 8.

⁹ Data: 2024 Commonwealth Fund International Health Policy Survey of Older Adults, BOD VOL1 TAB 9.



21. There is a severe shortage of family physicians in Ontario. With only one family physician per 1,000 people, Ontario has one of the lowest family physician to population ratios in the entire country.¹⁰ Compounding this shortage is the fact that the proportion of family physicians practicing comprehensive longitudinal family medicine is falling.¹¹ The family physician shortage is further impacted by a growing population and a population which is ageing. As well, increased patient care complexity and expectations, and a higher prevalence of chronic health issues means that physicians must spend

¹⁰ Li K, Frumkin A, Bi WG, et al. "[Biopsy of Canada's family physician shortage](#)," *Fam Med Com Health* 2023;11:e002236, pp. 1-4 at p. 2, BOD VOL 1 TAB 10.

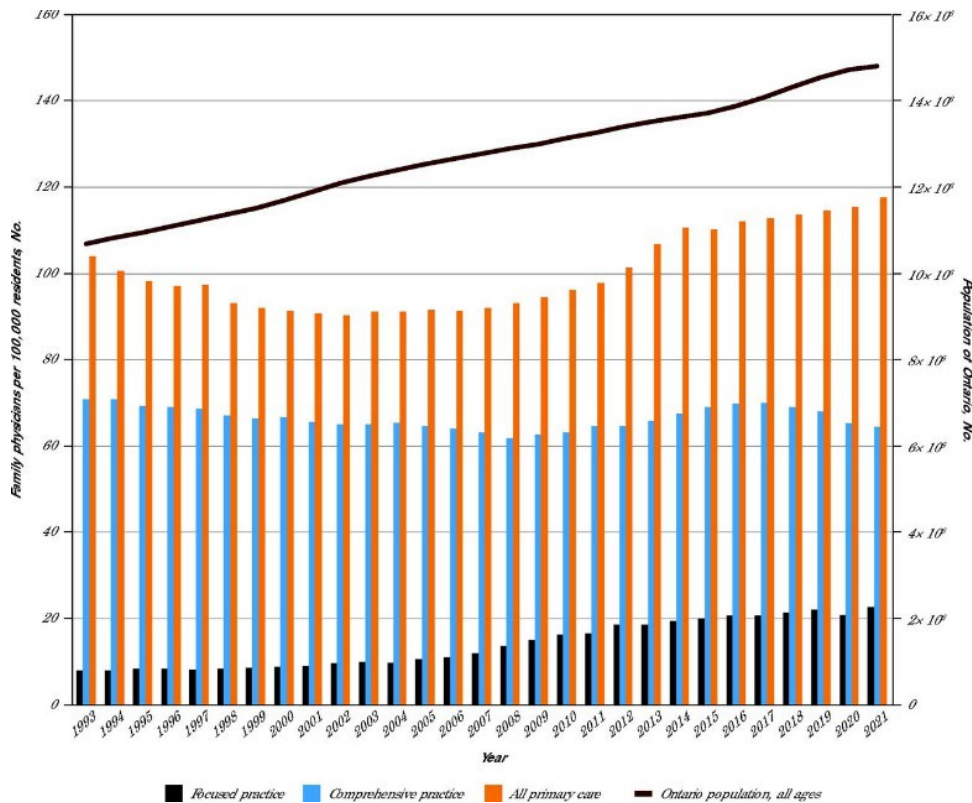
¹¹ Premji K, Green ME, Glazier RH, et al, "[Characteristics of patients attached to near-retirement family physicians: a population-based serial cross-sectional study in Ontario](#)" *BMJ Open* 2023;13:e074120, pp 1-9 at p. 1, ("Premji et al") BOD VOL 1 TAB 11; Lavergne et al, "[Declining Comprehensiveness of Services Delivered by Canadian Family Physicians Is Not Driven by Early-Career Physicians](#)," *Ann Fam Med*. 2023 Mar-Apr; 21(2): 151–156, BOD VOL 1 TAB 12.

more time on each patient visit, further increasing the demands on an already overwhelmed system.¹²

22. A recently published study in the *Annals of Family Medicine* confirm these trends showing a decline in the practice of comprehensive family medicine in Ontario in the face of a growing population. This study found that Ontario's population (all ages) increased from 10.7 million in 1993 to 14.8 million in 2021, an increase of 38.5%. During the same time-period, the number of comprehensive family physicians only increased by 25.9%. This means that, adjusted for population growth, there were fewer comprehensive family physicians available to serve Ontarians (71 to 64 per 100,000 population).¹³

¹² *Li, supra* at p. 1, BOD VOL 1 TAB 10.

¹³ Ansari H. et al., "[Family Physicians in Focused Practice in Ontario, Canada: A Population-Level Study of Trends From 1993/1994 Through 2021/2022](https://doi.org/10.1370/afm.240377)," *The Annals of Family Medicine* May 2025, 23 (3) 181-190; DOI: <https://doi.org/10.1370/afm.240377> BOD VOL 1 TAB 13.



23. Of particular note, the study's authors posit that family physicians are "choosing focused practice, particularly hospital-based work, due to better remuneration, more job flexibility (i.e., to take vacation or parental leaves), more team supports, no overhead, no hassles of running a small business, and an overall better quality of life."¹⁴ Furthermore, they conclude that the "decline in comprehensive family physicians is concerning due to the facts that 22% of Canadians lack access to primary care, population health needs are increasing, and the physician workforce is aging and nearing retirement."¹⁵ The OMA could not agree more.

24. As noted in the Year 1 Brief, doctors who choose to continue to practice family medicine face the daily challenges of working in an overwhelmed and increasingly

¹⁴ *Ibid.*

¹⁵ *Ibid.*

broken system. On the one hand, the complexity of their work has greatly increased as a result of an aging population, increased chronic disease, and the expansion of clinical practice guidelines. On the other hand, their ability to spend time on much-needed clinical work is affected by an overwhelming and continually increasing administrative burden which can amount to between 10 and 19 hours a week, as well as by increasing patient expectations.¹⁶ Because of backlogs and bottlenecks elsewhere in the health care system, it is often very difficult to get patients the diagnostic tests or a visit with the specialist that they need, adding strain, workload and time for family physicians concerned about ensuring that their patients get access to necessary quality care.¹⁷ All of this in turn is leading to higher levels of burnout amongst family physicians.¹⁸

25. The Ontario government itself has recognized that access to primary care is a major problem in the province. In response, in January 2025, the government announced the Primary Care Action Plan, supported by the government's investment of \$1.8 billion to connect all Ontarians--two million more people--to a publicly funded family doctor or primary care team within four years. Dr. Jane Philpott has been appointed to lead this new primary care action team (PCAT).¹⁹

26. The model for improving access being adopted by PCAT is built around primary care teams made up of a family physician or nurse practitioner and other health care

¹⁶ Foxman, *supra*, BOD VOL 1.TAB 5; Ontario College of Family Physicians, "[A Profession in Crisis: The survival of family medicine in Ontario](#)" (May 31, 2023), ["OCFP Crisis"], BOD VOL 1 TAB 14. As the OCFP concludes: "Results from the survey conducted on behalf of the Ontario College of Family Physicians, of more than 1,300 family doctors clearly show a full-blown crisis. An alarming number of family doctors – 65 per cent – are preparing to leave the profession or reduce hours in the next five years, reporting that they are overwhelmed with unnecessary administrative work and a lack of support. Already, 2.2 million are without a family doctor. The most recent data also shows 1.7 million Ontarians have a family doctor aged 65 or older who are poised to retire. Adding to the crisis is a clear trend in medical students not choosing family medicine."

¹⁷ *Ibid.*

¹⁸ Canadian Medical Association, [National Physician Health Survey. 2021](#), at p. 17, BOD VOL 1 TAB 15.

¹⁹ Government of Ontario, [Ontario News Release - Ontario Connecting 300,000 More People to a Family Doctor and Primary Care Teams This Year - April 10, 2025](#), BOD VOL 1 TAB 16.

professionals such as nurses, physician assistants, social workers, dietitians and more. PCAT's goal is to create and expand up to 300 additional teams to attach the approximately 2 million unattached to primary care.

27. In the immediate term, the government has committed to investing more than \$235 million in 2025-26 to establish and expand 80 additional primary care teams across the province, attaching 300,000 more people to primary care this year. The OMA certainly recognizes this as a constructive step towards addressing the crisis in family medicine, including the attachment crisis.

28. There are some limitations in the government's approach to date, however. Access to funding in the current model is based around expanding existing team-based models, namely Community Health Centre (CHCs), Family Health Teams (FHTs), Nurse Practitioner-Led Clinic (NPLCs), and Indigenous Primary Health Care Organization (IPHCOs). This means that physicians are only eligible to apply for part of this funding if they either joined one of those organizations or create a FHT. Given that FHO and other family physicians who are not eligible for funding under the currently approved PCAT models actually attach proportionately more patients than the currently approved models, this is a policy area that the government may wish to reconsider.

29. To be clear, funding under the PCAT initiative is not direct compensation for physicians. Indeed, the existence of the PCAT process in no way obviates the need under the current negotiating and arbitration process to address the shortage of primary care physicians and their inadequate compensation. Nor does PCAT fully address the recruitment and retention problems facing family medicine. Indeed, the success of the PCAT initiative is highly dependent on an adequate supply of family physicians practicing comprehensive care.

30. Equally important, in order for the government to meet their mutual commitments regarding attachment, it is critical that the government continue to work constructively and collaboratively with the OMA.

(iii) Increasing Patient Complexity

31. As discussed more fully in the Year 1 Arbitration Brief at paragraphs 45-48, physicians today see patients with more complex physical, mental and social needs than was previously the case. The prevalence of multiple chronic conditions in Ontario is growing, with ‘minor’ or ‘moderate’ conditions slightly declining while ‘major’ conditions increased. Overall, the age-sex standardized patient resource intensity has increased by about 0.5 percent each year from 2008-09 to 2017-18.²⁰

32. One study has found that 6.1% of the population of Ontario—approximately 725,500 people—had high comorbidity, but that only 15% of these people were rostered to practices offering interprofessional team-based care.²¹ Often, people with high needs do not have access to the services they need, such as care coordination, emotional counselling, and assistance with managing functional limitations. In the absence of receiving the necessary support, this workload burden falls on the family physician. Moreover, patients with unmet needs are likely to experience difficulties in accessing primary care and are therefore less likely to participate in preventative care and more likely to visit the emergency department.²²

(iv) Administrative Burden and Increasing Workload

33. Another challenge facing physicians is the unprecedented administrative burden that has been added to their already high workloads which, amongst other things, takes

²⁰ Steffler M, Li Y, Weir S, Shaikh S, Murtada F, Wright JG, Kantarevic, J. *Trends in prevalence of chronic disease and multimorbidity in Ontario, Canada*. Canadian Medical Association Journal. 2021 Feb 22;193(8): E270-7., BOD VOL 1 TAB 17.

²¹ Jopling S, Wodchis WP, Rayner J, *et al* [“Who gets access to an interprofessional team-based primary care programme for patients with complex health and social needs? A cross-sectional analysis”](#) BMJ Open 2022;12: e065362. doi: 10.1136/bmjopen-2022-065362, BOD VOL 1 TAB 18.

²² Jamie Ryan et al., [“How High-Need Patients Experience Health Care in the United States” Commonwealth Fund](#) (December 2016), BOD VOL 1 TAB 19

away from their ability to provide clinical care, as thoroughly reviewed in the OMA's year 1 arbitration brief at pages 21-23.

34. As discussed in the recent article by Storseth et al., the main drivers of administrative burden include health system requirements, inadequate technology, and the complexity of patient populations. Technology is both a solution and a source of new burdens. For example, e-referral platforms may reduce workload for specialists but increase it for primary care providers. Effective solutions must address the learning, compliance, and psychological costs of administrative work, and avoid simply shifting the burden from one practitioner to another:²³

²³ Oliver Storseth, Karen McNeil, Agnes Grudniewicz, Rebecca H. Correia, François Gallant, Rachel Thelen, M. Ruth Lavergne, "[Administrative burden in primary care](#)" Canadian Family Physician Jun 2025, 71 (6) 417-423; DOI: 10.46747/cfp.7106417 BOD VOL 1 TAB 20.

Table 2. Categories of administrative burden, relevance to primary care, and examples from review

CATEGORY OF ADMINISTRATIVE BURDEN	RELEVANCE TO PRIMARY CARE	PRIMARY CARE EXAMPLES FROM REVIEW
Learning costs: search processes people engage in to figure out what services they might need and how to access them ²⁶	• Search process to obtain information needed to access services • Obtaining information to support clinical decisions (eg, identifying places accepting referrals, navigating unfamiliar processes to obtain insurance or other benefits) • Learning costs associated with new technology, often implemented to address administrative burdens	"Administrative burden encompasses the onerous experience of determining eligibility."³¹ "[I]t was unclear who must wait, for how long exactly, when applications could be submitted, and which administrative processes to follow."³²
Compliance costs: typical examples of people's negative encounters with systems, telephone calls, and paperwork ²⁶	• Documentation, data entry, and maintenance of patient records • Information exchange with other parts of the health system, including management of clinical messages, referrals, billing, and insurance claims • Completion of forms to access insurance or other supports • Compliance costs can be exacerbated by inefficient tools and inadequate technology for management of information and associated tasks	"Administrative burden refers to the amount of documentation, especially paperwork, that an individual provider must complete."³³ "These administrative burdens arise from: detailed clinical documentation and data entry; inefficient user interfaces; ... and management of clinical messages and inboxes."³⁴
Psychological costs: stress and frustration that come from navigating these systems ²⁶	• Changing scope of work for general practitioners, which makes this area of medicine seem less desirable, more stressful, less supported, and contributes to experiences of burnout • Stress of navigation and coordination within complex and disconnected health systems, and associated worries that "balls are being dropped" • Lack of adequate support and resources for patients and caregivers • Limited health, reading, and technological literacy for patients that make the navigation of health systems stressful and challenging • Social and structural determinants of health: income, housing security, gender, race, ethnicity, and more as barriers to health systems, which in turn foster stress, frustration, and disproportionate access	"[O]ther stress from applying or maintaining a benefit such as health insurance."³¹ "[C]ognitive burdens caused by reminders and irrelevant or redundant patient data."³⁴ "This is captured in the concept of <i>treatment burden</i> defined as the workload of treatment and self-management for chronic conditions, its impact on patient functioning, and stressors that exacerbate it like healthcare financial concerns."³⁵ "High workload, such as long working hours, complex job functions, poor communication, and administrative burdens are associated with burnout symptoms and stress."³⁶

(v) Physician Burnout

35. With a health care system at the breaking point, physicians are also at a breaking point and suffering from increased levels of burnout. These problems predated the pandemic but have only gotten worse since then.²⁴

36. According to OMA surveys, in March 2020, just prior to the pandemic, 29% of Ontario physicians had high levels of burnout with two-thirds experiencing some level of

²⁴ CPSO, "[Physician Burnout and COVID-19](#)," *Dialogue*, (June 12, 2020), BOD VOL 1 TAB 21.

burnout. By March 2021, these rates had increased, with 34.6% of Ontario physicians reporting high levels of burnout and almost three-quarters reporting some level of burnout. Female physicians and younger physicians were particularly at risk (unweighted results).²⁵ After weighting survey responses to reflect OMA membership demographics, the overall rate of high levels of burnout among physicians in Ontario increased from 28.0% in 2020 to 34.7% in 2021, a 1-year increase of 6.8 percentage points. According to OMA members, the biggest contributors towards burnout are patient expectations/patient accountability, reporting and administrative obligations, health system sustainability, the practice environment for physicians, the culture of medicine, and compensation and financial pressures.

(vi) Physician Recruitment and Retention

37. As set out on pages 83 to 107 of the OMA’s Year 1 arbitration brief, Ontario is in the midst of a physician human resources crisis, which is affecting many specific practice areas more severely, although there are real concerns about physician recruitment and retention in all regions and specialties. The OMA reiterates and relies upon its submissions on recruitment and retention in its Year 1 brief. It also summarizes and updates some of those submissions below.

38. In the Year 1 Arbitration Award, the Board accepted that there was a physician recruitment and retention problem. Arbitrator Kaplan found as follows:

We accept on the evidence that there is a physician shortage. Somewhere between 1.35 million and 2.3 million people in the province are not attached to a family doctor. These are real numbers. The Ministry’s own documents – which we ordered disclosed – demonstrate that there is a problem to address. See the *Health Human Resource Overview, May 2022 (Overview)*. The Overview acknowledges the need for more family doctors, and specialists in emergency medicine and anesthesia, and for doctors in rural, northern and remote regions. Family medicine was a particular

²⁵ Gajjar J, Pullen N, Li Y, et al, “Impact of the COVID-19 pandemic upon self-reported physician burnout in Ontario, Canada: evidence from a repeated cross-sectional survey” *BMJ Open* 2022;12:e060138. doi: 10.1136/bmjopen-2021-060138 [“Gajjar”], BOD VOL 1 TAB 22.

concern as the growth rate for family doctors was below the growth rate for population (1.4% vs, 1.6%). As the Overview observed, “family medicine growth [should] rest at or slightly above the population growth....” What was being said, in other words, in the Ministry’s words, in this Ministry document, was that the problem is structural: the number of new family doctors needs to significantly exceed population growth and until and unless it begins to do so, the attachment problem will persist and deteriorate.

Clearly, more family doctors are needed as are more doctors practising comprehensive longitudinal medicine...[I]t is obvious that the citizenry is ageing – the Government acknowledges this brings with it increased complexity – and, accordingly, demands on doctors can only be expected to grow. In the OMA’s view, this leads to a case for increased compensation; in family medicine, for example, it argues that paying doctors more will incentivize new doctors to decide to practice comprehensive longitudinal care and to encourage existing doctors to continue to do so.

...Compensation is not the only answer, but it is an important one...²⁶

39. The OMA submits that physician recruitment and retention continues to be a problem and supports the OMA’s proposals both for normative increases and targeted funding. The evidence that Ontario is facing a physician human resources crisis can be seen, for example, in the unprecedented number of patients unattached to a family physician, the closures and crowding of emergency departments, the long wait lists to see a specialist, and the backlog of surgical procedures and diagnostic imaging in the post-pandemic era.

40. According to the OMA Physician Resources Integrated Model²⁷ (“PRIME”), there was an estimated shortage of 2,781 physicians in the province of Ontario in fiscal year

²⁶ [R v Ontario Medical Association](#), 2024 CanLII 86115 (ON LA), [“Year 1 Award”], BOD VOL 1 TAB 23.

²⁷ PRIME is a model developed by the OMA to help improve physician workforce planning in Ontario. PRIME uses the census data of all 15,832,204 Ontario residents who were alive at any time between April 1, 2023 and March 31, 2024 and who were eligible for the Ontario Health Insurance Plan (“OHIP”) during this period. For each Ontario resident, the number of annual visits from physicians in each specialty is

2023, with acute shortages in Family Practice, Psychiatry, Pediatrics, Emergency Medicine, Internal and Occupational Medicine, and Anesthesiology. These shortages are set out by specialty in the following table:

Specialty	SHORT-TERM GAP		
	Total services (#)	Total services (%)	Total MDs
Anesthesiology	146,437	7.3%	112.9
Cardiac Surgery	31,727	17.6%	16.9
Cardiology	476,814	9.3%	71.5
Dermatology	171,064	13.3%	32.9
Diagnostic Radiology	266,939	1.7%	22.0
Emergency Medicine	575,653	10.0%	237.7
Endocrinology & Metabolism	145,778	13.9%	43.8
Family Practice & Practice in General	2,830,085	5.2%	743.9
Gastroenterology	109,251	10.5%	37.3
General Surgery	178,252	8.1%	73.8
General Thoracic Surgery	25,428	14.3%	8.4
Geriatrics	80,725	32.0%	61.8
Hematology	110,261	12.2%	31.9
Infectious Diseases	66,812	17.0%	38.2

calculated using the OHIP Claims Database. The relationship between the number of annual visits and patients' characteristics is then estimated and the utilization of physician services by each patient to the level of care achieved in a benchmark population is compared. Finally, the relative shortages in physician services as the difference between what patients currently receive and what they would have received based on their needs only (i.e. if their socioeconomic variables were the same as in the benchmark population) is calculated.

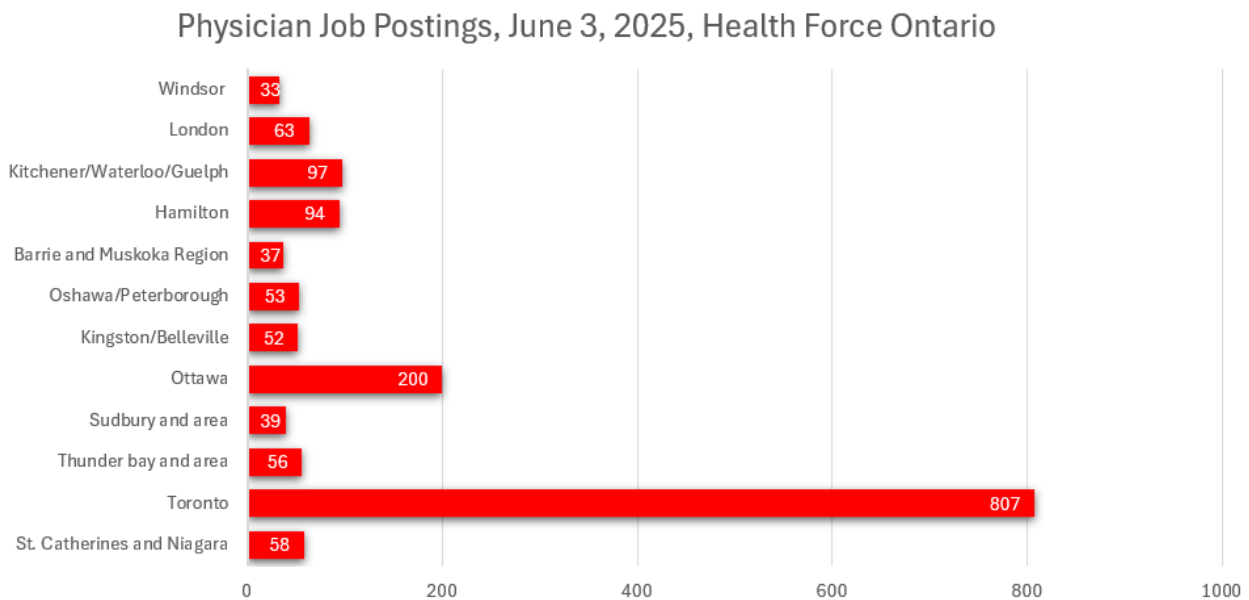
Internal and Occupational Medicine	654,062	9.4%	193.5
Medical Oncology	103,645	9.4%	20.5
Nephrology	123,194	10.2%	25.7
Neurology	85,515	8.7%	48.9
Neurosurgery	29,006	12.3%	16.4
Nuclear Medicine	82,614	39.4%	21.6
Obstetrics & Gynecology	187,332	5.3%	56.7
Ophthalmology	139,785	4.6%	23.6
Orthopedic Surgery	136,772	6.6%	46.3
Otolaryngology	81,616	7.0%	21.4
Pediatrics	595,509	15.4%	285.9
Physical Medicine & Rehabilitation	119,731	18.7%	48.4
Plastic Surgery	73,187	10.3%	29.4
Psychiatry	368,009	12.8%	300.4
Radiation Oncology	37,338	7.8%	18.5
Respiratory Disease	132,088	9.5%	34.7
Rheumatology	79,132	8.6%	22.7
Urology	79,480	5.7%	19.6
Vascular Surgery	63,259	13.7%	13.6
Grand Total	8,386,500	6.8%	2,780.8

41. According to the annual report titled “Physician Opportunities in Canada”, compiled by the Canadian Medical Association, as of July 2024, there were 1,135 full-

time permanent physician positions open in Ontario advertised on websites, including 562 family medicine positions and 573 medical specialists.²⁸

42. This data also reveals troubling gaps between the number of job openings in various specialties versus the number of graduates from training programs. For example, in July 2024 there were over 2,600 family medicine opportunities in Canada, whereas in 2023 there were only 1,432 graduates from family medicine training programs. Similarly, in July 2024, there were full-time postings for 5,181 physicians in all of Canada but only 3,601 postgraduate exits in 2023. As well, many of the postings had remained unfilled for months.²⁹

43. In addition, according to data from Health Force Ontario for 2025, there are vacancies for almost 2,800 full-time, part-time and locum physicians across the province, as set out below:



²⁸ Physician Opportunities in Canada”, compiled by the Canadian Medical Association, BOD VOL 4 TAB 129.

²⁹ *Ibid.*

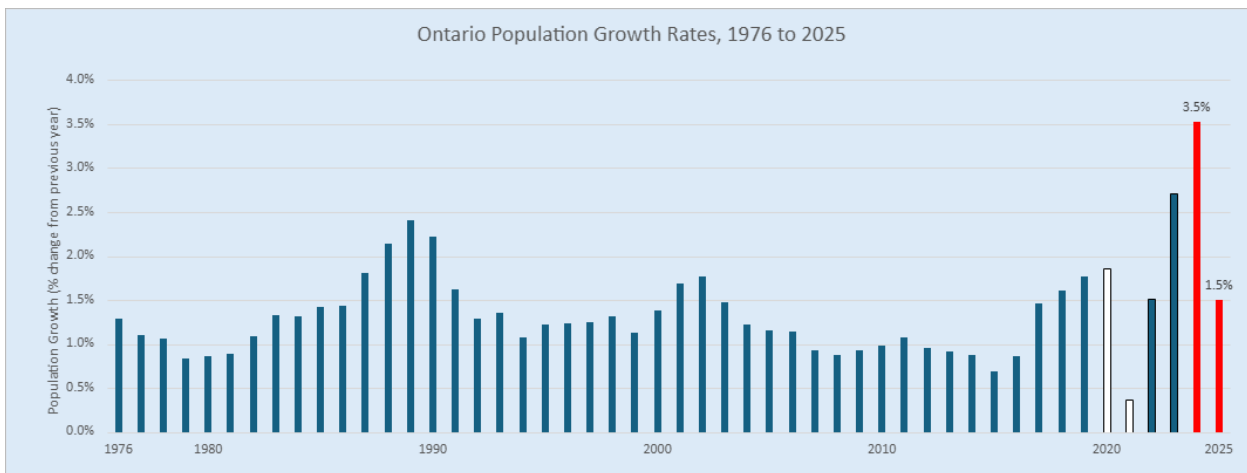
44. Lastly, within Ontario, there is also significant variation in the number of physicians per 1,000 population. Whereas there are 4.81 physicians per 1,000 people in Toronto, there are only 1.82 to 2.17 physicians per 1,000 people in other Ontario Health regions as of 2023:³⁰

Physician per 1,000 population by Ontario Health Region [1, 2]**

West			Central			Toronto			East			North		
1.98	2.00	2.07	1.70	1.75	1.82	4.57	4.56	4.81	2.15	2.16	2.17	2.08	2.10	2.12
2017	2020	2023	2017	2020	2023	2017	2020	2023	2017	2020	2023	2017	2020	2023

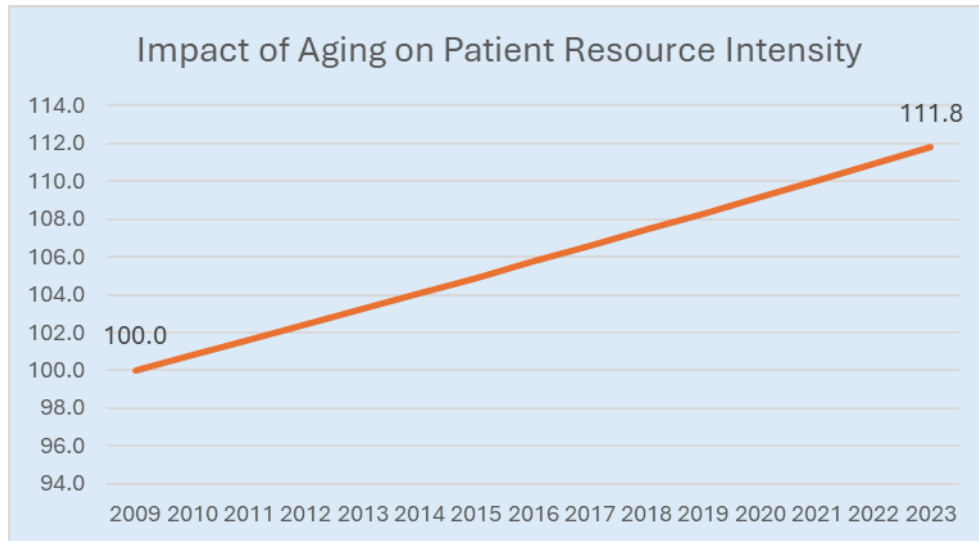
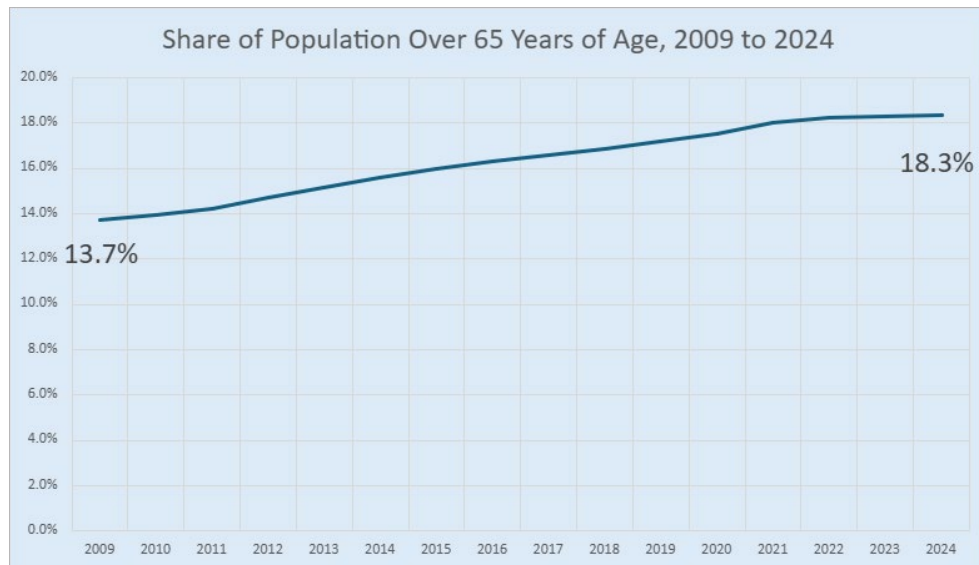
45. At the same time, the physician human resource crisis will only continue to worsen in the future if something is not done. This is in part because of Ontario's continued population growth and the fact that Ontario's population is also aging.

46. Ontario population is expected to grow at an average rate of 1.5 percent per year, after the historical growth rates in 2022 and 2023:

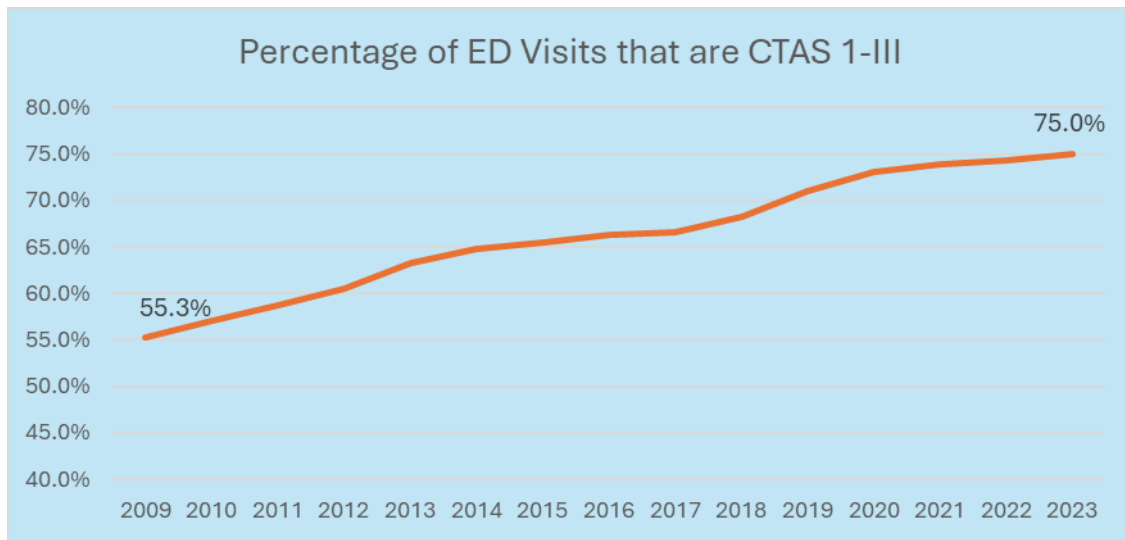


³⁰ Source: The Ontario Physician Reporting Centre. 2023 Physicians in Ontario Annual report – Hamilton, ON: OPRC; 2024, BOD VOL 1, TAB 24; and Statistics Canada. Table 17-10-0134-01 Estimates of population (2016 Census and administrative data), by age group and sex for July 1st, Canada, provinces, health regions (2018 boundaries).

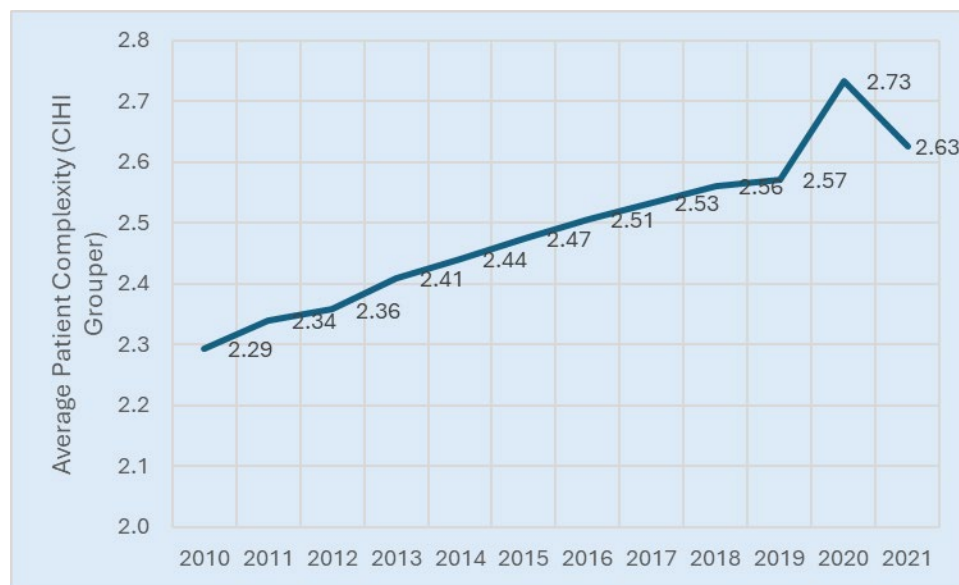
47. At the same time, the proportion of Ontario population over the age of 65 has been increasing over time, from 13.7 percent in 2009 to 18.3 percent in 2023, which has a substantial impact on resource intensity:



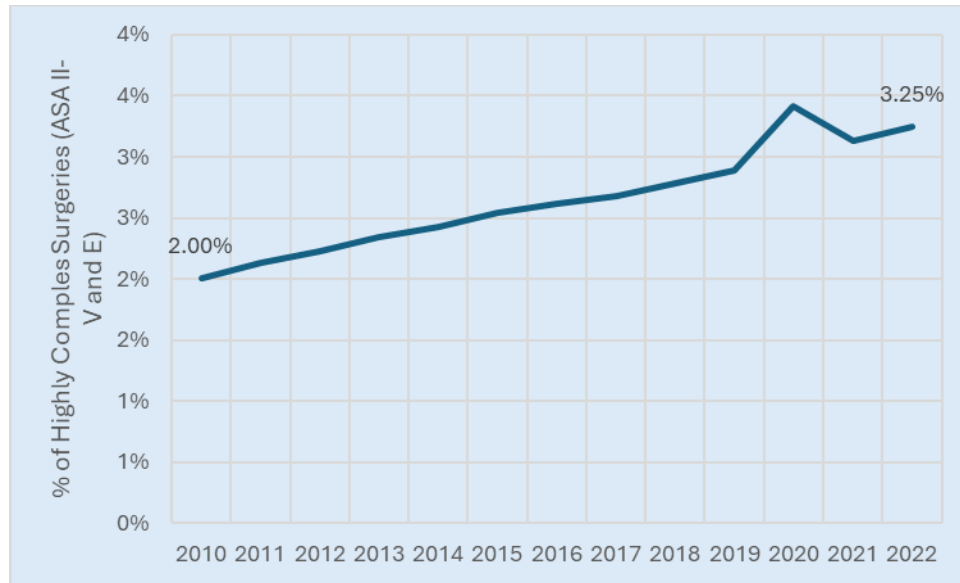
48. There are also many indicators that patient complexity has been increasing substantially over the last decade. For example, the proportion of Emergency Department visits that are more complex (CTAS levels I-III) has been steadily increasing over time, from 55% in 2009-10 to 75% in 2023-24:



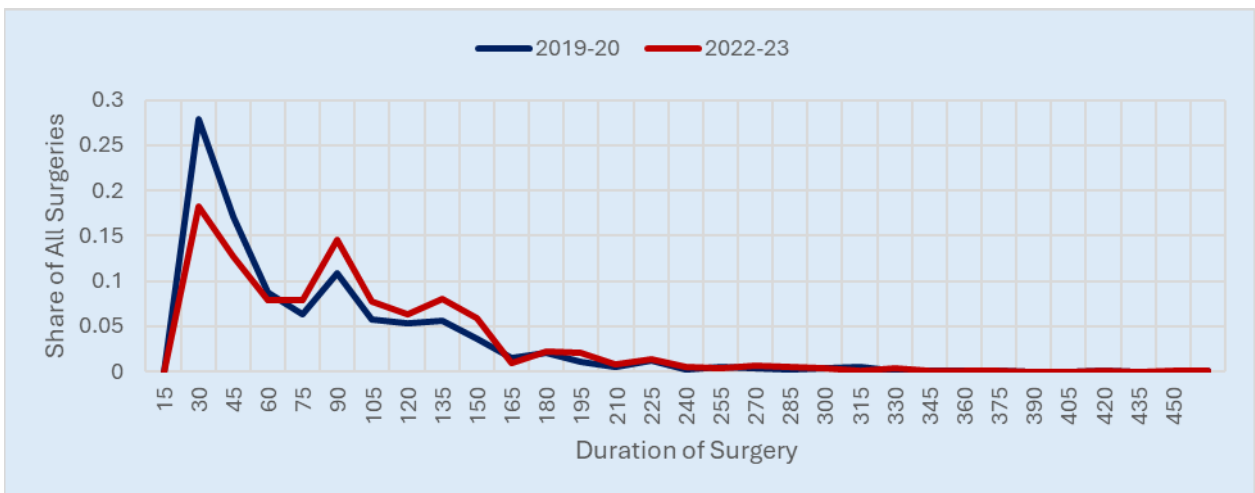
49. Another indicator of growing patient complexity is that the average resource intensity for patients, as measured by the CIHI Population Grouper, has also been steadily increasing over time:



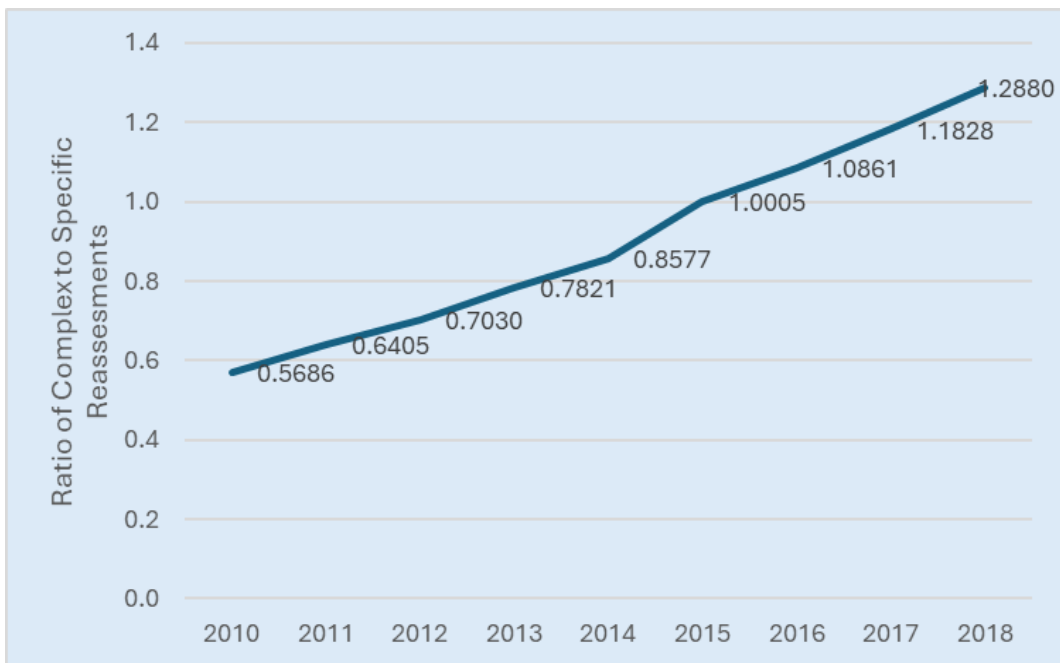
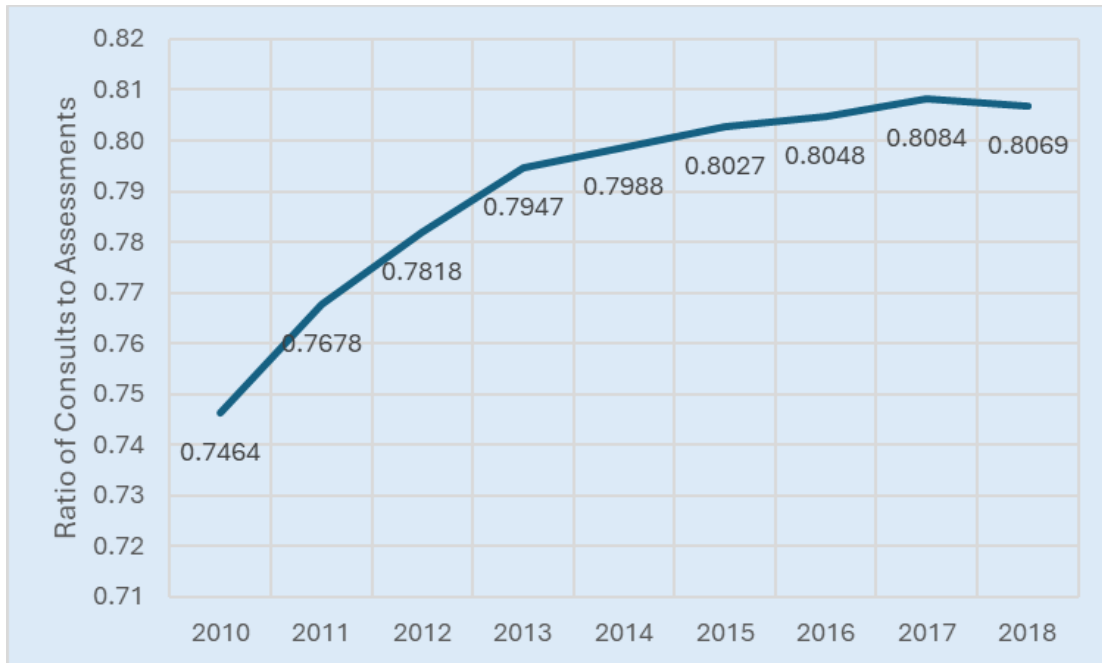
50. The proportion of surgical procedures that are more complex (ASA Levels III – V and ASA E) has also been steadily increasing over time, as a proportion of all surgical procedures:



51. The average duration of surgical procedures has also increased from the pre-COVID period, from the average of 87.6 minutes in 2019-20 to 102.3 minutes in 2022-23:

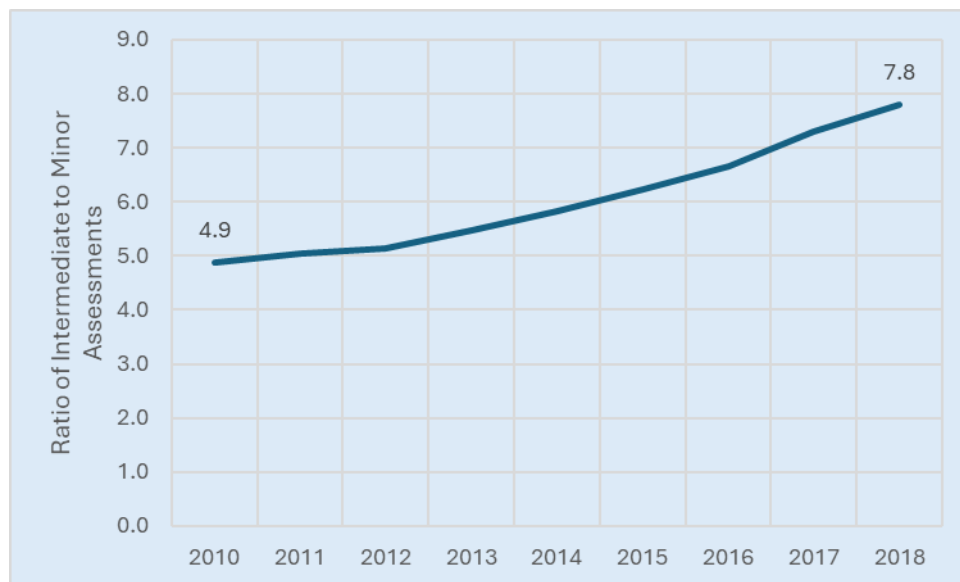
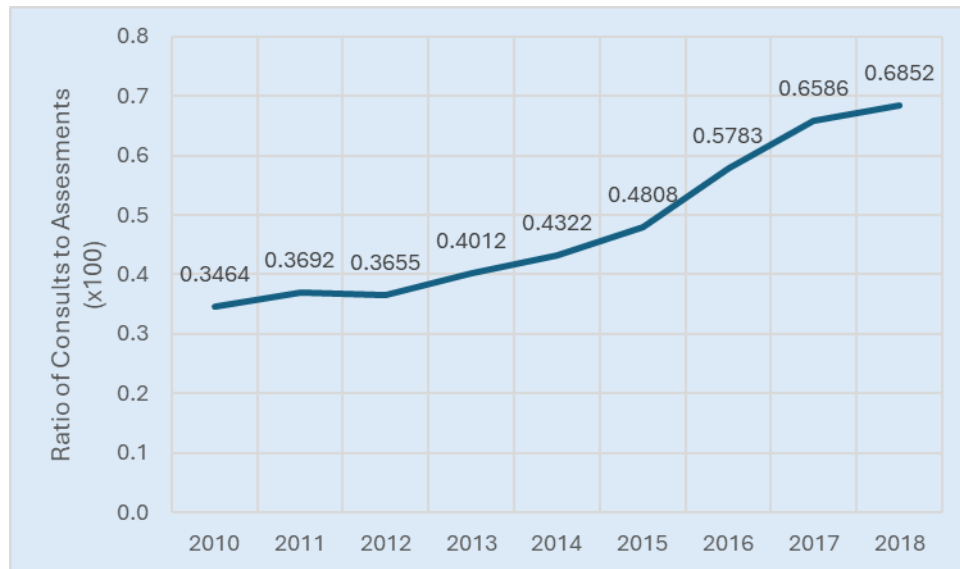


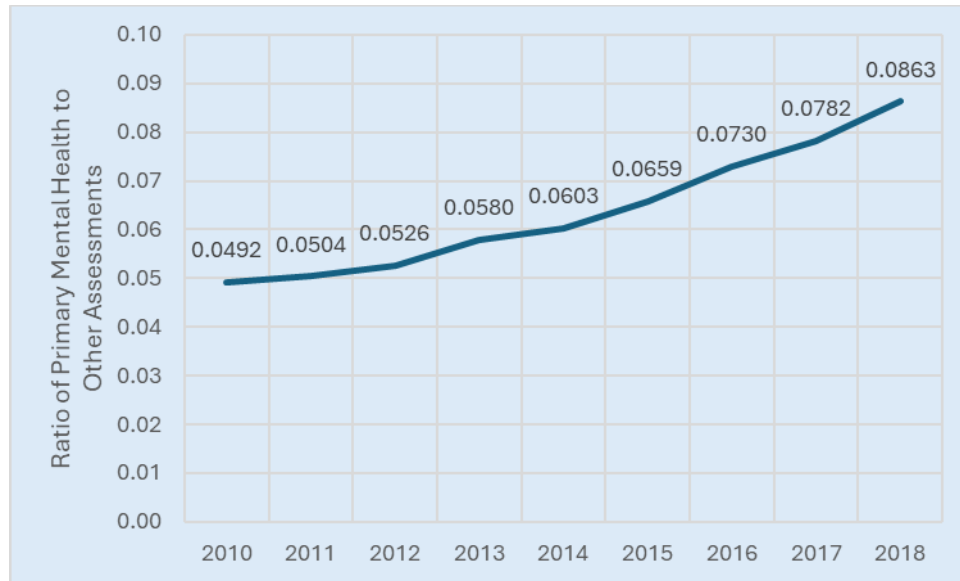
52. For Medical Specialists, the ratio of consultations (more complex) to assessments (partial and specific, less complex) has been increasing over time. The same is true about the ratio of complex re-assessments to specific reassessments. [Note: the data from 2019-20 is hard to analyze given that K083 virtual code was used for all types of visits]:



53. Similarly, the ratio of consultations to assessments has also increased over time for Family Medicine, as has the ratio of intermediate A007 assessment (more time consuming) to minor A001 assessments. Importantly, the ratio of primary mental health

care to other assessments has also been increasing. [Again, the data from 2019-20 onward is harder to analyze given the temporary virtual codes.]

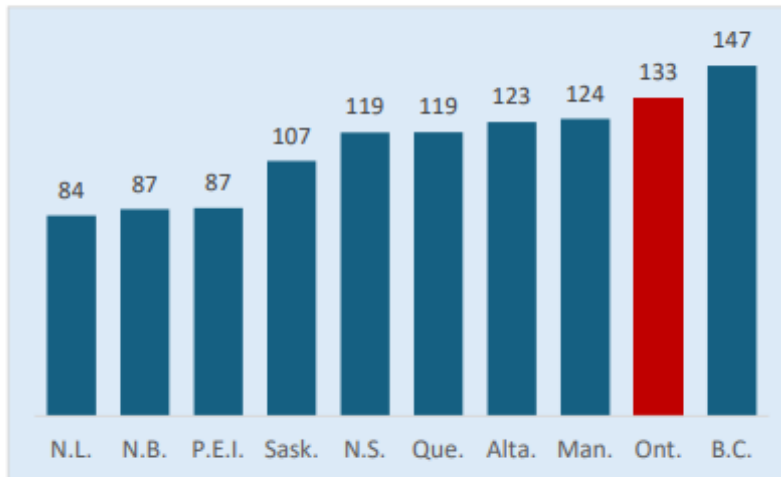




54. All of this provides compelling evidence of increasing and growing demands for physician health services at the same time as the physician human resource crisis remains severe.

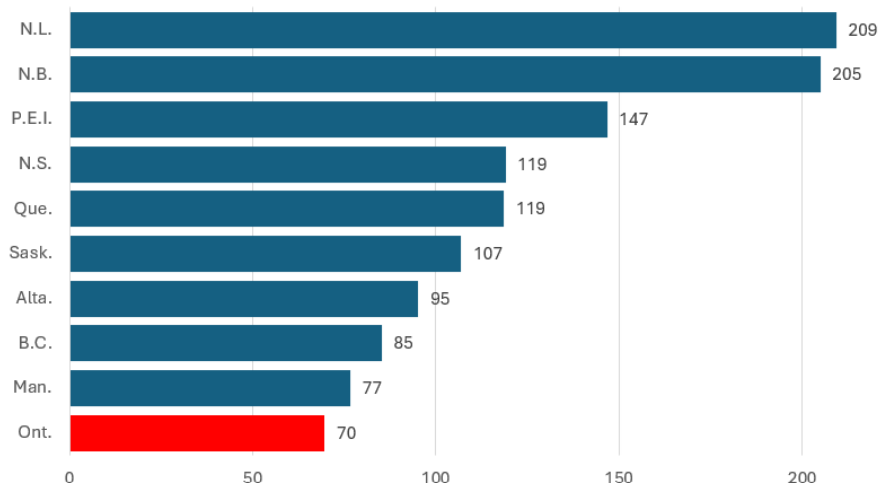
55. In response to the growing demands for physician health services, the supply of physician services has only expanded moderately and has failed to keep pace. In 1971, Ontario had the second highest physician to population ratio in Canada; since then Ontario has had the lowest growth rate in the country in the number of physicians:

Number of total physicians per 100,000 population, by jurisdiction, Canada, 1971

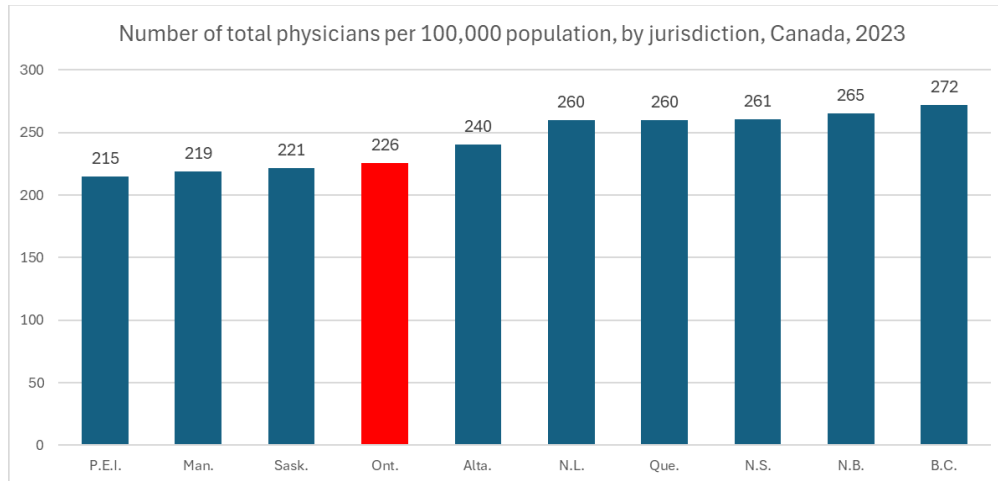


Source: Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2022 — Historical Data. Ottawa, ON: CIHI; 2023.

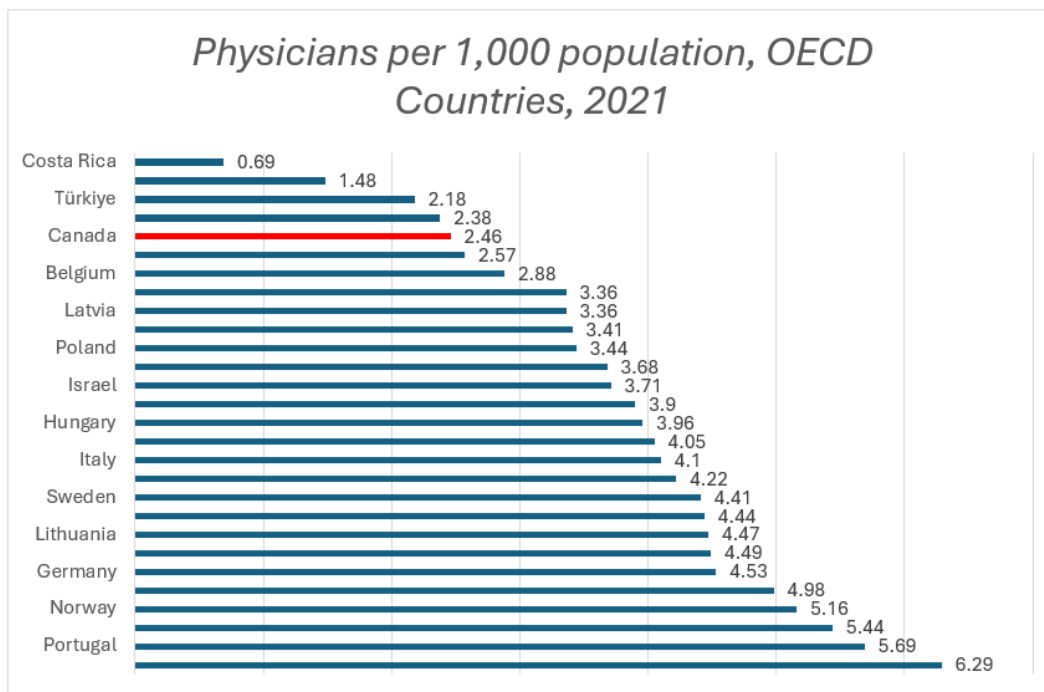
Percent Change in the number of physicians per 100,000 population, by jurisdiction, Canada. 1971 to 2023



56. As a result, in 2023, Ontario had the fourth lowest physician to population ratio, resulting in increased demands on physicians in the province, making work in other provinces more appealing:

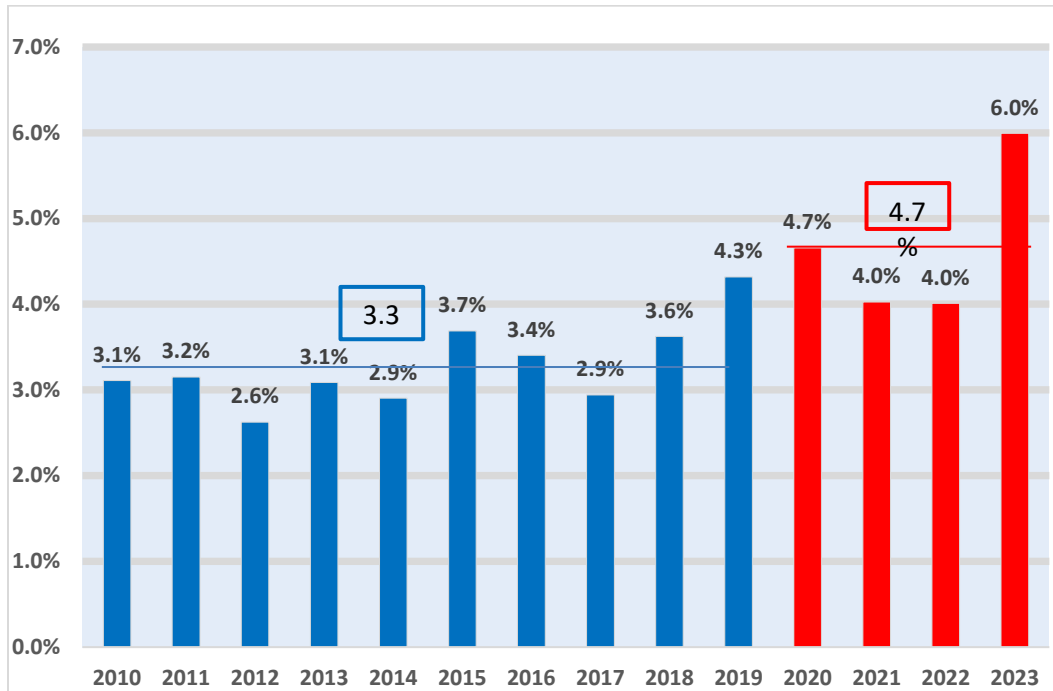


57. This ratio is low in comparison to most other OECD countries:



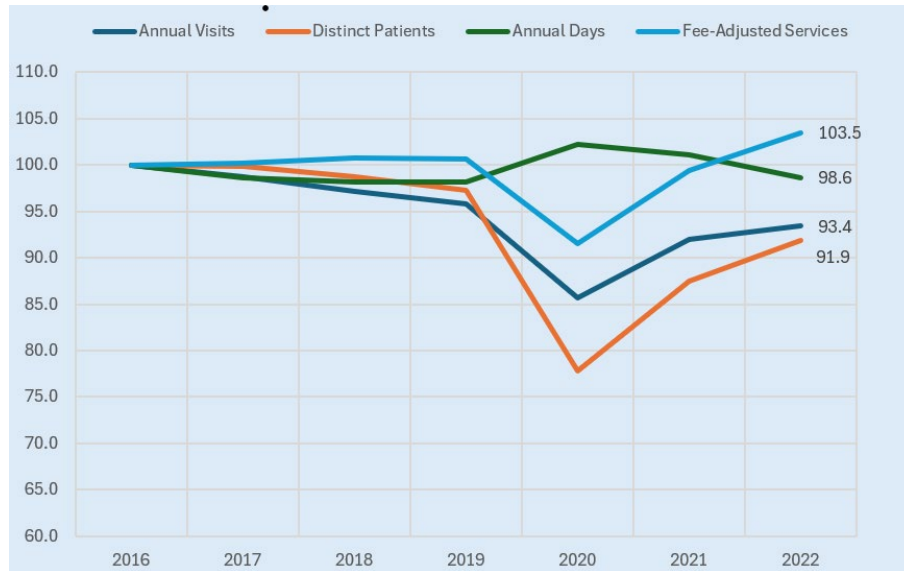
58. The exit of physicians is well underway. For example, the proportion of physicians leaving practice in Ontario in the post-pandemic era is more than one full percentage point higher than in the pre-pandemic era, as seen in the following chart:

Percent Physicians Exiting from Active Practice, Ontario, 2009 to 2023

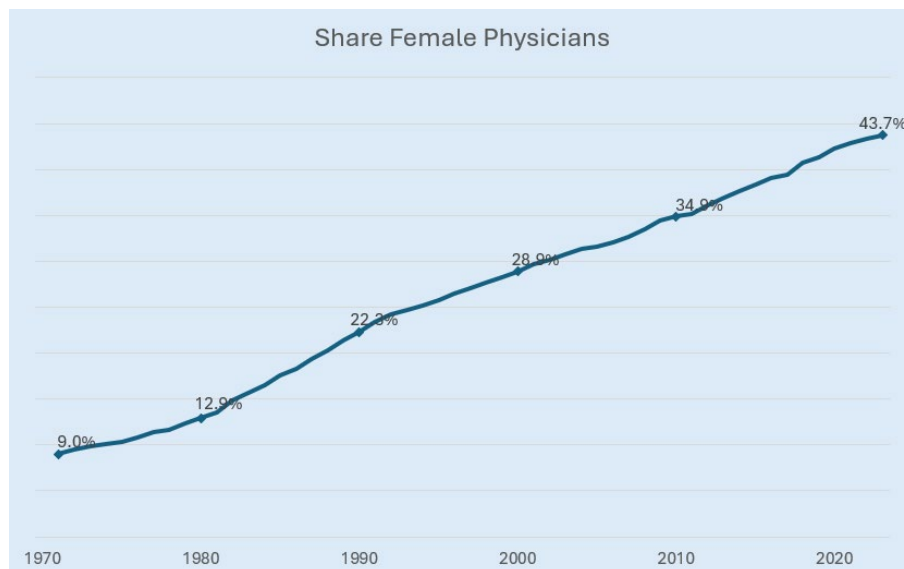


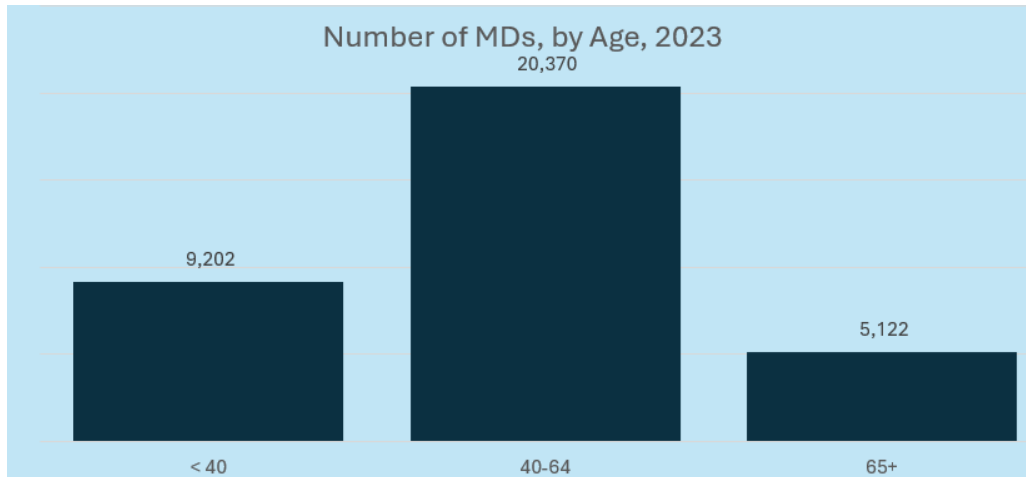
Source: Ontario Physician Reporting Centre, Physicians in Ontario Longitudinal Dataset (2009-2023 - Hamilton, ON: OPRC; 2025)

59. As set out above (and as detailed in the OMA Year 1 arbitration brief), there is compelling evidence that there has been a significant increase in the complexity of patients and medical visits over time. Thus, while visits per physician may be down somewhat, those visits involve patients with greater complexity. Indeed, when services per physician is adjusted for complexity, services per physician have actually grown moderately, by about 0.6 percent per year:



60. Changing physician demographics may also affect the number of services per physician, in particular the increasing share of female physicians and the changing age composition of the physician workforce:





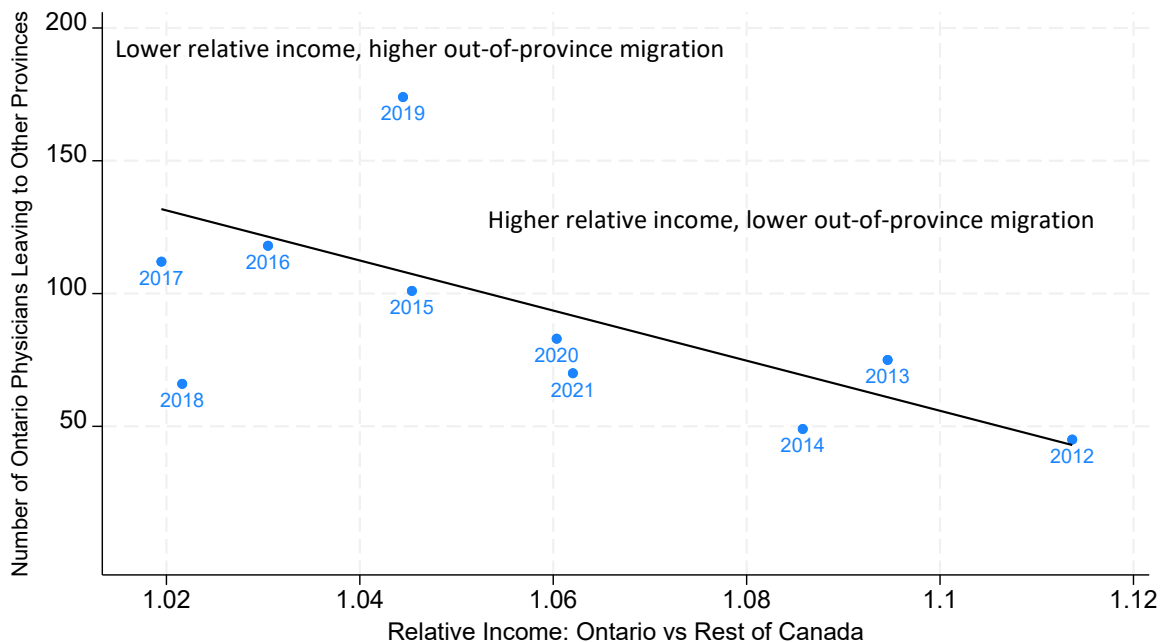
61. In the face of these growing physician recruitment and retention challenges, the OMA also submits that improved compensation remains a key, if not the key, to addressing the crisis. Although improved compensation does not have an immediate impact on adding new physicians, which depends in large part on government policy on medical training and international medical graduates, improved compensation can affect the total supply of physician services by increasing the number of services each physician provides and by decreasing the number of physician exits due to retirement and out of province migration.

62. Empirical studies of physician responses to changes in fee schedules in Canada³¹, suggest that targeted fee increases incentivize physicians to provide more services, while broad-based fee increases incent physicians to provide fewer services. In Ontario, the fee changes are almost exclusively targeted. Specifically, after the conclusion of Physician Services Agreements, each physician specialty receives a funding that it then allocates to specific fee codes through a bilateral Physician Payment

³¹ [Nicolas Jacquemet, Bruce Shearer](#). Physicians' multitasking and incentives: empirical evidence from a natural experiment. *Journal of Health Economics*, 2008 Dec;27(6):1436-50, BOD VOL 1 TAB 25; Jasmin Kantarevic, Boris Kralj, and Darrel Weinkauf. Income effects and physician labour supply: evidence from the threshold system in Ontario. *Canadian Journal of Economics*, Vol. 41, No. 4 November 2008, BOD VOL 1 TAB 26; Shearer, Bruce and Somé, Nibene Habib and Fortin, Bernard, "[Measuring Physicians' Response to Incentives: Evidence on Hours Worked and Multitasking](#)" (May 28, 2018). CRREP working paper series 2018-09, BOD VOL 1 TAB 27.

Committee. The broad-based, or across-the-board, increases to all fees are extremely rare and occurs only as temporary measures until the permanent allocation of funding to specific fees can be implemented in the Schedule of Benefits. Therefore, higher fees for targeted fee codes will likely incent physicians to provide more of these services.

63. Similarly, CIHI data on physician incomes in each province and the number of physicians leaving Ontario to practice in another Canadian province for the 2012 to 2021 period clearly demonstrate the strength of the relationship between the decision on where to practice and the relative compensation:



Data Sources: Canadian Institute for Health Information. National Physician Database 2023; Ontario Physician Reporting Centre 2024.

64. Research has also confirmed that decisions around early retirement and feelings of dissatisfaction with the profession are tied to compensation. For example, “compensation that has not kept pace with inflation” has been identified by the OCFP as a specific factor driving the shortage of family physicians.³² Similarly, Flood et al. have

³² Ontario College of Family Physicians, [“Without urgent action, nearly 1 million in Toronto could be without a family doctor by 2026”](#) (March 5, 2024).

confirmed that the shortage of family physicians is explained in part by the higher earning potential of other specialties.³³

C. The Binding Arbitration Framework and Criteria for Interest Arbitration:

65. As set out at pages 27-30 of the OMA's Year 1 brief, the present arbitration is taking place pursuant to the Binding Arbitration Framework Agreement ("BAF"),³⁴ which sets out the dispute resolution process to be used by the parties in the event they cannot reach a negotiated settlement with respect to the Physician Services Agreement ("PSA"). The OMA's submissions with respect to interest arbitration criteria are set out at pages 31-35 of the Year 1 Brief.

66. The OMA relies upon and reiterates the submissions made on the BAF and criteria in its Year 1 brief.

67. As set out in the BAF and confirmed in the Year 1 Arbitration Award, the central role of the Arbitration Board is to award "compensation increases that achieve fair and reasonable compensation for Ontario's physicians in a high-quality patient-centred sustainable publicly funded health care system."³⁵

68. The OMA notes, in particular, that, pursuant to the BAF, the Arbitration Board has full power to decide any issue in dispute, on such terms as it determines to be appropriate. It is not limited to choosing either the OMA's position or the government's position (s. 18). The Arbitration Board is given the authority to determine all matters

³³ Flood CM, Thomas B, McGibbon E., "[Canada's primary care crisis: Federal government response](#)," *Healthcare Management Forum*, 2023;36(5):327-332 at 327, BOD VOL 1 TAB 28.

³⁴ Binding Arbitration Framework ["BAF"], BOD VOL 1 TAB 29, which is Appendix A to the OMA and MOH, Representation Rights and Joint Negotiations and Dispute Resolution Agreement, BOD VOL 1 TAB 30.

³⁵ Year 1 Award, *supra*, BOD VOL 1 TAB 23.

related to the conduct of the hearing. There are very limited powers of review of the final decision of the Arbitration Board (s. 19).

69. The agreement provides a list of factors for the Arbitration Board to consider and also provides that the Arbitration Board may consider any other factors it considers relevant. In other words, the Board is not bound by any factor and can determine the weight to be given to the respective factors (s. 25). The listed factors are:

- (a) The achievement of a high quality, patient-centred 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.

70. With respect to the criteria, as set out in the 2019 Kaplan arbitration award, while no single factor should be “accorded primacy,” at the centre of the board’s “mission in resolving the matters in dispute is to ensure a high-quality patient-centred sustainable

publicly funded health care system with fair and reasonable compensation for Ontario's physicians."³⁶

71. In the Year 1 Award, Arbitrator Kaplan also noted the particular relevance of recruitment and retention, holding that there was, in fact, compelling evidence of recruitment and retention issues and that compensation was one important part of the answer to recruitment and retention problems.³⁷ While compensation increases will not automatically resolve the recruitment and retention issue, it is unquestionably a driver in attracting employees.³⁸

72. With respect to the other criteria listed in the BAF, Arbitrator Kaplan further noted in the 2019 Arbitration award that "replication and identification of appropriate comparators" are "key interest arbitration criteria."³⁹ This has been confirmed by countless arbitrators, who have found that the overarching goal of interest arbitration is to replicate the agreement that the parties would have achieved in free collective bargaining had they been able to do so, with or without the resort to strikes or lockouts.⁴⁰

⁴¹ As has been explained, "the replication principle requires the panel to fashion an

³⁶ *Ministry of Health and Long-Term Care and Ontario Medical Association*, (February 18, 2019, unpublished) ["2019 Kaplan Arbitration Award"] at p. 4, BOD VOL 1 TAB 31.

³⁷ Year 1 Award, *supra*, BOD VOL 1 TAB 23.

³⁸ [*The Crown in Right of Ontario v The Ontario Secondary School Teachers' Federation and The Elementary Teachers' Federation of Ontario*](#), 2024 CanLII 8967 (ON LA) ["ETFO and OSSTF"], BOD VOL 1 TAB 32.

³⁹ 2019 Kaplan Arbitration Award, *supra*, at p. 8, BOD VOL 1 TAB 31.

⁴⁰ *Re Board of School Trustees, District No. 1 (Ferne) and Fernie District Teachers' Association* (1982), 8 LAC (3d) 157 at 159 (CLB) Dorsey ["Re Board of School Trustees"], BOD VOL 1 TAB 33.

⁴¹ Cited in *Re Beacon Hill Lodges of Canada and Hospital Employees Union*, (1985) 19 L.A.C. (3d) 288, BOD VOL 1 TAB 34.

adjudicative replication of the bargain that the parties would have struck had free collective bargaining continued.”⁴²

73. In this context, “freely bargained outcomes are the touchstone” when trying “to replicate free collective bargaining, and to ensure that the parties end up no better and no worse than if their right to strike and lockout had not been curtailed.”⁴³

74. The OMA submits that for the present arbitration, the arbitral criteria of replication, comparability and recruitment and retention should be given particular consideration and that these criteria unequivocally support the OMA’s proposals. As set out below, the OMA reviews the application of these criteria as they bear on normative increases.

⁴² University of Toronto and University of Toronto Faculty Association (Salary and Benefits Grievance) (2006), 148 L.A.C. (4th) 193 at paragraphs 12-17, BOD VOL 1 TAB 35.

⁴³ [*Participating Hospitals v CUPE/OCHU & SEIU \(Bill 124 Reopener\)*](#), 2023 CanLII 50888 (ON LA) [“CUPE/OCHU and SEIU”], BOD VOL 1 TAB 36.

D. Overview of the Year 1 Award, Bargaining and Subsequent Awards:

75. The OMA relies upon and reiterates its submissions regarding the history of bargaining and negotiations between the parties prior to the Year 1 award as set out in its Year 1 brief at pages 36 to 61. The following section updates those submissions from the Year 1 award to present.

76. On September 12, 2024, the Arbitration Board released in its Year 1 Arbitration Award. In the Award, Arbitrator Kaplan held that “there is a recruitment and retention issue” in that “[s]omewhere between 1.35 million and 2.3 million people in the province are not attached to a family doctor.” He also found that “compensation...is an important” part of the answer to this problem.⁴⁴

77. While refusing to make any definitive findings as to why doctors are seeing fewer patients, he concluded that “targeted increases should include focusing on increasing attachment and improving accessibility.”⁴⁵

78. Arbitrator Kaplan also rejected the Ministry’s independent contractor paradigm for doctors, noting that the most important hallmark of an independent contractor is the ability to set price, which Ontario doctors cannot do.⁴⁶

79. While finding that incomes may have risen above price increases, Arbitrator Kaplan firmly rejected any inference “that this is based on improper physician billing practices, rather than resulting from the services physicians are providing to patients.” He also rejected the argument that “simply because Ontario’s doctors are currently well

⁴⁴ Year 1 Award, *supra*, BOD VOL 1 TAB 23.

⁴⁵ *Ibid.*

⁴⁶ *Ibid.*

paid...that this means that they should not receive both a proper normative increase and redress/catch-up for past (established) losses.”⁴⁷

80. In the award, Arbitrator Kaplan also found that “administrative duties are diverting doctors from performing clinical care” and must be addressed as part of targeted investments.⁴⁸

81. With respect to the OMA’s catch-up claim, Arbitrator Kaplan found that “the 2021-24 PSA was negotiated before inflation became a significant factor, rising to 6.8% in 2022 and 3.9% in 2023” and that “Ontario’s physicians [had been left] further behind economically at the end of the 2021-24 PSA than they were at the beginning.” He also found that, in the 2021-24 period, all other hospital health sector groups had received much larger normative increases, establishing a “classic and compelling case for a normative increase plus redress/catch-up on account of unprecedented inflation in the pervious PSA.” Regarding the impact of the Bill 124 wage restraint legislation on physicians, Arbitrator Kaplan further found that “while Bill 124 did not expressly apply to physician expenditures, it dictated the result in the first two years of the previous PSA” and that a case had been established for redress/catch-up due to rising inflation during the previous PSA. Given that “there was remediation across the OPS and broader public sector where Bill 124 had applied...it would be equally inappropriate and unjustifiable for [physicians] not to be treated generally the same.” As a result, he awarded a redress/catch-up amount of 6.95%. In addition, he awarded a normative amount [of 3%] replicating the amount awarded to other hospital health care unions for the year in question.⁴⁹

⁴⁷ *Ibid.*

⁴⁸ *Ibid.*

⁴⁹ *Ibid.*

82. With respect to targeted investments, Arbitrator Kaplan further held as follows:⁵⁰

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 underserved 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.

83. Since the Year 1 Award was released, the parties have held approximately 49 days of bargaining and mediation. That work has resulted in the release of two further arbitration awards. As noted in these awards, the parties were able to reach agreement in many areas, with a few issues remaining to be resolved by Mr. Kaplan. As well, the parties reached agreement with respect to improved compensation for pregnancy and parental leave.

84. In an Award dated April 21, 2025, targeted price increases were allocated to physician services compensation for Rural and Northern physicians, including through changes to the Rural and Northern Physician Group Agreement (RNPGA), the Sioux Lookout Regional Physicians' Services Inc. Agreement (SLRPSI) and three existing primary care physician funding agreements in Kenora. With respect to SLRPSI and Kenora specifically, the negotiations included and reflected the input of Indigenous and health care leadership in the respective regions. While the parties were able to reach agreement on many of the terms of the targeted allocation to Rural and Northern

⁵⁰ *Ibid.*

Communities, there were outstanding matters determined in a supplemental award from Arbitrator Kaplan.⁵¹

85. On the same day, Arbitrator Kaplan also released an award regarding Emergency Departments. The award included new targeted investments to stabilize Emergency Departments and improvements to physician funding for Emergency Departments, much of which reflected structural changes and compensation improvements agreed to by the parties.⁵²

86. On April 23, 2025, the parties announced their agreement with respect to improvements to pregnancy and parental leave benefits for doctors. These include the following:⁵³

- leaves that commence on or after April 1, 2025, will have an increased maximum benefit amount of \$2,000 for all physician parents.
- For birth parents, the length of leave will increase to 22 weeks; for non-birth parents the length of leave will continue to be 17 weeks.
- Additionally, the amount of gross eligible income a physician can earn while on leave will increase from \$1,300 per week to \$3,000 per week.

87. The parties now submit the remaining issues in dispute for Years 2, 3 and 4 of the PSA to arbitration.

⁵¹ *R v Ontario Medical Association*, April 21, 2025 (Kaplan) – Northern and Rural Award, BOD VOL 1 TAB 37.

⁵² *R v Ontario Medical Association*, April 21, 2025 (Kaplan) – EDAFA Award. BOD VOL 1 TAB 38.

⁵³ Pregnancy and Parental Leave Benefit Program (PPLBP) Improvements agreement. BOD VOL 1 TAB 39.

PART II - ECONOMY, ONTARIO'S FISCAL POSITION, AND HEALTH CARE SPENDING

88. The Ontario economy is best described as performing well, despite headwinds. On the one hand, the OMA acknowledges that, both in Canada and globally, a degree of economic uncertainty has been created by the United States' imposition of and frequent reversals on tariffs. At the same time, as recently stated by Ontario's Finance Minister, Peter Bethlenfalvy, Ontario's "finances are in the best health they've been in decades" and the Ontario Government is making "the necessary investments to protect Ontario and build the economy of tomorrow."⁵⁴ The underlying strength and resilience of Ontario's economy is also reflected in the 2025 Ontario Budget, which states that "Ontario's finances are in the strongest position they have been in over a decade".⁵⁵

89. The present moment is also one of considerable investment by the Government in Ontario's health sector, as described further below. In this context, with solid economic fundamentals and the need for continued investment in health care, the arbitrary and quickly changing actions of the US government and the resulting shifting macroeconomic environment, are largely a distraction and should in no way be determinative of what increases should be awarded for years 2, 3, and 4 of the PSA or what targeted investments are needed to ensure the continued functioning of Ontario's health care system.

⁵⁴ Toronto Star, "[Trump's trade war a 'wake-up call': Ontario finance minister warns](#)" (May 20, 2025) – [[Toronto Star](#)], BOD VOL 1 TAB 40.

⁵⁵ Ontario, [2025 Ontario Budget: A Plan to Protect Ontario](#) (May 15, 2025) at p. 7 and p. 133 ("2025 Budget"), BOD VOL 2 TAB 41.

A. Ontario's Economy in 2024 and the First Quarter of 2025 Performed Well

90. Throughout 2024, Ontario's economy performed well with the resulting overall economic figures for the year being positive and stable. As reflected in the 2025 Budget, "Ontario's economy proved to be resilient in 2024, with real GDP increasing by 1.5 per cent."⁵⁶ As well, employment rose in 2024 by 140,000 (+1.7 per cent).⁵⁷ Compared to the predictions from the 2024 budget, the reality reflected "much stronger real and nominal GDP growth in 2024, alongside robust job creation."⁵⁸ Ontario's 2024–25 deficit is also projected to be only \$6.0 billion, which is \$3.8 billion lower than the outlook published in the 2024 Budget,⁵⁹ once again demonstrating a stronger fiscal position than anticipated.

91. This view of solid economic fundamentals in 2024 and at the start of 2025 is also shared by private sector economists. For example, in their April 2025 Economic Outlook, Deloitte noted the "[s]trong growth at the end of 2024 and beginning of this year" that "will keep annual growth for 2025 in positive territory."⁶⁰ The solid economic performance in 2024 has continued into the first quarter of 2025. As explained by Doug Porter, the Chief Economist with BMO Capital Markets:⁶¹

⁵⁶ *Ibid.* at p. 133.

⁵⁷ *Ibid.* at p. 135.

⁵⁸ *Ibid.* at p. 134.

⁵⁹ *Ibid.* at p. 167.

⁶⁰ Deloitte, "Economic Outlook - April 2025 Edition" ("Deloitte Economic Outlook") at p. 3, BOD VOL 2 TAB 42.

⁶¹ Reuters, "[VIEW Canada's economy grows by 2.2% annualized rate in first quarter](#)" (May 30, 2025), BOD VOL 2 Tab 43.

I think the bottom line here is the economy held up better than most had expected. We were looking for a decent first quarter but it was better than decent...

On top of that...is the early reading on April is for a small gain following a similar size one-tenth (of a percentage point) increase in March. That's frankly quite impressive...

There's no real sign of distress in the economy from the GDP figures and I think that's the most important message.

92. This private sector view has also been confirmed by the Financial Accountability Office of Ontario, who have recently reported that “Ontario’s economic activity measured by real Gross Domestic Product (GDP) increased by a solid 0.6% in the fourth quarter of 2024, led by gains in household spending, international exports and residential investment, partially offset by a reduction in inventories” and that the “latest economic indicators suggest mostly positive results for Ontario’s economy in the first quarter of 2025, with gains in employment, retail and wholesale trade, manufacturing sales, and exports.”⁶²

93. Thus, even in the face of some economic headwinds from the arbitrary and changing US tariff policy, Ontario’s economy is, to date, performing well.

B. Measures of Economic Health

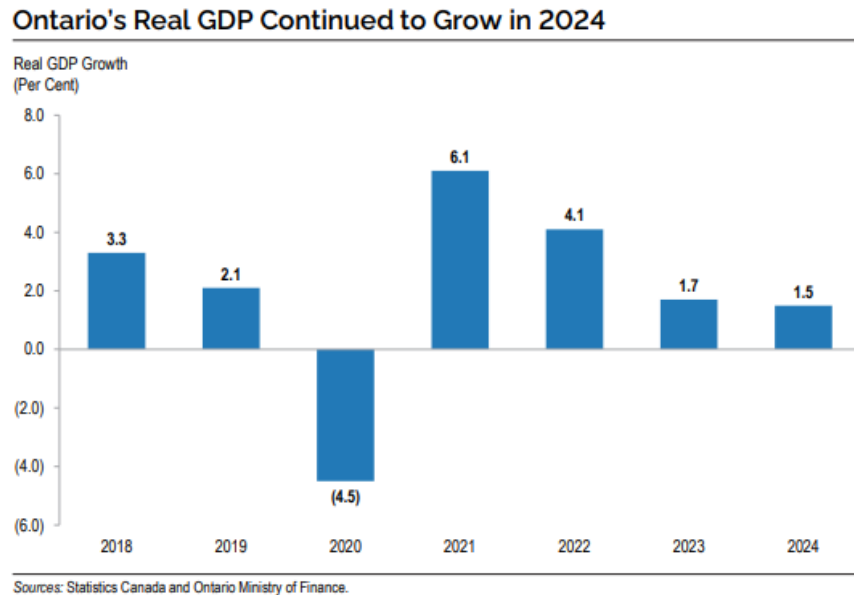
(i) Real GDP

94. According to the 2025 Ontario budget, Ontario’s real GDP is projected to rise by 0.8 per cent in 2025, 1.0 per cent in 2026, and 1.9 per cent in 2027 and 2028.⁶³ This

⁶² FAO, *Ontario Economic Monitor: October 2024 to March 2025*, <https://fao-on.org/wp-content/uploads/report/oem-2025-q1/OEM-Oct-24-to-Mar-25-EN.pdf>, BOD VOL 2 TAB 44.

⁶³ 2025 Budget, *supra*, at pp. 139-141, BOD VOL 2 TAB 41.

follows exceptional gains in real GDP growth of 6.1% and 4.1% in 2021 and 2022 respectively, and solid real GDP growth of 1.7% and 1.5% in 2023 and 2024.⁶⁴



95. The Ontario government's outlook in this respect is broadly in line with that of the independent Financial Accountability Office's ("FAO") "tariff scenario", which is forecasting average annual growth of 1.4% and 1.3% over the 2025 to 2028 period⁶⁵.

96. The 2025 Budget projections are in fact below the average of private-sector forecasts.⁶⁶ For example, Deloitte is forecasting real GDP growth of 1.2% in 2025 alone, as reflected in the following chart:⁶⁷

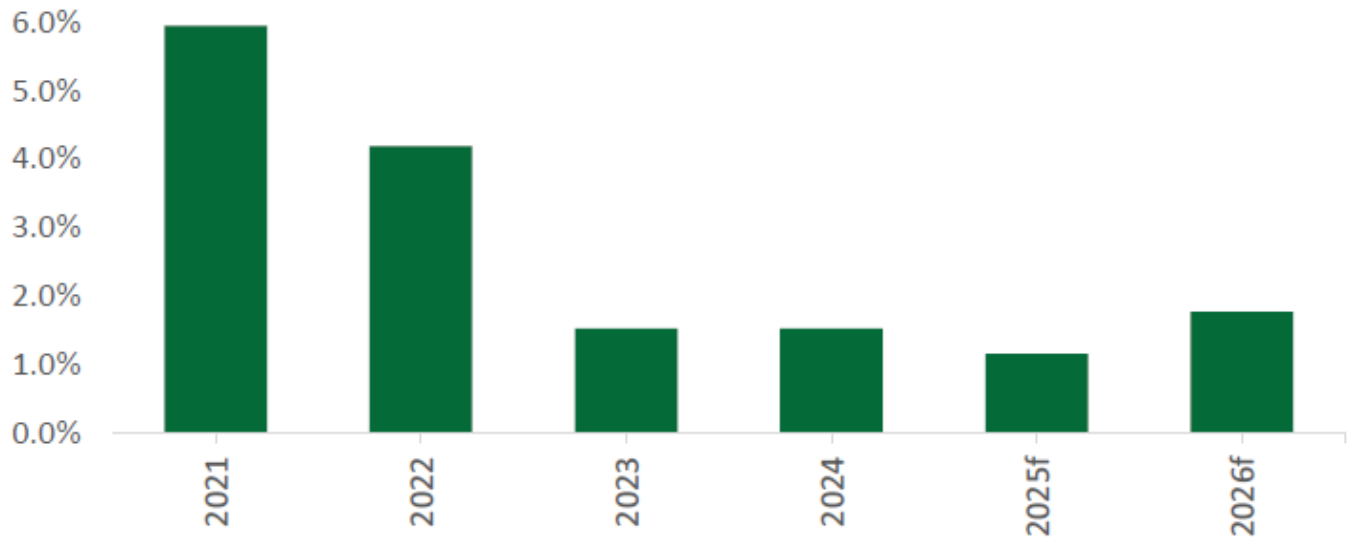
⁶⁴ *Ibid.* at p. 126.

⁶⁵ FAO, [2025 Ontario Budget Note](#), at p. 1, BOD VOL 2 TAB 45.

⁶⁶ *Ibid.*, p. 133.

⁶⁷ [Deloitte Economic Outlook](#), *supra*, p. 3, BOD VOL 2 TAB 42.

GDP, percent change



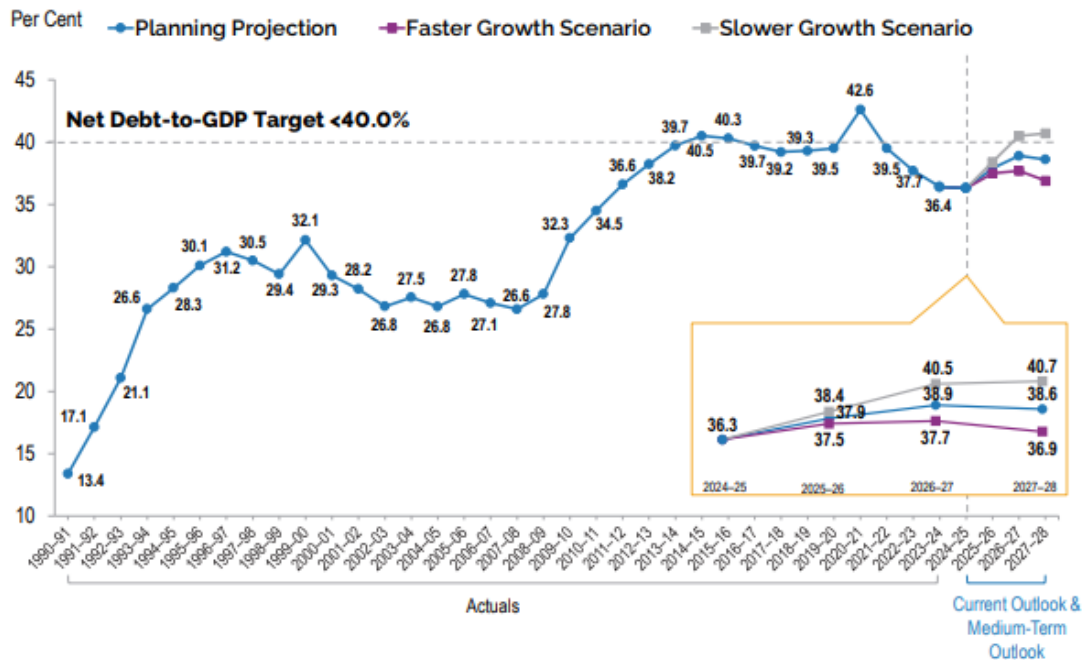
(ii) Net-debt-to-GDP ratio

97. One measure often referred to in reviews of Ontario’s fiscal health is the provincial government’s net debt-to-GDP ratio. This ratio is projected to be 37.9 per cent in 2025–26, comfortably under the government’s target of 40 per cent and “low compared to much of the last decade.”⁶⁸ Over the medium term, the net debt-to-GDP is forecast to be 38.9 per cent in 2026–27, and 38.6 per cent in 2027–28. These forecasts are reflected in the following chart, alongside slower and faster growth scenarios. Notably, even under the government’s worst-case scenario, net debt-to-GDP will remain in the target 40 per cent range.⁶⁹

⁶⁸ The Conference Board of Canada, “[Course Correction: Our Analysis of the Ontario Budget 2024](#)” (16 May 2025), [“Conference Board”], BOD VOL 2 TAB 46.

⁶⁹ [2025 Budget](#), *supra* at p. 212. BOD VOL 2 TAB 41.

Chart 4.10
Net Debt-to-GDP



Note: See Chapter 3: Ontario's Fiscal Plan and Outlook for details on the Faster Growth and Slower Growth scenarios.
Sources: Statistics Canada and Ontario Ministry of Finance.

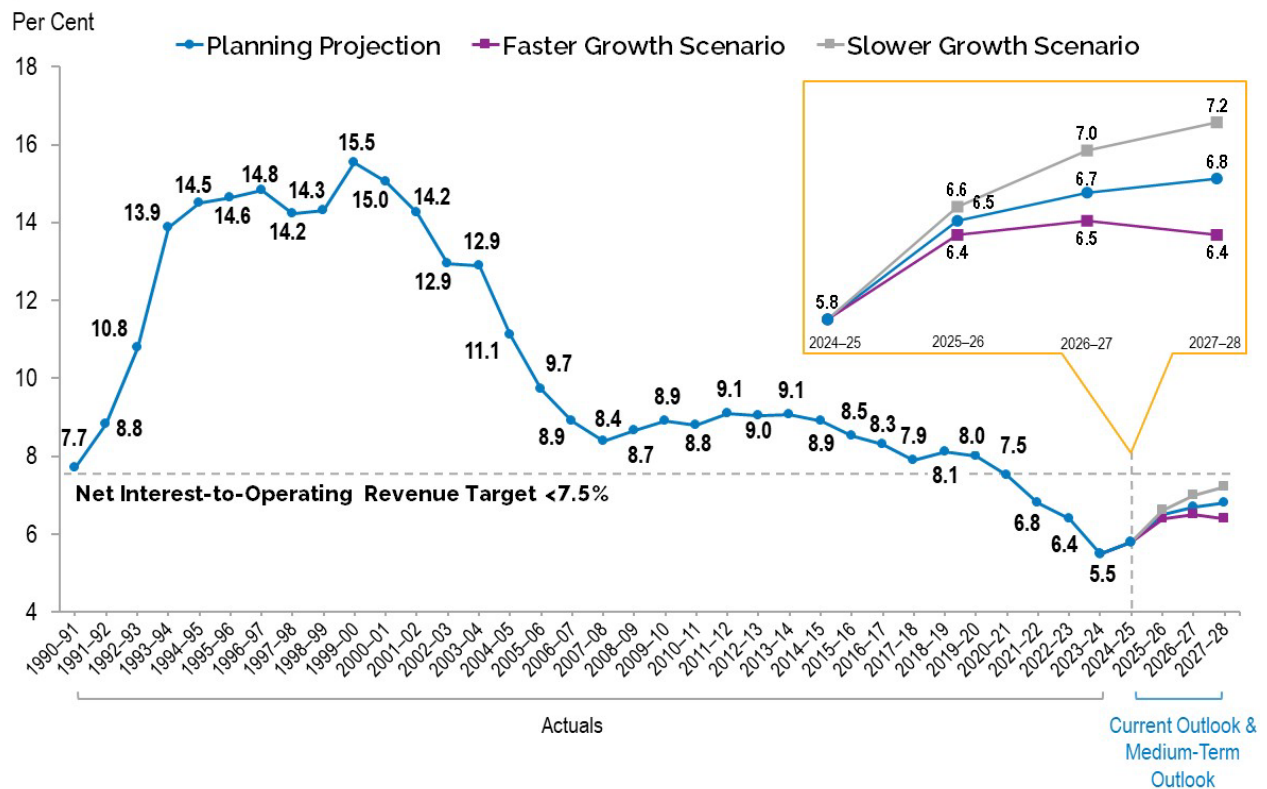
(iii) Interest on Debt

98. Another commonly used indicator of fiscal health is the province's net interest-to-operating revenue ratio, which "represents how much Ontario needs to spend on interest for every revenue dollar received." The ratio is projected to be 5.8 percent in 2024–25, 6.5 percent in 2025–26, 6.7 percent in 2026–27 and 6.8 percent in 2027–28, all comfortably under the government's target of 7.5% and "close to the lowest levels it has been at since the 1980s". Even under the government's worst case slow growth scenario, the ratio is not expected to go above 7.2% in the medium term, as reflected in the following chart:⁷⁰

⁷⁰ 2025 Budget, *supra*, at p. 214, BOD VOL 2 TAB 41.

Chart 4.12

Net Interest-to-Operating Revenue (formerly Interest on Debt-to-Revenue)



Note: See Chapter 3: *Ontario's Fiscal Plan and Outlook* for details on the Faster Growth and Slower Growth scenarios.

Sources: *Public Accounts of Ontario* (1990–1991 to 2023–2024) and Ontario Financing Authority.

99. In the view of David Dodge, the former Bank of Canada governor who also served as the Government of Ontario's expert in *Ontario English Catholic Teachers Assoc. v. His Majesty*, these two fiscal targets, net-debt-to-GDP ratio under 40% and interest-on-debt-to revenue ratio under 10%, are key indicators of Ontario's fiscal health.⁷¹ As set out above, both of these measures are forecast to remain within the appropriate target ranges and thus reflect Ontario's fundamentally healthy fiscal situation, even taking into account the potential impact of U.S. tariffs.

⁷¹ [Ontario English Catholic Teachers Assoc. v. His Majesty](#), 2022 ONSC 6658 (CanLII) at paras. 277-278, BOD VOL 2 TAB 47.

100. In fact, as of May 2025, interest costs are the lowest as a percentage of revenue the province has seen since the 1980s⁷² and Ontario's credit rating has, in fact, been upgraded by both Morningstar DBRS and S&P in 2024 in response, in part, to the fact that Ontario's net debt-to-GDP and net debt-to-operating revenue ratios are at some of the lowest rates seen since the early 2010s.⁷³

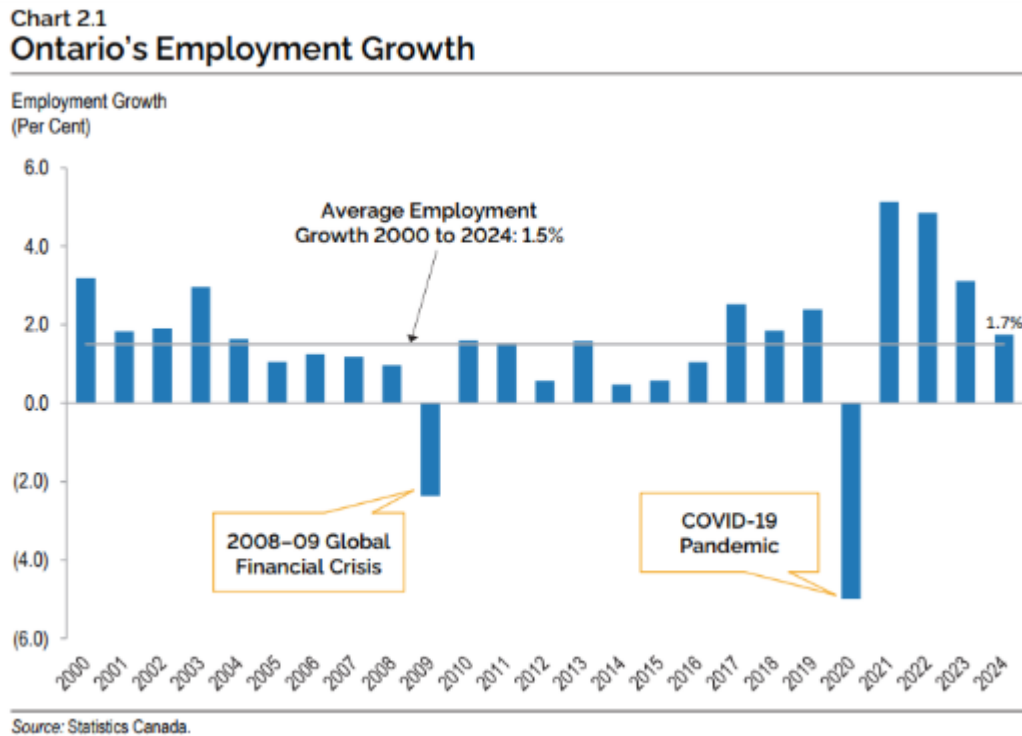
(iv) *Employment Rate*

101. The post-pandemic period in Ontario has also been marked by strong job growth, resulting in a continued tight labour market. Employment growth has remained strong in 2024, following three particularly strong years of employment gains.⁷⁴ The following chart shows that the growth in employment remained higher than the average across the 2020-2024 period:

⁷² "Toronto Star", *supra*, BOD VOL 1 TAB 40.

⁷³ 2025 Budget, *supra*, at p. 7, BOD VOL 2 TAB 41.

⁷⁴ *Ibid* at p. 135.



102. Furthermore, according to the 2025 Ontario budget, employment growth is projected to remain positive at 0.9% in 2025-26, 0.4 per cent in 2026, and 0.9 per cent in 2027.⁷⁵

(v) Return to Surplus by 2027

103. While the Government is projecting deficits of \$14.6 billion in 2025–26 and \$7.8 billion in 2026–27, specifically in order to provide the spending support needed to invest in the economy and to respond to shifting US trade policies, Ontario is on track to a forecasted surplus of \$0.2 billion in 2027–28, the fourth year of the PSA.⁷⁶

⁷⁵ *Ibid.*, at pp. 139-141.

⁷⁶ *Ibid.*, at p. 4.

104. Notably, Ontario's actual deficit in 2024-25 at 6 billion was significantly lower than the 9.8 billion that had been forecasted in the 2024 budget.⁷⁷

C. Inflation

105. Following a period of unusually high inflation in 2020 to 2023, inflation in Ontario in 2024, and to date in 2025, while still above the Bank of Canada's target rate of 2% has begun to stabilize. According to the 2025 Budget, Ontario Consumer Price Index (CPI) inflation averaged 2.4 per cent in 2024, down from 3.8 percent in 2023. According to the Budget, it is anticipated that inflation will be 2.3 percent in Ontario in 2025 and 2 percent in both 2026 and 2027, although potential counter tariffs on US goods are anticipated to have somewhat of an inflationary impact that could push these numbers higher.

106. While inflation has begun to moderate, it is important to note that the labour market in Ontario is continuing to absorb the impact on living costs of elevated rates of inflation in the 2020-23 period.

D. US Tariff Policy Should Not be a Basis for Determining Physician Increases

107. As noted above, the Ontario Government has based its design of its 2025 Budget on assumptions about the impact of U.S. trade policy on Ontario's economy and about the investments by all levels of government that will be required to mitigate that impact. The seemingly unending parade of new tariffs on new countries and new products, periodic pauses in tariff implementation and escalations in tariff increases announced in dead-of-the-night social media postings, staged meetings in the Oval Office and rally speeches provide little in the way of solid ground on which to build a view of the future, much less a point of departure for economic policy in Ontario over the next few years. The uncertainty created by the erratic (irrational) swings in U.S. trade policy is itself a potentially significant drag on economic activity, even without any consideration of the

⁷⁷ *Ibid.*

likelihood that high tariffs on key manufacturing inputs like steel and aluminum will themselves have a negative effect on U.S. economic activity that far outweighs whatever modest gains might be made in U.S. steel and aluminum production. The Conference Board of Canada's statement that "fiscal plans are full of uncertainty given the current circumstances"⁷⁸ is clearly in the running for understatement of the year.

108. However, at the same time, the OMA submits that this Board of Arbitration cannot, nor should it, base its decisions regarding what constitutes fair and reasonable normative increases for physicians affecting the entire health care sector in Ontario on the current and shifting macroeconomic environment, which as a result of the arbitrary actions of the US government, is unpredictable. This changing tariff context is largely a distraction which should not in any way be determinative.

109. While US tariffs create a degree of uncertainty, it is important to remain somewhat circumspect about them, particularly since the actual tariffs themselves are changing daily. This is vividly illustrated by the recent US Court of International Trade ruling that the President does not have the authority to impose duties against Canada and Mexico under the guise of emergency powers, only to have the tariffs temporarily reinstated the next day by the United States Court of Appeals for the Federal Circuit pending an appeal.⁷⁹

110. As well, one should not overstate the impact of the actual US tariffs on Canada at the present moment. Notably, as a result of the Trump administration's reversal of certain planned tariffs, 94% of Canada's trade with the US is currently tariff-free because it is compliant with the Canada-US-Mexico Free Trade Agreement (CUSMA). This

⁷⁸ Conference Board, *supra*, BOD VOL 2 TAB 46.

⁷⁹ Catherine Levesque, "U.S. federal appeals court reinstates Trump's tariffs — for now," National Post (May 29, 2025), BOD VOL 2 Tab 48

includes most energy products and potash fertilizer, some of Canada's key exports.⁸⁰ Thus, Canada is "facing a lower average tariff rate than many other countries" and "news on the tariff front is better-than-expected."⁸¹

111. This fact has been confirmed by a recent RBC report which found that Canada faces the lowest average effective tariff of any major U.S. trade partner, and that Canada's economic path is "considerably less treacherous than it did just a few months ago." The report confirms that based on U.S. Census Bureau data, nearly 90 per cent of Canadian exports to the U.S. remained duty-free in April.⁸²

112. In light of all of the reversals to date by the Trump administration, it is also reasonably possible that the remaining tariffs could be lifted in the near-to-medium term. There is constant talk about ongoing negotiations between Canadian and American officials, and it is impossible to predict what the tariff reality will be by the time this arbitration hearing commences or during this board's deliberations. However, even if some tariffs remain, the most recent forecasts from the independent Financial Accountability Office for Ontario on the impact of tariffs reflect confidence that the economy will adjust over time, projecting average GDP growth at 1.8% from 2027-2029, only 0.1% less than the 1.9% growth predicted in a no-tariff scenario.⁸³

113. In addition, economists have noted that there are "unexpected silver linings from the situation," which include a "renewed focus on boosting our productivity and

⁸⁰ Politico, "[It's Outrageous That You Banned American Products From Your Shelves](#)", BOD TAB 49; RBC, "[CUSMA compliance rush: Will it shield Canada from U.S. tariffs?](#)", BOD TAB 50; See also The Globe and Mail, "[Canada's economy in flux as Trump starts cutting tariff deals](#)", BOD VOL 2 TAB 51.

⁸¹ Deloitte Economic Outlook, *supra*, at p. 2. BOD VOL 2 TAB 42.

⁸² RBC, "[Canada's economic outlook: Shifting tides as tariff threats de-escalate](#)," (June 13, 2025), BOD VOL 2 TAB 52.

⁸³ FAO, "[The Potential Impacts of US Tariffs on the Ontario Economy](#)" (2025), BOD VOL 2 TAB 53.

diversifying our trade.” In this context, “Canada’s economy may well find itself emerging from this shock stronger and more resilient.”⁸⁴

114. As well, so far, the impact of tariffs has been relatively modest, as summarized by the Conference Board of Canada recently in their review of the 2025 Ontario budget:⁸⁵

The good news is that the fiscal outlook is not as bleak as it may seem. New spending was mostly targeted to protect the economy from the impact of the trade dispute and is short term in nature. Meanwhile, the U.S. administration’s softer tone on global tariffs since “Liberation Day” on April 2 provides a shred of hope that the two countries can work out a trade deal soon. Although risks remain elevated, a return to balance by 2027-28 seems feasible based on our own projections for the Ontario economy.

115. Overall, while there are undoubtedly challenges to the economy, the Ontario economy, as confirmed by the 2025 Ontario budget, is resilient and well-positioned to weather them.

E. Health Care Spending by the Ontario Government

116. As reflected in the recent Ontario 2025 budget, the Government is continuing to make significant investments in the health care sector, including in priority areas for the OMA, such as working towards addressing the crisis in primary care.

117. Examples of current investments by the Ontario government in the health care sector include the following:

- a) \$160 million over three years to expand the Learn and Stay Grant: Building on its announcement from October 2024, the learn and stay grant will be expanded to enable, amongst others, medical school students in the 2–4-

⁸⁴ Deloitte Economic Outlook, *supra*, at p. 3. BOD VOL 2 TAB 42.

⁸⁵ Conference Board, *supra*, BOD VOL 2 TAB 46.

year cohorts to qualify for free tuition and books if they commit to practicing comprehensive family medicine in Ontario for five years;⁸⁶

- b) The government is also investing up to \$300 million to build up to 17 new and expanded community-based primary care teaching clinics in communities with high rates of unattachment to primary care, raising the government's total investment in Ontario's Primary Care Action Plan to \$2.1 billion;⁸⁷
- c) Ontario's Primary Care Action Plan will implement a broad series of initiatives for people in need of primary care by 2029, including the creation and expansion of over 305 additional primary care teams to connect approximately two million people to primary care. This includes investing upwards of \$235 million in 2025–26 to establish and expand up to 80 additional primary care teams across the province that will connect 300,000 more people to primary care this year, and provide support for primary care infrastructure renewal for the expansion of eligible team-based models; and
- d) The government will invest up to \$280 million over two years to support the expansion of Integrated Community Health Service Centres. These centres will deliver Magnetic Resonance Imaging (MRI) and Computerized Tomograph (CT) scans, endoscopy procedures and orthopedic surgeries in the community setting.

118. Other areas related to Ontario Government health-care sector spending include:⁸⁸

- Hospital funding
 - \$103 million in additional planning grants, which builds on Ontario's ambitious plan to support over 50 major hospital projects and deliver approximately 3,000 new hospital beds;

⁸⁶ Government of Ontario: [Ontario Expanding Learn and Stay Grant to Train More Family Doctors in Ontario](#), October 25, 2024, BOD VOL 2 TAB 54.

⁸⁷ *Ibid.*

⁸⁸ 2025 Budget, *supra*, BOD VOL 2 TAB 41.

- \$1.1 billion in additional hospital funding for 2025–26, which includes up to 4 per cent in base and targeted funding, and one-time funding for the surgical system
- Mental health and addictions
 - Building on supports provided in 2024–25, a total of approximately \$550 million over four years to support 28 new HART Hubs across the province;
 - More than \$303 million over the next three years to stabilize the community-based mental health and addictions services sector. This commitment will provide a four per cent increase in the sector's base funding to support community-led and delivered mental health programs;
 - An increase in investment in the Ontario Autism Program by \$175 million in 2025–26, bringing this year's total funding to \$779 million. The Ontario Autism Program provides children and youth with access to supports such as applied behaviour analysis therapy, speech-language pathology, occupational therapy, mental health services and equipment;
 - \$60 million to support the new centre for brain science at Sunnybrook Health Sciences Centre to connect those with complex mental health conditions to the care they need
- Long-term care
 - The government plans to build 58,000 new and upgraded beds to modern design standards across the province by 2028;
 - A new construction funding support program to ensure long-term care operators and builders have additional flexibility and support to continue Ontario's historical level of construction. This new program will unlock more than 8,000 new and redeveloped beds in Ontario. The Loan Guarantee Program also continues to be available to support financing the development of long-term care beds in non-municipal, not-for-profit projects
- Ontario Fertility Treatment
 - An additional \$100 million in 2027–28 to support the continued expansion of the Ontario Fertility Program. This funding will nearly triple the number of individuals who are able to receive a government-funded

IVF cycle, increase the capacity of fertility clinics and help clear existing waitlists both in hospitals and community settings;

- The previously announced new tax credit, effective Jan. 1, 2025, would build on Ontario's existing Medical Expense Tax Credit and would provide support of 25 per cent on eligible fertility treatment expenses up to \$20,000, for a maximum credit of \$5,000 per year
- Other
 - Increasing the Employer Health Tax (EHT) exemption from \$490,000 to \$1 million. The EHT exemption increase helps businesses by reducing the tax for eligible private-sector employers; and
 - An additional \$15.5 million over three years, starting in 2025–26, to increase the McMaster Nuclear Reactor's production of medical isotopes to a 24-hour-per-day, seven-day-per-week schedule, which will expand the supply and diversity of isotopes produced to help spur new discoveries. This investment will help create 16 new jobs by 2030, enable the creation of a commercial spinoff and joint venture for medical isotopes, and establish additional nuclear and neutron beam R&D capabilities, as well as develop and commercialize new medical treatments.

119. When the projections regarding health care expenditure in the 2024 Fall Economic Statement are compared to those in the 2025 Ontario Budget, it is notable that an increase of approximately \$5.4 billion in health care expenditure for 2025 and 2026 is now being forecasted as reflected in the following table:

	Projection Year	
Health Expenditure (\$ Billions)	2025	2026
2025 Ontario Budget	\$91.1	\$92.4
2024 Ontario Fall Economic Statement	\$88.1	\$90.0
Difference Budget Minus FES	\$3.0	\$2.4

120. In its *2025 Ontario Budget Note*, the Financial Accountability Office of Ontario also commented on the increase in health care spending, noting, in particular, \$10 billion in new health sector spending, including physician compensation, investments in

primary care, and higher projected utilization of health care services.⁸⁹ Health sector spending is projected to grow at an average annual rate of 2.4% from 2023-24 to 2027-28.⁹⁰ In addition, the FAO noted that 10-year spending on hospital infrastructure is projected to increase by \$5.6 billion.⁹¹

121. The clear message in this extensive list of health care investments is that the Government is not prepared to allow the incessant economic policy noise coming from south of the border to distract from the need to continue to strengthen the ability of our health care system to meet the needs of Ontarians now and into the future.

122. The OMA would go further to suggest that strengthening and improving the resilience of Canada's signature public service – health care – is as important for nation building in the face of threats from the United States as a new pipeline or highway.⁹²

123. Many of the key health care investments contemplated by the Government are intended to address shortages of health care workers, including physicians, and to address the crisis in access to primary care in Ontario. The Government acknowledges that we need more doctors and other health care providers, and compensation must be at the centre of that effort.

124. Investment in health care is much needed and welcome. Health spending per capita in Ontario was \$5,104 in 2023, the second lowest among provinces and \$547 (9.7%) below the Canadian average.

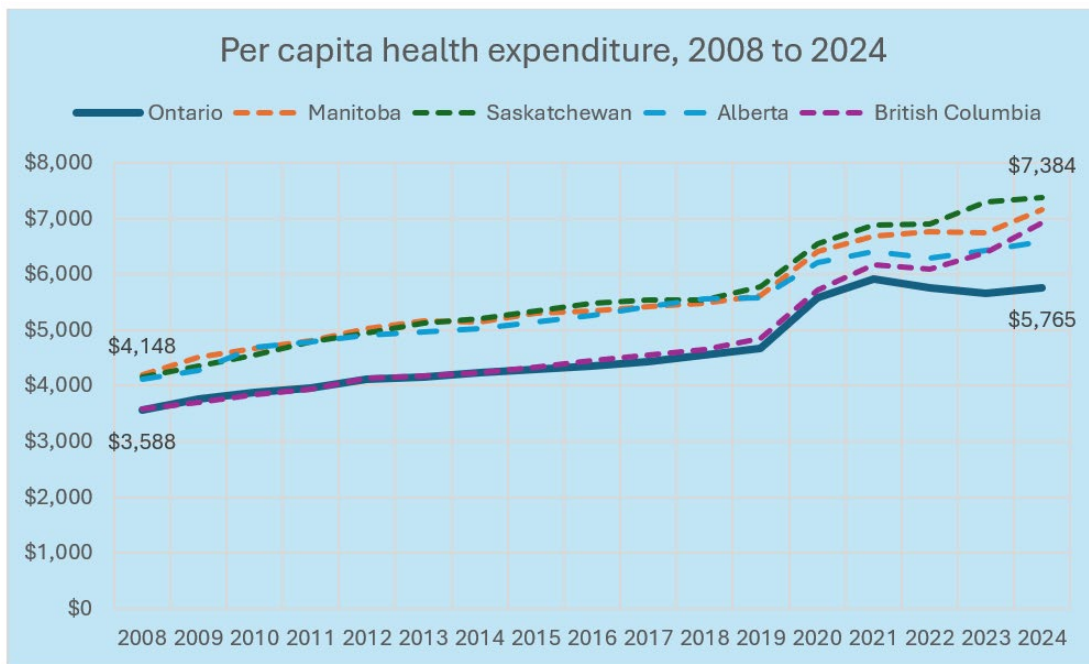
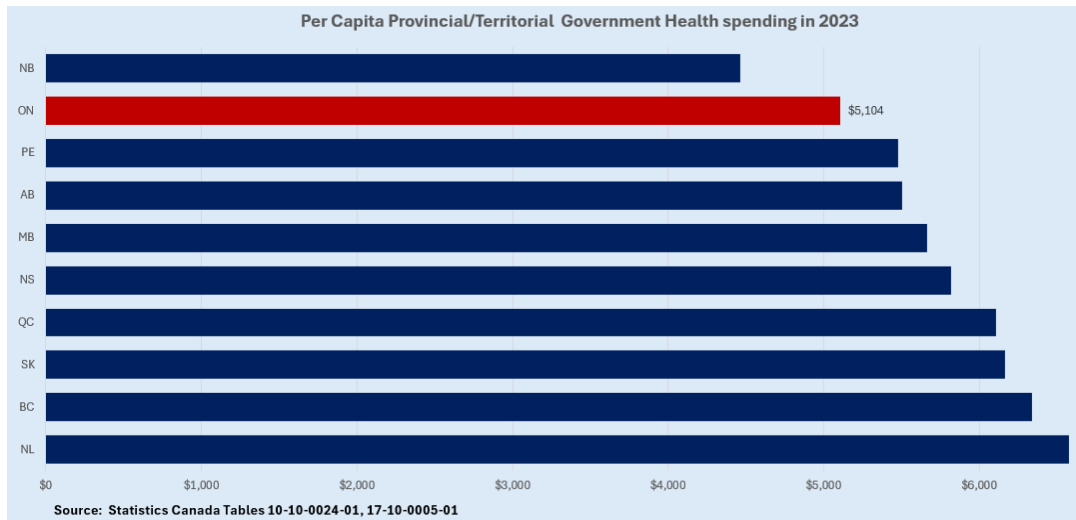
⁸⁹ FAO, [2025 Ontario Budget Note](#) (2025) at p. 8.

⁹⁰ *Ibid.* at p. 9.

⁹¹ *Ibid.* at p. 10.

⁹² Andre Picard, "'Nation-building' projects should also reflect Canadian values" *Globe and Mail* (June 10, 2025), BOD VOL 2 TAB 55.

125. When one looks over the longer term, a clear decline in health spending in Ontario relative to other provinces is starkly apparent. The following graph compares Ontario's per capita health expenditure from 2008 to 2024.



126. The OMA submits that physician compensation and its direct impact on promoting physician attachment to the health care system has an important role to play in realizing the Government's health care objectives and cannot be allowed to drop down its list of priorities.

PART III - PROPOSAL FOR GLOBAL INCREASES FOR YEARS 2, 3, 4

The OMA is proposing the following global increases for Years 2, 3, and 4:

Year 2 – 3.75%

Year 3 – 3.75%

Year 4 – 3.75%

A. Background to OMA’s Global Increase Proposal

127. The OMA proposes normative increases of 3.75% in each of Years 2, 3 and 4. The OMA submits that this proposal is supported by comparability, including normative increases bargained and awarded to other groups in the Broader Public Sector (BPS) including other health care professionals. It is also supported by the significant investments in physicians made by other provinces as seen in their most recent Physician Services Agreements. Moreover, even with the Year 1 award, physician compensation in Ontario continues to trail inflation and the industrial aggregate index.

128. In this board’s Year 1 award, Arbitrator Kaplan expressly recognized that the 9.95% increase was composed of both a “redress/catch-up increase” and a “normative increase” of 3%. He explained, “[h]aving provided for a significant redress/catch-up increase, we have, however, awarded a normative amount replicating the amount awarded to other hospital health care unions for the year in question.”⁹³

B. Bargaining Trends in 2024-25 in the Broader Public Sector

129. As explained by Arbitrator Kaplan in his 2019 Arbitration award between the parties, with respect to the criteria listed in the BAF, “replication and identification of

⁹³ Year 1 Award, *supra*, BOD VOL 1 TAB 23.

appropriate comparators” are “key interest arbitration criteria,”⁹⁴ given that the goal of interest arbitration is to replicate the agreement that the parties would have achieved in free collective bargaining, had they been able to do so.⁹⁵ As noted, in this respect, Arbitrator Kaplan found other health sector settlements and awards of particular relevance.

130. In the following, the OMA examines current bargaining trends with a particularly focus on the health sector but also considers the public sector more broadly. The OMA focusses in particular on settlements and awards ratified or released in 2024 or the first quarter of 2025 for the same years in question as Years 2, 3, and 4.

131. As these settlements and awards demonstrate, there continues to be a strong normative trend of across-the-board wage increases of 3% or above for each of the years in question.

(i) Hospital Sector Increases

132. At present, the key central hospital tables represented by ONA, CUPE, SEIU and OPSEU are either in bargaining or awaiting interest arbitration awards. As a result, there is no clear settlement trends from these central tables as yet. For 2024/25, Year 1 of the PSA, these central tables received the following wage increases:

ONA – April 1, 2024 – 3%⁹⁶

CUPE/OCHU - September 29, 2024 – 3.00%.⁹⁷

⁹⁴ 2019 Kaplan Arbitration Award, *supra*, at p. 8, BOD VOL 1 TAB 31.

⁹⁵ *Re Board of School Trustees*, *supra*, BOD VOL 1 TAB 33.

⁹⁶ *Participating Hospitals (Represented by the Ontario Hospital Association) v ONA*, 2023 CanLII 65431 (ON LA), BOD VOL 2 TAB 56.

⁹⁷ *The Participating Hospitals v OCHU/CUPE*, 2024 CanLII 33105 (ON LA), BOD VOL 2 TAB 57.

OPSEU – April 1, 2024⁹⁸ - 3.00%

133. There are, nonetheless, a number of other hospital health sector settlements and awards ratified or awarded in 2024 or the first quarter of 2025, some of which include wage increases for 2025/26 and 2026/27. The clear trend in these settlements is for wage increases of 3% or more. The following table includes 111 hospital settlements or awards from 2024 or 2025 representing over 70,000 employees, 38 of which include wage increases for 2025/26 or 2026/27. The average wage trend from these settlements is around 3% for each of 2024/25, 2025/26 and 2026/27.

HOSPITAL SETTLEMENTS AND AWARDS FROM 2024 AND FIRST QUARTER OF 2025⁹⁹

Employer Name	Union	Local	Effective Date	Expiry Date	No of EEs	2024	2025	2026	Ratification
Wingham & District Hospital	LIUNA	3000	01/04/2022	31/03/2025	25	3.0			05/01/2024
Thunder Bay Regional Health Sciences Centre	ONA		01/04/2023	31/03/2025	1,111	6.8	3.0		08/01/2024
Royal Ottawa Health Care Group	ONA		01/04/2023	31/03/2025	241	3.0			12/01/2024
Muskoka Algonquin Healthcare	ONA		01/04/2023	31/03/2025	201	3.0			23/01/2024
Muskoka Algonquin Healthcare	ONA		01/04/2023	31/03/2025	201	3.0			23/01/2024
Haliburton Highlands Health Services	ONA		01/04/2023	31/03/2025	50	7.5	3.0		24/01/2024
Kingston Health Sciences Centre	CUPE	4106	01/04/2022	31/03/2025	427	3.0			07/02/2024

⁹⁸ *The Participating Hospitals v OPSEU*, 2023 CanLII 75478 (ON LA), BOD VOL TAB 58.

⁹⁹ Ontario, [Collective Bargaining Ontario Database](#), Retrieved June 2025.

Scarborough Health Network	OPSEU	575	01/04/2022	31/03/2025	1,102	3.0			14/02/2024
Orillia Soldiers Memorial Hospital	ONA		01/04/2023	31/03/2025	425	3.0			20/02/2024
London Health Sciences Centre	ONA		01/01/2024	31/12/2025	91	7.3	4.0	3.0	23/02/2024
Royal Ottawa Health Care Group	OPSEU	439	01/04/2022	31/03/2025	248	3.0			28/02/2024
Royal Ottawa Health Care Group	OPSEU	479	01/04/2022	31/03/2025	295	1.0			28/02/2024
Almonte General Hospital	CUPE	3022	29/09/2023	28/09/2025	179	3.0			18/04/2024
Baycrest Centre For Geriatric Care	SEIU	1	01/01/2024	31/12/2025	450	3.0	3.0		18/04/2024
Baycrest Centre For Geriatric Care	SEIU	1	01/01/2024	31/12/2025	400	3.0	3.0		18/04/2024
Bluewater Health	SEIU	1	01/01/2024	31/12/2025	736	3.0	3.0		18/04/2024
Brockville General Hospital	CUPE	5666	29/09/2023	28/09/2025	315	3.0			18/04/2024
Cambridge Memorial Hospital	SEIU	1	01/01/2024	31/12/2025	230	3.0	3.0		18/04/2024
Cambridge Memorial Hospital	SEIU	1	01/01/2024	31/12/2025	187	3.0	3.0		18/04/2024
Collingwood General And Marine Hospital	SEIU	1	01/01/2024	31/12/2025	185	3.0	3.0		18/04/2024
Cornwall Community Hospital	CUPE	7811	29/09/2023	28/09/2025	450	3.0			18/04/2024
Georgian Bay General Hospital	SEIU	1	01/01/2024	31/12/2025	254	3.0	3.0		18/04/2024

Guelph General Hospital	CUPE	57	29/09/2023	28/09/2025	200	3.0			18/04/2024
Guelph General Hospital	CUPE	57	29/09/2023	28/09/2025	323	3.0			18/04/2024
Haliburton Highlands Health Services	SEIU	1	01/01/2024	31/12/2025	218	3.0			18/04/2024
Hamilton Health Sciences	CUPE	7800	29/09/2023	28/09/2025	3,249	3.0			18/04/2024
Hawkesbury And District General Hospital	CUPE	1967	29/09/2023	28/09/2025	209	3.0			18/04/2024
Headwaters Health Care Corp	SEIU	1	01/01/2024	31/12/2025	262	3.0	3.0		18/04/2024
Health Sciences North	CUPE	1623	29/09/2023	28/09/2025	1,121	3.0			18/04/2024
Hospital For Sick Children	CUPE	2816	29/09/2023	28/09/2025	322	3.0			18/04/2024
Hotel Dieu Shaver Health & Rehabilitation Centre	SEIU	1	01/01/2024	31/12/2025	211	3.0	3.0		18/04/2024
Huron Perth Healthcare Alliance	CUPE	4727	29/09/2023	28/09/2025	522	3.0			18/04/2024
Joseph Brant Memorial Hospital	CUPE	1065	29/09/2023	28/09/2025	275	3.0			18/04/2024
Joseph Brant Memorial Hospital	CUPE	1065	29/09/2023	28/09/2025	400	3.0			18/04/2024
Kingston Health Sciences Centre	CUPE	1974	29/09/2023	28/09/2025	1,916	3.0			18/04/2024
Lake of The Woods District Hospital	CUPE	822	29/09/2023	28/09/2025	186	3.0			18/04/2024
Lakeridge Health Corp	CUPE	1999	29/09/2023	28/09/2025	2,160	3.0			18/04/2024

Markham Stouffville Hospital	CUPE	3651	29/09/2023	28/09/2025	271	3.0			18/04/2024
Markham Stouffville Hospital (Oak Valley Health)	CUPE	3651	29/09/2023	28/09/2025	316	3.0			18/04/2024
Markham Stouffville Hospital (Oak Valley Health)	CUPE	3651	29/09/2023	28/09/2025	308	3.0			18/04/2024
Mics Group of Health Services	SEIU	1	01/01/2024	31/12/2025	225	3.0	3.0		18/04/2024
Muskoka Algonquin Healthcare	SEIU	1	01/01/2024	31/12/2025	171	3.0	3.0		18/04/2024
Niagara Health System	SEIU	1	01/01/2024	31/12/2025	499	3.0	3.0		18/04/2024
Niagara Health System	SEIU	1	01/01/2024	31/12/2025	1,738	3.0	3.0		18/04/2024
North Bay Regional Health Centre/Centre Régional De Santé De North Bay	CUPE	139	29/09/2023	28/09/2025	1,062	3.0			18/04/2024
North York General Hospital	SEIU	1	01/01/2024	31/12/2025	1,236	3.0	3.0		18/04/2024
Northumberland Hills Hospital	CUPE	2628	29/09/2023	28/09/2025	268	3.0			18/04/2024
Orillia Soldiers Memorial Hospital	SEIU	1	01/01/2024	31/12/2025	218	3.0	3.0		18/04/2024
Orillia Soldiers Memorial Hospital	SEIU	1	01/01/2024	31/12/2025	198	3.0	3.0		18/04/2024
Pembroke Regional Hospital	CUPE	1502	29/09/2023	28/09/2025	485	3.0			18/04/2024

Perth And Smiths Falls District Hospital	CUPE	2119	29/09/2023	28/09/2025	224	3.0			18/04/2024
Peterborough Regional Health Centre	CUPE	1943	29/09/2023	28/09/2025	752	3.0			18/04/2024
Queensway-Carleton Hospital	CUPE	2875	29/09/2023	28/09/2025	589	3.0			18/04/2024
Quinte Health Care Corp	SEIU	1	01/01/2024	31/12/2025	226	3.0	3.0		18/04/2024
Renfrew Victoria Hospital	CUPE	1548	29/09/2023	28/09/2025	219	3.0			18/04/2024
Riverside Health Care Facilities Inc	CUPE	4807	29/09/2023	28/09/2025	211	3.0			18/04/2024
Ross Memorial Hospital	CUPE	1909	29/09/2023	28/09/2025	344	3.0			18/04/2024
Royal Ottawa Health Care Group	CUPE	942	29/09/2023	28/09/2025	210	3.0			18/04/2024
Royal Ottawa Health Care Group	CUPE	942	29/09/2023	28/09/2025	227	3.0			18/04/2024
Royal Victoria Regional Health Centre	SEIU	1	01/01/2024	31/12/2025	851	3.0	3.0		18/04/2024
Scarborough Health Network	CUPE	5852	29/09/2023	28/09/2025	1,948	3.0			18/04/2024
Sioux Lookout Meno-Ya-Win Health Centre	CUPE	4373	29/09/2023	28/09/2025	277	3.0			18/04/2024
Southlake Regional Health Centre	SEIU	1	01/01/2024	31/12/2025	530	3.0	3.0		18/04/2024
Southlake Regional Health Centre	SEIU	1	01/01/2024	31/12/2025	534	3.0	3.0		18/04/2024

Southlake Regional Health Centre	SEIU	1	01/01/2024	31/12/2025	194	3.0	3.0		18/04/2024
St Joseph's Health Centre	CUPE	1033	29/09/2023	28/09/2025	397	3.0			18/04/2024
St Joseph's Healthcare	CUPE	786	29/09/2023	28/09/2025	1,691	3.0			18/04/2024
Thunder Bay Regional Health Sciences Centre	SEIU	1	01/01/2024	31/12/2025	487	3.0	3.0		18/04/2024
Thunder Bay Regional Health Sciences Centre	SEIU	1	01/01/2024	31/12/2025	254	3.0	3.0		18/04/2024
Toronto East Health Network - Michael Garron Hospital	SEIU	1	01/01/2024	31/12/2025	473	3.0	3.0		18/04/2024
Toronto East Health Network - Michael Garron Hospital	SEIU	1	01/01/2024	31/12/2025	425	3.0	3.0		18/04/2024
Trillium Health Partners	CUPE	5180	29/09/2023	28/09/2025	2,820	3.0			18/04/2024
Unity Health Toronto	CUPE	5441.00	29/09/2023	28/09/2025	1,058	3.0			18/04/2024
Unity Health Toronto	CUPE	5441.01	29/09/2023	28/09/2025	3,011	3.0			18/04/2024
West Park Healthcare Centre	SEIU	1	01/01/2024	31/12/2025	389	3.0	3.0		18/04/2024
William Osler Health Centre	CUPE	145.2	29/09/2023	28/09/2025	1,204	3.0			18/04/2024
Winchester District Memorial Hospital	CUPE	3000	29/09/2023	28/09/2025	168	3.0			18/04/2024
Women's College Hospital	SEIU	1	01/01/2024	31/12/2025	179	3.0	3.0		18/04/2024
Ottawa Hospital	OPSEU	464	01/04/2022	31/03/2025	2,100	3.0			23/04/2024

West Park Healthcare Centre	ONA		01/04/2022	31/03/2025	33	3.0			21/05/2024
Sault Area Hospital	Unifor	1359	11/10/2023	10/10/2025	260	3.0			23/05/2024
Sault Area Hospital	Unifor	1359	11/10/2023	10/10/2025	590	3.0			23/05/2024
St. Joseph's Care Group	Unifor	229	11/10/2023	10/10/2025	444	3.0			23/05/2024
Michael Garron Hospital	OPSEU	566	01/04/2022	31/03/2025	209	3.0			31/05/2024
North York General Hospital	ONA		02/04/2023	01/04/2025	61	3.0			10/06/2024
Children's Hospital of Eastern Ontario - Ottawa Children's Treatment Centre	LIUNA	3000	01/04/2022	31/03/2025	726	3.0			21/06/2024
Children's Hospital of Eastern Ontario - Ottawa Children's Treatment Centre	LIUNA	3000	01/04/2022	31/03/2025	726	3.0			21/06/2024
St Joseph's Continuing Care Centre	ONA		02/12/2022	31/03/2025	49				24/06/2024
Woodstock Hospital	Unifor	636	01/04/2024	31/03/2027	72	3.0	3.0	3.0	25/07/2024
Hôpital Montfort/Montfort Hospital	CUPE	4721-02	30/09/2023	29/09/2025	238	3.0	7.4	2.6	26/07/2024
Ottawa Hospital	CUPE	4000	29/09/2023	28/09/2025	4,400	3.0			26/07/2024
Hôpital Montfort/Montfort Hospital	CUPE	4721	30/09/2023	29/09/2025	633	3.0			02/08/2024
Toronto Grace Health Centre	ONA		01/04/2023	31/03/2025	158	6.6			29/08/2024

Ontario Teaching Hospitals	PARO		01/07/2023	30/06/2026	5,000	3.0	2.6		24/09/2024
St. Thomas Elgin General Hospital	OPSEU	159	01/04/2024	31/03/2027	432	3.0	3.0	3.0	27/09/2024
Humber River Health	NOWU		01/01/2023	31/12/2024	225	4.9			02/10/2024
University Health Network- Toronto General Hospital	SEIU	1	01/01/2024	31/12/2025	236	3.0	3.0		11/10/2024
Humber River Health	IBT	419	11/10/2022	10/10/2025	197	3.0			15/10/2024
Toronto Rehabilitation Institute	CUPE	1156	29/09/2023	28/09/2025	397	3.0			16/10/2024
University Health Network (Toronto Rehabilitation Institute)	CUPE	1156.01	29/09/2023	28/09/2025	407	3.0			16/10/2024
Health Sciences North	ONA		14/06/2022	31/03/2025	984	3.0			23/10/2024
University Health Network - Toronto General Hospital	CUPE	5001	29/09/2023	28/09/2025	398	3.0			24/10/2024
University Health Network - Toronto General Hospital	CUPE	5001	29/09/2023	28/09/2025	464	3.0			24/10/2024
University Health Network - Toronto Western Hospital	CUPE	5001.01	29/09/2023	28/09/2025	334	3.0			24/10/2024
University Health Network - Toronto Western Hospital	CUPE	5001.04	29/09/2023	28/09/2025	267	3.0			24/10/2024
Ontario Shores Centre For	OPSEU	331	01/04/2023	31/03/2025	593	3.0			16/01/2025

Mental Health Sciences									
Ontario Shores Centre For Mental Health Sciences	OPSEU	331	01/04/2023	31/03/2025	288	3.0			16/01/2025
Ontario Shores Centre For Mental Health Sciences	OPSEU	331	01/04/2023	31/03/2025	254	3.0			16/01/2025
Trillium Health Partners - Health Care Professionals	ONA		01/04/2021	31/03/2025	95	4.7	3		21/01/2025
Windsor Regional Hospital	CUPE	1132	29/09/2023	28/09/2025	394	3.0			02/04/2025
Windsor Regional Hospital	IBEW	636	01/04/2024	31/03/2026	372	3.0	3.0		03/04/2025
Centre For Addiction And Mental Health	OPSEU	500	01/04/2022	31/03/2025	2,620	3.0			28/04/2025
AVERAGE						3.2	3.1	2.9	
TOTAL EEs					70,871				

(ii) Municipal Sector Increases

134. Similar, if not higher, trends are evident in settlements from the municipal sector for Years 2, 3, 4 of the PSA.

135. The following table includes 78 municipal sector settlements or awards for 32,429 employees which were ratified or awarded in 2024 or 2025. Notably, the average wage increase is 3.8% for 2025/26, 3.3% for 2026/27, 3.1% for 2027/28.

MUNICIPAL SETTLEMENTS AND AWARDS FROM 2024 AND FIRST QUARTER 2025¹⁰⁰

Employer Name	Union Name	Local	Effective Date	Expiry Date	EEs	2024	2025	2026	2027	Ratification
Corporation of The Town of Marathon	CUPE	87	01/10/2023	30/09/2026	14	3.5	3.5			03/01/2024
Corporation of The United Counties of Leeds & Grenville	OPSEU	494	01/01/2024	31/12/2025	85	4.0	2.7			04/01/2024
Corporation of the County of Essex	CUPE	2974.1	01/04/2023	31/03/2026	54	3.0	3.0			04/01/2024
Corporation of The City of Temiskaming Shores	CUPE	5014	01/01/2024	31/12/2027	54	4.0	4.0	2.5	2.0	10/01/2024
Corporation of The Municipality of Central Huron	IBEW	636	01/01/2024	31/12/2027	22	10.4	3.0	3.0	2.0	23/01/2024
Corporation of the Township of Southwold	CUPE	35.7	01/01/2024	31/12/2026	15	4.0	1.0			24/01/2024
Corporation of The Township of Chapleau	CUPE	887	01/01/2024	31/12/2028	12	4.0	3.5	3.0	2.0	08/02/2024
Municipal Corporation of the City of Dryden	IBEW	1730	01/01/2024	31/12/2027	75	6.0	4.0	3.0	3.0	12/02/2024
Corporation of The Township of Malahide	CUPE	35.2	01/01/2024	31/12/2026	15	9.0	3.0	3.0		15/02/2024
Corporation of The Township of Addington Highlands	IUOE	793	01/01/2024	31/12/2027	10	8.0	4.5	4.0	3.4	15/02/2024
Corporation of The City of Pembroke	CUPE	24	01/01/2024	31/12/2027	81	0.0	3.2	3.2	3.2	20/02/2024
Corporation of The Village of Point Edward	CUPE	153.2	01/01/2024	31/12/2027	11	3.5	3.2	3.2	3.2	27/02/2024
Corporation of The City of Brantford	CUPE	181	02/04/2023	03/04/2027	191	7.5	3.0	3.0		27/02/2024
Corporation of the County of Haliburton	CUPE	1960	01/01/2024	31/12/2027	26		6.8	5.3	3.5	04/03/2024
Corporation of The City of Thunder Bay	CUPE	87	01/01/2023	31/12/2026	663	3.5	3.0	3.0		04/03/2024

¹⁰⁰ Ontario, [Collective Bargaining Ontario Database](#), Retrieved June 2025.

Township of Tudor and Cashel	IUOE	793	01/01/2024	31/12/2027	6	10.7	10.6	6.0	5.9	08/03/2024
Corporation of the Municipality of Thames Centre	CUPE	107	01/01/2024	31/12/2027	18	4.2	5.6	5.4	5.3	11/03/2024
Regional Municipality of Peel	CUPE	966	01/02/2023	31/01/2026	302	3.5	3.5			13/03/2024
Corporation of The Township of Ignace	CUPE	87-1	01/06/2023	31/05/2025	13	3.0	5.0			20/03/2024
The Corporation of the Township of Red Rock	SEIU	2	01/01/2024	31/12/2027	6	3.2	3.3	3.3	3.3	21/03/2024
Corporation of the Township of Minden Hills	CUPE	4286	01/01/2024	31/12/2027	31	6.6	4.0	3.5	3.5	24/03/2024
Corporation of The City of Stratford	CUPE	1385	01/01/2023	31/12/2025	153	3.0	3.0			25/03/2024
Corporation of The City of Stratford	CUPE	197	01/01/2023	31/12/2025	41	3.0	3.0			25/03/2024
Corporation of the City of Peterborough	CUPE	504	01/01/2024	31/12/2026	166	0.9	11.2	5.4		27/03/2024
Regional Municipality of Durham	CUPE	1785	01/04/2023	31/03/2026	408	3.3	3.0			04/04/2024
Corporation of The City of Elliot Lake	CUPE	170	01/01/2024	31/12/2027	45	3.0	2.9	2.9	2.6	08/04/2024
Corporation of Loyalist Township	OPSEU	428	01/01/2023	31/12/2025	18	3.0	2.0			09/04/2024
City of Ottawa	CIPP		01/01/2023	31/12/2025	2,775	2.5	2.5			11/04/2024
Corporation of The City of Brantford	CUPE	181	02/04/2023	01/04/2027	81	3.0	3.0	3.0		30/04/2024
Corporation of The City of Cambridge	CUPE	1882	01/01/2024	31/12/2027	218	4.5	3.3	3.2	3.1	30/04/2024
Township of Schreiber	CUPE	87-07	01/05/2024	30/04/2028	12	7.6	4.5	4.5	4.5	01/05/2024
Corporation of the Town of Whitby	CUPE	53	01/06/2023	31/05/2026	180	3.0	3.0			04/05/2024
Corporation of Haldimand County	CUPE	4700	01/01/2024	31/12/2027	188	3.5	3.5	3.0	3.0	06/05/2024
Corporation of The Town of Hawkesbury	CUPE	1026-02	01/04/2023	31/03/2026	12	3.0				13/05/2024
Corporation of the Municipality of Brighton	CUPE	5085	01/01/2024	31/12/2026	46	8.0	4.7	4.7		14/05/2024

Corporation of The City of Belleville	CUPE	907	01/01/2024	31/12/2027	211	5.0	3.5	3.0	3.0	14/05/2024
Corporation of The Town of Lasalle	CUPE	701.1	01/01/2022	31/12/2026	4	3.2	3.2	3.5	3.5	21/05/2024
Regional Municipality of Halton	OPSEU	261	01/01/2023	31/12/2027	14	3.0	3.0	2.5	2.5	22/05/2024
Municipality of Black River-Matheson	CUPE	1490	01/04/2023	31/03/2027	16	4.0	3.0	3.0		23/05/2024
Corporation of The City of Oshawa	CUPE	250	01/01/2024	31/12/2026	220	3.5	3.2	3.0		29/05/2024
Corporation of the County of Lambton	LIUNA	3000	01/01/2024	31/12/2026	70	3.5	3.5			05/06/2024
Corporation of The Township of Bonfield	CUPE	4616-02	01/01/2024	31/12/2027	14	5.0	4.0	3.0	3.0	05/06/2024
Municipality of Chatham-Kent	CUPE	12.1	01/01/2024	31/12/2027	190	3.0	3.0	2.8	2.7	07/06/2024
Corporation of the City of Peterborough	CUPE	126	01/01/2024	31/12/2026	271	8.9	3.0	3.0		11/06/2024
Corporation of the City of Mississauga	CUPE	66	01/04/2023	31/03/2027	160	3.0	3.0	3.0		12/06/2024
Regional Municipality of Halton	CUPE	2620	01/01/2024	31/12/2028	190	3.5	3.5	3.2	3.2	19/06/2024
Corporation of The City of Brantford	CUPE	181	02/04/2023	03/04/2027	119	3.0	3.0	3.0		25/06/2024
Corporation of The City of London	CUPE	107	01/01/2024	31/12/2027	805	3.5	3.0	3.0	2.7	25/06/2024
Hamilton City	CUPE	1041	01/01/2023	31/12/2026	350	3.0	3.0	3.0		26/06/2024
Corporation of the Municipality of Wawa	USW	9246	01/08/2024	31/07/2028	15	10.5	0.3	0.4	0.6	14/07/2024
Corporation of The Municipality of Highlands East	CUPE	4416	01/01/2024	31/12/2027	31	8.6	5.1	3.5	3.5	16/07/2024
Corporation of The City of Mississauga	CUPE	66-02	01/04/2023	31/03/2027	37	3.0	3.0	3.0		02/08/2024
Corporation of The City of Woodstock	CUPE	1146	01/01/2024	31/12/2026	185	3.9	3.5	3.5		11/08/2024
Corporation of The City of Kawartha Lakes	CUPE	855	01/01/2024	31/12/2027	275	4.0	3.5	3.0	3.0	27/08/2024
Corporation of The City of Kawartha Lakes	CUPE	855	01/01/2024	31/12/2027	386	4.0	3.5	3.0	3.0	27/08/2024

Corporation of The Town of Parry Sound	CUPE	17	01/01/2024	31/12/2026	42	3.0	3.3	3.2		28/08/2024
Corporation of The Township of Clearview	CUPE	1217	01/04/2024	31/03/2028	33	3.0	3.0	3.0	2.5	04/09/2024
Corporation of The City of Sarnia	CUPE	3690	01/01/2024	31/12/2026	131	3.2	3.2	3.2		10/09/2024
Corporation of The City of Sarnia	CUPE	2713	01/01/2024	31/12/2026	57	3.2	3.2	3.2		10/09/2024
Corporation of The City of Sarnia	CUPE	153	01/01/2024	31/12/2026	56	3.2	3.2	3.2		10/09/2024
Corporation of The Town of Cobalt	CUPE	127	01/07/2024	30/06/2028	6	2.9	2.5	3.0	3.5	20/09/2024
Corporation of The County of Simcoe	CUPE	5820	01/01/2024	31/12/2026	170	11.2	3.0	3.0		24/09/2024
Corporation of The County of Simcoe	CUPE	5820.01	01/01/2024	31/12/2026	129	11.9	3.0	3.0		24/09/2024
Corporation of The Town of Collingwood	IBEW	636	01/09/2024	31/08/2028	11	2.7	2.8	2.8	2.7	29/10/2024
Corporation of The Township of O'Connor	CUPE	87	01/08/2024	31/07/2028	3	3.0	3.0	3.0	3.0	04/11/2024
Corporation of the Township of Wellington North	CUPE	255.11	01/07/2024	30/06/2026	25	9.1	3.0			06/11/2024
Corporation of the City of Brampton	CUPE	831	01/04/2024	31/03/2027	544	3.0	3.0	3.0		20/11/2024
Corporation of the City of Brampton	CUPE	831	01/04/2024	31/03/2027	504	3.0	3.0	3.0		20/11/2024
Corporation of The Town of Amherstburg	IBEW	636	01/01/2025	31/12/2027	67		8.1	3.0	3.0	09/12/2024
Corporation of the City of Richmond Hill	CUPE	905.16	01/04/2024	31/03/2027	215	6.9	3.5	3.0		11/12/2024
Corporation of The City of Vaughan	CUPE	905.20	01/04/2024	31/03/2028	270	3.8	3.5	3.0	3.0	06/02/2025
Corporation of The City of Vaughan	CUPE	905.21	01/04/2024	31/03/2028	347	3.8	3.5	3.0	3.0	06/02/2025
City of Toronto	CUPE	79	01/01/2025	31/12/2028	12,001		8.8	3.9	3.8	26/03/2025
City of Toronto	CUPE	79	01/01/2025	31/12/2028	12,251		6.8	3.9	3.8	26/03/2025
City of Toronto	CUPE	79	01/01/2025	31/12/2028	1,555		6.8	4.0	3.9	26/03/2025
Regional Municipality of Waterloo	CUPE	1656	01/01/2025	31/12/2027	233		7.3	3.0	3.0	28/03/2025

Corporation of the City of Markham	CUPE	905.15	01/04/2024	31/03/2027	196	3.8	3.5	3.0		07/05/2025
Corporation of the City of Markham	CUPE	905.14	01/04/2024	31/03/2027	265	3.8	3.5	3.0		07/05/2025
Average						4.5	3.8	3.3	3.1	
TOTAL EEs					32,429					

(iii) Police and Fire Sector Increases

136. Police and Fire Sector settlements and arbitral awards from 2024 and 2025 are also all 3% or higher for 2025/26, 2026/27 and 2027/28.

137. The following table includes 28 fire and police sector settlements or awards for 28,861 employees, which were ratified or awarded in 2024 or 2025. Notably, the average wage increase is 4.2% for 2025/26, 3.2% for 2026/27, 3.5% for 2026/27.

FIRE AND POLICE SETTLEMENTS AND AWARDS FROM 2024 AND FIRST QUARTER 2025¹⁰¹

Employer Name	Union Name	Local	Effective Date	Expiry Date	No. of EEs	2024	2025	2026	2027	Ratification
Corporation of The Town of Collingwood	Collingwood Professional Firefighters Association - International Association of Firefighters (IAFF)	938	01/01/2024	31/12/2026	28	4.0	3.0	2.3		28/10/2024
Corporation of the Town of Richmond Hill	Richmond Hill Professional Firefighters Association - International Association of Firefighters (IAFF)	1957	01/01/2023	31/12/2025	208	3.0	2.9			19/06/2024
Corporation of The Town of Oakville	Oakville Professional Firefighters Association - International Association of Firefighters (IAFF)		01/01/2023	31/12/2024	253	2.9				02/08/2024

¹⁰¹ Ontario, [Collective Bargaining Ontario Database](#), Retrieved June 2025.

Corporation of The City of Kitchener	Kitchener Professional Firefighters Association - International Association of Firefighters (IAFF)		01/01/2023	31/12/2026	233	2.9	2.9	2.7		08/01/2024
Corporation of The Town of Oakville	Oakville Professional Firefighters Association - International Association of Firefighters (IAFF)		01/01/2023	31/12/2024	253	2.9				02/08/2024
Corporation of the City of Hamilton	Hamilton Professional Firefighters Association - International Association of Firefighters (IAFF)	288	01/01/2023	31/12/2026	550	2.9	2.8	2.8		15/07/2024
Corporation of The City of Quinte West	Ontario Professional Firefighters Association (OPFFA)	1328	01/01/2024	31/12/2026	17	3.2	3.3	3.0		17/04/2024
Corporation of Norfolk County	International Association of Machinists and Aerospace Workers (IAMAW)	103	01/01/2023	30/11/2026	30	3.0	3.0			24/01/2024
Corporation of the Town of Ajax	Ajax Professional Firefighters Association - International Association of Firefighters (IAFF)	1092	01/01/2022	31/12/2024	127	2.0	3.5			29/04/2024
Ontario Public Service	Ontario Provincial Police Association		01/01/2023	31/12/2026		4.5	2.8	2.75		22/07/2024
Toronto Police Services Board	Toronto Police Association - Police Association of Ontario (PAO)		01/01/2024	31/12/2024	5,350	5.0				16/12/2024
Toronto Police Services Board	Toronto Police Association - Police Association of Ontario (PAO)		01/01/2024	31/12/2024	1,750	5.0				16/12/2024
Halton Regional Police Services Board	Halton Regional Police Association - Police Association of Ontario (PAO)		01/01/2023	31/12/2023	696	3.5				10/01/2024
Halton Regional	Halton Regional Police Association		01/01/2023	31/12/2023	277	3.5				10/01/2024

Police Services Board	- Police Association of Ontario (PAO)									
Peterborough Police Services Board	Peterborough Police Association - Police Association of Ontario (PAO)		01/01/2024	31/12/2028	141	3.0	3.3	2.5	3.3	04/03/2024
Regional Municipality of Peel Police Services Board	Peel Regional Police Association - Police Association of Ontario (PAO)		01/01/2025	31/12/2029	950		6.9	3.5	3.6	09/07/2024
Barrie Police Services Board	Barrie Police Association - Police Association of Ontario (PAO)		01/01/2024	31/12/2028	163	4.0	3.5	3.5	3.5	07/01/2024
Regional Municipality of Peel Police Services Board	Peel Regional Police Association - Police Association of Ontario (PAO)		01/01/2025	31/12/2029	1,950		6.9	3.5	3.5	09/07/2024
Barrie Police Services Board	Barrie Police Association - Police Association of Ontario (PAO)		01/01/2024	31/12/2028	265	4.0	3.5	3.5	3.5	08/01/2024
Toronto Police Services Board	Toronto Police Association - Police Association of Ontario (PAO)		01/01/2024	31/12/2024	1,200	5.0				16/12/2024
City of Ottawa	Ottawa Professional Firefighters Association - International Association of Firefighters (IAFF)	162	01/01/2024	31/12/2028	1,030	3.9	5.1	3.5	3.5	16/04/2025
Corporation of The City of Thunder Bay	Thunder Bay Professional Firefighters Association - International Association of Firefighters (IAFF)	193	01/01/2023	31/12/2024	200	3.0				03/02/2025
Corporation of the City of Markham	Markham Professional Firefighters Association - International Association of Firefighters (IAFF)	2727	01/01/2024	31/12/2026	300	4.7	4.0	3.9		07/05/2025
Toronto Police Services Board	Toronto Police Association -		01/01/2025	31/12/2029	1,775		4.5	3.1	3.5	25/04/2025

	Police Association of Ontario (PAO)									
Ottawa Police Services Board	Ottawa Police Association - Police Association of Ontario (PAO)		01/01/2025	31/12/2029	1,527		6.9	3.5	3.5	29/01/2025
Toronto Police Services Board	Toronto Police Association - Police Association of Ontario (PAO)		01/01/2025	31/12/2029	1,260		4.5	3.1	3.5	25/04/2025
Ottawa Police Services Board	Ottawa Police Association - Police Association of Ontario (PAO)		01/01/2025	31/12/2029	748		6.9	3.5	3.5	29/01/2025
Toronto Police Services Board	Toronto Police Association - Police Association of Ontario (PAO)		01/01/2025	31/12/2029	5,400		4.5	3.1	3.5	25/04/2025
Average						3.6	4.2	3.2	3.5	
TOTAL EEs					26,681					

138. Of these, two awards/settlements of particular note are the Ontario Provincial Police Association (OPPA) and the Toronto Police Association. In July 2024, the Ontario Provincial Police ratified a four-year contract for the period of 2023-2026, which provided for increases totaling 14.75% over the life of the contract, making them, at the time, the highest paid officers in the province, a position historically held by the TPA.¹⁰²

139. More recently, in April 2025, the TPA ratified a five-year collective agreement (2025-2029) that will see them returned to their historic position as the highest paid officers in the province, with a total compounded wage increase of 17.66% over the life of the contract.¹⁰³ As discussed further below, and as between the OPP and the Toronto Police, historically, Ontario doctors were compensated better than comparators in other

¹⁰² Liam Casey and Allison Hones, [“OPP officers ratify 4-year deal to become highest paid cops in Ontario,”](#) Global News (25 July 2024), BOD VOL 2 TAB 59.

¹⁰³ Jennifer Pagliaro and Ben Spurr, “Toronto police members set to vote on nearly 18-per-cent pay hike over five years,” Toronto Star (17 April 2025), BOD VOL 2 TAB 60.

provinces. The OMA's proposed normative increase is needed to return them to that position.

(iv) Post-Secondary Sector Increases

140. Comparable wage settlement trends can also be seen in the post-secondary sector. The following table includes 33 settlements or awards from the post-secondary sector affecting 31,055 employees in the provinces, which were ratified or awarded in 2024 or 2025. The settlement wage trends that emerge from these are wage increases on average of 2.9% in 2025/26, 3.0 in 2026/27 and 3.1% in 2027.

UNIVERSITY SETTLEMENTS AND AWARDS FROM 2024 AND FIRST QUARTER 2025 ¹⁰⁴										
Employer Name	Union Name	Local	Effective Date	Expiry Date	EEs	2024	2025	2026	2027	Ratification
Carleton University	CUPE	2424	01/07/2023	30/06/2026	1,000	3.0	3.0			26/02/2024
Toronto Metropolitan University	CUPE	3904	01/01/2024	31/08/2027	1,396	6.1	2.5	2.5		22/10/2024
Carleton University	CUPE	2424	01/07/2023	30/06/2026	1,000	3.0	3.0			26/02/2024
University of Guelph	UGFSEA		01/05/2024	30/04/2027	173	9.3	3.5	3.0		08/07/2024
The Governing Council of The University of Toronto	CUPE	3261	01/07/2023	30/06/2026	789	2.0	1.8			16/03/2024
York University	CUPE	3903	01/09/2023	30/08/2026	2,200	2.8	2.8			19/04/2024
University of Western Ontario	PSAC	610	01/09/2023	31/08/2027	2,500	2.5	2.0			02/05/2024
University of Guelph	CUPE	3913	01/09/2023	31/08/2026	400	3.5	3.7			05/04/2024
University of Guelph	CUPE	3913	01/09/2023	31/08/2026	1,500	3.2	3.2			05/04/2024

¹⁰⁴ Ontario, [Collective Bargaining Ontario Database](#), Retrieved June 2025.

University of Guelph	UGFA		01/07/20 24	30/06/20 27	820	3.8	3.5	3.0		11/11/2024
Governing Council of The University of Toronto	CUPE	3261	01/07/20 23	30/06/20 26	306	2.0	1.8			16/03/2024
Governing Council of The University of Toronto	CUPE	1230	01/07/20 23	30/06/20 26	323	2.0	1.8			04/04/2024
King's University College	CUPE	5265	01/05/20 24	30/04/20 27	229	5.7	3.0	3.0		25/09/2024
University of Ottawa/Université d'Ottawa	CUPE	2626	01/09/20 22	31/08/20 25	2,700	2.5				17/04/2024
Laurentian University	LUSU		01/07/20 24	30/06/20 27	236	4.0	4.0	4.0		11/07/2024
University of Ottawa	PIPSC		01/05/20 23	30/04/20 26	290	3.0	2.5			14/03/2024
York University	CUPE	3903	01/09/20 23	30/08/20 26	1,200	2.8	2.9			19/04/2024
Board of Governors of Lakehead University	CUPE	3905	01/09/20 23	31/08/20 26	450	4.0	2.5			22/05/2024
University of Guelph	UGFSEA		01/08/20 24	31/07/20 27	211	3.8	3.5	3.0		08/07/2024
York University	YUFA		01/05/20 24	30/04/20 27	1,650	3.1	2.8	2.8		19/08/2024
Governing Council of the University of Toronto	CUPE	3902	01/01/20 24	31/12/20 26	4,300	9.0	2.0	1.8		11/03/2024
McMaster University	IUOE	772	01/05/20 24	30/04/20 29	11	5.5	5.5	5.5	4.3	06/06/2024
Wilfrid Laurier University	PSAC		01/09/20 23	31/08/20 26	372	3.0	3.0			30/01/2024
Wilfrid Laurier University	UFCW	175	01/08/20 24	31/07/20 27	55	11.7	3.0	2.0		07/06/2024
University of Western Ontario	UWOSA		01/07/20 24	30/06/20 28	875	4.5	2.0	2.0	2.0	19/08/2024
Toronto Metropolitan University	TFA		01/07/20 23	30/06/20 26	1,013	3.0	3.0			16/07/2024

University of Ontario Institute of Technology	OPSEU		01/07/20 23	30/06/20 27	400	3.0	3.0	3.0		30/05/2024
Skilled Trades Ontario	OPSEU	503	01/01/20 23	31/12/20 25	110	3.0	2.0			04/11/2024
York University	YUSA		01/08/20 24	31/07/20 27	1,600	2.9	2.9			11/02/2025
University of Ottawa	APUO		01/05/20 24	30/04/20 26	1,300	2.5				14/02/2025
University of Guelph	USW	4120	01/05/20 25	30/04/20 28	900	3.8	2.3			22/05/2025
Ontario College of Art & Design University	OCADFA		01/07/20 23	30/06/20 26	587	3.0	3.0			16/01/2025
Brock University	OSSTF		01/05/20 24	30/04/20 27	159	3.5	3.4			27/01/2025
Carleton University	CUASA		01/05/20 24	30/04/20 27		2.5	2.5	2.5		02/05/2025
AVERAGE						3.9	2.9	2.9	3.1	
TOTAL EEs					31,055					

(v) Increases in the Ontario Public Service (OPS) and Other Groups Paid from the Public Purse

141. Like the Hospital and Health Sector, many of the larger OPS groups including OPSEU and AMAPCEO are currently in bargaining for the 2025-2028 time period.

142. There are some settlements of note affecting employees or others paid by the government of Ontario. In particular, professionals working for the Government of Ontario have received above normative increases.

143. For example, in January 2025, the Professional Engineers of the Government of Ontario (PEGO) reached a settlement for the January 1, 2023 to December 31, 2026

period affecting approximately 600 members.¹⁰⁵ This settlement provided for combined increases of 17% over four years including a 5.5% special adjustment in 2024, and normative wage increases of 3.5, 3, 3 and 2 % in each of the years.

144. More recently, in June 2025, the Association of Physicians and Dentists in the Public Service, psychiatrists who are Ontario public servants reached a three-year settlement with the government for the period January 1, 2023 to December 31, 2025. This settlement provides for wage increases totalling 16.55 over the course of three years, including a 3.5% special adjustment in each of 2024 and 2025, and normative wage increases of 3.5%, 3% and 3% in each of 2023, 2024, and 2025.¹⁰⁶

145. In the same vein, recently, the Government announced a 35% increase to the salary of Members of the Provincial Parliament, together with an improved pension plan.¹⁰⁷ When asked “why now?”, Finance Minister Bethlenfalvy responded “if not now, when”, stating that the increase was both “fair and reasonable” and notably “*very fair in the current environment*”.¹⁰⁸

146. Another group that has received significant increases in 2024/25 and 2025/26 are Ontario Provincial Judges. As a result of their most recent Judicial Remuneration Commission, which resulted in their salary being 95.27% of the salary of a Superior Court Judge, the Judges received an increase of 4.9% in 2024/25 and will be receiving a further increase of 4.9% in 2025/26 when IAI is taken into account.

¹⁰⁵ PEGO Memorandum of Settlement - January 23 2025, BOD VOL 2 TAB 61.

¹⁰⁶ AOPDPS Memorandum of Settlement - June 1, 2025, BOD VOL 2 TAB 62.

¹⁰⁷ Government of Ontario, “[Ontario Adjusting Compensation for Members of Provincial Parliament with All-Party Support](#),” (May 29, 2025) BOD VOL 2 TAB 63.

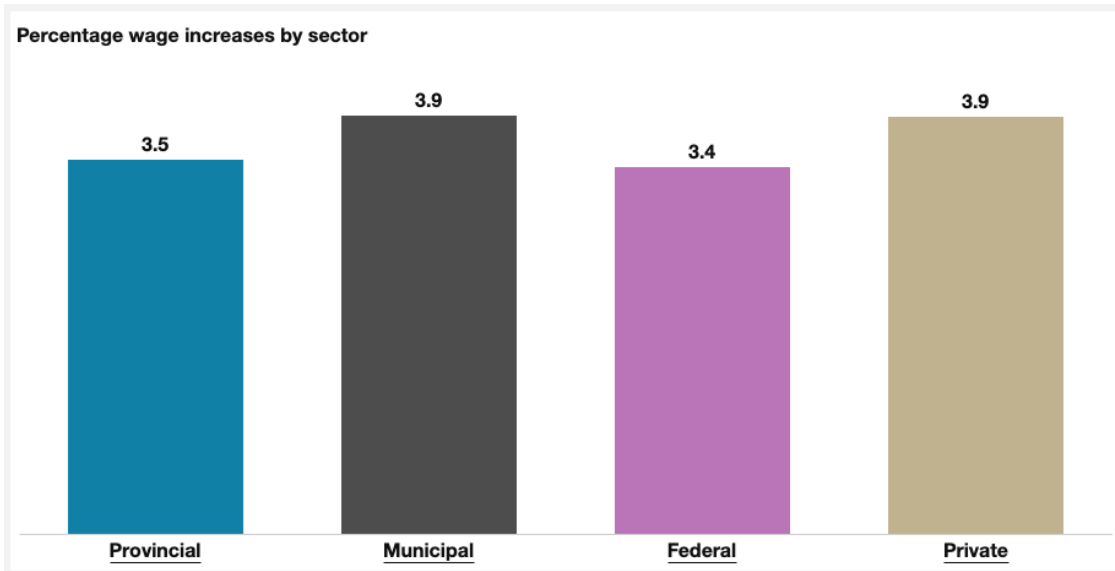
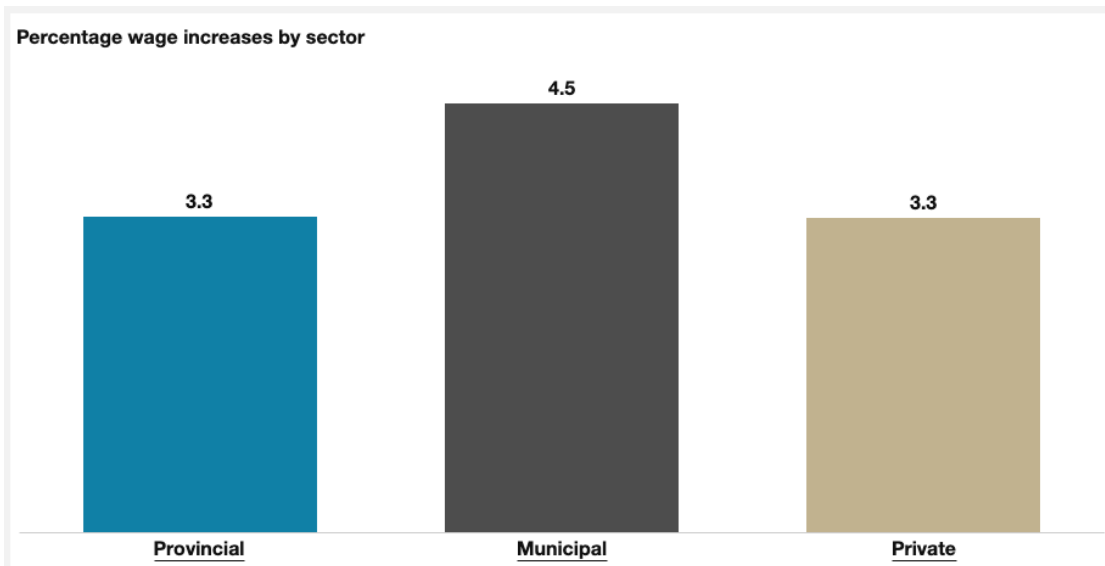
¹⁰⁸ CP24, “[Bethlenfalvy defends decision to give Ont. MPPs a raise, says it's the 'right thing to do'](#)” (video) (May 29, 2025), online (emphasis added).

147. These examples provide further evidence that the government itself recognizes the need to provide highly paid professionals with above normative increases where circumstances warrant. This is particularly the case where recruitment and retention is a concern, such as here. The OMA submits that similar consideration should be shown to Ontario's doctors.

C. Bargaining and Wage Trends in 2024-25 Generally

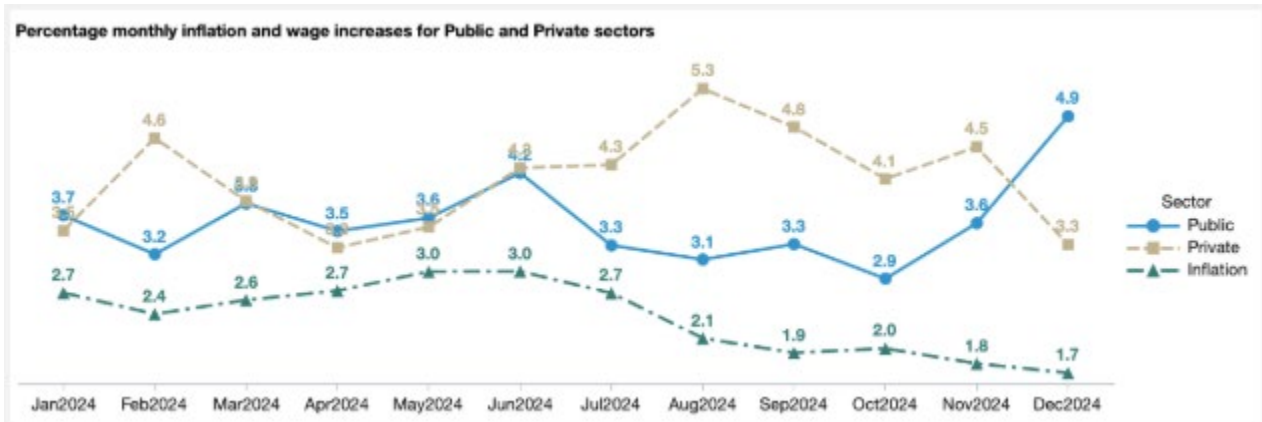
148. Looking beyond the recent wage trends in Ontario in the broader public sector to trends in the private sector and federal sector, as the following charts from the Ontario government's own "Collective Bargaining Wage Trends" website make clear, negotiated annual percentage wage increases for the provincial broader public sector averaged 3.5% for settlements reached in 2024, and 3.3% for the first quarter of 2025.¹⁰⁹ Similar trends were also apparent in the municipal, federal and private sectors with the average annual percentage wage increase of 3.9%, 3.4% and 3.9% in 2024 respectively and 4.5% in the Municipal sector and 3.3% in the private sector in 2025. These results are illustrated by the following charts:

¹⁰⁹ Ontario Government "[Collective Bargaining and Wage Trends](#)" Retrieved May 2025.

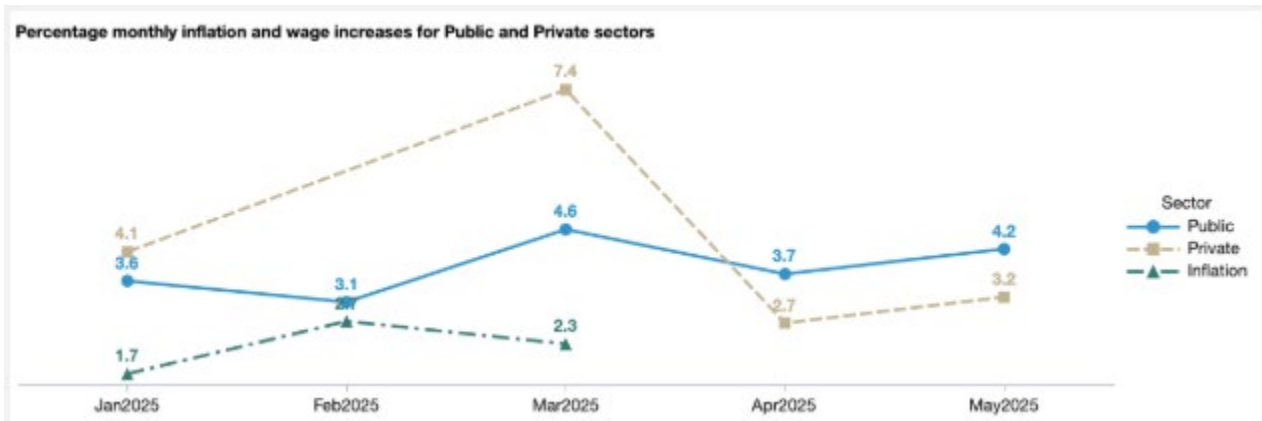
2024**First Quarter 2025**

149. In the public sector in 2024 and the first quarter of 2025 are in fact trending higher than the rate of inflation during the same time period as illustrated by the following charts from the Ontario government's "Collective Bargaining Wage Trends" website:¹¹⁰

2024



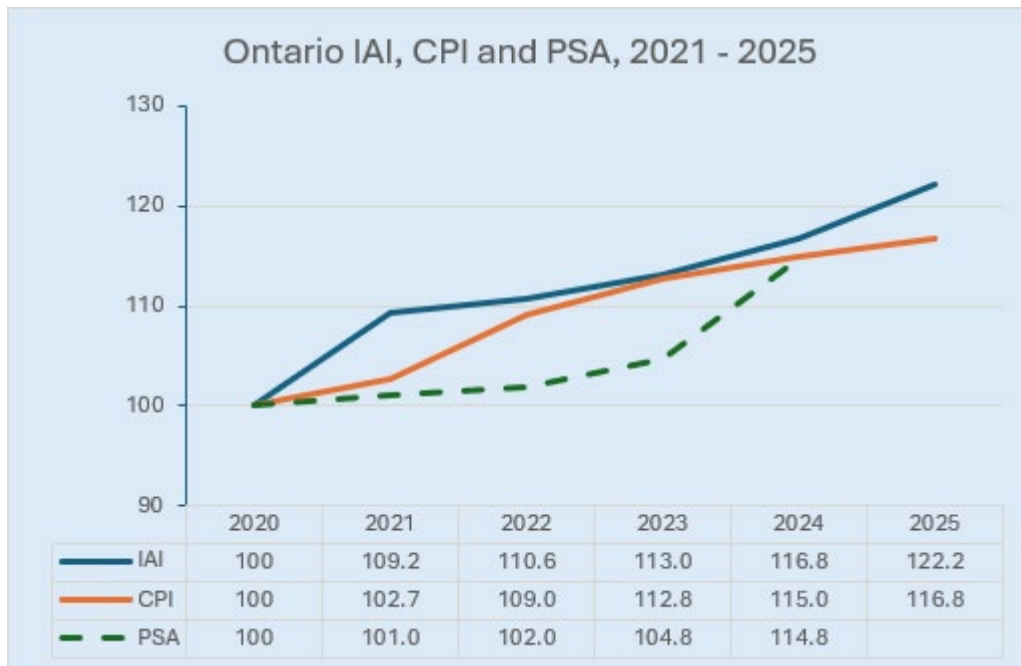
2025 Q1



150. In contrast, the compensation increases received by Ontario's doctors since the 2021 PSA, are trailing both inflation and the Industrial Aggregate Index (IAI), even when the year 1 PSA award is taken into consideration. This is illustrated in the following

¹¹⁰ Government of Ontario, "[Collective Bargaining Wage Trends – Overview: Sectoral Analysis \(2024 and 2025\)](#)". Retrieved May 2025.

graph, which uses the Ontario IAI and CPI numbers from Statistics Canada measured on the fiscal year.



151. The IAI numbers for Ontario are particularly revealing. The IAI, published by Statistics Canada, is a measure of the average weekly earnings of employed Canadians. It includes all economic activities in Canada during a given year, excluding sectors primarily involved in agriculture, fishing, trapping, private household services, religious organizations, and the military. The IAI for 2024 for Ontario as measured on a fiscal year basis was 3.7% and for 2025 is 5.5%. In comparison, the normative increase in year 1 of the PSA was only 3% and for year 2, 3 and 4, the OMA is seeking an increase of 3.75. In light of increases to the IAI, the proposed increases are more than reasonable.

D. Comparison to Physicians in Other Provinces

152. Pursuant to section 25 of the Binding Arbitration Framework, comparability to physician compensation in other jurisdictions is another consideration which the Board

may take into account.¹¹¹ It is also a factor, which the previous Arbitration Board looked to and accepted, noting for example that “Ontario doctors have had their compensation frozen, while their counterparts in other jurisdictions have seen increases.”¹¹²

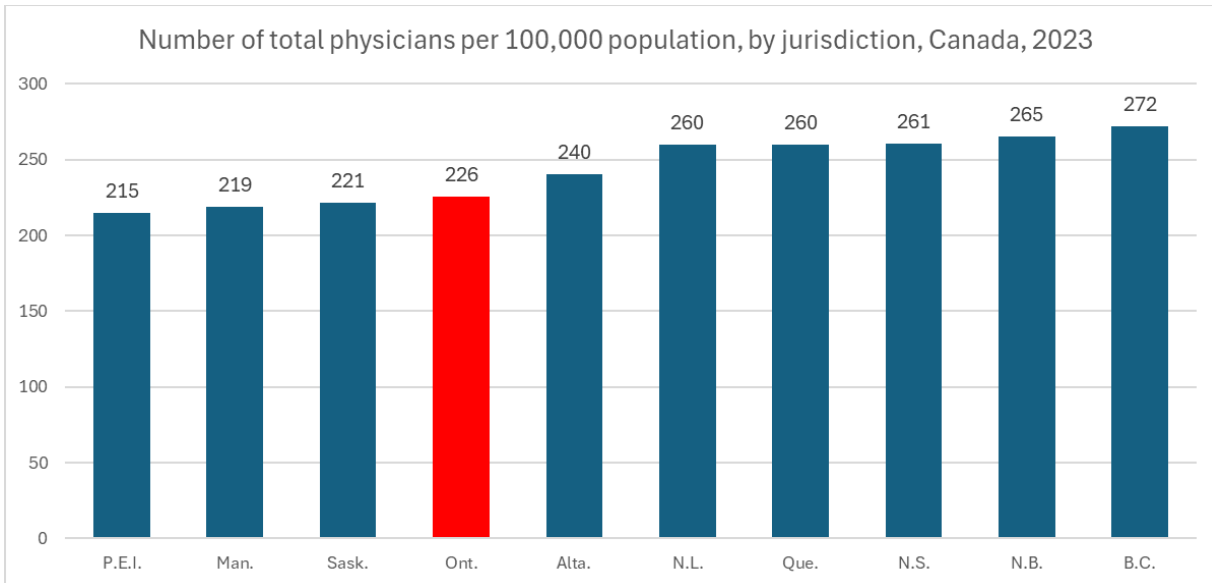
153. The OMA relies upon its submissions on this issue in its Year 1 Brief at paragraphs 371-423, including with respect to relative gross clinical payments and average clinical fees. As set out in the Year 1 Brief and as remains the case today, in contrast to other provinces, physicians in Ontario do not compare favourably when gross clinical payments per full-time equivalent (FTE) physician and fees are compared.

154. When comparing remuneration between provinces, it is also important to remember that Ontario has one of the highest population to physician ratios in the country,¹²⁴ which means that every doctor in Ontario must provide services to more patients than the average physician in the rest of Canada, a fact not reflected in their remuneration. As well, Ontario has one of the highest costs of living in the country, second only to BC.¹¹³ Both of these factors must be taken into consideration when comparing physician compensation in Canada.

¹¹¹ BAF, *supra*, BOD VOL 1 TAB 29.

¹¹² 2019 Kaplan Arbitration Award, *supra*, BOD VOL 1 TAB 31.

¹¹³ “[British Columbia is the Most Expensive Province in Canada to Live](#)” Voroni by Visual Capitalist BOD VOL 2 TAB 64



Source: Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2023 — Data Tables. Ottawa, ON: CIHI; 2024.

155. Notably, given that the OMA seeks both normative general increases and targeted compensation increases in priority areas, the agreements for physicians in other provinces, in addition to receiving general or normative increases, also include very large influxes of investments, particularly in targeted priority areas. The global increases and additional compensation in these agreements is summarized in the following table:

PROVINCE	TERM	GLOBAL INCREASES	ADDITIONAL COMPENSATION
New Brunswick	April 1, 2020 to March 31, 2025	2% - 2020/21; 1.5% - 2021/22;	Also includes funding for targeted priorities including a new Provincial Hospitalist Program, enhanced funding for ICUs and emergency departments, and a

		1.5% - 2022/23; 1.5% - 2023/24; 1.5% - 2024/25	commitment to enhance remuneration for anesthesiology
Nova Scotia	April 1, 2023 to March 31, 2027	3% - 2023/24 3% - 2024/25 2% - 2025/26 2%- 2026/27	PSA includes funding for fee increases, investments in a new Longitudinal Family Medicine Payment Model. It also includes targeted investments in priority areas. These priority areas include: • overhead/attachment fee, • APPs, • new “invisible” work codes, • new hourly rates of ER physicians, • Practice Support (\$25,000) and Retention Incentive (\$16,000) for rural specialists, increased on call funding, parental leave, • increased locum funding, • virtual care, and • physician retirement fund, amongst others. The overall estimated new funding under the agreement is in excess of \$200M, an overall increase of approximately 20% over the course of the PSA, or about 4.7% compounded annual growth

Prince Edward Island ¹¹⁴	April 1, 2024 to March 31, 2029	2024/25 – 0% 2025/26 – 30% 2026/27 - 0% 2027/28 – 2% 2028/29 - 2% Total cumulative impact of the five-year agreement is 34.5%	The PSA includes additional investments: On-call fees, Overhead stipends (\$25k per FFS physician), Admin/Indirect Stipend of \$220/hr for FFS physicians Surgery Cancellation Fee of \$348.00 Catastrophic Pay/Income Stabilization for FFS
Newfoundland and Labrador	October 1, 2023 -	In negotiation	
Manitoba	October 1, 2023 – March 31, 2027	2023/24 - Market% (4.2%) 2024/25 - 2% 2025/26 - 2% 2026/27 – 2%	Overall increase to physician compensation over 4-year term expected to be 18-20% PSA includes additional investment in, amongst others • 21,000 signing bonus. • Retention payments to continue every 5 years and recognize up to 2 years of residency training • New Family Medicine Plus model • Extended Visit Tariff for complex visits involving 2 or more complaints • Funding for focus practice areas (addictions, MAID,

¹¹⁴ Prince Edward Island Physician Services Agreement 2024-2029, BOD VOL 5 TAB 130.

			care of the elderly and other areas) • Time-based stipend for indirect services • Panel Payment • 15% premium to all in-patient and ER visits • Practice support premium will add \$3.50 to in-person visits to help offset increasing overhead costs (max of 50 claims per day) • New surgical assistant model funding surgical assistants at 40% of surgeon rate (60% for specialist surgical assistants) • Investments to on call programs and alternative payment programs • Rural and Northern Retention Fund of \$25,000 paid every 3 years (in addition to current programs) • 35% fee premium to remote communities and 25% to other communities • Funding targeted to ensuring coverage in rural emergency departments • Virtual care at 100% (including telephone) • Increase from \$1,500 to \$2,000/wk for Parental leave 20 weeks.
Saskatchewan	April 1, 2022, to	2022/23 – 5.5% (3% + 2.5%	Agreement features a record setting increase in funding for

	March 31, 2026	additional adjustment) 2023/24 – 3% 2024/25 – 2% 2025/26 – 2%	physician services of approximately \$245 million, including: • \$50M investment in a new primary care payment model for family physicians that unifies existing volume-based pay with a new capitation payment (based on patient contacts and panel size); • An innovation fund of up to \$10 million annually over the duration of the agreement, that will increase the amount of team-based care in primary health care settings; • Funding to address gender pay inequity in physician fee codes, as well as new funding to support physician training and awareness related to equity, diversity, racism, and truth and reconciliation; • A new Rural and Northern Practice Recognition Premium that recognizes the unique nature and critical importance of rural medicine; • Introduction of permanent virtual care codes to increase efficient access to health services for patients and reduce unnecessary travel for appropriate services; and • Increased funding to support long term retention, parental leave and continuing medical education.
--	-------------------	---	---

Alberta	April 1, 2022 – March 31, 2026	2022/23 – 1% 2023/24 – 1% 2024/25 – 1% 2025-26 – market rate	The agreement also included the following: • \$40M investment in primary care models and commitment to review capitation funding • Business Cost Program - +\$3.59 per office visit (up to 50/day) • Reinstatement of \$1,000 Medical Liability Reimbursement deductibles; • Reinstatement of the CME program. Benefits set at \$2,200 per year per qualified physician • \$15M per year for recruitment and retention of physicians in underserved areas; • Additional \$12 million per year to improve access in underserved areas (primarily via Rural, Remote, Northern Program) • \$2 million per year for the Rural Education Supplement and Integrated Doctor Experience program. • New program to address payments for care provided to patients without health coverage. In addition to the current PSA, Alberta has recently announced a new additional investment of \$200
---------	--------------------------------------	--	--

			million in primary care. ²⁶⁶
British Columbia	April 1, 2022 - March 31, 2025	2022/23 - 4.0% 2023/24 - 6.5% - up to 7.5% with COLA 2024/5 - 2.7% - up to 3.7% with COLA <i>Possibility of additional increases of up to 2.25% contingent on the growth in CPI over the term of the agreement</i>	PSA includes new investment of over \$700 million per year, an investment of 13.2% increase over the course of the 3 years. 60% of the funding is targeted to priorities, including: • Increasing the Business Cost Premium for all and expanding it to include hospital income for specialists with community offices. Paid to physicians who are responsible for operating costs of community offices • Addressing income disparities among specialists • Developing new fees for specialists • Recognizing after-hours work and addressing disparities for AP (alternately paid) physicians • Supporting family physicians who provide community longitudinal family practice (discussed further below) • Modernizing the BC Family Doctor Fee Guide to simplify the process and address equity • Improving retirement savings and parental leave benefits • Funding to address workload challenges (including current backlogs and anticipated workload growth) for Service Contract and Salaried physicians • Additional investments in Continuing Medical Education, Physician Disability Insurance

			Program, Parental Leave Program, Contributory Professional Retirement Savings Program and CMPA rebate program • 10% increase to On Call program and 25% increase to tray fee program • New funding for Palliative Medicine, after-hour procedures • Continuation of virtual care and bilateral process for implementing any amendments to virtual care fees The OMA estimates that the introduction of the LFP model represents an additional investment of upwards of \$400M in addition to the \$700 million in the PSA,
--	--	--	--

156. The OMA's proposed Year 2, 3, and 4 increases of 3.75% a year are supported by all of the above considerations, including the need to improve Ontario's relative position in comparison with other provinces. This will in turn address the continued recruitment and retention problems summarized above.

PART IV - TARGETED PROPOSALS

A. Family Medicine Proposal

The OMA proposes a modernized Family Health Organization model, which is intended to retain current physicians and attract new physicians, increase patient enrollment, and improve patient access to primary care. The new model, which has been largely agreed but not finalized during the negotiation and mediation process with the assistance of the Chair, 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 Comprehensive Care Capitation 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 to increase overall compensation, and to enhance the existing capitation rate compensating physicians for care provided to rostered patients

*Pursuant to this new model, the funding for the comprehensive care capitation payment and access bonus will be reinvested to partially fund a **new hourly rate of \$80 an hour** for the time a FHO physician spends providing care, including time spent on direct care and indirect care (including clinical administration). (See below for details re: hourly rate).*

*The **Shadow Billing rate** for in-basket services will be increased from 19.4% to **30%**. The shadow billing rate for all in-basket procedures set out in Appendix A will increase from 19.4% to **50%**.*

*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.*

*The current Group Management Leadership Payment (GMLP) of up to a maximum of \$25,000 will be maintained. In addition, there will be an additional **Enhanced GMLP** to a maximum of **\$100,000** (prorated) annually, for group leadership activities.*

*A new **Patient Attachment Bonus** will apply to all Patient Enrolment Model (“PEM”) physicians, in addition to any capitation rate (see below for details as to bonus amount). As well, there are other new or increased payments in support of attachment.*

*The **FHO complement** will be increased by an **additional 240 total spots** for April 1, 2024, to March 31, 2025. The Ministry has proposed no further commitment to managed entry for subsequent years, while the OMA has proposed this continue for each year thereafter, on the same terms as under the 2021-24 PSA. The parties have agreed that the managed entry restrictions will not apply to physicians entering the FHO model from the FHG model. The parties have also agreed to broaden the FHO co-location guidelines, and that the FHO/FHN contract will be amended such that in-patient services provided in-hospital are considered out of basket and paid the full fee for service amount. The FHO boilerplate agreement will be updated to reflect agreed-to/awarded changes.*

*The OMA has proposed that the **FHG premium** be increased from 10% to **20%**.*

Other aspects of the proposal include an improved information sharing, enhanced exemption for hospital on-call counting for after-hours coverage, and a dispute resolution mechanism. See below for further details.

COST: 132 million in Year 1 (from amounts already awarded) and \$77 million in Year 2 for the FHO proposal; \$40 million in Year 1 (from amounts already awarded) for Unattached Patient Fees; and \$41 million in Year 2 for FHG premium.

(i) The Crisis in Family Medicine

157. As described in detail in the OMA's Year 1 Brief at paragraphs 28-37 and 470-551, Ontario is experiencing an unprecedented crisis in family medicine. The OMA relies on those submissions and reiterates and updates them below with additional information. Currently, an alarming 2.5 million people in this province do not have a family doctor,¹¹⁵ and unless necessary reforms are made, this number is expected to almost double to 4.4 million by next year.¹¹⁶ Family physicians are essential to our publicly funded health care system, helping patients stay healthy, preventing disease by

¹¹⁵ OCFP, "[New Data Shows There Are Now 2.5 Million Ontarians Without a Family Doctor](#)", July 11, 2024, BOD VOL 2 TAB 65.

¹¹⁶ OCFP Nov. 7 2023, *supra*, BOD. VOL 1 TAB 7.

identifying risk factors, managing chronic disease, and getting their patients access to specialist care, diagnostics, and many other health-care services. Access to a family physician is the bedrock foundation of our health system. Investments in primary care are needed so that Ontarians can get the care they need and deserve. While the Ministry has committed to significant investments to promote team-based care through the PCAT process, it is also critical to ensure meaningful investments are made directed at recruiting and retaining family physicians in comprehensive and longitudinal care.

158. Family physicians have long been struggling to hold a broken system together, facing a patient attachment crisis, the growing burden of administrative tasks, increased patient complexity, and physician burnout. The result has been family physician shortages across the system that are impacting access to timely and effective patient care.

159. There is compelling evidence regarding the shortage of longitudinal comprehensive family medicine physicians. For example, in a study published in May 2025, the authors found that while the number of family physicians increased from 104 to 118 per 100,000 from 1993 to 2022 in Ontario, the number of *comprehensive* family physicians actually decreased from 71 to 64 per 100,000 in the same time period.¹¹⁷

160. Another study by Premji et al. from June 2025 has found that since 2019, the “growth in the overall comprehensive FP workforce stagnated (2019: 9377; 2022: 9375).” As well, “in 2022 there was a decline in the number and proportion of early-career physicians (age <35 years)” with an “increasing proportion of the workforce...age 65 and older (2008: 10.0%; 2013: 14.4%; 2019: 13.9%; 2022: 15.2%), and correspondingly, an increasing number and proportion of patients are attached to near-retirement [family physicians].” Another troubling statistic is that “[p]atients attached to near-retirement FPs were older and had higher levels of chronic conditions compared with patients across the overall FP workforce.” As a result, the authors conclude that

¹¹⁷ [“Family Physicians in Focused Practice in Ontario”](#) *supra*, BOD VOL 1 TAB 13.

“[c]hanges to the comprehensive FP workforce since the COVID-19 pandemic, together with increasing patient complexity, raise concerns about the workforce’s capacity to absorb patients whose [family physicians] are poised to retire.”¹¹⁸

161. While recruiting new physicians to comprehensive family medicine is key to addressing the shortage, the evidence suggests that the incoming generation is not convinced about the benefits of engaging in a primary care practice. While the “absolute number of family medicine residency training positions in Canada has expanded over time, increasing by 100.9% between 2006 and 2023 (811 vs 1629 positions)” and while “per capita family medicine residency spots increased by 63.1% over the same period (2.49 vs 4.06 per 100,000 Canadians...), [s]ince 2015, a growing number of positions have gone unfilled.” Specifically, in the first and second match rounds in 2023, 268 (16.5%) and 100 (6.1%) positions, respectively, remained vacant, an increase since 2010. This troubling trend was even more notable in Ontario with interest in family medicine decreasing by 11.2 percentage points in Ontario (40.2% of Canadian medical graduates (CMGs) in Ontario ranked family medicine as their first choice in 2015 compared to only 29% in 2023). In contrast, in the rest of Canada, that decline in interest was only 4.7%.¹¹⁹ As well, since 2015, there has been a notable decline in the number of CMGs who matched to family medicine for whom the specialty was their first choice.

162. Adding to the family medicine crisis is the growing administrative burden on family physicians. According to a June 2025 peer-reviewed study by Storseth et al, the administrative burden on family physicians is contributing to the current primary care crisis. The study finds that there has been an “expansion of administrative workload,

¹¹⁸ Kamila Premji, Richard H. Glazier, Michael E. Green, Shahriar Khan, Maria Mathews, Steve Nastos, Eliot Frymire, Susan E. Schultz, Bridget L. Ryan, “[Trends colliding: Aging comprehensive family physicians and the growing complexity of their patients](#)” Canadian Family Physician Jun 2025, 71 (6) 406-416; DOI: 10.46747/cfp.7106406, BOD VOL 2 TAB 66.

¹¹⁹ Daniel Myran, Maya Gibb, Kamila Premji, Clare Liddy, Claire Kendall “[Increased proportion of family medicine residents did not want to be family physicians](#)” Canadian Family Physician Jun 2025, 71 (6) 383-387; DOI: 10.46747/cfp.7106383, BOD VOL 2 TAB 67.

including time spent on indirect patient care (e.g., charting, forms, referrals) and practice operations,” driven by health systems, technological change and increased patient complexity. The study finds that the “cumulative administrative burden—including costs, time, and effort involved with completing this work—[is] a source of burnout for clinicians and reduced access to care for patients, and this may push family physicians to choose career options other than comprehensive community-based practice.”¹²⁰ Importantly, the authors conclude that administrative burden is not just about “unnecessary” paperwork, but that it also includes “functions that support continuity and coordination.” As such it is of vital importance that the solution to the family medicine crisis also address the administrative burden on family physicians.

(ii) Problems with the Current FHO Model

163. Adding to the pressures on Ontario family physicians, the current FHO model for physician payments is in need of significant reform and improvement. Separate and apart from the need to improve compensation overall, the FHO model also fails to compensate physicians for time spent providing necessary and expanding indirect patient care.

164. Another problematic aspect of the current payment model is negation—deducting on a first dollar for dollar basis from a physician's payments whenever one of their rostered patients receives care from another family doctor or general practitioner, such as at a walk-in clinic. Currently, an amount equal to up to 20% of a FHO physician's capitation payments is at risk a rostered patient receives in-basket care elsewhere (except for certain specific exemptions), regardless of whether the physician is otherwise providing accessible care. For example, if a patient chooses to go to a walk-in clinic close to their office because it is more convenient than booking with their family physician, it is the family physician who is penalized. Similarly, if a patient is admitted to

¹²⁰ [“Administrative burden in primary care”](#) *supra*, BOD VOL 1 TAB 20.

hospital and treated by a family doctor or is seen by a family physician in the emergency department, any in-basket codes would be negated.

(iii) The Family Medicine *Proposal* – Areas of Agreement

165. Starting from the joint recognition that Ontario is experiencing a growing number of unattached patients and with the shared objective of enhancing access to longitudinal comprehensive family medicine, the parties have worked constructively over many days and months of bilateral negotiations and mediation to develop a modernized Family Health Organization model (“FHO+”). This new model, described in detail below, is intended to retain current physicians and attract new physicians to family medicine, increase patient enrollment, and improve patient access to primary care.

166. The proposed changes for family medicine include investing additional funding in the new FHO model, reintroducing fees for attracting unattached patients, reinvesting the comprehensive care (CC) capitation payment and the access bonus, increasing the shadow billing component, introducing an hourly rate to compensate for time spent providing direct and indirect patient care, and a new patient attachment bonus to all Patient Enrolment Model physicians to meet the shared objective of improving rostering and attachment for all PEM physicians. The overall intent of these changes is to enhance both patient attachment and access to care, not only by increasing overall compensation, but also to enhance the proportion of physician payments resulting from time spent providing direct and indirect accessible care, while at the same time maintaining the widely acknowledged health system benefits of a capitated primary care system providing comprehensive longitudinal care.

167. The new model also removes “negation”, which has been a longstanding source [of](#) extreme frustration amongst FHO physicians, since it unfairly and disproportionately penalizes physicians on a first dollar-for-dollar basis where patients seek and receive in-basket services from other family doctors, save for limited exceptions.

168. The elements of the Family Medicine Proposal agreed to between the parties include the following:

- **NEGATION:** Eliminate negation and reinvest the Access Bonus in the revised FHO model
- **CC CAP:** Eliminate the CC cap and reinvest in the revised FHO model
- **HOURLY PAYMENT:** Introduce an hourly payment of \$80 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 physicians to provide care in their clinics/offices.

The hourly rate will apply to all insured services provided to rostered patients (within the usual family practice setting, as set out below). 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. (85% of the hourly rate) The parties mutually recognize 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 are set at 14 hours in a single day, with a 28 consecutive day limit of 240 hours.

No more than 25% of the total physician's hours billed (averaged over 28 consecutive days) can be for indirect patient care and clinical administrative work. Clinical administration time (CAT) will be no more than 5 percent of the total amount of time claimed by the physician for direct and indirect patient care, measured over twenty-eight consecutive days.

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 (Hourly Rate Payment Rules) (below) sets out additional payment rules regarding the hourly rate.

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:

- A. **Direct Patient Care** (Fee QXXX) is payable for time spent personally providing insured 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
- B. **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
- C. **Indirect Patient Care** (Fee QYYY) is payable for time spent personally providing the insured 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:
 - 1. Documentation of patient interactions and charting.
 - 2. Review of results: labs, imaging, consultations, and other reports.
 - 3. Preparing referrals and requisitions.

4. Chart review.
5. Discussion with, and providing advice and information to the patient or the patient's representative, via synchronous or asynchronous care communication, that is an insured service directly related to pre or post direct patient care
6. Care coordination and care planning
7. Conferencing, consulting, and meeting with other physicians and/or other health professionals for a specific patient or patients.
8. Conferencing and meeting with family members and/or patient medical representatives.
9. Reviewing and analyzing clinically related information/research directly related to the needs of a particular patient (e.g.: investigating particular diagnostic and therapeutic interventions).
10. 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).
11. 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.

D. Clinical Administration (Fee QAAA) 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:

1. Proactive patient management and review for screening interventions, disease management, and provision of care (e.g., mammograms, colon cancer screening, immunizations, diabetes management).
2. Electronic Medical Record (EMR) updating and management that requires physician expertise.
3. 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.

E. 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.

- **SHADOW BILLING:** The Shadow Billing rate for in-basket services will be increased from 19.41% to 30%. The shadow billing rate for all in-basket procedures set out in Appendix A (In-Basket Procedures with 50% Shadow Billing) will increase from 19.41% to 50%.
- **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.

APPENDIX A - IN BASKET PROCEDURES WITH 50% SHADOW BILLING

Fee Schedule Code	FSC Descriptor
G365A	D./T. PROC.-GYNAECOLOGY-PAPANICOLAOU SMEAR
G378A	D./T. PROC. GYNAECOLOGY-INSERTION OF IUD
G552A	D./T. PROC. GYNAECOLOGY-REMOVAL OF IUD
R048A	SKIN-EXC.-LOC.MALIG.INCL.BIOPSY-FACE/NECK-1 LESION.
R051A	INTEG.SYST.SKIN-LASER SURG.ON GR.1 TO 4 MALIG.LESIONS
R094A	SKIN-EXC-SIMPLE-MALIG.LESION-OTHER AREA-INCL.BIOPSY-ONE.

Z101A	SKIN-INC.-ABSCESS-SUBCUT.-ONE -LOC.ANAES.
Z110A	INTEGUMENTARY SYST.EXTEN.DEBRIBEMT ONYCHOGRYPHOTIC NAIL
Z113A	INTEGUMENTARY SYST.BIOPSY(S)-ANY METHODSUTURES NOT USED
Z114A	SKIN-INC.-FOREIGN BODY-LOC. ANAES.
Z116A	SURG.PROC SKIN-BIOPSY(S)ANY METHOD WHEN SUTURES USED
Z117A	SKIN.CHEM/CRYOTHERAPY MINOR SKIN LESIONS 1/MORE
Z122A	SKIN-EXC.-GROUP 4-FACE/NECK-ONE LESION-LOC. ANAES.
Z125A	SKIN-EXC.-GROUP 4-OTHER AREAS-ONE LESION-LOC. ANAES.
Z128A	SKIN-DESTRUCTION FINGER/TOENAIL PART/COMP./NAIL PLATE EXC.1
Z129A	SKIN-DESTRUCTION-FINGER/TOENAIL-SIMPLE-PART/COMPL.-MULTI
Z154A	SKIN-SUTURE LACER.-UPTO 5CM.-FACE-TIE BLEEDERS/LAYERS.
Z156A	SKIN-EXC-SUT.-BENIGN LESIONS-SINGLE.
Z157A	SKIN-EXC-SUT.-BENIGN LESIONS-TWO LESIONS.
Z158A	SKIN-EXC-SUT.-BENIGN LESIONS-THREE/MORE LESIONS.
Z159A	SKIN-& SUBCUT-REMOVAL BY ELECTROCOAG.-SINGLE LESION
Z160A	SKIN-& SUBCUT-REMOVAL BY ELECTROCOAG.-TWO LESIONS
Z161A	SKIN & SUBCUT.-REMOVAL BY ELECTROCOAG.-THREE/MORE LESIONS
Z162A	SKIN-EXC-SUT.-NAEVUS-ONE.
Z175A	SKIN-SUTURE LACER.-5.1CM-10CM.-OTHER AREA.
Z176A	SKIN-SUTURE-LACERATION-UPTO 5CM.
Z314A	NOSE-EPISTAXIS-CHEM/ELECTROCAUTERY-UNIL.
Z315A	NOSE-EPISTAXIS-ANTERIOR PACKING
Z535A	INTESTINES-ENDOSCOPY-SIGMOIDOSCOPY W/WITHOUT ANOSCOPY
Z543A	ANUS-ANOSCOPY

Z545A	ANUS-INC. THROMBOSED HAEMORRHOID
Z847A	EYE-CORNEA-INCISION-REM. SINGLE EMBEDDED FOREIGN BODY LOC.
E542A	SKIN/SUBCUT TISSUE-INSERTION OF SUTURES OUTSIDE HOSP-ADD
G462A	Administration of oral polio vaccine
G538A	IMMUNIZATION - Other immunizing agents not listed above
G840A	IMMUNIZATION - Diphtheria, Tetanus, and acellular Pertussis vaccine/ Inactivated Poliovirus vaccine (DTaP-IPV) – pediatric
G841A	IMMUNIZATION - Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus, Haemophiles influenza type b (DTaP-IPV-Hib) – pediatric
G842A	IMMUNIZATION - Hepatitis B (HB)
G843A	IMMUNIZATION - Human Papillomavirus (HPV)
G844A	IMMUNIZATION - Meningococcal C Conjugate (Men-C)
G845A	IMMUNIZATION - Measles, Mumps, Rubella (MMR)
G846A	IMMUNIZATION - Pneumococcal Conjugate
G847A	IMMUNIZATION - Diphtheria, Tetanus, acellular Pertussis (Tdap) – adult
G848A	IMMUNIZATION - Varicella (VAR)

- 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.

- **PATIENT ATTACHMENT BONUS:** This applies to all PEM physicians, in addition to any capitation rate. The parties have agreed that this will be implemented effective July 1, 2025.

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

In addition:

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

- 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.
- 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).

The following criteria must be met for the physician to receive the patient attachment bonus:

- All PEM groups are eligible to bill the new fee.
- The fees applicable to newly enrolled patients may only be billed once by the same group enrolling the same patient.
- Payment of the fee requires the patient be enrolled to the FHO group.
- 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.
- 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.
- 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 in any of these areas.

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 2028-32 PSA.

- **IN-BASKET CONTINUITY OF CARE:** The parties agreed that continuity of care is important and have agreed on a measure to track continuity of care. However, as explained further below, the parties do not agree on how this continuity of care measure is to be used or the percentage to be used in determining whether continuity of care has fallen below an “acceptable” level and, if so, the consequences, if any, for this happening.

The in-basket continuity of care will be based on 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.

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: <u>Provided by Group</u> – in-basket services provided by the FHO group to whom the patient is enrolled, including by locums registered to the FHO group <u>Provided by Other Acceptable Provider</u> – 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 <i>(Denominator)</i>	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

The parties agree that it is desirable to show the number of patient visits, and the in-basket continuity measure for each FHO physician. The Ministry agrees to provide a separate standalone report to be provided to each physician monthly via the existing Medical Claims Electronic Data Transfer (MCEDT) account.

- **FHO COMPLEMENT/MANAGED ENTRY:** The FHO complement will be increased by an additional 240 total spots on the same terms as under the 2021-24 PSA, including the following.
 - 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;
 - Any unused spots can be rolled over to the subsequent year (including unused spots from the prior 2021-24 PSA);

- Replacement physicians will be permitted and processed outside the Managed Entry process;
- 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;
- The Ministry will report quarterly to the OMA on the filling of the entry of physicians into the model pursuant to these provisions.

The parties are agreed to these elements of the proposal regarding the increase to the FHO complement although they disagree regarding duration. The OMA proposes April 1, 2024, to March 31, 2025, and for each year thereafter. However, the parties have agreed that the managed entry restrictions will not apply to physicians entering the FHO model from the FHG model.

- **FHO CO-LOCATION GUIDELINES** will be broadened as follows:
 - If all physicians in a group cannot be in the same location, there should be no less than 2 physicians in each location.
 - 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.
 - In areas with a RIO score of 1 to 5, close proximity to be defined as being within a 10 km radius.
 - In areas with a RIO score of greater than 5, close proximity to be defined as being with a 30 km radius.
 - 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.

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

- **LOCATION OF SERVICES WITHIN FHO/FHN:** 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.
- **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 FHO+. Arbitrator Kaplan to remain seized on any issue related to the updated boilerplate language.

- **IMPROVED INFORMATION SHARING:** As part of the data sharing agreement, the parties to discuss and agree on a process to enable improved sharing of primary care physician data.
- **FHO Contract, Appendix B - Physician 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.*

- **Effective date and transition**

The parties agree that the new FHO+ model will be implemented effective April 1, 2026

- **Fee for service billing limits:** 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

- **Exemption for hospital on-call counting for after-hours coverage**

The parties have agreed that this board will remain seized with respect to this OMA proposal, since the parties are continuing to work together to resolve this issue. The OMA's proposal is as follows:

In order to meet the exemption from after-hours coverage where more than 50% of physicians in a group provide regular after-hours care of hospital in-patients, the following rules are being applied by the Ministry:

- for FHOs not located in northern/rural areas, a minimum of 14 service dates per quarter, with a service date defined as the physician billing certain Ministry designated after-hours hospital fee code; and
- for northern and rural FHO physicians, a minimum of 7 service dates per quarter, with a service date defined as the physician billing a Ministry designated after-hours hospital fee code
- for northern and rural FHO physicians, a minimum of 7 service dates per quarter, with a service date defined as the physician billing a Ministry designated after-hours hospital fee code.

The OMA proposes that, where a physician works a weekday night hospital on-call shift, this will be deemed to equal 2 service dates, and where a physician works a weekend hospital on-call shift, this will be deemed to equal 3 service dates (regardless of whether an after-hour hospital fee code is billed).

- **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.

(iv) The Family Medicine *Proposal* – Areas of Disagreement

169. While there are significant areas of agreement between the parties on the elements of the FHO+, there remain various areas of disagreement, the most important of which is whether it is either necessary or appropriate to provide some measure of “accountability” for physicians practicing under the new model. This different approach

is founded on the OMA's position that, while measuring continuity of care can provide relevant information to physicians about their practice and patients in their practice, a continuity of care measure should not be used to impose financial consequences on FHO physicians. Rather, the focus of the new model should be solely on incentivizing improved access and attachment, thereby making financial consequences inappropriate and unnecessary.

170. To be clear, the parties have agreed on a "continuity of care" measure that would measure and track 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, a defined term tentatively agreed to by the parties. However, where the parties disagree over whether there should be any financial consequences if a physician falls below a minimum threshold, and if so, what the threshold should be and what the consequences, if any, should be.

171. In addition, the OMA has proposed that the FHG bonus be doubled, i.e. increased from 10% to 20%. The Ministry has opposed this proposal.

(a) Continuity of Care

1. No need for an Accountability Measure with Financial Consequences

172. While the OMA agrees that informing physicians of the continuity of care within their practice is an important tool FHO physicians can use to monitor and improve continuity, the OMA does not agree that the continuity of care indicator should be used to inform the creation of an accountability model that would impose financial consequences on family physicians whose continuity falls below a certain measure.

173. In the OMA's view, various elements of both the existing and restructured FHO model are intended to promote appropriate continuity of care. Measuring continuity of care can play an important role in providing information to physicians about their own and their group's performance. However, from the OMA's perspective, the structure of

the new model itself (including the hourly rate for time spent providing care, and enhanced shadow billing) establishes sufficient measures to incentivize continuity of care, while at the same time ensuring the model attracts and retains physicians into comprehensive longitudinal care.

174. While continuity of care is a useful measure of accessibility, insofar as it relates to the consistency of the relationship between FHO physicians and their rostered patients, it does not capture or reflect many elements of accessible and high-quality primary care, including complexity of care, quality of clinical decision-making, patient preferences, or system-level barriers to access. Furthermore, continuity can be influenced by factors outside the physician's control, including patient mobility and choice, and system design. Relying solely on continuity as a measure of performance risks oversimplifying the multidimensional nature of accountability in family medicine, which itself is sufficiently promoted by the restructuring of the FHO model.

175. As a result, the OMA submits that continuity of care should not be used to impose financial consequences on physicians.

2. *Alternatively, any Continuity of Care Threshold be no more than 70%*

176. As set out above, the parties have agreed that for the purpose of measuring in-basket continuity of care, the appropriate indicator of services provided by FHO physicians is all in-basket primary care visits provided to the FHO physician's rostered patient 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 above. This continuity of care measure is appropriate for FHOs in the Ontario context and is based on relevant and available data. It is also a significant improvement over the current negation model as it is more tailored with respect to what is included in the in-basket services in the numerator and denominator and is calculated at the FHO group level rather than the individual physician level.

177. However, at issue in this arbitration is not only whether there should be a continuity of care measure with financial consequences (and, as the OMA has submitted, there is no need to impose financial consequences), but also, in the alternative, if there are to be financial consequences, what should the minimum continuity of care threshold be, and what should any consequences be.

178. In the OMA's view, the Ministry's proposal for an 80% continuity of care threshold would unduly expand the number of physicians who would face financial consequences for falling below the Ministry's proposed continuity of care threshold, without evidence of any commensurate clinical benefit. The OMA asserts that, if there is to be a measure of accountability, it should be no more than 70%, addressing a more realistic measure of minimum continuity, and imposing a consequence only on those who are outliers and fall well below a meaningful measure of the provision of care.

179. In the OMA's submissions, there is no empirical basis supporting the Ministry's proposed 80% threshold. The Ministry identified a number of studies that it relied upon, as summarized in the table below to demonstrate, allegedly, that its 80% measure was more appropriate than the OMA's 70% measure.

Study	Continuity cut-off	Additional Notes
Cheng et al, 2011 ¹²¹ (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-Iltu et al, 2007 ¹²² (Canada)	- Low: <=50%	For patients with any condition

¹²¹ Cheng SH, Hou YF, Chen CC. "[Does continuity of care matter in a health care system that lacks referral arrangements?](#)" Health Policy Plan. 2011 Mar;26(2):157-62. doi: 10.1093/heapol/czq035. Epub 2010 Aug 10. PMID: 20699348, BOD VOL 2 TAB 68

¹²² Ionescu-Iltu R, McCusker J, Ciampi A, Vadeboncoeur AM, Roberge D, Larouche D, Verdon J, Pineault R. "[Continuity of primary care and emergency department utilization among elderly people.](#)" CMAJ. 2007

	- Medium: 50-80% - High: >80%	
Menec et al, 2006 ¹²³ (Canada)	- Low: <=75% - High: >75%	For patients with any condition
Menec et al, 2005 ¹²⁴ (Canada)	- Low: <=75% or <=50% (for comparison) - High: >75% or >50% (for comparison)	For patients with any condition
Chen & Cheng, 2011 ¹²⁵ (Taiwan)	- Low: 47% - Medium: 47-86% - High: >=86%	For patients with Diabetes
Worrall & Knight, 2011 ¹²⁶ (Canada)	- Low: <75% - High: >=75%	For patients with Diabetes
Lin et al, 2010 ¹²⁷ (Taiwan)	- Low: 47% - Medium: 47-75%	For patients with Diabetes

Nov 20;177(11):1362-8. doi: 10.1503/cmaj.061615. PMID: 18025427; PMCID: PMC2072991. BOD VOL 3 TAB 69.

¹²³ Menec VH, Sirski M, Attawar D, Katz A. "[Does continuity of care with a family physician reduce hospitalizations among older adults?](#)" J Health Serv Res Policy. 2006 Oct;11(4):196-201. doi: 10.1258/135581906778476562. PMID: 17018192. BOD VOL 3 TAB 70.

¹²⁴ Menec VH, Sirski M, Attawar D. "[Does continuity of care matter in a universally insured population?](#)" Health Serv Res. 2005 Apr;40(2):389-400. doi: 10.1111/j.1475-6773.2005.00363.x. PMID: 15762898; PMCID: PMC1361147. BOD VOL 3 TAB 71.

¹²⁵ Chen CC, Cheng SH. "[Better continuity of care reduces costs for diabetic patients.](#)" Am J Manag Care. 2011 Jun;17(6):420-7. PMID: 21756012, BOD VOL 3 TAB 72.

¹²⁶ Worrall G, Knight J. "[Continuity of care is good for elderly people with diabetes: retrospective cohort study of mortality and hospitalization.](#)" Can Fam Physician. 2011 Jan;57(1):e16-20. PMID: 21252120; PMCID: PMC3024182. BOD VOL 3 TAB 73.

¹²⁷ Lin W, Huang IC, Wang SL, Yang MC, Yaung CL. "[Continuity of diabetes care is associated with avoidable hospitalizations: evidence from Taiwan's National Health Insurance scheme.](#)" Int J Qual Health

	- High: $\geq 75\%$	
Knight et al, 2009 ¹²⁸ (Canada)	- Low: $< 75\%$ - High: $\geq 75\%$	For patients with Diabetes

180. These studies use various indices, each capturing distinct aspects of the continuity concept. For example, the Usual Provider of Care (UPC) index measures the density of visits to the most frequently seen provider, while the Continuity of Care Index (COCI) quantifies the dispersion of visits among multiple providers, and the Sequential Continuity (SECON) index accounts for the sequence of visits. These indices are not interchangeable and may yield different continuity scores for the same patient depending on the chosen metric.

181. Moreover, thresholds for what constitutes "high," "medium," or "low" continuity also vary across studies. Some studies use absolute cutoffs (e.g., ≥ 0.75 for high continuity), while others use tertiles based on the distribution within a specific population, leading to potential inconsistencies across different settings and populations. Furthermore, the minimum number of visits required to calculate continuity differs among studies (ranging from ≥ 1 to ≥ 4 visits), and some include categories such as "no primary provider" or "low user" to account for patients not engaged in regular care.

182. These methodological choices are often driven by data availability, population characteristics, and the specific outcomes being studied, introducing subjectivity into both the construction and interpretation of continuity measures. As such, the process of

Care. 2010 Feb;22(1):3-8. doi: 10.1093/intqhc/mzp059. Epub 2009 Dec 9. PMID: 20007170, BOD VOL 3 TAB 74.

¹²⁸ Knight JC, Dowden JJ, Worrall GJ, Gadag VG, Murphy MM. "[Does higher continuity of family physician care reduce hospitalizations in elderly people with diabetes?](#)" Popul Health Manag. 2009 Apr;12(2):81-6. doi: 10.1089/pop.2008.0020. PMID: 19361251, BOD VOL 3 TAB 75.

measuring continuity is inherently subjective, and results must be interpreted with an understanding of these underlying complexities and limitations.

183. Moreover, none of the studies referenced by the Ministry replicate the proposed approach to measuring continuity agreed to by the OMA and the Ministry. Most published studies calculate COC at the individual physician level, using indices such as the UPC or the COCI, but none employ the exact definitions or thresholds being proposed for inclusion in the revised FHO model.

184. As well, these studies do not establish a clear, evidence-based threshold for what constitutes the minimum acceptable level of continuity required for patients. While some studies categorize continuity of care into high, medium, and low based on sample-specific distributions or arbitrary cutoffs, these thresholds are not standardized and often reflect the characteristics of the study population or specific patient diseases (i.e. diabetes) rather than a universally applicable standard. As a result, there is no consensus on what value of continuity of care should be considered minimally acceptable or aspirational in a policy context.

185. Many of the studies also focus on specific populations, such as elderly patients, individuals with chronic diseases (notably diabetes), or high healthcare users, rather than the general patient population seen in primary care, and were conducted in healthcare systems with different structures, referral patterns, and patient expectations. Among the Canadian studies, there is also variation in the benchmarks used for high and low continuity. For example, the Alberta study set two benchmarks for continuity of care (50% and 75%) but found no material difference in outcomes between these thresholds. This finding underscores the uncertainty around what level of continuity should be considered meaningful or actionable for accountability purposes.

186. Thus, a critical review of the empirical evidence reveals that there is no consensus on what the threshold for continuity of care should be, and certainly not when used as an accountability measure for family medicine physicians. Most significantly, the

OMA submits that there are no studies, including those provided by the Ministry which support the Ministry's proposed 80% threshold.

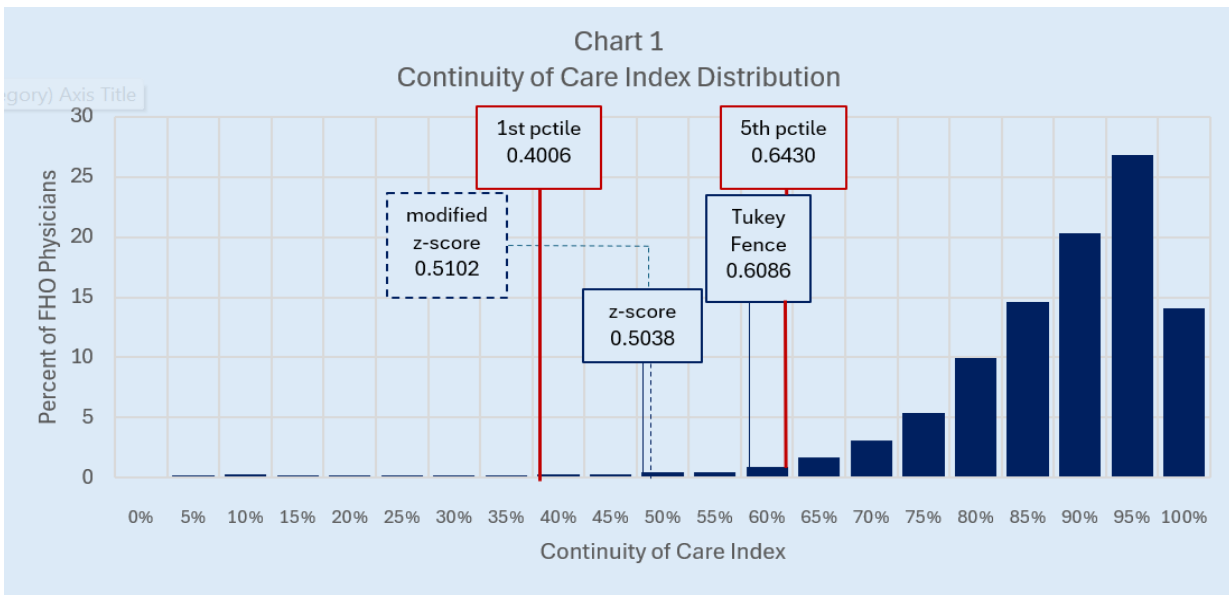
187. As a result, in the OMA's submission, if there is to be an accountability measure, which the OMA opposes as being unnecessary in the context of the revised FHO, it should be focused on those whose performance is demonstrably below the province's norm—the true outliers--thereby supporting accountability while recognizing the realities of current practice.

188. In the absence of a clear evidence-based minimum threshold for continuity of care in the literature, the only defensible approach is to define who are outliers based on statistical norms within the Ontario context. It has been recognized by all parties that the majority of family medicine physicians in Ontario are providing excellent care. Given this premise, the OMA proposes that, if an accountability measure is to be awarded, it should apply only to physicians whose continuity of care falls below a statistically defined threshold below the provincial mean continuity of care.

189. There are a number of commonly used outlier detection methods. For normal distributions, a common metric is the so-called z-score, measuring whether an observation is within 2 or 3 standard deviations from the mean. When the distribution is not normal, an alternative modified z-score is used that relies on the median rather than the mean. Another commonly used measure is based on the interquartile range (the difference between the 25th and 75th percentile of the data) called Tukey's Fences. It is also common to define outliers based on the percentile methods, which often identify outliers as those that fall below the 1st percentile or above the 99th percentile. Lastly, analysts also often use the box plot analysis that highlight outliers by marking points beyond the established fences.¹²⁹

¹²⁹ The z-score for observation x is calculated as $z=(x-\mu)/\sigma$, where μ is the mean and σ the standard deviation. This works well when the underlying distribution is normal. The modified z-score for observation x is $z_MOD=0.6745(x-Median)/(Median\ Absolute\ Deviation)$. This measure works better than the standard

190. Using the agreed upon continuity of care index (i.e. proportion of eligible visits that patients enrolled to a physician receive from any physicians in the FHO group to which this physician belongs) the distribution of continuity of care for the FHO physicians in fiscal year 2023-24 is presented in the chart below, together with several statistical thresholds regarding outliers.

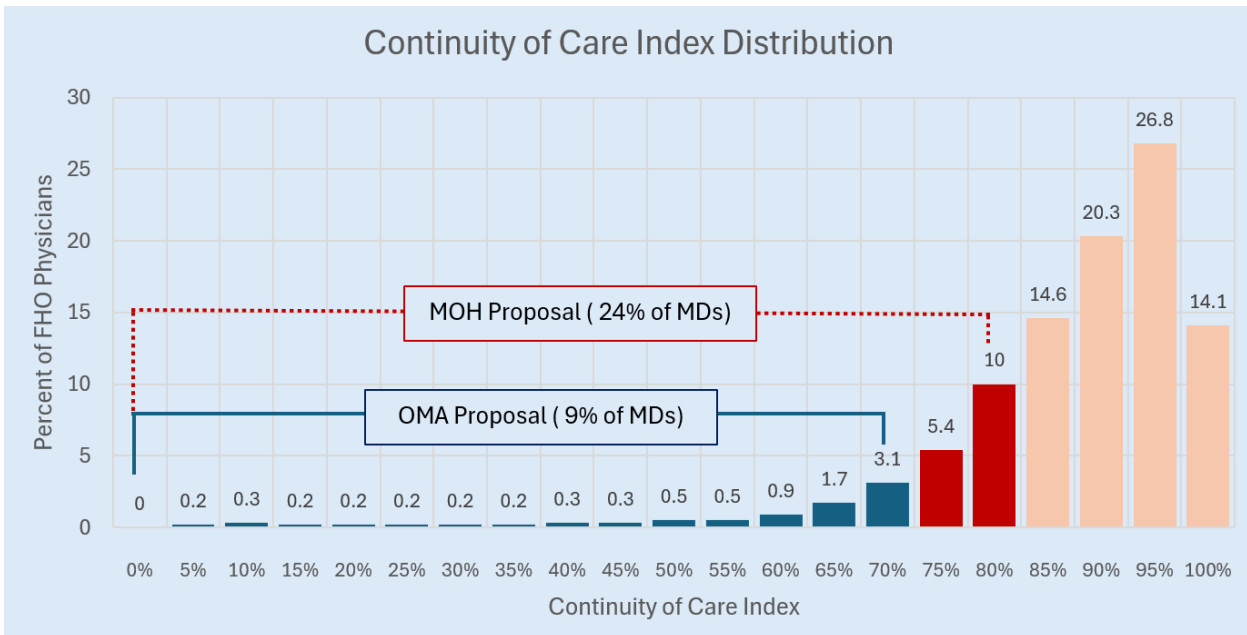


As is apparent from this chart, a statistical threshold for an outlier would be as low as 40%, and is not higher than 64%

191. Even if one were to look to the bottom 10th percentile, which would capture more physicians than are considered to be outliers under any standard statistical measure, the continuity of care threshold would be 72%.

z-score when the underlying distribution is not normal or symmetrical. The lower bound for the Tukey fence is calculated as $Q1 - 1.5 \times IQR$, where $Q1$ is the 25th percentile, and IQR is the difference between the 75th and 25th percentile. This is a very flexible, non-parametric method that is widely used in constructing box plots.

192. Based on this analysis, if there is to be a minimum threshold, it should be set at no higher than 70%, which would capture about 9% of Ontario FHO physicians. In contrast, the ministry proposal of 80% quartile, capturing 24% of physicians. The difference between these two approaches is illustrated in the chart below.¹³⁰



193. As this chart demonstrates, even a 70% continuity of care threshold would capture 9% of physicians, which exceeds any statistical measure of outliers. In contrast the Ministry's proposal would capture a much larger number of family physicians (24%) including those whose continuity of care clearly falls within an acceptable range.

3. *Alternatively, 10% Not 20% Financial Consequence*

194. In addition, if the Board decides to impose any form of financial consequences, they should not be for more than 10% of the capitation rate in the relevant quarter. In

¹³⁰ OHIP Claims, fiscal year 2023-24. The data includes any physician signatory to an FHO group at any time between April 1, 2023 and March 31, 2024. NOTES: The continuity of care index is calculated as the proportion of all eligible visits to patients enrolled to each FHO physician provided by any of the physicians in the same group. Eligible visits exclude all out-of-basket services and in-basket services provided in a hospital, an emergency department, or by a GP Focus physician, and certain other visits as described in the brief.

comparison, the Ministry's anticipated position is that 20% of the capitation rate should be at risk. If there is to be a financial consequence, physicians should not be disproportionately affected, but rather any consequence should constructively promote improvements in performance. If the financial consequence is as large as that proposed by the Ministry, this risks being counter-productive. Any financial consequence should not be inappropriately harsh.

195. As well, the OMA notes that, as agreed by the parties in principle, if financial consequences are to be imposed, this can only occur after a physician has been informed of their performance and given an opportunity to improve before any financial consequences are imposed. Specifically, on this point the parties have agreed that if there is to be a continuity of care indicator, particularly one imposing financial consequences, this is to be calculated in each quarter, based on service date, on the following basis:

- 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.
- 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 percentage of Q1 capitation payments.
- This process will be applied on a rolling basis for each quarter following the initial Q1.

(b) Increase to FHG Premium from 10% to 20%

197. The FHG premium has remained the same since its inception in 2004 whereas premiums applicable to other patient enrollment models such as the shadow billing and after-hours have both increased. There continue to be over 2,100 FHG physicians in

Ontario, rostering and attaching patients, and managing the care of 2.7 million patients. As outlined extensively in this brief and in the year 1 arbitration brief, patient complexity and management of their longitudinal care has become more onerous over time, as has the administrative burden facing family physicians. To reinforce support for and to incentivize longitudinal family practice by FHG physicians, this premium should be increased as proposed by the OMA.

B. Anesthesia

In order to address the present-day shortage of anesthesiologists and to quickly stabilize the current situation, the OMA is proposing:

1. Creation of a daily in-hospital sessional stipend

2. Updating of the ACT concept to permit anesthesiologists to be remunerated for the supervision of anesthesia extenders for the provision of anesthesia care (ACT-2025).

COST: \$60 MILLION out of remaining year 1 allocation (net after the section's contributions)

(i) Background to Anesthesiology Proposal

196. Anesthesiologists have long been recognized for their crucial role in perioperative care, particularly in the operating room setting. Their traditional responsibilities include preoperative patient evaluation and optimization, administration and management of anesthesia during surgery, continuous monitoring of vital functions, acute pain management, and immediate postoperative care. Their expertise in managing patient safety and well-being during surgery has enabled significant advancements in surgical procedures and have allowed for increasingly complex and lengthy surgical interventions, significantly advancing the field of surgery¹³¹.

197. Along with perioperative care, Anesthesiologists also have an expanding role outside of the operating room with Non-Operating Room Anesthesia ("NORA") expanding rapidly. NORA encompasses various procedures and interventions along with advanced medical management, such as complex pain care and substance use care. The list of NORA is ever-expanding but includes interventional radiology procedures, complex endoscopic procedures, assistance with acute stroke management, electrophysiologic cardiac procedures, obstetrical care, pain

¹³¹ See also OMA "Proposal on Anesthesiology: Mediation Presentation to William Kaplan and Ministry of Health" (March 2025), ["Anesthesiology Presentation"] BOD VOL 5 TAB 143.

management interventions, and electroconvulsive therapy provides only a snapshot of NORA activities.

198. Anesthesiologists are specialist trained providers who have at least 5 years residency training post-medical school. In Canada. Other medical professionals providing similar anesthetist services may include anesthetists, who are family medicine practitioners with typically one year of anesthesia training, and Anesthesia Assistants (“AA”), who are certified professionals, usually respiratory therapists who have at least 1 year of anesthesia specific training. The AAs support anesthesiologists and do not act independently.

(ii) A Shortage of Anesthesiologists

199. At present, Ontario is facing an acute province-wide shortage of anesthesiologists with major implications for safe and effective patient care. Over the past ten years, the situation has evolved “from a shortage and distribution imbalance to a full-blown crisis” with anesthesiologist shortages acting as a “major barrier to surgical access” and the majority of anesthesiology departments “reporting significant challenges with recruitment and retention.”¹³²

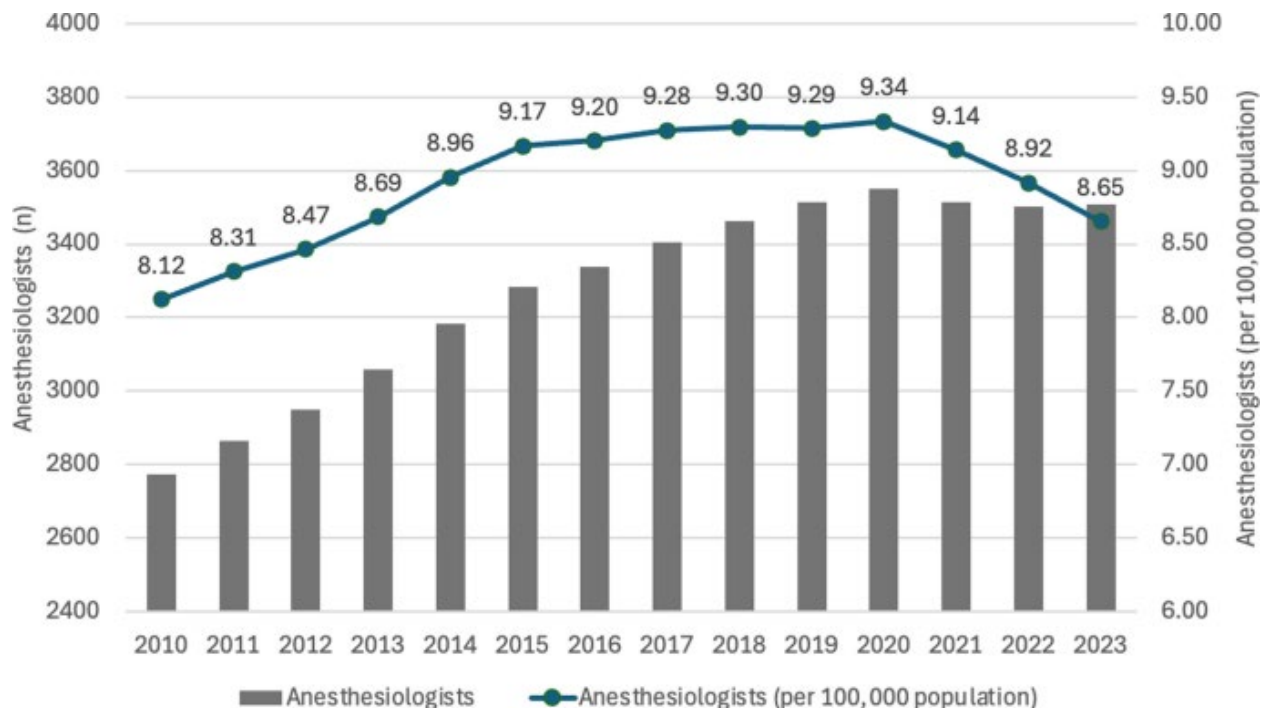
200. The shortage of anesthesia care providers has reached critical levels, resulting in delays in surgical care and limitations in anesthesia coverage for other hospital services. Reliable anesthesia staffing is essential to enable surgeries and diagnostic procedures, to meet wait times targets and to tackle growing clinical backlogs. Yet, because of these shortages, surgical backlog and patient wait times continue to worsen. The surgical backlog is estimated at over 206,000 patients in Ontario.¹³³ As of January 2024, 65.1%

¹³² Aucoin, S., Raazi, M. Reality check—an urgent call for innovation in Canadian anesthesia care delivery. *Can J Anesth/J Can Anesth* 71, 1595–1605 (2024). <https://doi.org/10.1007/s12630-024-02875-2>, BOD VOL 3 TAB 76.

¹³³ Government of Ontario, "[Ontario Reducing Wait Times for Surgeries and Procedures](#)", January 16, 2023, BOD VOL 3 TAB 77.

of the 6,414 children on the surgical waitlist at SickKids were waiting longer than clinically recommended for surgeries.

201. As illustrated by the following graph, the number of anesthesiologists per capita have fallen sharply since 2020 in Canada:¹³⁴



202. In contrast to peer nations, Canada has fewer anesthesia providers per capita. For example, there are 15.88 anesthesia providers per 100,000 people in the U.S., 14.23 in the U.K., and 20.57 in Australia.¹³⁵ As well, a number of other countries, such as the

¹³⁴ Orser, B.A., Wilson, C.R. & Jivraj, N.K. Strategies to increase access to physician-led anesthesia care in Canada. *Can J Anesth/J Can Anesth* 71, 1586–1594 (2024). <https://doi.org/10.1007/s12630-024-02874-3>, BOD VOL 3 TAB 78.

¹³⁵ World Federation of Societies of Anaesthesiologists, [World Anaesthesiology Map](#), BOD VOL 3 TAB 79; See also Law, Tyler J. MD, MSc, FRCPC et al., “[The Global Anesthesia Workforce Survey: Updates and Trends in the Anesthesia Workforce](#).” *Anesthesia & Analgesia* 139(1):p 15-24, July 2024. | DOI: 10.1213/ANE.0000000000006836, BOD VOL 3 TAB 80; See also Simkin S, Orser BA, Wilson CR, McVicar JA, Crozier M, Bourgeault IL. The Physician Anesthesia Workforce in Canada From 1996 to 2018: A Longitudinal Analysis of Health Administrative Data. *Anesth Analg*. 2023 Dec 1;137(6):1128-1134. doi: 10.1213/ANE.0000000000006650. Epub 2023 Nov 16. PMID: 38051290; PMCID: PMC10629603, BOD VOL 3 TAB 81.

U.S., France, Norway and Sweden have moved to joint care models with the use of alternative non-physician anesthesia providers,¹³⁶ further expanding their anesthesia capacity.

203. Within Canada, Ontario, alongside Quebec, has the lowest number of specialist anesthesiologist per capita.¹³⁷

Table 1 Number of specialist anesthesiologists obtained from the CIHI for 2021²⁵

Province/Territory	Number of specialist anesthesiologists	Number of FPAs	Specialist PAP density per 100,000 population	PAP density per 100,000 population	Number of CCAAs	Number of PAPs per CCAA
Newfoundland and Labrador	64	1	12	12	11	6
Prince Edward Island	18	0	11	11	0	0
Nova Scotia	142	1	14	14	31	5
New Brunswick	90	3	11	12	21	4
Quebec	775	4	9	9	111	7
Ontario	1,359	171	9	10	282	5
Manitoba	140	30	10	12	7	24
Saskatchewan	116	18	10	11	9	15
Alberta	426	62	10	11	61	8
British Columbia	578	96	11	13	116	6
Yukon	1	6	2	16	0	0
Northwest Territories	0	4	0	9	0	0
Nunavut	0	2	0	5	0	0
Total	3,709	398	10	11	545	7

FPA numbers obtained from the current registered members of The College of Family Physicians of Canada.¹⁰⁸ PAP density calculated from the fourth quarter population statistics for 2021 from Statistics Canada.¹⁵ CCAA numbers were provided by the Canadian Society of Respiratory Therapists.¹⁰⁹

CCAA = Certified Clinical Anesthesia Assistant; CIHI = Canadian Institute for Health Information; FPA = family practice anesthetist; PAP = physician anesthesia provider

204. The causes of the shortages are complex and include population growth outpacing anesthesiologist numbers, training programs being slow to expand, increasing patient complexity, and an increasing number of surgeries being offered to patients that were not previously offered.

¹³⁶ *Ibid.*

¹³⁷ Leir, S.A., Law, T.J. & Bould, M.D. The anesthesia human resources crisis in Canada. *Can J Anesth/J Can Anesth* 71, 1612–1626 (2024). <https://doi.org/10.1007/s12630-024-02869-00>, BOD VOL 3 TAB 82.

205. Compounding the problem is high-level of attrition as a result of anesthesiologists seeking work outside of hospitals in independent health facilities, private medical clinics (e.g. plastic surgery, dental) or in chronic pain clinics. This attrition is further driven by anesthesiologist burnout resulting in their reducing their clinical work while seeking a better work-life balance while trying to mitigate their high clinical workloads in the face of overwhelming demands.¹³⁸

206. Another factor contributing to the crisis is the growth of NORA¹³⁹ with some centers in Ontario reporting NORA accounting for approximately 40% of intraoperative activity.

207. One of the most significant emerging areas within NORA is endovascular stroke therapy. In these time-sensitive procedures, anesthesiologists play a vital role in rapidly assessing and stabilizing patients, managing sedation or general anesthesia as required, monitoring and maintaining optimal physiological parameters, and facilitating quick recovery to allow for neurological assessment. There has been an exponential expansion of endovascular stroke therapy with expectations that it will become similar to emergent cardiac interventional care for acute coronary syndromes. However, unlike the majority of patients who present with acute myocardial infarction who can be safely managed by the cardiologists performing cardiac catheterization, stroke patients by definition have altered neurologic conditions often causing altered consciousness and mental capacity thus necessitating the advanced support provided by anesthesiologists.

208. The development of NORA is expected to compound the existing shortage of anesthesiologists in Ontario and worldwide.

¹³⁸ Phillip Drost, "[An anesthesiologist shortage is delaying surgeries across Canada, physicians say](#)" CBC Radio (January 23, 2024), BOD VOL 3 TAB 83.

¹³⁹¹³⁹ Nagrebetsky, Alexander MD, MSc*; Gabriel, Rodney A. MD†; Dutton, Richard P. MD, MBA§; Urman, Richard D. MD, MBA‡. Growth of Nonoperating Room Anesthesia Care in the United States: A Contemporary Trends Analysis. *Anesthesia & Analgesia* 124(4): p 1261-1267, April 2017. | DOI: 10.1213/ANE.0000000000001734, BOD VOL 3 TAB 84; see also Simkin, *supra*, BOD VOL 3 TAB 81.

209. As well, the anesthesia shortage will only worsen in coming years as more than a third of the current workforce is over 55 and contemplating retirement. Ontario's population added nearly four million residents between 2000 and 2024, and the population is expected to grow by another nine million over the next couple of decades. As noted, Ontario had around 9 anesthesiologists per 100,000 residents. If the province reaches its highest projected population in 2046, the ratio will be further reduced. As well, the exodus of anesthesiologists to other provinces, where both remuneration and support are better, can be expected to continue if concerns are not addressed.

210. A recent OMA survey among anesthesiologists revealed that many physicians report unsustainably high workloads mainly due to staffing shortages. Ontario's Anesthesiologist (OMA Section), who surveyed Ontario Anesthesiology Chiefs in 2023, found that 59% of Ontario hospitals reported operating room closures in the last six months due to anesthesiologist vacancies despite the current anesthesiologist workforce reporting an average work week of over 60 hours/week per individual. Hiring and retaining anesthesia staff has become the hardest task of most anesthesia leaders with eighty-four per cent also stating that they needed to hire more anesthesiologists in order to properly staff operating rooms.¹⁴⁰ Seventy-three per cent of Chiefs reported that their departments were regularly working short-staffed and sixty-eight per cent reported denying vacation or increasing someone's work hours to cover shifts.

211. There is a shortage of at least 150 anesthesiologists in Ontario, with notable shortages in northern and rural Ontario. As an example of the effect, in the Fall of 2024, the Ottawa Hospital had a reported shortage of over 20 anesthesiologists, which means that approximately 100 patients each week were not having surgeries, an extremely

¹⁴⁰ Anesthesiology Presentation, *supra*, BOD VOL 5 TAB 143. See also Noushin Ziafat. ["There simply aren't enough people': Canada's shortage of anesthesiologists contributing to surgical backlog, group says"](#) CTV News (August 4, 2024), BOD VOL 3 TAB 85.

troubling statistic which is replicated in varying degrees throughout the entirety of the province.¹⁴¹

(iii) The OMA's Proposal to Respond to the Crisis

212. In response to this crisis, the OMA's Anesthesiology proposal is two-pronged and involves (i) the creation of a daily in-hospital sessional stipend and (ii) the updating of the Anesthesia Care Team concept to allow anesthesiologists to be remunerated for the supervision of anesthesia extenders for the provision of anesthesia care.

213. Despite multiple calls for a national anesthesiology human resource strategy over the past three decades,¹⁴² there has been limited action in this regard. Anesthesiology staffing has not generally been managed successfully, with only patchwork solutions at both the provincial and local levels. Strategies have primarily focused on reducing barriers for internationally trained anesthesiologists. Even an increase in anesthesiology residency training positions would take a decade before it would have any noticeable impact given the lengthy residency training requirements. Recognizing an international

¹⁴¹ See for example, Dave Waddell, "[Anesthesiologists shortage forces reduction in Windsor Regional's elective surgical schedule](#)" Windsor Star (November 21, 2019), BOD VOL 3 TAB 86; "[Hospital limits services over staff shortage in anesthesia department](#)" TB News Watch (April 12, 2022), BOD VOL 3 TAB 87; Darren Taylor "[Surgical wait list grows at SAH due to anaesthesiologist shortage](#)" Soo Today (April 27, 2023), BOD VOL 3 TAB 88; Jeffrey Ougler "'Noticeable' swell in Sault Area Hospital surgery waitlist blamed on specialist shortage" Sault Star (May 18, 2023), BOD VOL 3 TAB 89; Carly Weeks "[Canada faces critical anesthesiologist shortage, causing backlog of surgeries](#)" Globe and Mail (August 23, 2023), BOD VOL 3 TAB 90.

¹⁴² Aucoin, *supra*, BOD VOL 3 TAB 76; See also Canadian Medical Association, "[Anesthesiology Profile](#)", Updated December 2019, BOD VOL 3 TAB 91; Byrick, R. J.; Craig, D.; Carli, F. "A Physician Workforce Planning Model Applied to Canadian Anesthesiology: Assessment of Needs." Can J Anesth/J Can Anesth 2002, 49 (7), 663–670. <https://doi.org/10.1007/BF03017442>, BOD TAB 92; Donen, N.; King, F.; Reid, D.; Blackstock, D. Canadian Anesthesia Physician Resources: 1996 and Beyond. Can J Anesth/J Can Anesth 1999, 46 (10), 962–969. <https://doi.org/10.1007/BF03013132>, BOD VOL 3 TAB 93; Orser, B. A.; Wilson, C. R. Canada Needs a National Strategy for Anesthesia Services in Rural and Remote Regions. CMAJ 2020, 192 (30), E861–E863. <https://doi.org/10.1503/cmaj.200215>, BOD VOL 3 TAB 94; Canadian Anesthesiologists' Society. [Strategies to Address the Surgical Backlog and Health Human Resource Issues in Anesthesia](#), (October 2023) BOD VOL 3 TAB 95.

shortage of anesthesiologists, there will be an ever greater need to retain Ontario anesthesiologists in the next decade.

214. When looking for solutions to the present crisis, it is helpful to examine how the previous anesthesiologist crisis was successfully addressed in Ontario. In the early 2000s, anesthesiology numbers reached concerning levels that compromised surgical activity at that time. Ontario had an unprecedented action day when anesthesiologists across the province closed non-emergent activity to bring attention to the situation. The Ontario OMA section worked with MOH to come up with a timely solution that quickly stabilized the situation and allowed for almost two decades. The solution at that time was a combination of funding through the creation of new fee codes outside of negotiations as well as the creation of Anesthesia Care Teams.

215. The Anesthesia Care Team (ACT) model, implemented in Ontario for nearly two decades, is an efficient approach to delivering anesthesia care. It involves collaboration between anesthesiologists and Anesthesia Assistants (AAs). In this model, AAs, who are specially trained registered nurses or respiratory therapists, work under the direct supervision of anesthesiologists.

216. The ACT model has predominantly been restricted to anesthetic care for cataracts and eye procedures. This program no longer required a one anesthesiologist to one patient ratio but instead had one anesthesiologist supervising multiple patients with the assistance of AAs. It recognized that the delegation of aspects of patient care could be safely accomplished with improved monitoring and the close supervision of highly skilled allied health professionals. This approach successfully addressed Ontario's anesthesiologist shortages and provided safe and efficient care. Given its success, there have been calls to expand the ACT model further. Ontario's Anesthesiologists have advocated increased government funding to implement the model more widely, viewing it as a practical solution to help address the province's healthcare challenges and reduce surgical wait times.

217. As further elaborated below, the OMA is proposing a similar strategy to address the present-day shortage in order to stabilize the rapidly deteriorating climate amongst anesthetists.

(a) *In-Hospital Sessional Stipend*

218. The OMA is proposing the creation of an in-hospital sessional stipend (ISS) of \$500 per day for in-hospital work on-site during a regular scheduled weekday, whether in the operating room or performing NORA activity. This payment does not apply where the majority of hours worked attract after-hours or holiday premium pay, or HOCC payment.

219. The payment of an ISS is not unprecedented in Canada. Quebec and New Brunswick provide anesthesiologists with a daily stipend of over \$700 dollars for a typical 8-hour day.¹⁴³ The ISS would provide an incentive to anesthetists to remain in the province and to perform in-hospital services rather than work in a multitude of off-site clinics where, at present, they may well be more highly compensated. It would also make Ontario more attractive and more competitive both nationally and internationally.

220. The stipend would not be paid for anesthetists performing critical care work, after-hour activities, or out of hospital and work at independent health facilities.

221. Ontario's Anesthesiologists, the OMA Section, recognizes the gravity of the situation and the need for incentivizing in-hospital activity and would support 20% of the cost of the ISS up to a maximum of 60% of their PPC allocation (approximately \$20 million) to this initiative, to come out of the year 1 allocation. With the section's contribution, the government's share of funding would be 60 million dollars (to come of year 1 targeted funding).

¹⁴³ New Brunswick Department of Health, Letter to Anesthesiologists re: Anesthesia Per Diem, May 15, 2023, BOD VOL 4, TAB 134.

(b) ACT-2025: Supervisory Remuneration

222. The original Anesthesia Care Team (ACT-2007) model in Ontario was established to address a recognized shortage of anesthesiologists. As noted, under this model, a single anesthesiologist could oversee 2-4 operating rooms, each staffed by an anesthesia assistant (AA) or nurse, focusing almost exclusively on ophthalmologic procedures, primarily cataract surgeries. This program is limited to a select number of centres. The remuneration structure for anesthesiologists consisted of a fixed fee of approximately \$70 per procedure, while hospitals received a fixed payment of about \$35 per case. At the time of implementation, these values were comparable to the prevailing fee-for-service rates. However, these rates have since become outdated, and the model's scope remains limited, despite the persistent and worsening shortage of anesthesiologists.

223. The current context in Ontario is marked by ongoing and even greater shortages in the anesthesia workforce, leading to delays in surgical care and increasing pressure on the healthcare system. Projections suggest that this shortage will continue to worsen over the next decade. To address these challenges, there is a clear need to expand the ACT model to additional centres and extend the coverable cases beyond ophthalmology, ensuring that surgical throughput can be maintained and surgical backlogs reduced. At the same time, balancing financial sustainability and efficiency with patient safety and access to care is essential.

224. The ACT-2025 proposal would expand the ACT application from ophthalmology to include a broader range of low- to moderate-acuity surgical procedures. Only cases with low to moderate acuity would be eligible under this model, and high-acuity cases, such as those classified as ASA IV or V, would be explicitly excluded from ACT-2025 billing to maintain patient safety standards.

225. There would be a clearly defined limit on the maximum number of concurrent rooms/procedures an anesthesiologist may supervise. The attending anesthesiologist is present in the rooms at the most critical stages (i.e. induction and extubation) and is at

all times immediately available to respond as required. The current ACT-2007 can have 2-4 rooms. However, given that cataract is very low risk, the OMA would suggest that the maximum be no more than 3 and more likely 2 (ophthalmology for new centres could however do up to 4). Other countries have similar ratios with some American sites going up to 4.

226. The supervising anesthesiologist must be immediately available and able to respond to emergencies (consistent with Canadian Anesthesiologists' Society (CAS) guidelines).

227. A significant change in the ACT-2025 proposal is the shift from a fixed fee per case to a modifier-based billing structure. Given the diversity of non-ophthalmologic cases, a fixed fee is no longer appropriate. Instead, a billing indicator would need to be developed to identify cases managed under the ACT-2025 model. This indicator would recognize that the case was managed by an anesthesiologist supervising multiple rooms with AAs or nurses. The benefit to the system is the increased efficiency gained through increased throughput.

228. The proposal should ensure ongoing monitoring to ensure quality and safety. Hospitals participating in the ACT-2025 model should track and report safety, quality, and efficiency metrics for these cases, including adverse events, cancellations, and throughput. All AAs, nurses and other physician extenders must meet standardized training and credentialing requirements, with ongoing competency assessments. Oversight for implementation, compliance, and continuous quality improvement would remain the responsibility of the Chief of Anesthesia or a designated department leader.

229. The OMA proposal would allow an anesthesiologist to safely manage more than one procedure in different operating rooms, occurring concurrently, thereby improving access to care while improving the coordination of care and services for patients. What is required for these teams to be effective, is for someone to oversee and be responsible for the coordination and reviewing of the care provided by that team. The OMA is proposing permitting billing for this activity would extend and safely expedite the amount

of care anesthesiologists are able to provide. As happened with the first ACT initiatives, the OMA believes these changes will improve patient access and address the ever-growing surgical waitlist.

230. The Anesthesia Care Team model would allow Anesthesiologists to see more patients, enhance operating room use, safety and efficiency and leads to greater job and patient satisfaction. Importantly, the expanded use of Anesthesia Assistants could increase access, particularly in underserved areas where physician recruitment is challenging. Anesthesiologists estimate that approximately 50% more procedures can be undertaken with the ACT model, e.g. 5-6 joint replacement per day (vs. 3-4 under the conventional anesthesia care model) and 50% more MRI/CT, cataracts and endoscopy procedures. Evaluation of the Anesthesia Care Team model also suggests savings of 15-30% due to decreased length of stay and higher throughput (The Anesthesia Care Team model has demonstrated 15% cost savings for hip and knee replacement and 30% cost savings for cataract surgery when evaluated in 2009.)

C. HOCC - Burden-Based On-Call Program Proposal

The OMA proposes that:

- a. call levels be determined based on three key factors: (1) hospital after-hours billings, (2) in-person expected response times, and (3) most responsible physician (MRP) status,*
- b. three new levels be added to the current program to better reflect the burden of call, and*
- c. payments to be made on a per diem (rather than per annum) basis based on new burden level as follows:*

Current Burden Level	New Burden Level	After-Hours Criteria	In Person Response	Current Per Diem Payment	New Per Diem Payment
<i>I, II</i>	<i>1</i>	<i>On Site</i>	<i>On Site</i>	<i>\$500</i>	<i>\$800</i>
	<i>2</i>	<i>> 20%</i>	<i>1 hr.</i>		<i>\$650</i>
	<i>3</i>	<i>< 20%</i>	<i>1 hr.</i>		<i>\$500</i>
<i>III</i>	<i>4</i>	<i>> 15% or MRP²</i>	<i>3 hrs.</i>	<i>\$100</i>	<i>\$250</i>
	<i>5</i>	<i>< 15%</i>	<i>3 hrs.</i>		<i>\$100</i>
<i>IV</i> <i>(see note ¹ below)</i>	<i>6</i>		<i>24 hrs.</i>	<i>\$5,000 per year per group</i>	<i>\$50</i>

COST OVER 4 YEARS: as per proposal in year 1 brief

(i) Background to On-Call Coverage

231. Being "on-call" requires a physician to handle all non-scheduled clinical work during regular working hours in addition to previously scheduled responsibilities. Physicians on-call must also manage urgent patient issues during evenings, nights,

weekends, and statutory holidays. They are required to respond to phone or pager inquiries and be available to attend in person on short notice.¹⁴⁴

232. The Hospital On-Call Coverage (HOCC) program was established under the 2000 Framework Agreement between the Ministry of Health (MOH) and the Ontario Medical Association (OMA). Its main goal was to “enhance and stabilize the delivery of hospital On-Call services to Ontario patients” and to “provide stability and predictability in physician On-Call coverage across Ontario.”

233. Since then, the HOCC program has undergone several important updates. Nonetheless, key elements—such as the algorithm used to assign physician groups to funding levels—have remained unchanged.

234. In the 2021 Physician Services Agreement (PSA), the MOH and OMA agreed to a major overhaul of the HOCC program, aiming to better recognize the burden of On-Call work by developing levels of call intensity based on agreed-upon indicators, with a commitment to invest up to \$75 million in the new program.

235. Responsibility for designing the new On-Call program was assigned to the bilateral HOCC Working Group. To date, the group has not reached an agreement on all elements of the new program, and its progress has also been hindered by uncertainty over the available investment in the program, which remains to be determined by this Board.

236. The OMA’s burden-based on-call coverage proposal presented here is consistent with the principles recognized in the 2021 PSA.

¹⁴⁴ See also Dr. Eric Touzin, OMA Presentation on Hospital On-Call Coverage (HOCC) Program Presentation to Arbitrator Kaplan, May 16, 2025, BOD VOL 5 TAB 147.

(ii) **Problems with the Current Program**

237. In the current Hospital On-Call Coverage (“HOCC”) program, each specialty of practice is assigned to one of 4 levels, as follows:¹⁴⁵

Level	Specialty
I	Family Medicine
II	Anesthesia, General Surgery, Orthopedic Surgery, Obstetrics and Gynecology, Neurosurgery, Vascular Surgery, Urology, Plastic Surgery, Cardiac and Thoracic Surgery; Psychiatry, Internal Medicine, Pediatrics, Critical Care, Transplant Medicine
III	Cardiology, Emergency Medicine, Gastroenterology, Hematology/Oncology, Infectious Diseases, Neurology, Respiriology, Endocrinology, Geriatrics, Hyperbaric Medicine; Otolaryngology, Ophthalmology; Diagnostic Radiology
IV	Immunology, Dermatology, Physical Medicine, Rheumatology, Radiation Oncology, Gynecologic Oncology; Interventional Radiology, Nuclear Medicine

238. The payment to each group is then based on the group’s specialty of practice (which determines its level), and the number of physicians in the group (which determines the minimum coverage), as follows:

Level I/II			Level III	
MDs	Minimum Coverage	Annual Payment	Minimum Coverage	Annual Payment
5+	100%	\$181,677	100%	\$36,335
4	91%	\$164,719	95%	\$33,911

¹⁴⁵ A complete description of the current hospital on-call coverage program can be found at: Government of Ontario, [Hospital On-Call Coverage Program](#), Updated July 2024, BOD VOL 3 TAB 96.

3	80%	\$145,341	91%	\$32,701
2	80%	\$145,341	81%	\$29,068
1	60%	\$109,006	54%	\$19,377

NOTE. Level IV payments are based on utilization of call-in fees, with the average current payment per group of about \$5,000.

239. There are a number of key concerns with the current On-Call program.

240. First, since each group is assigned a funding level based solely on its specialty of practice, the current model does not account for differences in the burden of call - such as requirements for in-person attendance, response times, volume of calls, and acuity of services - which can vary significantly between physician groups within the same specialty. For example, every Family Medicine On-Call group of 5 physicians receives \$181,677 per year, regardless of how burdensome their On-Call duties are.

241. Second, payment is based on the minimum rather than the actual coverage provided. This penalizes groups with fewer than 5 physicians if they provide more than the minimum coverage. For example, every group of 3 physicians at Level III receives \$32,701 per year, regardless of how much coverage they actually provide, as long as it exceeds the minimum requirement of 91%.

242. Third, in the current HOCC program, there are effectively only three levels of call (I/II, III and IV) which are not enough levels to differentiate the burden of call. In particular, this structure does not separately recognize On-Call for groups required to be on site. Further, there is no differentiation between groups within each current level of call. For example, all groups at Level II receive the same amount, regardless of the burden of On-Call; similarly, there is no further differentiation for groups at level III.

243. Finally, the program lacks flexibility to incorporate new specialties or subspecialties and does not allow for the expansion of groups to address emerging needs.

(iii) **The OMA's Burden-Based On-Call Coverage Proposal**

244. In light of these problems, the OMA proposes a new burden-based on-call coverage program. The OMA proposes that:

- a. call levels be determined based on three key factors: (1) hospital after-hours billings, (2) in-person expected response times, and (3) most responsible physician (MRP) status,
- b. three new levels be added to the current program to better reflect the burden of call, and
- c. payments be made on a per diem (rather than per annum) basis, as follows:

Current Burden Level	New Burden Level	After-Hours Criteria	In Person Response	Current Per Diem Payment	New Per Diem Payment
I, II	1	On Site	On Site	\$500	\$800
	2	> 20%	1 hr.		\$650
	3	< 20%	1 hr.		\$500
III	4	> 15% or MRP	3 hrs.	\$100	\$250
	5	< 15%	3 hrs.		\$100
IV (see note ¹ below)	6		24 hrs.	\$5,000 per year per group	\$50

NOTES. ¹The values represent the average payment per group per year, with each group receiving a payment based on actual call fee utilization.

245. In this proposal:

Hospital after-hours billings are defined as the proportion of total billings that are hospital-based provided after-hours, as identified by the after-hour fee codes

and associated services during weekdays and any services provided on weekends and statutory holidays.

After-hours threshold criteria are set so that the current HOCC level is split about equally between groups with above and below the average hospital after-hours billings. For example, the threshold of 20% splits the groups at the current HOCC level I/II into about an equal number of groups at levels 2 and 3, and the threshold of 15% splits the groups at the current HOCC level III into an equal number of groups at the new levels 4 and 5.

Most Responsible Physician (MRP) status is defined as the physician that, while On-Call, is the Admitting and Most Responsible Physician (MRP) and first On-Call for a closed unit of at least 20 in-patient beds (confirmed with the hospital). The physician is not acting as a consulting specialist with patients being admitted to another service.

New per diem rates are set at the same level for levels 3 and 5 as in the current HOCC program. Levels 2 and 4 incorporate a premium over the groups at the same HOCC level but lower after-hour billings or on-site requirement. These premiums are set at the level that brings the total cost of the OMA proposal to about \$75 million that the Parties committed to in the 2021 PSA.

All other provisions of the OMA proposal are presented in Appendix A below.

246. The OMA's proposal has many advantages and is a significant improvement to the current HOCC program. It recognizes that the burden of call may vary within groups of the same specialty. Specifically, groups with an on-site requirement are explicitly acknowledged, and the existing three levels (I, II, and III) are further differentiated to account for differences in the burden of call within the same specialty.

247. As well, the proposal uses objective data on after-hour billings to assess the burden of call. While this metric has limitations - particularly for certain specialties - it serves to identify those groups within the same specialty that have higher after-hour billings.

248. The proposal also incorporates MRP (Most Responsible Physician) status as a determinant of the burden of call and a key element of the new proposed program. The MRP is accountable for the entire course of a patient's hospital admission, including administrative responsibilities, coordination and documenting care, and discharge

planning and communication with other care providers. MRP status is a strong proxy for phone call volume and overall burden.

249. The MRP status is an objective metric that can be verified with the call groups and hospitals and used to compare the burden of call amongst groups that carry the MRP designation and those that do not. This is especially important in the absence of objective data on the number, length, and timing of phone calls. Under the proposed model, MRP status can elevate a physician's burden level—for example, moving a group from Level 5 to Level 4.

250. In addition, the proposal recognizes the burden on groups that provide more than the minimum coverage. The per-diem compensation system was agreed upon by the OMA and MOH in the 2008 Physician Services Agreement, with interim payments for groups with fewer than 5 physicians providing higher coverage levels. However, a permanent per-diem system applicable to all groups has not yet been implemented.

251. Finally, the proposal minimizes disruption to current patterns of On-Call coverage. Specifically, the OMA's proposal seeks to ensure that no physician group is adversely impacted, which is crucial for maintaining stability and predictability in the delivery of hospital On-Call services in Ontario—one of the original objectives of the HOCC program under the 2000 Framework Agreement. Additionally, this provision acknowledges the value of expert judgment in the assignment of specialties to burden levels, a system developed and refined over more than 20 years and strongly aligned with practices in other Canadian provinces.

252. The OMA's costing of its proposal is based using actual data on 2,555 physician groups who applied for the new burden-based program. Of these, the complete data is available for 2,234 groups. For these groups, the costing was based on the following assumptions:

- a. The metric used was the proportion of total billings that are hospital-based that are provided after-hours, as identified by the after-hour fee codes and

associated services during weekdays and any services provided on weekends and statutory holidays.

- b. The thresholds used for after-hours are 15% (separating levels 4 and 5) and 20% (separating levels 2 and 3). These burden levels effectively separate levels III into an equal number of groups at levels 4 and 5, and levels I/II into an equal number of groups at levels 2 and 3.
- c. The per diem rates for levels 1 to 6 were, respectively, \$800, \$650, \$500, \$250, \$100 and \$50. For level 6, it is assumed that the groups cover on average 54 percent of days (the minimum required coverage level for Level III).
- d. A number of new specialties were assigned the following HOCC levels: I – Hospitalist Medicine; III - Surgical Assistants, Palliative Medicine, Addiction, and Laboratory Medicine; and IV – Genetics; which are then assigned to the new levels based on the after-hour billings.
- e. Current specialties of practice in Interventional Radiology and Gynecological Oncology were assigned to HOCC level II and Rheumatology to HOCC level III, which are then assigned to the new levels based on the after-hour billings.
- f. On-Site groups were identified as groups in Family Medicine, Hospitalists, Anesthesia, Obstetrics and Gynecology, and Internal Medicine, and 10% of self-identified groups in Critical Care and Pediatrics.

253. The remaining 321 groups lack data on either the specialty of practice or the number of physicians. For these groups, the costing was based on the average for 2,234 physician groups with complete data.

254. The estimated total cost of this proposal is \$92.5 million.

Appendix A. Other Provisions of the OMA Burden-Based On-Call Program Proposal

New Groups:

A new sub-specialty group can be eligible to be registered in the new Program if it meets the following criteria:

- a. The new sub-specialty is recognized by the CPSO, or is otherwise recognized as a distinct sub-specialty by the OMA parent section;*

- b. At the hospital site where the new sub-specialty is requested, there must be a physician group in the main specialty with at least five active members providing after-hours hospital On-Call coverage;*
- c. The rotation for the new sub-specialty must be first On-Call, completely separate from the physician group in the main specialty;*
- d. The rotas for the main specialty and the new sub-specialty must operate concurrently and separately from one another with no cross-coverage; and*
- e. Seamless call must be provided by both rotations.*

A bilateral expert panel will review the application based on these criteria and make its recommendation. The expert panel may request more information from the applicant groups, and the applicant groups will have an opportunity to resort to a dispute resolution mechanism.

Program Expansion:

A bilateral On-Call Committee will be established with a mandate to make recommendations on an annual basis for new On-Call groups or for the expansion of existing groups, within the funding determined for this purpose by the Parties through the Physician Services Agreement.

The bilateral On-Call Committee shall be composed of an equal number of OMA and Ministry representatives. Any disputes at the bilateral HOCC committee will be referred to the referee for final and binding resolution.

Second On-Call Stipends:

Currently, only the departments of General and Family Medicine, Anesthesia, Obstetrics and Gynecology, General Internal Medicine, and Pediatrics (Neonatal Intensive Care units only) may be eligible for a second stipend.

In the new program, any physician specialty may be eligible for a second stipend if they meet the following criteria, specifically:

- a. The department seeking the second stipend must have at least ten active members providing after-hours hospital On-Call coverage (there do not need to be ten physicians on each of the two call schedules);*
- b. The rotation seeking the second On-Call stipend must be first On-Call (i.e. two physicians must be providing first On-Call after-hours coverage to the hospital at all times). Funding for second call, i.e. back-up coverage, is not provided;*

- c. *The two rotas must operate concurrently and separately from one another with no cross-coverage. When applying for the second stipend, copies of both On-Call rotation schedules must be submitted to clearly demonstrate that the two physician groups operate separately;*
- d. *Seamless call must be provided by both rotations, and*
- e. *For medical sub-specialties such as but not limited to Endocrinology, Nephrology, Gastroenterology, Respiriology, Cardiology and Geriatric Medicine, after-hours On-Call rotas seeking HOCC funding must be first On-Call, completely separate from the Internal Medicine and/or any other On-Call schedule.*

In addition, Family Medicine, Hospitalists, and Internal Medicine groups can be considered for the third and fourth stipend, based on the number of adult “medical beds” (non-surgical/psychiatry) to determine how many admitting MRPs are required or based on the total number of active members in excess of 10 physicians.

Premiums:

*The GP Anesthesia and Ruralty Premiums will be consolidated into a single premium. The initial **per-diem** amount will be set based on the group’s new burden level and RIO score, as follows:*

<i>New Burden Level</i>	<i>RIO Score 31 to 44</i>	<i>RIO Score 45 to 100</i>
<i>1</i>	<i>\$150</i>	<i>\$250</i>
<i>2-3</i>	<i>\$100</i>	<i>\$150</i>
<i>4-5</i>	<i>\$50</i>	<i>\$100</i>
<i>6</i>	<i>\$25</i>	<i>\$50</i>

These rates will be increased by the same global increase as the On-Call flow through rate.

Other Provisions:

All other provisions not explicitly mentioned in the OMA proposal to continue as in the current HOCC program, such as regional call and intra-sectional allocation.

Dispute Resolution:

(a) Initial Placement in the HOCC Burden-Based System

1. *The HOCC Working Group will provide each physician group and their hospital with a period of 10 days to provide any updated or additional information to the Working Group that they want the Working Group to consider in determining the placement of the physicians within the new burden-based HOCC system ("the level").*
2. *The HOCC Working Group will consider all of the material provided by each physician group (with the support and input from their hospital) in order to determine the level to which the physician group will be assigned.*
3. *If the Working Group agrees on the level, the physician group and the hospital shall be advised accordingly with brief reasons to explain the basis for the placement in that level. The Working Group shall determine the date for implementation. Any dispute with respect to the initial date of implementation will be determined by William Kaplan.*
4. *In the event that either the physician group or the hospital believe that the information they have provided has not been appropriately considered or properly applied in placing the physician group in a specific level, either the hospital or the physician group can appeal to the HOCC Appeal Board (the "Appeal Board") as provided below.*
5. *In the event that the Working Group cannot agree on the level, the matter will be determined by arbitrator William Kaplan (or such other person agreed upon by the parties) on an expedited basis and in accordance with a process determined by the arbitrator. However, the arbitrator will give the Working Group, the hospital and the physician group the opportunity to make brief oral or written submissions as the arbitrator so determines.*
6. *The decision of the arbitrator shall be final and binding on the Working Group, the hospital and the physician group and will be implemented as directed by the arbitrator.*

(b) HOCC Appeal Board

7. *Where the hospital or the physician group seeks to challenge the decision of the HOCC Working Group with respect to initial process, they shall advise the Working Group of the challenge and the basis for the challenge within 10 calendar*

days of being advised of the level placement. The dispute shall be referred by the Working Group to the HOCC Appeal Board for a final and binding determination.

- 8. The HOCC Appeal Board shall be composed of one representative of the OMA, one representative of the Ministry of Health and the referee under the Binding Arbitration Framework who will serve as Chair of the Appeal Board.*
- 9. The Chair shall determine the process for the hearing of the appeal while ensuring that the Working Group representatives, the physician group and the hospital are given an opportunity to make written or oral submissions as determined by the Chair.*
- 10. The decision of the Appeal Board shall be issued as soon as possible following the hearing of the appeal. In the event that the parties are not unanimous in their decision, the decision of the Chair shall be the decision of the Appeal Board.*
- 11. The decision of the Appeal Board will be final and binding on the parties, the physician group and the hospital.*

(c) Reconsideration

- 12. Either the hospital or the physician group may seek a reconsideration of their placement based on an allegation of a material change in circumstances. The party seeking the reconsideration shall provide both the HOCC Working Group and the other party with a brief summary of the basis for the claim and any evidence in support of the claim.*
- 13. The claim will be considered by the HOCC Working Group and the procedure set out in (a) and (b) above shall apply.*

D. Repair and Modernization of Existing Alternative Payment Programs (APPs)

The OMA proposes \$40 million dollars in targeted funding over the life of the 2024-28 PSA (\$10 million dollars for each year), with the funding to be allocated in the following manner:

- 1. Establish a bilateral APP Repair Working Group reporting to the Physician Services Committee. The APP Repair Working Group will be tasked with:*
 - a. Developing and applying evaluation framework to prioritize APPs requiring repair/modernization;*
 - b. Calculating the cost of repair and modernization using agreed upon methodology; and*
 - c. Recommending for implementation to PSC specific agreements reached by the Working Group throughout the course of the PSA.*
- 2. The OMA also proposes a comprehensive review of the APP agreements listed below, with a mandate to make recommendations for enhancements and modernization of the agreements. The OMA is proposing a working group to be established for each of these agreements:*
 - a. Care of the Elderly Agreement*
 - b. Northern Specialist APP*
 - c. Provincial Trauma Team Lead APP*
 - d. Regional Consulting Pediatrics APP*

It is to be noted that this proposed funding does not include repair costs for EDFA or the academic funding agreements (pediatrics and AHSCs generally), which are the subject of separate proposals below.:

COST: \$40 million total (\$10 million in each of Years 1, 2, 3, and 4).

(i) Background to APPs

255. Alternate Payment Plans (“APPs”), as compared with the traditional fee-for-service model, are intended to provide income stability, maintain service levels, and

serve as an effective tool in recruiting and retaining specialists in practices where the traditional fee-for-service payment model is not appropriate and does not reflect the work performed.

256. In recent years, the province has witnessed a surge in Expression of Interest (“EOI”) requests (68 EOIs in 2022 vs 20 EOIs in 2015) for these alternative plans, which highlights both the desire and the need for the expansion of alternate payment models.

257. There are currently approximately 280 APPs in the province, with a total expenditure of approximately \$1.57 billion.

258. Many of the existing agreements have been in place for a long period of time (e.g., Northern Specialist Agreement in 2008, Regional Consulting Pediatrics Agreement in 2007) but have not been reviewed to ensure they continue to meet the changing needs of patients, physicians, and the communities they serve.

259. Many APP arrangements are in dire need of repair and modernization, as funding levels agreed to at the time that these APPs were developed are no longer competitive or reflect current realities. Many of the APPs were to be reviewed periodically by the parties (e.g., Academic Health Sciences Agreement, Care of the Elderly Agreement etc.) to ensure they continued to be appropriate to their circumstances, but, generally, these reviews have not occurred. This deficiency must now be addressed to ensure the vitality and viability of those plans.

260. Targeted funding is required to be allocated to provide for the repair and modernization of APPs as set out below.

(ii) Proposal to Repair and Modernize APPS

261. In order to repair, modernize and provide for compensation increases in addition to normative increases to existing APPs, the OMA proposes \$40 million dollars in targeted funding over the life of the 2024-28 PSA (\$10 million dollars for each year), with the funding to be allocated in the following manner:

1. *Establish a bilateral APP Repair Working Group reporting to the Physician Services Committee. The APP Repair Working Group will be tasked with:*
 - a. *Developing and applying evaluation framework to prioritize APPs requiring repair/modernization;*
 - b. *Calculating the cost of repair and modernization using agreed upon methodology; and*
 - c. *Recommending for implementation to PSC specific agreements reached by the Working Group throughout the course of the PSA.*

2. *The OMA also proposes a comprehensive review of the APP agreements listed below, with a mandate to make recommendations for enhancements and modernization of the agreements. The OMA is proposing a working group to be established for each of these agreements:*
 - a. *Care of the Elderly Agreement*
 - b. *Northern Specialist APP*
 - c. *Provincial Trauma Team Lead APP*
 - d. *Regional Consulting Pediatrics APP*

It is to be noted that this proposed funding does not include repair costs for EDAFA or the academic funding agreements (pediatrics and AHSCs generally), which are the subject of separate proposals below.

E. Introducing New APP Agreements and Expanding Existing APPs

As per the 2021 PSA, a robust joint process has been developed to assess and respond to expansion proposals more systematically. The OMA proposes that the bilateral group finalizes the evaluation criteria as per the 2021 PSA and the working group review these requests bilaterally using the agreed upon evaluation criteria. To implement changes agreed to by the parties through the joint process, dedicated funding to permit APP expansion and new APPs must be provided.

The OMA proposes a \$30 million investment in the first year of the PSA and an incremental investment of \$30 million in each subsequent year of the PSA to enable the growth of current APPs and the establishment of new APPs.

Again, it is to be noted that this funding excludes expansion and growth of EDAFAs as well as the academic funding agreements (pediatrics and AHSCs generally), which are the subject of separate proposals below.

COST: \$120 million total (\$30 million in each of Years 1, 2, 3, and 4).

(i) Proposal for New and Expanding APPs

262. In general terms, growth and expansion of APP agreements is a critical priority that must be addressed through the 2024 PSA. As of October 2023, there were a total of approximately 120 EOI submissions to the Ministry requesting expansion of current APPs or the establishment of new agreements. These requests are expected to continue, and the number of APPs must expand in response to the growing demand for medical services.

263. To recruit new physicians necessary to meet increasing patient demands, physician groups must be able to submit requests and, it is hoped, receive approval from the Ministry and the funding to attract additional human resources before they can expand to meet clinical needs. This is often a difficult and time-consuming process and funding to allow for expansion may not always be available. In the past, the Ministry would either approve, deny or partially approve such expansion requests, often without providing the OMA or physician groups with a sound (or even any) rationale for its

decision. A more systematic and transparent process was required to assess expansion applications from APP groups.

264. As per the 2021 PSA, a robust joint process has been developed to assess and respond to expansion proposals more systematically. The OMA proposes that the bilateral group finalizes the evaluation criteria as per the 2021 PSA and the working group review these requests bilaterally using the agreed upon evaluation criteria. To implement changes agreed to by the parties through the joint process, dedicated funding to permit APP expansion and new APPs must be provided.

265. The OMA proposes a \$30 million investment in the first year of the PSA and an incremental investment of \$30 million in each subsequent year of the PSA to enable the growth of current APPs and the establishment of new APPs.

266. This proposal includes additional funding support for a new APP for Laboratory Medicine physicians, as discussed in part J below.

F. Amend Current Oncology APP Agreements

The OMA proposes as follows:

Radiation Oncology – Funding for Peer Review: *Peer review be included as an essential service and receive appropriate remuneration through the existing Radiation Oncology APP*

Gynecology oncology: *Shadow billing premium to be increased from 33% to 50% due to increasing complexities of the systemic therapies;*

Increased funding for fellows, clinical associates and non-APP oncologists.

Medical oncology/Neuro oncology: *Neuro-oncologists to be either added as a separate physician group under POAFP, or to develop a new APP for Neuro-oncology that offers the same compensation as the Medical Oncology AFP.*

COST: *\$15 million total (\$9 million in Year 1 and \$6 million in Year 2 to be divided as follows: 1.3 million for gynecologic oncology, \$12 million for peer review based on \$52.2 k per FTE, and \$1.8 million for Neuro Oncology).*

(i) Background for Oncology Proposals

267. The Provincial Oncology AFP (“POAFP”) has undergone restructuring in the past few years to allow independent governance of each specialty, with the original agreement now split into three separate agreements for radiation oncology, medical oncology and gynecological oncology. Through this process, it was recognized that the terms of separate agreements have not been reviewed and amended for over a decade. As a result, the OMA proposes the changes outlined below.

(ii) Radiation Oncology – Funding for Peer Review

268. The technological revolution in radiotherapy planning and delivery that emerged over the last 15 to 20 years and which continues to develop has improved patient outcomes, enabling greater treatment intensity and precision. It has also enhanced system capacity and resulted in much shorter overall treatment times. The widespread adoption of these highly complex and intense radiation treatment plans has, however, increased the risk of error in radiation planning and delivery compared to earlier, simpler

techniques. Radiation therapy involves high-dose, high-precision treatment that, if improperly delivered, can cause irreversible damage to healthy tissue. Having a second expert review treatment plans reduces that risk significantly.¹⁴⁶

269. Peer review of radiation treatment plans is now accepted as the most effective way to mitigate these risks and is considered best practice in most jurisdictions that employ modern radiotherapy. As a result, there is a need for a targeted funding increase to modernize the Radiation Oncology Alternative Payment Plan (APP) to fund Peer Review Quality Assurance (PRQA) as a standard, essential component of clinical radiation oncology practice.

270. PRQA is integral to the safe and effective patient treatment and a vital part of radiation oncology care, but it is currently unfunded. PRQA is a rigorous, prospective verification of individual treatment plans conducted by peer radiation oncologists to ensure patient safety, adherence to standards, and optimal treatment outcomes.

271. Though it has become a recognized standard of practice in Ontario, PRQA is not currently accounted for in the APP. Indeed, Ontario Health-Cancer Care Ontario (“OH-CCO”), in its oversight role for radiation therapy quality assurance in Ontario has issued practice guidelines establishing peer review as a standard of care¹⁴⁷ and as a collected quality metric with minimum specified acceptable activity standards. Peer review is conducted in each Regional Cancer Centre as a scheduled weekly or more frequent multidisciplinary (Radiation Oncology, Therapy, Medical Physics) group event where all

¹⁴⁶ See also OMA Section on Radiation Oncology, “Targeted Increase for Modernization of the Radiation Oncology APP” Presentation to Arbitrator William Kaplan, March 4, 2025, BOD VOL 5 TAB 144; See also Radiation Oncology – Peer Review QA (PRQA) not funded through Radiation Oncology APP Submitted in Response to Question Raised at the meeting on March 4th, March 7 2025, BOD VOL 5 TAB 145.

¹⁴⁷ Cancer Care Ontario, *Recommendations for Radiation Peer Review*, (May 2021), BOD VOL 3 TAB 97; See also Canadian Partnership for Quality Radiotherapy, [Quality Assurance Guidelines for Canadian Radiation Treatment](#) (December 30, 2019), BOD VOL X TAB. ¹⁴⁷ Cancer Care Ontario, *Recommendations for Radiation Peer Review*, (May 2021), BOD VOL 3 TAB 97; See also Canadian Partnership for Quality Radiotherapy, [Quality Assurance Guidelines for Canadian Radiation Treatment](#) (December 30, 2019), BOD VOL 5 TAB 146 **146**.

proposed complex treatment plans are presented clinically. Such plans are displayed visually, critiqued, and required changes recorded, allowing the optimization of treatment. All physicians participate in sessions related to their disease site. These meetings can be held virtually and regionally for rare diseases, where a single centre cannot meet a quorum for an effective meeting. OMA billing data (Interactive cost analysis FY2017-8) demonstrates that 43,221 treatment plans were undertaken by Radiation Oncologists in that fiscal year and that 39,785 (92%) qualified for Peer Review.

272. Peer-reviewed studies also confirm its importance. For example, a meta-analysis showed PRQA results in changed recommendation 28 % of the time, with major change recommendations in 12 % of cases.¹⁴⁸

273. Radiation oncologists currently dedicate an average of four hours per week to this task, often outside of regular clinical hours. This in turn leads to extended workdays and a cumulative burden that undermines both physician well-being and long-term sustainability. Thus, PRQA should be explicitly funded through the Radiation Oncology APP as a distinct, standard-of-care activity.

274. Based on weekly workload data, and median billings in 2019/2020, plus base funding, the OMA calculated a range of funding levels, based on assumptions of hours worked per week from \$47,132 to \$57,304, with a recommendation of a funding level at the midpoint of \$52,210. However, this figure is likely an underestimate. Since 2018, radiation oncology practice has grown considerably more complex, driven by technological advances and an increase in high-dose, stereotactic treatments. Annual billing and peer review volumes have grown alongside these demands, reinforcing the need to reassess compensation.

¹⁴⁸ Jomy J, Lu R, Sharma R, Lin KX, Chen DC, Winter J, Raman S. A systematic review and meta-analysis on the impact of institutional peer review in radiation oncology. *Radiother Oncol.* 2025 Jan; 202:110622. doi: 10.1016/j.radonc.2024.110622. Epub 2024 Nov 14. PMID: 39547365, BOD VOL 3 TAB 98.

275. Data from recent years show a dramatic increase in the volume of cancer cases in Ontario. In fiscal year 2019–2020, over 67,000 cases required radiotherapy, with nearly 80% of them undergoing peer review. Demand is expected to grow significantly with Ontario's aging population and rising cancer burden. Yet PRQA has been carried out as an unfunded good-faith effort by radiation oncologists for over a decade.

276. This situation is no longer sustainable. Without formal recognition and funding, the ability to continue delivering high-quality, safe, and timely cancer care is at risk. PRQA is a direct clinical service, essential to every patient receiving radiation treatment, and is fully endorsed by both clinicians and governing bodies as the standard of care. Modernizing the APP to include it is both logical and necessary.

277. Its continued omission from the APP is inconsistent with its clinical significance and the demands on physicians and this service must now be recognized and appropriately funded.

(iii) Gynecology Oncology

278. Systematic therapies administered by gynecologic oncologists are becoming increasingly complex, and many more patients are on targeted therapies (such as Parp-inhibitors and immunotherapy). Overall, patients are increasingly complex and unwell, with more comorbidities and more lines of therapy, and their visits require more time and more comprehensive work-ups. Similarly, the extent and complexity of gynecologic oncology surgeries and post-operative care has increased since the gynecologic oncology APP was implemented. Gynecologic oncology surgeons are performing more complex procedures to achieve optimal surgical outcomes for patients with gynecologic malignancies. In 2021/22, gynecologic oncology surgeons performed 61.3% more low rectal resections, 50% more splenectomies, 23% more ileostomies than in 2014/15.

279. As gynecology oncology is not an OHIP recognized medical specialty, gynecology oncologists submit shadow billed claims under the Obstetrics & Gynecology specialty. The current methodology for applying flow-through to each APP agreement, has resulted in a significant disparity in the value of shadow billing premiums amongst

oncologists, with gynecology oncologists receiving a 33% premium on shadow billed claims while their colleagues in medical oncology APP receive 61% premium on shadow billed claims.

(iv) Neuro-Oncology

280. Central Nervous System oncologists are represented by two professional groups:

- Neurologists who have Central Nervous System specialty training and are referred to as “neuro-oncologists”, and
- Medical oncologists who have Central Nervous System subspecialized training and are referred to as “medical neuro-oncologists”

281. Ontario is particularly dependent on the efforts of the neuro-oncologist group who direct the care of about 80% of patients in the province who have a primary brain tumour. Neuro-oncologists commonly serve as the most responsible physician for patients undergoing adjuvant therapy for a primary brain tumour and, in this role, they oversee treatment with systemic therapies, manage seizure and complications of disease and treatment, and offer patients guidance with medical decision-making.

282. The majority of medical oncology practitioners, including medical neuro-oncologists, are remunerated for their work with cancer patients through a POAFP. The POAFP recognizes the complexity of the services they provide, the importance of teaching and research to advance high quality cancer care for Ontarians and supports a sustainable workforce.

283. The POAFP, however does not extend to neuro-oncologists, who instead depend heavily on FFS billings, which does not provide equitable income commensurate with their clinical workload compared to their medical neuro-oncologists colleagues. Indeed, this inequity in funding has contributed to recent loss of neuro-oncologists at Hamilton and Trillium Health Sciences.

(v) The OMA's Oncology APPs Proposal

284. As a result, the OMA proposes as follows:

1. Radiation Oncology

a. Peer review be included as an essential service and receive appropriate renumeration through the existing Radiation Oncology APP

2. Gynecology oncology

a. Shadow billing premium to be increased from 33% to 50% due to increasing complexities of the systemic therapies;

b. Increased funding for fellows, clinical associates and non-APP oncologists.

3. Medical oncology/Neuro oncology

a. Neuro-oncologists to be either added as a separate physician group under POAFP, or to develop a new APP for Neuro-oncology that offers the same compensation as the Medical Oncology AFP.

An estimated \$15 million will be required to address these oncology changes (\$1.3 million for gynecologic oncology, \$12 million for peer review based on \$52.2 k per FTE, and \$1.8 million for Neuro Oncology).

G. Hospitalist APP

The OMA proposes the creation of a new Hospitalist APP, funded at no less than 20 million dollars.

285. One of the greatest challenges facing acute-care hospitals across Canada, is the increasing number of general medicine admissions to hospitals. Extensive research has identified this population as elderly (mean age 70) complex patients, with multiple chronic conditions (6 comorbid diagnoses on average), most commonly requiring emergency hospitalization for acute exacerbations or complications. They have been classified as general medicine admissions because of their wide range of discharge diagnoses.

286. General medicine admissions increased by over 30% between 2010-15 alone at the hospitals studied and now account for almost 20% of all admissions to acute-care hospitals, over 1/3 of emergency department (ED) admissions, and 1/4 of their bed days. Hospitals increasingly require hospital medicine services and hospitalists to provide Most Responsible Physician (MRP) care for these patients.

287. Currently, hospital medicine services and hospitalists are funded primarily through fee for service, but many hospitals are providing top-up funding in order to recruit and retain physicians to serve as MRPs. This practice has created inequality and instability across the province. As a result, the 2021 PSA established a bilateral Working Group to design a Hospitalist Medicine APP to help support and stabilize the provincial hospitalist system. The 2021 PSA stated that the Working Group's mandate includes "Parameters for a Hospitalist APP compensation structure and an appropriate rate/price to support a Hospitalist APP".

288. The Working Group has been diligently working on developing a comprehensive APP for Hospitalists in Ontario with the original implementation date set for April 1, 2023.

It has established broad principles for the new APP, including eligibility criteria for sections and specialties. However, the working group has not been able to reach an agreement on the best way to structure coverage for ED admissions, for overnight coverage, and in turn, the related implications for the APP. Despite several extensions, progress has stalled over the past several months. Both the Ministry and the OMA disagree on critical aspects of the APP.

289. As a result, in April 2025 the OMA provided notice to the Ministry that it would be seeking to use the arbitration process to resolve the dispute that has arisen with respect to funds available to support the development of Hospitalist APP as stipulated in the 2021 PSA. The OMA now requests that the arbitration board award its proposal to fund a new hospitalists APP at a cost of no less than 20 million dollars, in addition to utilizing the funding currently provided by hospitals as hospitalist physician compensation.

H. New Infectious Diseases, Genetics and Geriatrics APPs

Infectious Diseases: Increase the original \$39,785 average payment per Infectious Diseases specialist to an average payment of \$53,052 per physician in 2024/25, to reflect the value of flow-through increases over the ensuing years. Assuming 200 physicians would be eligible to receive the premium in 2024, this will result in an expenditure of \$10.6M. Current expenditures on the ID initiative under program parameters are expected to reach \$4.8M in 2024/25. Therefore, a further investment of \$5.8M is required to right-size the Infectious Diseases Funding Initiative to the 2011/12 levels.

Modernize and automate implementation of the initiative to allow for timely payment of funds under the ID Funding Initiative within 3 months of the end of the fiscal year in which services were provided.

Allow access to ID funding initiative to any new Infectious Disease physician.

Genetics: Direct the bilateral MOH-OMA Working Group to agree on amendments to existing APP agreements (including AHSC AFP) to bring the total average compensation for geneticists under these APPs to \$415,003.03 per FTE.

For all other FFS physicians a notional rate of \$361,157.55 and a 50% shadow billing premium should be made.

The cost to bring all eligible geneticists up to the target rate is estimated at \$6.54M (net of existing OHIP and hospital funding).

Allow access to the APP for any new geneticist in Ontario

Geriatrics: Allow every geriatrician in Ontario access to the APP as per parameters outlined below. Allow any new geriatrician in Ontario access to the APP

Offering an APP under above parameters to all eligible geriatricians in the Ontario will result in a cost of \$11.15M.

COST: \$23.4 million total

290. As part of the 2008 Physician Services Agreement, the OMA and the Ministry agreed to develop new funding models for Infectious Diseases, Genetics and Geriatrics. In all three cases the parties have agreed to implement temporary, application-based

funding models. Information collected through this application process was to be used to develop permanent funding models for each specialty. Due to deterioration of the relationship between the ministry and the OMA prior to the conclusion of the Binding Arbitration Framework, the work on permanent models was not undertaken until the agreement of the parties to re-engage in this process as part of the 2021-24 PSA.

291. In the result, working groups between the Ministry and the OMA have been established for each of the initiatives. However, the parties were unable to agree on numerous fundamental issues, most importantly whether the funding of the new agreements should be on a “cost neutral” basis. These disputes were referred to Arbitrator Kaplan who had remained seized on the issues under the 2021-24 PSA. The parties have now agreed that the issue of funding for these three areas will be determined by this Arbitration Board for the 2024-28 PSA.

(i) Infectious Diseases

292. In 2011/12, when the temporary Infectious Diseases Funding Initiative was implemented, a total program expenditure of \$3.7M was allocated to 93 eligible physicians for an average annual payment of \$39,785 per physician. Although the allocation of \$3.7M has been adjusted to reflect Infectious Diseases increases agreed to as part of each subsequent PSA, it was not adjusted to keep pace with increasing number of Infectious Diseases physicians in the province. In the result, the amount available for allocation was distributed amongst more and more physicians so that, in 2022/23 there were 188 eligible infectious diseases physicians, who received an average payment of \$22,531 per year as compared with an average payment of \$39,785 to fewer physicians in 2011-12.

293. Infectious Diseases has constantly placed as one of the lowest earning specialties as determined through the CANDI-RAANI hybrid model and ongoing reductions to annual funding available through the ID initiative will make it more difficult to recruit and retain ID physicians in Ontario.

294. As well, payments for ID initiatives are severely delayed. The Ministry should be directed to ensure payment is made within 3 months of the end of the fiscal years for which billings were made.

	Number of ID Physicians	Total Program Expenditure	Average Payment per ID physician
2011/12	93	\$ 3,700,000.00	\$ 39,784.95
2022/23	188	\$ 4,235,910.00	\$ 22,531.44

(ii) Genetics

295. Genetics was another specialty where the parties agreed to work on establishing a new APP, following up on their 2008 agreement to do so. Unlike the issue with geriatrics and infectious diseases, there was no requirement that the new arrangement be “revenue neutral”. Further to correspondence in February 2024 between the PSC co-chairs, the parties have agreed to a target rate of \$373,454.73 per FTE. Applying a cumulative year 3 and 1 increase of 11.1254% to the agreed to rate results in a new genetics rate of \$415,003.06 per FTE.

296. The OMA proposes as follows:

Direct the bilateral MOH-OMA Working Group to:

Agree on amendments to existing APP agreements (including AHSC AFP) to bring the total average compensation for geneticists under these APPs to \$415,003.06 per FTE.

For all other FFS physicians a notional rate of \$361.157.55 and a 50% shadow billing premium should be made.

There are currently 43.6 FTE geneticists in the province. The cost to bring all eligible geneticists up to the target rate is estimated at \$6.54M (net of existing OHIP and hospital funding).

Allow access to the APP for any new geneticist in Ontario

Additional funding required to bring genetics APP to new rate – \$6.5M

(iii) Geriatrics

297. Further to correspondence in February 2024 between the PSC co-chairs, the parties agreed to parameters of an APP which includes a notional rate of \$262,271 per FTE and a shadow billing premium of 86.85%. With Year 3 and Year 1 cumulative increase of 11.2451% the new notional rate per geriatrician for 2024/25 would be \$291.763.

298. The OMA proposes as follows;

Allow every geriatrician in Ontario access to the APP as per parameters outlined above.

Allow any new geriatrician in Ontario access to the APP.

There are up to 170 Fee-for-Service geriatricians in the province. Offering an APP under above parameters to all eligible geriatricians in the Ontario will result in a cost of \$11.15M.

I. **Physicians Practicing under Divested Provincial Psychiatric Hospitals (“DPPHS”)**

The OMA proposes the following changes to the approach to flowing through compensation increases to these physicians:

Structure DPPH adjustments as follows:

Target rate to be adjusted by the psychiatry specialty increase;

DPPH physicians receiving total compensation below the new target rate will have their total compensation topped up to the new target rate; and

DPPH physicians who are receiving total compensation that is above the new target rate will receive the psychiatry increase applied on their current total compensation.

DPPH physicians receive funding adjustments as agreed to under the terms of the PSA no more than 3 months after adjustments are provided to FFS psychiatrists.

299. There are 9 Divested Provincial Psychiatric Hospitals (“DPPHs”) in Ontario. While various types of practice arrangements exist within the DPPHs, the majority of psychiatrists work under the employment model, are paid an annual salary, and generally receive the same benefits as other employees within their organizations.

300. As part of the 2008 PSA, the OMA and the ministry implemented a top-up program to allow physicians working in DPPHs to receive a minimum compensation level based on the physicians’ type and level of work. As part of this work, the parties agreed to top-up physicians to that target rate. This resulted in a two-stream funding mechanism where the majority of physician compensation would flow from hospital global budgets while OHIP would top-up physicians to a target rate. The target rate has been adjusted in line with psychiatry increases resulting from each subsequent PSA.

301. The current funding structure has created a number of challenges including:

- significant delays in the flow of funds - Top up funding is determined based on reporting from each hospital which can occur at the end of each fiscal year, resulting in significant delays in the flow of funds. For example, although most

physicians in the province received permanent year 2 increases on April 1, 2023 as per the financial agreement outlined in 2021 PSA, physicians practicing under DPPH models have yet to receive these adjustments.

- adjustments up to target rate – Adjusting funds only up to a target rate means many physicians are not eligible for top-up funding, including many part time physicians whose pro-rated funding and FTE values make them ineligible for top ups. This has created an artificial cap on physician earnings under the DPPH that can result in physicians reducing their clinical activities at DPPHs once FTE requirements are met.
- reporting disputes – Despite multiple attempts to standardize compensation reporting from hospitals, significant disparities in the reporting of compensation components continue to persist. This often results in hospitals needing to resubmit reports, creating additional delays in top up payments to physicians.

302. The OMA proposes the following changes to the approach to flowing through compensation increases to these physicians:

Structure DPPH adjustments as follows:

Target rate to be adjusted by the psychiatry specialty increase;

DPPH physicians receiving total compensation below the new target rate will have their total compensation topped up to the new target rate; and

DPPH physicians who are receiving total compensation that is above the new target rate will receive the psychiatry increase applied on their current total compensation.

DPPH physicians receive funding adjustments as agreed to under the terms of the PSA no more than 3 months after adjustments are provided to FFS psychiatrists.

J. Laboratory Medicine

303. The 2021 PSA included a directive to develop a Laboratory Medicine Alternate Payment Plan (APP). However, the mandate was extremely narrow and constrained by a requirement for cost neutrality. Despite two extensions to the process, it became apparent that the resulting APP would not meet the needs of the membership. As a result, the OMA is requesting that the process be restarted and that new directives be included in the 2024 PSA, without a requirement for cost neutrality.

304. Laboratory Medicine has been waiting over 20 years for a payment model that provides fair compensation for fair work. Indeed, the current Laboratory Medicine Funding Framework Agreement (LMFFA) remains in draft form and was never finalized. The critical needs that must be addressed; the growth in pathology FTEs has simply not kept pace with the increasing volume and demand for services.

305. A new and modernized Laboratory Medicine APP must include the modernization of compensation, the streamlining of funding processes, and the incorporation of reliable workload metrics as well as attracting additional physicians to the work. This is the only way to deal with the crisis of excessive workload, low morale and high burnout rates, and to overcome the widening gap between workload and staffing,

306. Currently, laboratory medicine physicians are paid through two funding streams: one from hospitals and a top-up from the MOH/OHIP. There is consensus that a single funding stream administered by OHIP (with hospitals potentially administering pay) would be a more efficient and transparent solution. At present, hospitals are required to fund most laboratory physician payments directly from their base budgets, making it challenging to add new full-time equivalents (FTEs). When changes such as PSA increases are implemented, the lack of clarity between MOH and hospital funding often results in physicians and groups having to pursue payment themselves, with associated payment delay and confusion.

307. Under the current approach, there is also a very limited ability to measure and attain adequate staffing due to hospital funding restrictions and the absence of a

standardized process and criteria to request new positions. What is urgently needed in a new Laboratory Medicine APP is a standardized workload measure at the hospital level should be agreed to and used to guide appropriate staffing and funding. This is the only way to overcome the current situation involving growing and unfilled vacancies, a crippling recruitment crisis plagued by inadequate compensation including in comparison with other jurisdictions.

308. As a result, the OMA proposes that a revised directive be included in the 2024 PSA for the creation of a comprehensive Laboratory Physician Alternate Payment Plan without the restriction of cost neutrality. As under the 2021-24 PSA, the chair of the arbitration board should remain seized to deal with any disputes arising in the establishment of a modernized and comprehensive Laboratory Medicine APP.

K. Academic Health Science Centres (“AHSC”) Alternative Funding Plans (“AFPs”)

Academic Physicians provide complex patient care and the majority of medical education in Ontario. Since 2019, there has been a progressive decline in the number of full-time equivalent Academic Physicians, caused by both a decrease in the ability to retain current talent and a decrease in the ability to recruit new talent to AHSCs, which is negatively impacting the ability to deliver complex patient care and train the next generation of Ontario physicians.

The OMA proposes improved funding for Academic Physicians. This proposal advocates a strategic approach to “rightsize” academic physician funding to redress the decrease in per-physician funding, better align with the increased demands on Academic Physicians, and ensure sustainability and effectiveness in addressing Ontario’s healthcare challenges. This includes updating current funding models, enhancing support for educational activities, fostering an environment conducive to medical innovation, and continued provision of complex, high-quality patient care.

To support this investment and ensure accountability, the OMA also proposes that the Academic Medicine Steering Committee be re-established to provide a forum for the Ministry, OMA, Academic Physicians, AHSCs and Universities to engage in long-term human resource planning, enable development of new models of care, and explore non-fee-for-service Academic Physician funding arrangements.

COST: \$131 million for AHSCs (\$20 million from Year 1 award, and \$37 million a year in each of Years 2, 3, and 4).

(i) Background to AHSCs in Ontario¹⁴⁹

309. Ontario’s Academic Health Science Centres (“AHSCs”) play a unique and critical role in Ontario’s and, indeed, Canada’s healthcare system. In many ways, they are the “crown jewels” of that system and are internationally recognized for their clinical care, teaching, and research. Yet, as a result of many years of inadequate funding, they have been left to fall into crisis and urgently require an influx of funding if they are to be able to continue to fulfill their essential role. As discussed further below, the progressive

¹⁴⁹ Please see the Slide Deck Presentation, “Rightsizing Academic Medicine Funding,” Dr. Barry Rubin, Provincial Lead, Academic Health Science Centre, Presented to Arbitrator Kaplan, October 8, 2024, BOD Vol. 5, Tab 133.

decline in the number of FTEs in Academic Medicine since 2019 is having a severe and negative impact on patient care and Ontario's ability to train the next generation of physicians.

310. Ontario's AHSCs are located in Toronto, Mississauga, London, Hamilton, Kingston, Ottawa, Sudbury, and Thunder Bay. They provide highly specialized, tertiary, and quaternary care for complex illnesses, not typically available in community health care settings, such as complex cancer, cardiac, orthopedic, and neurosurgical procedures, transplantation, advanced radiation therapy, ECMO (e.g., for patients with lung failure due to COVID) and the treatment of rare diseases. AHSCs also perform a key educational role, training the majority of Ontario's doctors. They also conduct cutting-edge research to advance medical knowledge and practice.

311. AHSCs Alternative Funding Plans ("AFPs") were first created in the 2000 OMA and Ministry of Health and Long-Term Care Physician Services Agreement, where the parties agreed to implement AFPs in Hamilton, London, Ottawa and Toronto in order to promote and support the recruitment and retention of Academic Physicians.

312. Under the 2017-21 PSA, while limited additional funding was provided to the AHSC AFP in innovation funding (\$10 million dollars), the key proposal for additional funding for rightsizing and repair was referred to the parties for further discussion. Over five years later, no progress has been made and the crisis facing academic medicine has exacerbated and the sector is facing daunting challenges.

313. The OMA's AHSC proposal has been developed by the province's 17 AHSC Governance Organizations which represent 8,000 Academic Physicians. It is critical that the 2024-28 PSA include sufficient funding support to enable repair and rightsizing of Ontario's AHSC and to maintain a viable, competitive, thriving health care system in Ontario.

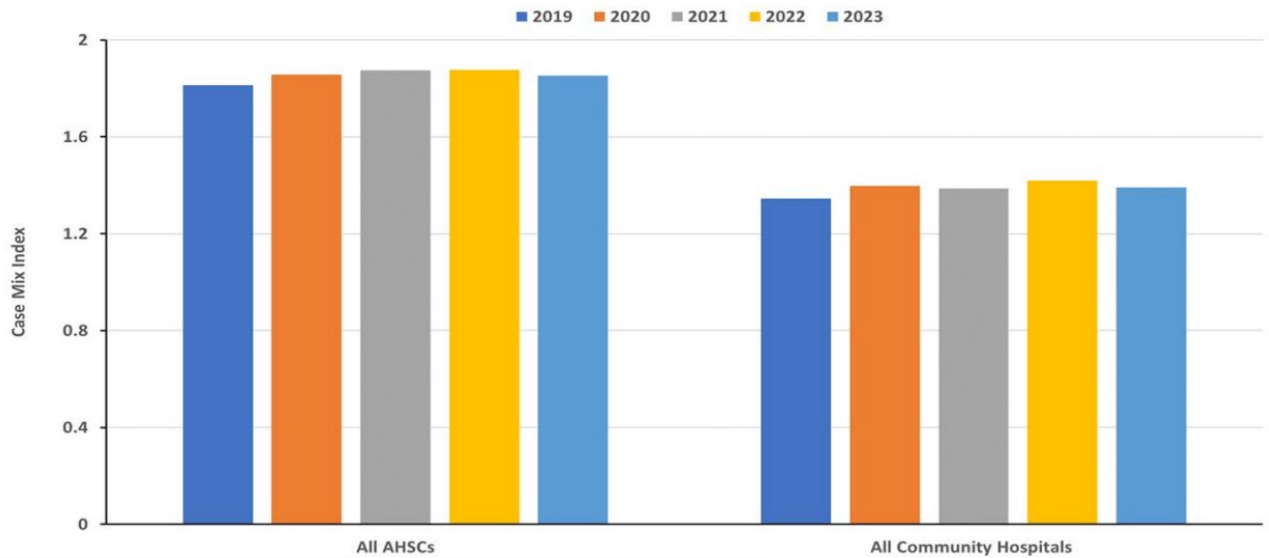
(a) Providing Highly-Specialized Complex Care

314. The physicians in AHSCs possess highly specialized expertise and skills that are in demand globally. The AHSCs are *the* primary referral centers for other hospitals and clinics across the province, providing care for the most complex cases.

315. AHSCs fulfill a unique role in Ontario's healthcare system. Indeed, there are many clinical services in the province that are provided exclusively by AHSC physicians. These include, amongst others, the following:

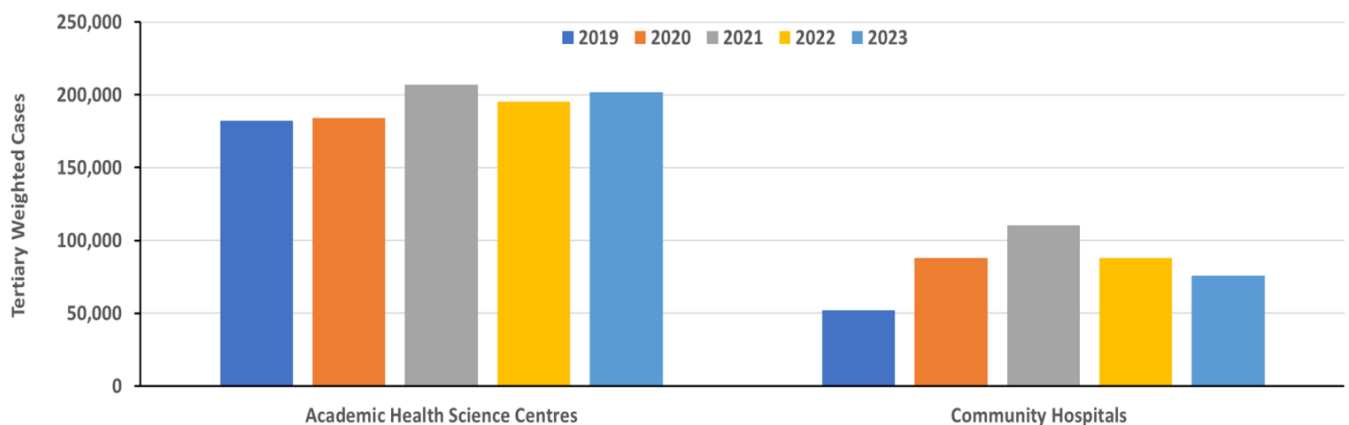
- Mechanical support (ECMO) for lung failure (e.g. due to COVID) or heart failure (e.g., after heart attack).
- Liver, heart, lung, kidney, pancreas, small bowel, corneal, stem cell, and hand transplantation.
- Management of the most complex heart and blood vessel diseases.
- Complex medical, surgical, and radiation therapy for cancer with simultaneous reconstructive surgery.
- Deep brain stimulation for Parkinson's Disease, movement disorders, and dementia.
- Complex orthopedic, ophthalmology, and obstetric and gynecologic procedures.
- Management of patients with rare diseases.

316. The higher complexity of care provided at AHSCs compared to community hospitals is reflected in the following graph, which illustrates differences in Case Mix Index (CMI). CMI measures the allocation of resources required to care for and/or treat patients.

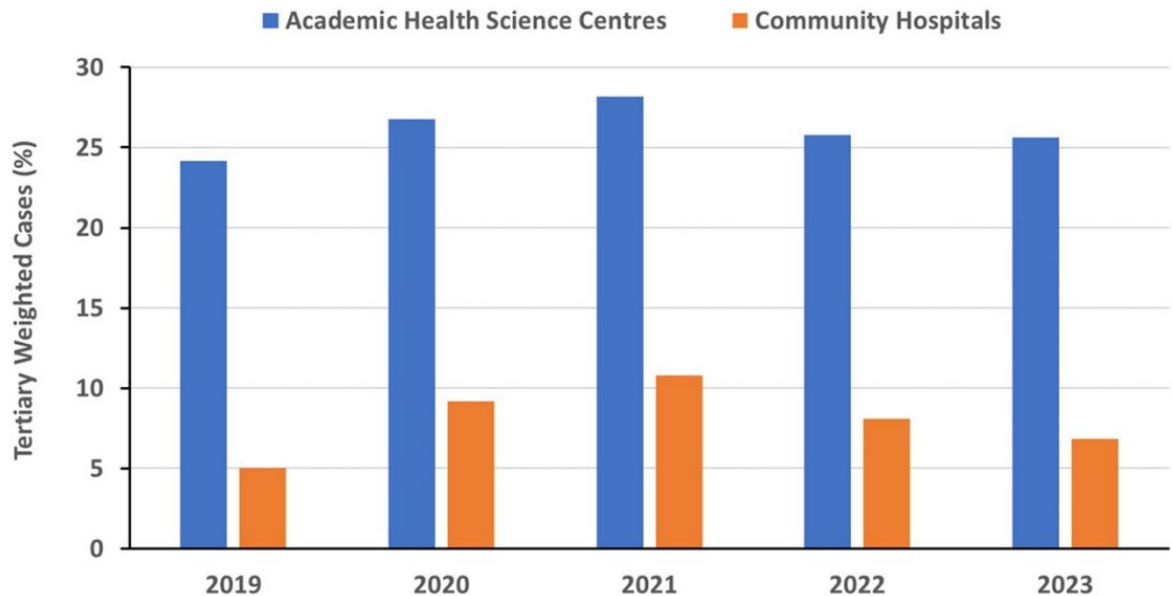


* Case mix index (CMI) measures the allocation of resources required to care for and/or treat patients in a group. Data from the OHA.

317. Another measure of complexity of care is tertiary weighted cases, which represent patients that require highly specialized skills, technology, and support services. As the following graph illustrates, using this measure, AHSCs provide care for more than double the number of tertiary weighted patients than are treated in community hospitals. In fact, tertiary weighted cases make up more than 25% of AHSC's caseload. In contrast, only 5-10% of community hospitals' caseloads are tertiary-weighted cases.



* Tertiary weighted cases represent patients that require highly specialized skills, technology, and support services. Data from the OHA.



318. It is clear that AHSCs are central to the overall functioning of Ontario's health care system. It is vital that their unique needs be recognized and adequately funded.

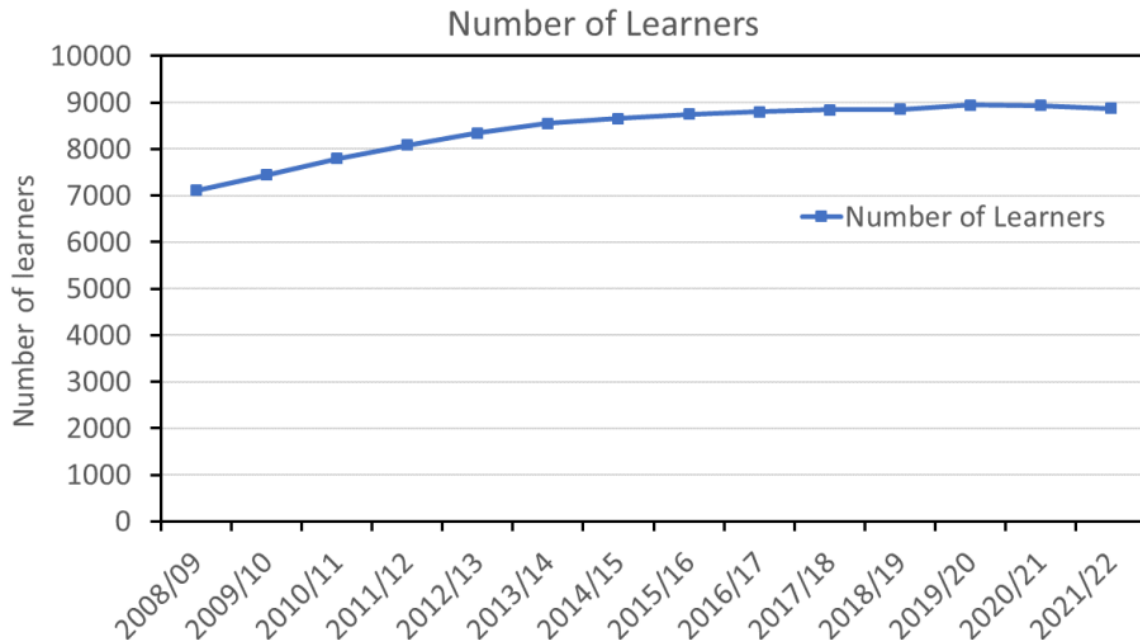
(b) Training the Next Generation of Doctors

319. AHSCs are integral to training the next generation of Ontario's physicians, including both primary care physicians and specialists. In fact, two-thirds of the physicians in Ontario were trained at an AHSC in Ontario. AHSCs must be appropriately funded and staffed if Ontario is to be able to continue to train a sufficient number of physicians to manage Ontario's growing, ageing and diverse population.

320. However, it must also be recognized that, because of the time spent by AHSC physicians in their core educational/training and research roles, they are somewhat restricted in terms of their ability to be remunerated for their clinical activities.

321. In recent years, as the province has sought to increase the number of physicians in Ontario, the educational role for Academic Physicians has only increased. As the

following graph illustrates, between 2008/09 and 2021/22, the number of learners at AHSCs, which includes medical students and residents, has increased 31%.



322. Similarly, the number of medical training days at AHSCs increased 31% over the same time period.

323. As well, the time and effort required to teach and evaluate learners has also increased. Demands on faculty are many. The Royal College of Physicians and Surgeons of Canada *Competence by Design* and the Ontario College of Family Physicians outcomes-based approach mandate that faculty responsibilities now include:

- Designing and evaluating Entrustable Professional Activities (“EPAs”), assessed by competency committees. EPAs are stage-specific clinical tasks that an individual can be trusted to perform in a given health care context, once they have demonstrated sufficient competence
- Observing individual clinical exams.
- Directly observing supervision of learners.
- Maintaining emphasis on experiential learning, which means most of medical education is not scalable and is labour-intensive.

324. This increased demand for medical education will exacerbate the continued recruitment and retention problems summarized above. Thus, there is a high degree of

rigor and effort required of faculty with respect to curriculum design and delivery, expected learner supports, comprehensive documentation, and addressing accreditation standards.

325. These challenges—delivering rigorous educational programs and simultaneously responding to the increasingly complex care needs of patients—while also facing physician shortages are felt every day in AHSCs such as Sunnybrook Hospital in Toronto.

326. Educational programs in place at Sunnybrook include subspecialty post-graduate level training. However, by way of one example only, enhancing subspecialty geriatric medicine training programs to produce more geriatricians (essential if Ontario is to meet the healthcare needs of a growing and aging population) can only occur if there are enough academic physicians to teach the cohort of physicians who are interested in pursuing this specialty. Due to extremely high clinical loads of complex patients, educational program directors now find it extremely challenging to hire expert teachers who are willing to take on new geriatrician trainees.

327. Similarly, at the undergraduate level, there are renewed efforts to teach the principles of “older adult medicine” to meet current population demographic needs, with the introduction of a new course on top of existing coursework at the University of Toronto. Two weeks of the curriculum are now devoted to older adult medicine in the final year of medical school. This will provide important skills to future primary care physicians, who will manage the vast majority of seniors, but also future surgeons, psychiatrists, ophthalmologists etc., who also will inevitably be looking after older adults. The course is to be taught by geriatric medicine physicians, family physicians, and geriatric psychiatrists. However, while this course is to be delivered to approximately 270 students, no new physician resources have been provided to do this work. Furthermore, with the emergence of new medical schools and the corresponding increase in medical school enrollment, the need for physicians to deliver curriculum and provide practical

training to new doctors will increase. In a field of medicine that is already under remunerated, funding for academic activities is desperately needed.¹⁵⁰

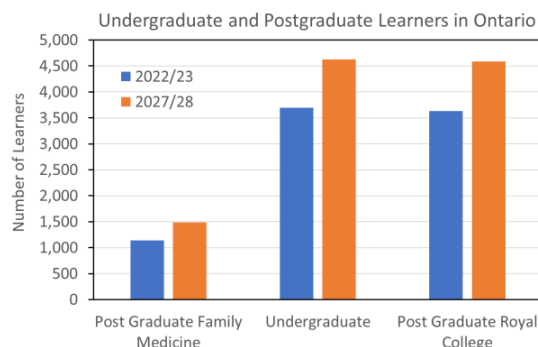
328. Based on Government announcements, by 2027/28, the number of undergraduate and postgraduate learners is projected to increase further by 26%. As Premier Doug Ford himself announced in the context of the 2023 budget:¹⁵¹

That's why we're expanding the number of undergraduate and graduate medical school spots and putting qualified Ontario students at the front of the line. We're training the next generation of Ontario doctors right here in Ontario to stay here and care for Ontario communities.

The new investment in Budget 2023 to add another 100 undergraduate medical school seats and another 154 postgraduate medical training seats builds on the expansion of 160 undergraduate and 295 postgraduate medical training seats announced last year, the largest expansion of Ontario's medical school system in over a decade.

329. The practical impact of these announcements on the number of learners at AHSCs is set out in the following table:

Medical School	Undergraduate Expansion (phased in, 2022 - 2026)	Postgraduate Expansion (phased in, 2024 - 2028)
McMaster	14	50
NOSM U	44	63
Ottawa	14	50
Queen's	34	52
Toronto	44	67
Western	16	50
Total	166	332



Year	Total
2022/23	8,471
2027/28	10,704

COFM: 73% of all medical training is now done at AHSCs (projected 71% in 2027/28).

¹⁵⁰ Information provided by Dr. Rajin Mehta, Geriatric Medicine Care Team, Sunnybrook Hospital

¹⁵¹ Government of Ontario - [Ontario Training More Doctors as it Builds a More Resilient Health Care System](#) – March 15, 2022, BOD VOL 3 TAB 99.

330. The need for rigorous educational oversight, direct clinical supervision, and competency-based medical education, which have all been mandated by provincial and federal physician regulatory agencies, has increased the time and effort required for Academic Physicians to teach medical learners. This is a crucial limitation because, as noted, two-thirds of the physicians who practice in Ontario were trained by Academic Physicians at an AHSC in Ontario.

331. While the OMA applauds the efforts to train more doctors in Ontario, the reality is that additional academic physicians are needed to teach these learners while being appropriately compensated. However, as outlined further below regarding the recruitment and retention problems facing AHSCs, the number of FTE physicians at AHSC has declined rather than increased in recent years, and AHSCs are increasingly unable to maintain sufficient physician human resources to meet present, let alone future, demands. This pressure is expected to increase further in the coming years. Patient care and academic demands, resource constraints, and concerns over the desire of physicians to have an improved work-life balance have led to the inability of AHSCs to recruit and retain sufficient Academic Physicians, with many transitioning to community practice, moving out of the province, or retiring from the practice of medicine.

(c) Research Innovation

332. Along with training the physicians required to care for Ontario's growing and aging population, AHSCs also drive health-care innovation through cutting-edge research, which in turn supports Ontario's knowledge-based economy and the development of innovative, life-saving clinical procedures.

333. As part of the 2008 PSA, \$10 million per year was dedicated to a newly established AHSC Innovation Fund. Under the 2017-21 Kaplan arbitration award, an additional \$10 million in funding was provided to the AHSC AFP in innovation funding. Since 2008-09, over \$200 million has been allocated to support 2,300 projects through the AHSC Innovation Fund. The AHSC Innovation Fund is a direct and concrete example of using targeted PSA funding to improve health care outcomes for Ontarians. Many

projects supported by the Innovation Fund have led to additional funding from peer-review agencies (CIHR) and international awards, and many have been implemented across Ontario.

334. Some of the selected high-profile Innovation Fund projects include:

- Development, calibration & testing of a Pediatric Automated Mobile Play Audiometer. Matt Bromwich, CHEO.
- Evaluation of a Unique Canadian Community Outreach Program Providing Obstetrical Care for Pregnant Adolescents. Nathalie Fleming and Amanda Black, The Ottawa Hospital.
- Bridge or continue coumadin for device surgery - RCT. David Birnie, The Ottawa Heart Institute (NEJM).
- Post op home monitoring after joint replacement. Homer Yang, The Ottawa Hospital (now in London).
- Harnessing mobile health technology to personalize the care of CKD patients. Sandy Logan, Sinai / UHN.
- Functional Recovery in Critically Ill Children: the "Weecover" longitudinal cohort study. Karen Choong and Douglas Fraser, Hamilton Health Sciences Centre and London Health Sciences Centre.
- Improving Decision-making for Empiric Antibiotic Selection (IDEAS). Nick Daneman, Sunnybrook.

335. If AHSCs are to continue performing this key research work and remain innovation leaders in Canada and globally, "right-sized" funding is essential.

(ii) Challenges Facing AHSCs in Ontario

336. While the vital role played by Ontario's AHSCs as outlined, only in very general terms above, cannot be disputed, the failure over many years to address the ongoing funding problems has led to a crisis for AHSCs, most notably with respect to their ability to retain physicians and recruit new physicians.

337. Funding for AHSCs has lagged well behind the growth in the demands and expectations placed on academic medicine. While the number of academic physician Full-Time Equivalents ("FTE", CIHI definition) in AHSCs increased 28.6% from 2008 to 2023, the \$210,000,000 in base AHSC AFP funding did not change over this time period. This significant dilution of AHSC AFP funds on a per-physician basis has limited the

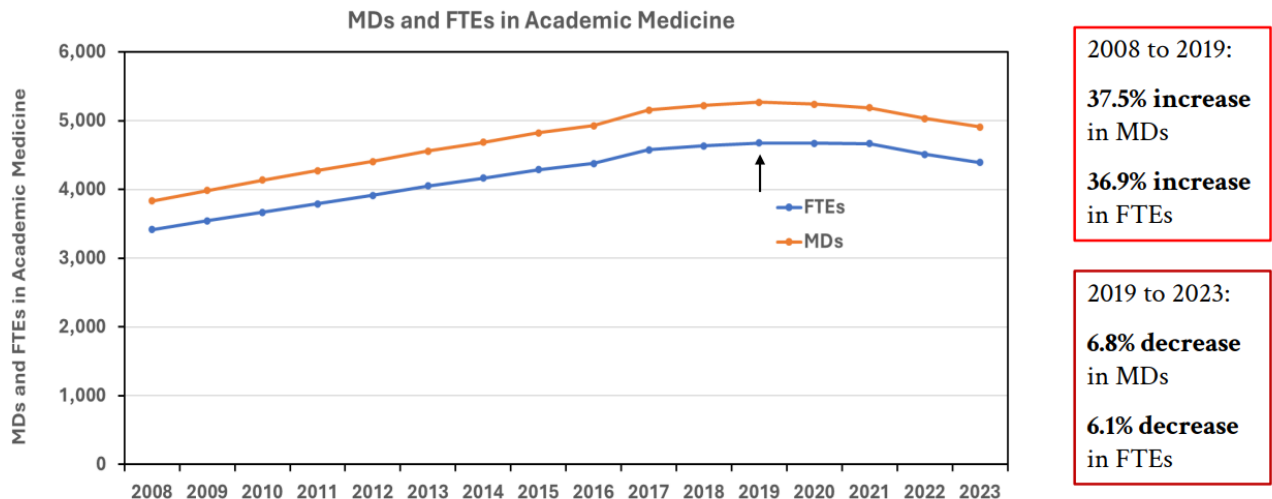
ability to recruit and retain much-needed Academic Physicians and has led to challenges providing seamless access to patient care in teaching hospitals and performing academic activities, including teaching.

338. The current crisis in academic medicine is the result of several complex and interrelated factors. As noted, academic physicians spend significant time fulfilling teaching, research, and innovation mandates, which, while essential to their roles, are all less well remunerated than the provision of clinical services. In addition, since the ability to perform clinical services is correspondingly reduced, the remuneration generated from performing these services is less than in the non-academic community. All of this has had a negative impact on the ability of academic medicine to recruit and retain academic physicians. Limitations in the number of academic physicians have led to a corresponding and direct impact on the ability of AHSCs to provide some healthcare services. Underfunding, overwork resulting from patient care and academic demands, as well as recruitment and retention challenges, have also led to high levels of burnout among academic physicians.¹⁵²

As academic and research centres providing highly specialized care, Ontario AHSCs compete in an international market for highly skilled and educated academic physicians, facing increasing recruitment and retention challenges. At the same time, more doctors need to be trained, the population is growing and aging, and the complexity of the health care demands of the population they serve has increased.

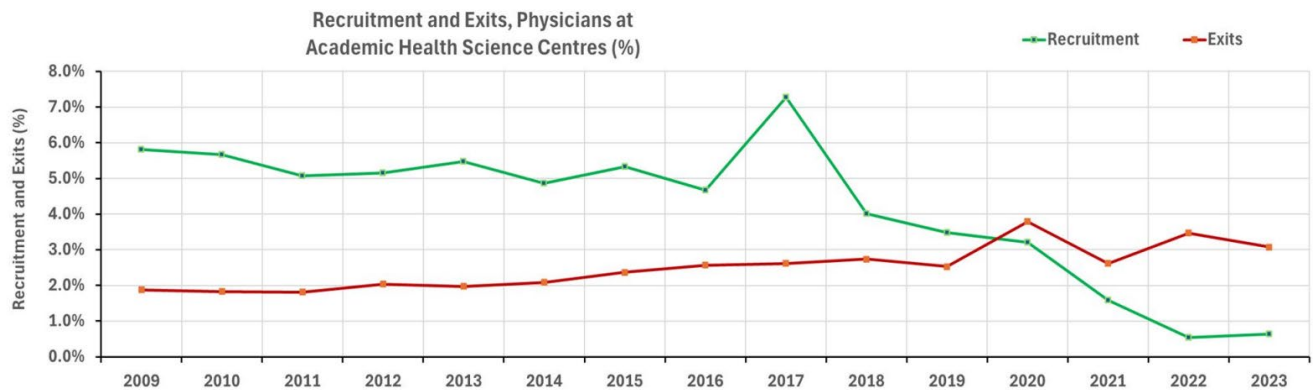
¹⁵² Rubin B et al. "Burnout and distress among physicians in a cardiovascular centre of a quaternary hospital network: a cross-sectional survey" CMAJ Open 11;9(1):E10-E18, 2021, BOD VOL 3 TAB 100; Jelen A, Rodin G, Graham L, et al. Prevalence and drivers of nurse and physician distress in cardiovascular and oncology programmes at a Canadian quaternary hospital network during the COVID-19 pandemic: a quality improvement initiative. BMJ Open 2024;14:e079106. doi:10.1136/bmjopen-2023-07910, BOD VOL 3 TAB 101.

As shown in the graph below, from 2019 - 2023, the number of FTE physicians at AHSCs decreased by 6.1%. In contrast, over the same time period, the number of physicians in Ontario increased by 8.7%, and the population of Ontario increased by 7.3%.



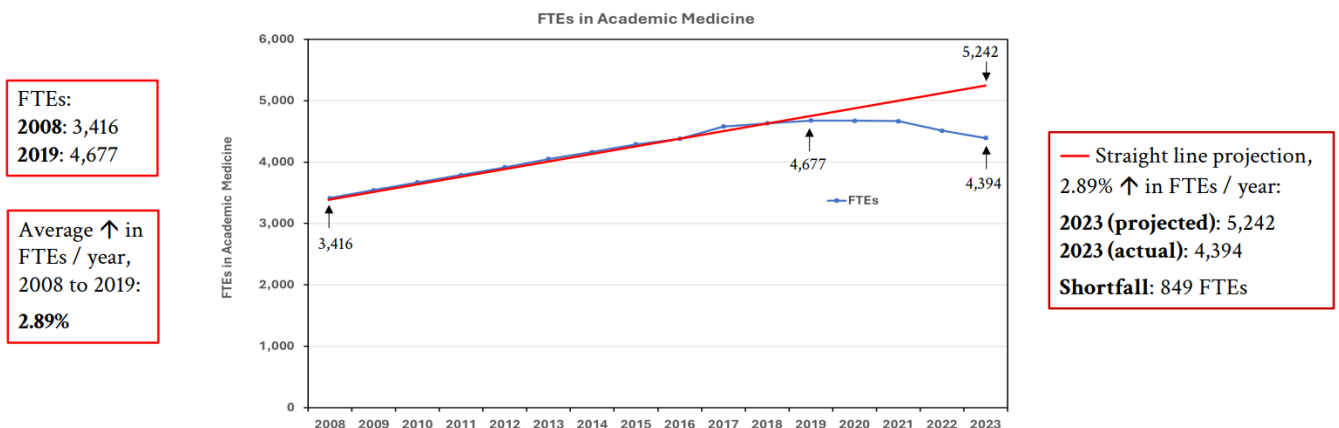
Preliminary data indicate that the number of Academic Physician FTEs continued to decrease in 2024, resulting in an overall 8.9% decrease in FTEs in Academic Medicine from 2019 to 2024. This ongoing decline in the number of Academic Physician FTEs further exacerbates the negative impact on patient care and the ability of AHSCs to train the next generation of physicians in Ontario.

339. Whereas physician recruitment at AHSCs was 5 – 6% a year between 2008 and 2016, recruitment has decreased progressively since 2017 and was less than 1% / year in 2022 and 2023, while exits from Academic Medicine (retired from medical practice, moved from an AHSC to a community hospital, or moved from an AHSC to a medical practice outside Ontario) was between 3 to 4% / year in 2022 and 2023. Due to the lack of AFP funding increases, AHSCs have been unable to offer sufficiently competitive remuneration packages that are necessary to attract highly skilled and in-demand specialized Academic Physicians to replace those who have retired from or left AHSCs to pursue other opportunities. The following graph illustrates this trend:



Preliminary data indicate that recruitment to AHSCs was 0.5% in 2024, while exits from Academic Medicine were 3.1% in 2024. The ongoing higher rate of exits compared to recruitment resulted in a continued decline in the number of Academic Medicine FTEs in Ontario.

340. In order to make up for the shortfall in the recruitment of FTE physicians to AHSCs from 2019 to 2023, 849 additional FTE physicians would need to be hired.



341. This shortage of physicians is having very concerning and immediate real-world impacts every day at AHSCs. A sample of these impacts is listed below¹⁵³:

- At London Health Science Centre (LHSC), patients have gone blind while waiting for ophthalmology care. LHSC is also the only trauma center in the Southwestern region. Due to the escalating shortage of tertiary/quaternary care physicians, it is increasingly difficult for primary and secondary care physicians to move patients they are unable to manage to the academic setting where they can obtain the care they require.
- At St. Joseph's and LHSC, the Department of Physical Medicine and Rehabilitation is unable to care for any mild traumatic brain injury patients who are sent back to their family doctor or the ER. Similarly, their ability to follow moderate to severely brain-injured patients in the medium to long term has been compromised. They can no longer follow individuals with spinal cord injuries in the long-term once their acute/sub-acute problems are addressed and must discharge these patients to the care of their family doctors, who have little experience or expertise managing them. Likewise, the majority of stroke patients cannot be followed in the medium to long term.
- The Ottawa Hospital needs but has been unable to recruit 16 physicians to fill new positions and 24 physicians to fill vacated positions, especially in Cardiology, General Internal Medicine, Palliative Care, and Hematology.
- At Queen's in Kingston, 35 of the 450 positions are currently vacant, especially in Emergency Medicine, Family Medicine, and Obstetrics.
- At Mt. Sinai Hospital (MSH), and within the University Health Network (UHN), there are insufficient staff physicians to cover the General Internal Medicine ward overnight, which requires nocturnist coverage paid with physicians' income. Additionally, MSH and UHN have been unable to recruit any physicians for Neurology, Hematology, and Infectious Diseases, and seven positions remain unfilled across surgery. UHN had to close the thrombosis clinic to new consults because of insufficient Hematologist capacity.

¹⁵³ Information provided by Dr. Clare Mitchell, MHA, LLM (Health) Hamilton, Dr. Hutnik, Dr. Keith Sequiera MD, FRCP(C), Dr. Barry Rubin, Dr. Elizabeth Grigoriadis, and Dr. Rajin Mehta.

- At St. Michael's Hospital, Medical Imaging has found it impossible to attract new hires when competing against community hospitals.
- The Ottawa Heart Institute has been trying unsuccessfully for two years to recruit three cardiologists to treat heart rhythm disorders. The Institute has also been unable to use two of its five cardiac cath labs to perform complex ablations for heart rhythm disorders due to a lack of Cardiac Anaesthesiology support.
- Surgeries had to be canceled at multiple hospitals due to a lack of Anesthesiologists.
- Sunnybrook Hospital is a dedicated stroke centre. When an acute stroke occurs, it can be due to a blood clot blocking a major vessel to the brain. With no blood supply, 1.9 million brain cells can be lost per minute, so every minute counts. At Sunnybrook, there are only a few highly trained physicians who can emergently insert a catheter into a blood vessel and remove the clot blocking it, thereby restoring blood flow to the brain. Functional recovery can be incredibly dramatic if this procedure is done in a timely manner. At Sunnybrook, there have been 10 instances in the August to December 2024 time period where strokes like this occurred, but, due to a lack of physician resources, patients were left waiting for this procedure.
- At Hamilton Academic Health Sciences Organization (HAHSO), there are physician shortages in multiple departments. As of December 2024, within the Department of Psychiatry, HAHSO had 6 positions open, which it had been struggling to fill. However, residents, who would ideally be the source of recruitment, have regularly chosen to work in community hospitals and private clinics, primarily because the remuneration for psychiatry positions at HAHSO is not competitive with those in the community. Similarly, Anesthesia at HAHSO has been unable to recruit and retain anesthesiologists for pediatric and adult care. HAHSO has lost 16 mid-career anesthesiologists to community hospitals in the past 5 years, resulting in regular operating room closures due to anesthesia shortages.
- At the Women's College Hospital Academic and Medical Services Group, shortages of academic physicians are also impacting access to clinical care. This is most evident in their specialized Dysautonomia and Complex Blood Pressure Disorder Clinic. This clinic covers the entire province, but

the wait time for admission is 2 years. These patients are extremely complex, and consultations can take a considerable amount of time to assess. Women's College has been unable to recruit additional physicians to work in this clinic in part due to its complexity and because consultations take very long with no dedicated OHIP fee codes to compensate appropriately for the work being done. Consequently, patients experience significant disability and even fatal complications while waiting for an appointment.

342. These are but a handful of examples that demonstrate the very real and very pressing recruitment and retention challenges being faced by AHSCs as a result of insufficient funding and an inability to offer competitive compensation. There is without question a crisis in academic health which impacts the entire province and beyond.

(iii) The OMA's AHSC Proposal

343. This proposal advocates a strategic approach to "right-size" academic physician funding and address the decrease in per-physician compensation, thereby better aligning with the increased demands on academic physicians and ensuring sustainability and effectiveness in addressing Ontario's healthcare challenges. This includes updating current funding models, enhancing support for educational activities, fostering an environment conducive to medical innovation, and continued provision of complex, high-quality patient care.

344. Specifically, the OMA seeks an award of \$137 million of targeted funds in the PSA for AHSC AFPs. This includes \$20 million to be allocated from the Year 1 Award, as well as an additional \$37 million a year in each of Years 2, 3, and 4.

345. The Provincial AFP received \$210,000,000 in funding to support 3,416 Academic Physician FTEs in 2008, which equals \$61,475 per FTE. Adjusted to present day, which includes the 13.9% flow-through funding increase from 2008 – 2023 and a 6.965% funding increase for Year 1 of the 2025 PSA, the funding per FTE should be \$74,860 / FTE.

346. Flow-through funding increases are intended as price increases, applied to the compensation rate per FTE. Flow-through funding is not intended to fund growth or increased demand.

347. The number of FTEs in academic medicine rose from 3,416 in 2008 to 4,394 in 2023, an increase of 978 FTE (28.6%). No AFP funding has been provided to account for the growth in FTEs in Academic Medicine from 2008 to 2023. Therefore, an FTE Academic Physician is compensated less under the AHSC AFP in 2024 than they were in 2008.

348. Thus, an additional $978 \text{ FTE} \times \$74,860 / \text{FTE} = \$73,213,531$ in AFP funding is required to account for the growth in FTEs in academic medicine from 2008 to 2023.

349. As noted above, the number of FTEs in Academic Medicine increased from 3,416 in 2008 to 4,677 FTEs in 2019, an average net recruitment of 2.89% / year. If recruitment to Academic Medicine had continued to increase at 2.89% / year after 2019, there would have been 5,242 FTEs at AHSCs in 2023. However, due to decreasing recruitment and increasing exits from Academic Medicine, there were only 4,394 FTE at AHSCs in 2023, a shortfall of 849 FTE. To support the recruitment of 849 FTEs to Academic Medicine, a further $849 \text{ FTE} \times \$74,860 / \text{FTE} = \$63,556,531$ in AFP funding is required.

350. The funding required to rightsize Academic Medicine funding is therefore \$73,213,531 to account for the unfunded growth in FTEs, plus \$63,556,531 to enable recruitment, which equals a total of \$136,770,062. This AFP funding would address issues of growth in Academic Medicine, the shortfall in recruitment, and the stagnant funding level per FTE since the inception of the Academic Medicine AFP.

351. As well, the OMA requests a mid-term reassessment of the Academic Medicine AFP effective April 1, 2026 to account for any further increases in academic physicians and teaching requirements, with this board of arbitration seized to resolve any dispute between the parties.

352. To support this investment and ensure accountability, the OMA also proposes that the Academic Medicine Steering Committee be re-established to provide a forum for the Ministry, OMA, Academic Physicians, AHSCs and Universities to engage in long-term human resource planning, enable the development of new models of care, and explore non-fee-for-service Academic Physician funding arrangements.

L. Northern Ontario Academic Medicine Association (“NOAMA”) AFP Proposal¹⁵⁴

The OMA proposes an increase of \$10.4 million for the NOAMA AFP to meet ongoing and increased needs of the AFP, in particular, the planned increase in learner numbers from 473 in 2022 to 787 in 2027/28, which necessitates an increase in the per learner funding amount.

COST: \$10.4 million for NOAMA

353. The problems facing all AHSC AFPs are further compounded for the Northern Ontario Academic Medicine Association (“NOAMA”). Northern Ontario is a complex region, that has historically been underserved. In order to increase the physician workforce across the North, the government created the Northern Ontario School of Medicine (NOSM). In the past five years and going forward, undergraduate and postgraduate expansion is ongoing. However, this expansion can only work if NOAMA can retain the physicians who are engaged in teaching and training. The NOAMA AFP thus must increase commensurate with learner expansion.

354. Northern Ontario covers 800,000 km², which is 5.5 times the size of Southern Ontario's land mass (139,000 km²). The population of Northern Ontario is 850,000, less than that of the city of Ottawa. NOSM University's territory extends from Kenora to Temiskaming Shores, a distance of 1,600 km. The two main teaching campuses of NOSM University, located in Thunder Bay and Sudbury, are 1,000 km apart. NOSM University's academic faculty work and teach across these various sites.

355. NOAMA has a separate AFP agreement with the government that was last amended in 2021 with a funding envelope that was based on a per learner allocation. At that time the number of learners at NOSM was 445. However, NOSM University will expand to 787 learners by 2027-28, but already there are significant capacity challenges. Coveted, and excellent clinical teaching sites are no longer able to take learners for their

¹⁵⁴ Information provided by Dr. Sarah Newberry.

rural rotations in second year, and several have indicated that they are not able to increase to the number of learners that would be ideal to meet expansion pressure, because of lack of health human resources in the community.

356. Mindemoya is a prime example of the kind of community in which NOSM U needs to be training learners to drive future workforce, and their current experience is telling and reflects the experience and fear of several of NOSM U's rural communities:

We had been struggling with 5 FTE in recent years, and as of January 1st, 2025, we have dropped to 4 FTE. Of those, 3.66 FTE do emergency department work. By August 2025 we will have an additional 1 FTE who will apply for faculty status. Two other physicians will join us but not be eligible for faculty status until the following year. As a result, our team notified NOSM U in the autumn of 2024 that we will be unable to take undergrad learners, with the exception of the CCC students, for the foreseeable future.

There is a moral injury that accompanies our situation that has led to this decision. We used to be a thriving teaching site. As the workload progressively increased in the absence of any increase in providers, which should have been funded years ago, our learners have watched. And decided that while this was a great place to learn, they had no intentions of returning to face a similar workload. Meanwhile, preceptors get disenchanted with teaching, when over and over their efforts fail to result in any additional recruitment. Not because of the lack of trying, but because those learners cannot see how working here is sustainable. I am concerned that our inability to continue to take undergrads will make us even further out of the picture when residents choose their spots, but we are also acutely unaware that if we give undergrad learners a poor experience it will be even worse...

As clinical service demands increase in relation to the health human resources in all of our communities and across academic disciplines at the AHSC's, our ability to meet expansion targets is imperiled.

357. The experience of Mindemoya is shared across the north. Additional funding will allow NOAMA to fund clinical teaching and will make Northern Ontario more attractive to the physicians that needed to serve Northern Ontario.

358. This is an urgent crisis. Currently at the Thunder Bay Regional AHSC, there are 186 FTE physicians with 44 FTE positions actively being recruited. Fully one in five positions remain vacant. In many of the services only one third to one half of the specialty complement is in place. In Pathology, all five of the FTE positions are currently vacant. Similarly, in Infectious Disease, two of two FTEs need to be recruited.

359. One of the most challenging service deficiencies at the TBRHSC is the lack of consistent Plastic Surgery coverage. At present, one of three FTE Plastic Surgeon position is filled. Without consistent coverage, ER physicians are now having to try to manage emergencies (burns, amputations, complex fractures and lacerations) with no local coverage. For example, recently, an individual who is right hand dominant had an amputation of his second digit to his metacarpal (index figure to knuckle) due to a crush injury and needed a definitive repair. As TBRHSC had no local coverage, the patient had to be transferred to a facility in Southern Ontario which took 3 days. These are very concerning delays that have a definite impact on patients.

360. The problems are similar at Sudbury Health Sciences Network, where there are 238 FTEs at present and 46.5 FTE actively being recruited for. In other words, 1 in 6 necessary positions at Sudbury HSN remain vacant. Numerous specialties are at risk. For example, General Internal Medicine is recruiting for 7 of 15 FTE. The lack of GIM specialists within the region is contributing to high patient volumes and workloads and the current program is not sustainable with only half the complement of GIM specialists. Similarly, Pediatrics is recruiting for 4 of a complement of 12. Emergency Medicine is recruiting for 5 FTE out of a complement of 30 and there is an anticipated loss of 5 more physicians in the coming months. Geriatrics is recruiting for 3 of 4 FTE. Infectious Disease is recruiting 3 of 3 positions (currently there is only a .5 FTE), with the entire service at risk if physicians are unable to recruit.

361. For Anesthesia, the shortage of physicians limits the number of operating rooms in Sudbury that can run every day. On a daily basis, 1-2 ORs cannot be used due to anesthesia and nursing shortages. Anesthesia staff are often scheduled to be in 2-3 places on the same day.

362. These shortages result in troubling statistics. For example, Northern Ontario has four times the provincial amputation rate because of a lack of family physicians, endocrine specialists, and limited access to chronic disease management.

363. Another troubling statistic is that the highest opioid death rates in the province are in Thunder Bay, Sudbury, North Bay, Sault Sainte Marie, and Timmins.¹⁵⁵ While the reasons for this are many, it is partly due to a lack of access to specialists who can support proper management of the pain of chronic musculoskeletal disease. While there should be at least 12 rheumatologists for Northern Ontario, there are currently only two. As well, there are too few physicians able to support addictions management across the whole region including at academic sites.

364. The NOAMA AFP is a critical enabler of retention of academic physicians and must increase commensurate with learner expansion. In light of the planned increase in learner numbers from 473 in 2022 to 787 in 2027/28, the per learner funding amount from 2020 needs to increase given the increase in the number of learners. The OMA proposes an increase of 10.4 million for the NOAMA AFP to meet these ongoing and increased needs.

¹⁵⁵ Aya Dufour, Jonathan Migneault, "[Northern Ontario's 5 largest cities continue to have highest opioid death rates in province](#)" CBC News (May 10, 2023), BOD VOL 3 TAB 102.

M. The Hospital for Sick Children (SickKids) AFP

The OMA proposes to repair the SickKids AFP to the 75th percentile in order to re-calibrate remuneration to 2007 levels. Funding at the 75th percentile will enable market competitive compensation, recruitment and retention, sustained excellence in new and existing clinical services, maintenance of a critical mass of diverse subspecialty expertise, and world-leading research discoveries and clinical implementation in pediatrics and surgery. The 75th percentile is also aligned to percentiles external to SickKids for relevant competitive specialties and tagged to adult competitive subspecialty percentile levels. There is a pressing need for improvements to funding and compensation for physicians in The Hospital for Sick Children's AFP.

COST OVER 4 YEARS: \$79 million, including \$10 million from Year 1 and \$23 million a year in each of Years 2, 3, and 4.

(i) Background to SickKids

365. The Hospital for Sick Children (SickKids) is recognized globally as a leader in pediatric care, training, and research, and plays an essential and unique role in Ontario's healthcare system. However, it is facing escalating challenges in the recruitment, retention, and remuneration of physicians that require urgent solutions.¹⁵⁶

366. SickKids is one of the top-ranked specialized pediatric hospitals in the world.¹⁵⁷ Its subspecialty physicians, surgeons, anesthesiologists, and psychiatrists possess unique training and expertise, often in areas requiring years of advanced study beyond standard medical training.

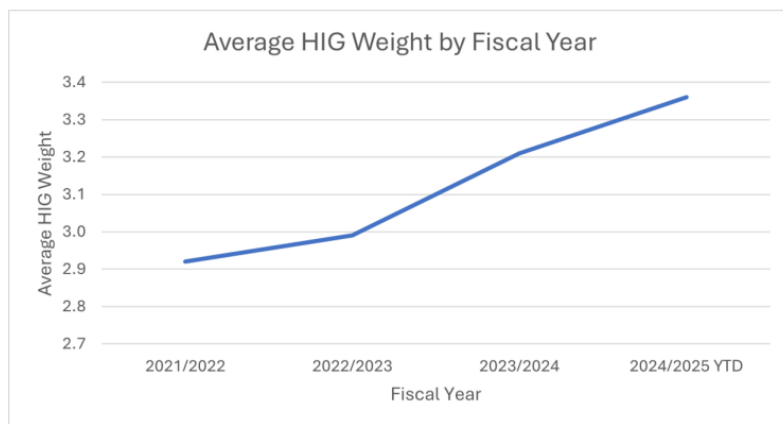
367. Sick Kids provides over half of all tertiary and quaternary pediatric care in Ontario and serves as a critical provincial resource for children with highly complex and rare conditions. Many of these children are referred from other hospitals—33% of inpatients are transfers from facilities that offer some level of subspecialty pediatric care, but which

¹⁵⁶ SickKids, AFP-OMA Arbitration Presentation, "SickKids: An Essential Ontario Resource," January 14, 2025 (updated), BOD VOL 5 TAB 138

¹⁵⁷ "[World's Best Specialized Hospitals 2024](#)" Newsweek, BOD VOL 3 TAB 103.

still require the depth or breadth of SickKids' expertise. The hospital delivers more than 350 unique programs, services, and procedures that are not available elsewhere in Ontario.

368. The Health Based Allocation Model (HBAM) Inpatient Group (HIG) is a method used in Ontario to classify acute care inpatients. As the following chart demonstrates, Sick Kids average HIG has been steadily increasing in recent years:



HIG = HBAM (Health Based Allocation Model) Inpatient Grouping

369. SickKids is also a system leader. It coordinates pediatric inpatient beds across the Greater Toronto Area (GTA), leads surgical waitlist initiatives, and accepts patients when other centres are unable to provide appropriate care. In addition, it provides consultation to other pediatric hospitals on the management of complex cases.

370. In addition, SickKids is very involved in education and training. SickKids trains the majority of Ontario's pediatric workforce, including general pediatricians, subspecialists, and pediatric surgeons. Accordingly, SickKids helps to ensure a supply of future practitioners with the advanced skills needed to care for children across the province.

371. The SickKids AFP's last contract was 2007. The AFP includes two independent groups with their own governance, employment structures and needs: the "Pediatric Specialties Association" and the "Pediatric Consultants Partnership"

Paediatrics (PCP)**18 Divisions**

Adolescent Medicine

Paediatric Medicine (generalists)

Neurology

Cardiology

Nephrology

Paediatric Emergency Medicine

Paediatric Dermatology

Haematology-Oncology

Clinical Pharmacology & Toxicology

Clinical and Metabolic Genetics

Respiratory Medicine

Cardiology

Rheumatology

Gastroenterology, Hepatology & Nutrition

Endocrinology

Immunology & Allergy

Neonatology

Developmental Paediatrics (Bloorview)

Paediatric Specialties Association (PSA)

Cardiovascular Surgery [Division]

General and Thoracic Surgery [Division]

Orthopaedic Surgery [Division]

Neurosurgery [Division]

Plastic and Reconstructive Surgery [Division]

Urology and Transplant Surgery [Division]

Anesthesia and Pain Medicine [Department]

Critical Care Medicine [Department]

Ophthalmology & Vision Sciences [Department]

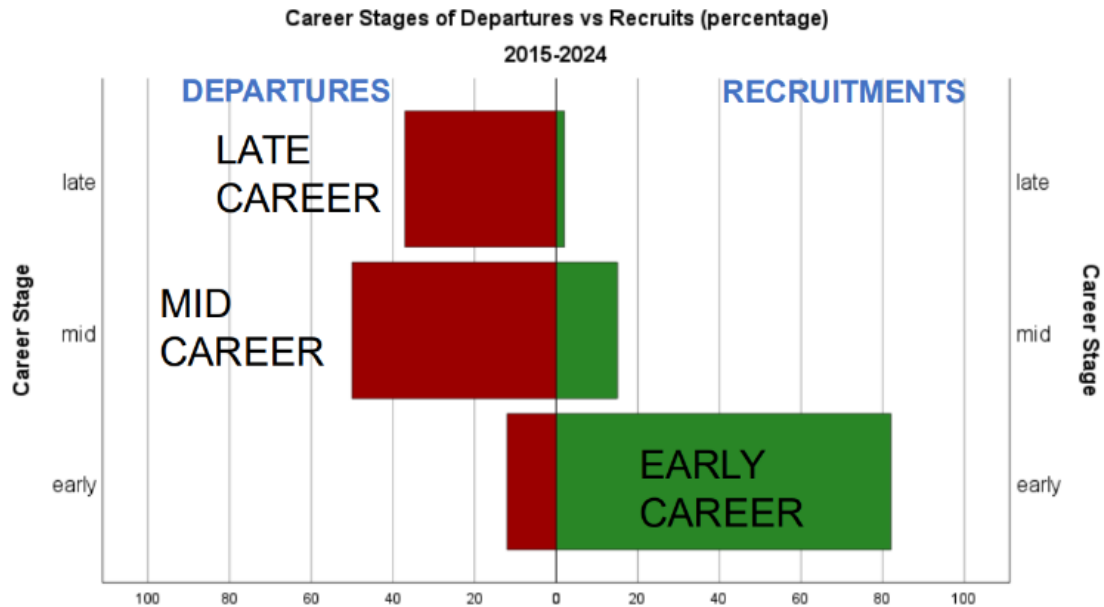
Otolaryngology, Head and Neck Surgery [Department]

Psychiatry [Department]

372. SickKids is the most research-intensive pediatric hospital in Canada and second overall in the country. The SickKids AFP has historically enabled world-leading innovation that provides direct and unparalleled benefits to the health of children in Ontario and globally. The integration of clinical care with research and education ensures that new discoveries are rapidly translated into practice. This academic environment has been a key factor in attracting top-tier talent; however, that attraction is no longer sufficient to offset significant compensation gaps.

(ii) SickKids Current Reality – Underfunding Leading to Physician Shortages

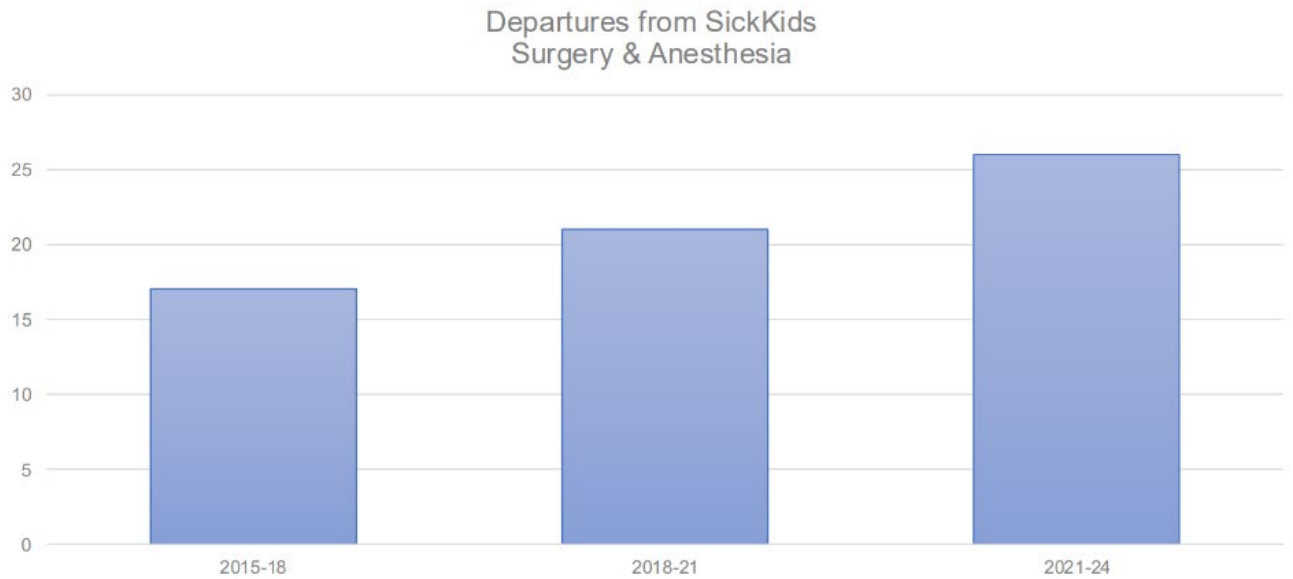
373. SickKids is experiencing a growing physician retention and recruitment crisis. As the following graph illustrates, excluding retirements, over 20% of its surgical and anesthesia faculty have resigned, many mid- or late-career, and are being replaced almost exclusively by newly trained faculty.



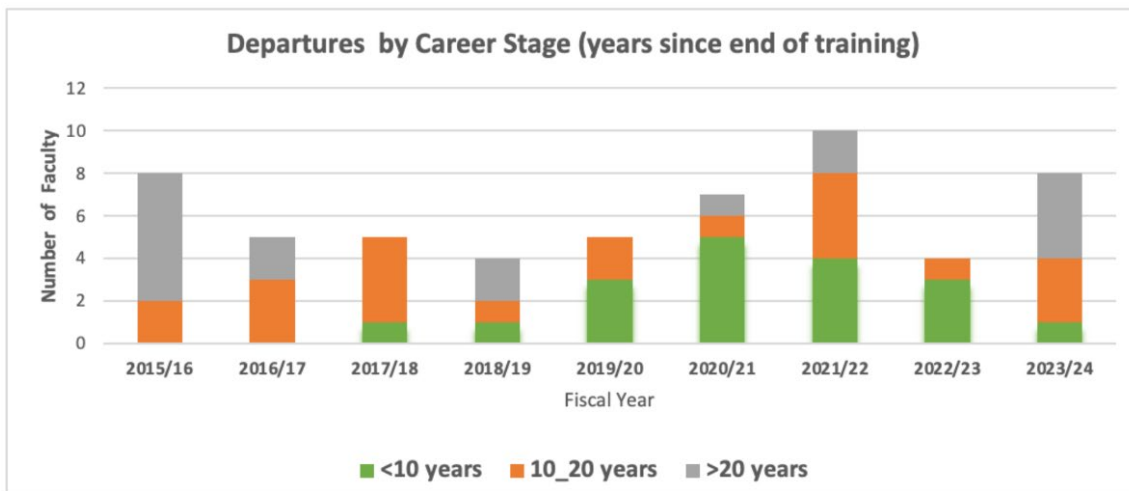
374. Remuneration is a critical driver of this exodus, which significantly affects the continuity and quality of care. Recruiting replacements is increasingly difficult as the talent pool for highly specialized pediatric roles is extremely limited locally, nationally, and internationally.

375. Forty-one percent of the departing physicians have left for major US Hospitals, such as Texas Children's, Boston Children's, and UCLA, where compensation and the cost of living are more favourable. In surgery and anesthesia, the candidate pool is shrinking further because most physicians train first in adult specialties and often opt for more lucrative adult-focused careers rather than pursue the additional years of pediatric specialization required at SickKids. As a result, SickKids is losing its historical "hometown advantage," which was important in enabling it to retain Ontario-trained talent.

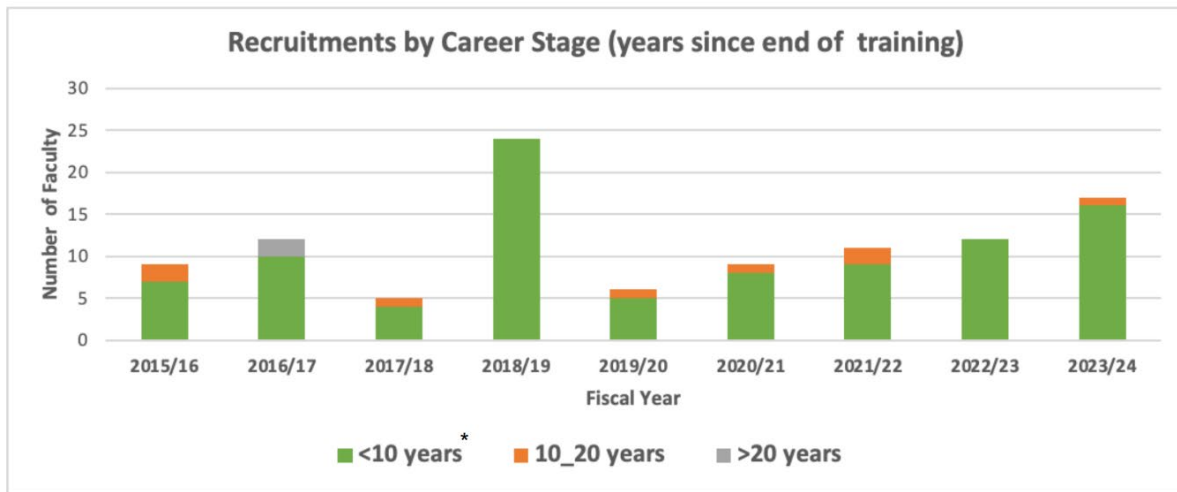
376. The recruitment and retention problem is also escalating, as more & more skilled surgeons & anesthesiologists are leaving compared to what was happening in earlier periods:



377. As illustrated by the following graphs, as more experienced pediatric subspecialists leave, they are replaced with less experience/newly trained physicians:



*Retirements not included
Data cut-off Jan 2024*



378. Across almost all subspecialties, resignations have increased by 18%. In contrast, Canadian peers have a resignation rate of 2-5%. As well, SickKids has seen a turnover of 60% Division Head Leaders.

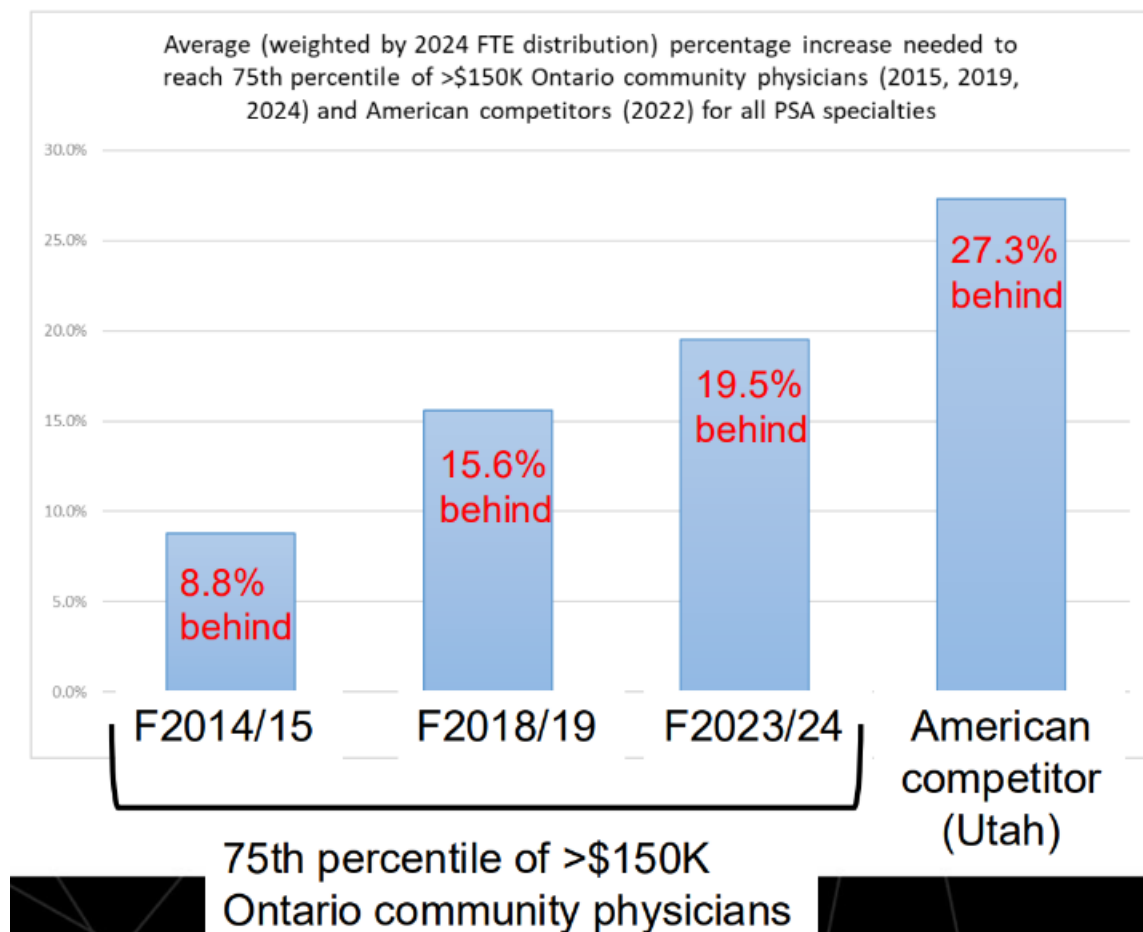
379. From 2016 to 2024, there were 56 departures. SickKids has information on only 48 of these. 40 of the departures were lateral moves with 8 going to leadership positions. Seventeen of the 40 went to US/International academic centers, 8 of the 40 went out of province and 15 of the 40 went to another community in Ontario. Since 2024, there has been a further 16 resignations of subspecialists, all lateral moves mostly to the US or other countries.

380. The crisis is particularly acute in certain disciplines. In urology, for example, an early 2024 recruitment campaign failed to attract a single qualified applicant. A promising candidate—an experienced American-trained urologist who had once worked at SickKids—ultimately declined due to salary concerns and Toronto's high cost of living.

381. In cardiology, there has been turnover in 15 of 22 positions in the past nine years, not including retirements. These roles require multiple levels of training post-medical school and are not interchangeable. For example, only three of SickKids' cardiologists are trained in interventional procedures. A recent recruitment effort for this sub-specialty

required two searches and produced only eight candidates, of which only three-four had the expected qualifications, significantly lower than what prior searches yielded 10 years earlier. Ultimately, a non-Canadian new graduate was hired. The main barrier, once again, was salary.

382. The salaries for SickKids physicians have fallen behind both national and international benchmarks. As of fiscal year 2023/24, remuneration for surgery and anesthesia lags up to 27.3% behind U.S. competitors:



383. SickKids AFP salary growth has also not kept pace with inflation (which has seen a 42.1% increase since 2007), further eroding SickKids' ability to compete. The cost of living in the GTA is also a significant factor in the SickKids crisis.

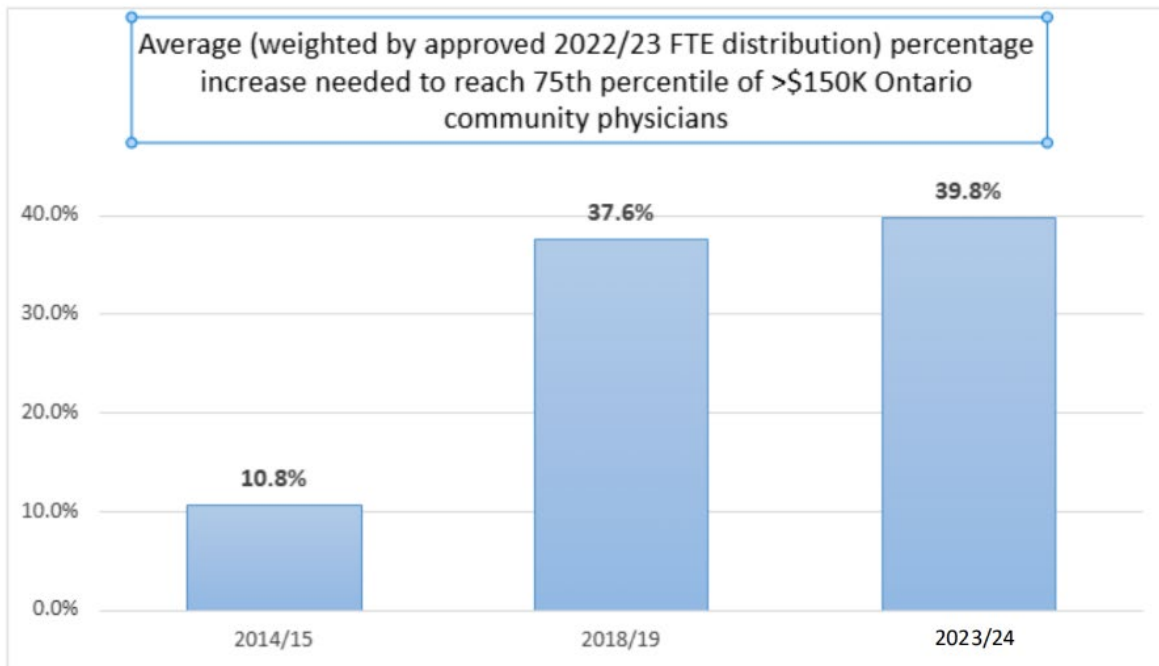
384. The result has been that SickKids is unable to compete with the salaries offered in other provinces, such as Alberta, and other countries, most notably the US.

385. SickKids historic 2007 alignment with the 75th percentile of external benchmarks enabled SickKids to recruit new physicians and retain their complement in clinical practice and in research, an advantage which has now been lost due to salary erosion. SickKids funding must return to those 2007 levels if it is to be able to preserve its standard of care.

(iii) The SickKids AFP Renewal Proposal¹⁵⁸

386. As the following graph illustrates, the remuneration for SickKids subspecialists has fallen far behind the 75th percentile:

¹⁵⁸ See also SickKids, AFP Proposal, March 19, 2024, BOD VOL 5 TAB 139; SickKids, AFP Briefing Note Addendum for Paediatrics PCP, March 21, 2024, BOD VOL 5 TAB 140; SickKids, AFP Proposal Addendum Perioperative Services PSA, March 21, 2024, BOD VOL 5 TAB 141; SickKids, Surgery and endoscopy outside of SickKids to MOH PSA PCP responses, March 18, 2025, BOD VOL 5 TAB 142.



387. The OMA proposes to repair the SickKids AFP to the 75th percentile. Funding at the 75th percentile will enable SickKids to offer competitive compensation to both recruit new physicians and retain their current complement, which will, in turn, ensure, sustained excellence in the ability to provide new and existing clinical services, maintain a critical mass of diverse subspecialty expertise, and promote world-leading research discoveries and clinical implementation in pediatrics and surgery. The 75th percentile is also aligned to percentiles external to SickKids for relevant competitive specialties and tagged to adult competitive subspecialty percentile levels.

388. The SickKids proposal includes a comprehensive plan to address these challenges. The OMA is requesting the following improvements:

- \$64.7 million to repair the AFP to 75th percentile benchmarks

The current flow-through methodology has led to a growing compensation gap between SickKids physicians and their community counterparts. Replacing this model with one based on 75th percentile benchmarks by specialty would ensure competitive and equitable pay. This change builds

on the original intent of the Physician Services Agreement, which was to maintain compensation parity across Ontario.

- \$10.7 million for Clinical Fellows and Physician Assistants

Clinical Fellows and Physician Assistants are essential to managing the increasing complexity of patients at SickKids. They play a central role in delivering high-quality, 24/7 care, including surgical assistance and rapid patient response. However, a significant funding gap persists. The OMA proposal includes \$8.2 million for Clinical Fellows and \$2.5 million for Physician Assistants for a combined funding request of \$10.7 million to support these critical roles and ensure continued, safe, and timely care.

- \$2 million to increase the shadow billing premium

To more accurately reflect the indirect care SickKids physicians provide, an increase in the shadow billing premium from 22.3% to 25% is proposed. This adjustment would bring SickKids in line with other academic centres and include updated accountability metrics to ensure transparency and alignment with health system goals.

- Create an Expansion Fund to support growth and timely recruitment

A 5% expansion fund (approximately \$3.25 million of the total AFP contract) would offer a reliable source of funding to support physician recruitment in response to growing demand. A formal process with the Ministry could govern access to the fund, improving responsiveness and reducing current delays and risks associated with the Expression of Interest (EOI) process.

- Adjustment to FFS Billing Thresholds

Flexibility is also sought for FFS billing under special circumstances, such as addressing surgical backlogs. These arrangements would be time-limited and subject to jointly agreed parameters, ensuring that collaboration across institutions can occur without unnecessary administrative barriers and in a timely fashion.

389. In sum, it is well known and accepted that SickKids is the last resort for many of Ontario's sickest children. In many cases, SickKids delivers services that no other hospital in the province can provide, but its ability to do so is under immediate threat. The recruitment and retention crisis is escalating, placing critical clinical services and

patient outcomes at risk. Without immediate AFP renewal and funding reform, Ontario risks losing access to the kind of cutting-edge, integrated care that SickKids uniquely provides. The OMA requests that its proposal be awarded.

N. Children’s Hospital Academic Medical Organization ’’) AFP

The OMA proposes to establish a notional rate for each pediatric subspecialty at CHAMO using the 75th percentile of community FFS for full time physicians in each specialty. Pediatric subspecialists practicing at CHAMO require significant, additional training beyond that which would be typically required of their community counterparts. Whereas most CHAMO physicians could transition to practicing in the community, very few community-based specialists possess the necessary skill and expertise to practice at CHEO. Hence, the 75th percentile is an appropriate benchmark to establish notional targets for physicians practicing under the CHAMO AFP.

There is a pressing need for improvements to funding and compensation for CHAMO physicians. By repairing uncompetitive physician compensation to be in line with its comparators, right-sizing physician resources, and funding hospitalists, this proposal will give CHEO the tools to address the hospital’s wait-time crisis. In doing so, children and youth in Eastern and Northeastern Ontario will be enabled to access care equitable to elsewhere in Ontario.

COST OVER 4 YEARS: \$99 million, including \$15 million from Year 1, \$28 million a year in each of Years 2, 3, and 4, and an additional \$20 million to account for the need for further FTEs as per the proposal below.

(i) Background to CHEO and CHAMO¹⁵⁹

390. The Children’s Hospital of Eastern Ontario (“CHEO”) is a critical hub for pediatric care in Canada. It is the only children’s hospital within a 28,000 square kilometre area, serving 500,000 children and youth annually across Eastern and Northern Ontario – a number projected to grow significantly in coming years. Indeed, from 2016-2021, the Ottawa region’s child and youth population grew at a rate 9 times higher than the provincial average.¹⁶⁰

391. As the only referral centre for pediatric care for regions in Eastern and Northern Ontario, CHEO plays a unique and critical role in treating acutely and chronically ill

¹⁵⁹ See CHAMO slide deck of presentation, “Why a new AFP is critical to the future of CHEO kids,” presented to Arbitrator Kaplan on January 14, 2025 (“CHAMO Slide Deck”), BOD VOL 5 TAB 134.

¹⁶⁰ Statistics Canada, [Focus on Geography Series, 2021 Census of Population, Ottawa - Gatineau, Census metropolitan area](#). BOD VOL 3 TAB 104

children. CHEO is the only pediatric hospital in the region that admits children outside of the neonatal period. Furthermore, there are essentially no outpatient pediatric services within the region other than community Emergency Departments. As a result, children who are turned away from CHEO must travel considerable distances to receive necessary care. If and when CHEO's capacity is strained, patients and their families have few other options. The hospital additionally serves as a tertiary trauma centre for areas of Nunavut, and the Outaouais region of Western Quebec.

392. CHEO is also home to one of only two Level I pediatric trauma centres in Ontario (along with the Hospital for Sick Children in Toronto) and is one of only seven of its kind in Canada.

393. CHEO provides specialized pediatric care in the following areas:

- a specialized acute-care hospital
- a research-intensive health care organization
- an autism service provider
- a children's treatment centre
- a rehabilitation service
- a pediatric palliative care hospice
- a service coordinator with community providers
- a training centre for future pediatric providers
- Pediatric Anesthesiology and Pain Medicine
- Clinical Genetics
- Pediatric Lab medicine
- Pediatric Medical imaging
- Pediatric Medicine and medical subspecialties
- Child and Adolescent Psychiatry
- Pediatric Surgery and surgical subspecialties

394. At present, CHEO, and thereby Eastern Ontario as a whole, is facing an increasing gap in providing access to pediatric acute care due to critical staff shortages in specialized program areas. This crisis is primarily due to CHEO's increasing challenges in recruiting and retaining physicians.

395. The Children's Hospital Academic Medical Organization ("CHAMO") funds the care that is provided by CHEO physicians through an AFP. Over the years, this funding has fallen very far behind what is needed to recruit and retain specialized pediatric doctors. At current staffing levels, CHAMO physicians are struggling to continue to provide necessary, critical care to children and youth.

396. CHAMO is asking that as part of the new PSA, the Board award adequate funding to address the current challenges and to recruit and retain the necessary physicians.¹⁶¹

(ii) CHEO's Current Reality – Underfunding Leading to Physician Shortages

397. First established in 2002, the CHAMO Alternative Funding Plan ("AFP") was last renegotiated in 2006, with only modest adjustments made since then. CHEO now faces highly urgent capacity pressures and a recruitment and retention crisis that must be alleviated immediately through substantially enhanced funding to the CHAMO AFP.

398. The failure to maintain competitive and reasonable funding for physician compensation across CHAMO has inevitably resulted in a serious recruitment and retention crisis, and in severe effects on children. CHAMO is seeing an increasing number of resignations and vacancies, is unable to recruit experienced physicians for leadership roles and unable to recruit at all in many areas.

399. By repairing compensation to competitive and reasonable levels, CHAMO will be able to better attract and retain the physicians that CHEO and the community desperately need.

400. At the time the CHAMO AFP was initially funded, the agreement was intended to bring physician compensation into a range that is competitive with community and academic comparators. The stable base funding offered through the AFP allowed

¹⁶¹ CHAMO Slide Deck, *supra*, BOD VOL 5 TAB 141., See also CHEO, "At a Turning Point" Document, BOD Vol. 5, Tab 144.

CHAMO to attract highly specialized clinicians to provide specialized and complex care to children in Eastern Ontario.

401. The CHAMO AFP received a flow-through increase in 2009 which was, however, associated with a 3% reduction to the AFP base. Further flow-through increases occurred in 2010 and 2011, followed by two consecutive flow-through decreases in 2013 and a unilaterally imposed decrease in 2015. The latter was subsequently reversed in 2020/21.

402. Due to the urgent need to address their recruitment challenges, CHAMO submitted to the Ministry and was approved for bridge funding. It is important to note, however, that the bridge funding approval is entirely separate and above the present CHAMO proposal submitted through PSA process. The present proposal, however, does include repair or rate increases for the FTEs hired through the bridge funding, as they were approved at the same rates as existing CHAMO physicians, and thus also require repair funding.

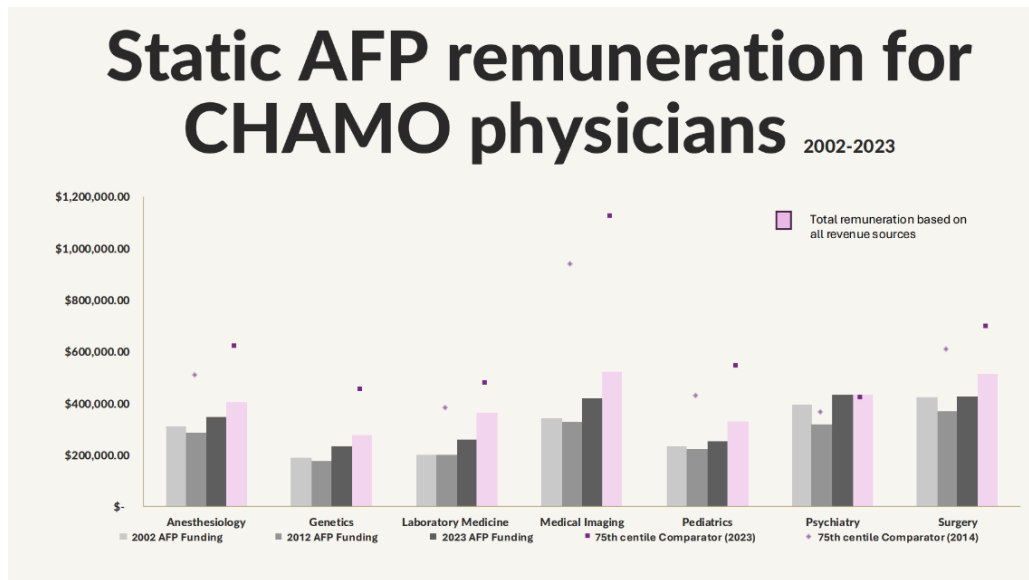
403. Thus, apart from flow through from the 2021 PSA and Year 1 award and emergency bridge funding, CHAMO has received no further increases and has not had a significant infusion of funding to address competitiveness or recruitment in 11 years. As a fully comprehensive AFP that includes all clinical and academic work, the CHAMO AFP provides the only mechanism CHEO departments have to hire new physicians. Other than funding for new recruits or limited increases through PSA settlements, the CHAMO agreement has not had changes for over 15 years and has not been significantly changed since its inception in 2002.

404. Over the 19 years since the last comprehensively renegotiated AFP – bargained in 2006 – the region has experienced steady population growth beyond the provincial average.¹⁶² However, neither physician allocations nor the number of physicians

¹⁶² Statistics Canada, [Focus on Geography Series, 2021 Census of Population, Ottawa - Gatineau, Census metropolitan area](#).

employed by CHEO have kept pace. The CHAMO AFP was designed to fund the organization for the region's population need in the early 2010s, but the demographics have changed significantly since then.

405. Since 2002, CHAMO physician compensation has remained largely static:



406. After years of a growing AFP funding shortfall, CHAMO's remuneration has become far less competitive. Indeed, when measured against relevant comparator hospitals, CHAMO compensates physicians in Anesthesia **35% less**, Emergency Medicine **45% less**, Medical Imaging **30% less**, Neurosurgery **49% less**, Pediatric Medicine **35% less**, and Urology **19% less**.¹⁶³

407. Pediatric specialization requires years of training, and, in at least the case of CHEO, this added specialization is not being recognized through compensation - in fact, it is the opposite. This shortfall has resulted in many physicians choosing to leave CHEO for higher-paying jobs in adult care, private clinics, or other pediatric institutions across Ontario and the country. Others have left for opportunities in the community, often citing

¹⁶³ See CHAMO Slide Deck, *supra*.

remuneration as the driving factor. Over the past 4 years, the number of physician resignations (excluding retirements) has spiked, leading to a substantial drop in the hospital's overall physician count.¹⁶⁴

408. The retention difficulties brought on by a lack of funding have contributed to a strained work environment for the physicians who remain. Staff shortages have resulted in specialists from different service areas having to be temporarily redeployed into emergency, critical care, and pediatric medicine. This has led to the temporary shutdown of different service areas and a serious impact on critical operations. On average, shortages have led to 28 OR days having to be cancelled each month, and up to 30% of ED shifts left unfilled.¹⁶⁵

409. Because of these same issues, filling vacancies has proven to be nearly impossible for various specialties, particularly in recruiting experienced physicians for leadership roles. Given the burnout and low morale among current physicians, it is unsurprising that is difficult to find new recruits to take on a position with a high workload, aggressive call schedule, and sub-par remuneration.

410. CHEO has had difficulty recruiting into the increasing vacancies across all seven of its medical departments, with poor remuneration rates compared to other sites as the most commonly cited reason for this. The severely outdated CHAMO agreement has led to discrepancies in remuneration with other similar pediatric centers in Ontario and a 40% vacancy rate in some specialties.

411. Several departments have been severely impacted and are struggling to maintain their current complement, let alone recruit replacements. Medical Imaging, for instance, has lost over 42% of its physicians since 2018. Medical Imaging P3/4 MRI and

¹⁶⁴ See CHAMO Slide Deck, *supra*, BOD VOL 5 TAB 141. See also CHAMO, Resignations and Failed Recruitments, 2019-2024, BOD VOL 5 TAB 143.

¹⁶⁵ See CHAMO Slide Deck, *supra*, BOD VOL 5 TAB 141.

ultrasound wait times are now the longest in the province with a median wait time for P4s of 350 days. While admittedly this wait time has decreased from 750 days, this improvement will not be sustainable due to radiologist and anesthesia shortages. In the past year, 3 radiologists have left CHEO due to noncompetitive remuneration and high workload. Recruitment to fill retirement vacancies has been increasingly unsuccessful for the same reasons. Medical imaging currently has a 40% vacancy with only 7.4/ 12.6 FTEs in place.

412. The Department of Pediatrics lost 41 physicians (28%) since 2018 compared to only 10 physicians over the five preceding years. Other departments, including the Department of Anesthesiology, are not only losing physicians, but existing doctors are choosing to reduce their availability in order to supplement their income with more lucrative opportunities in the community. Additionally, the Department of Surgery has lost over 125 years of surgical experience between 2018 and 2021.

413. In Psychiatry, staffing shortages have led to 90% of kids with mental health care needs waiting up to 18 months for their first appointment. CHEO has opened a new Mental Health Transition Unit to deal with high acuity crisis patients, which aims to remove them from the ED environment and provide short stay stabilization and arrange for the transfer to community services ASAP. However, there is an urgent need for psychiatrists to staff this unit and address the ongoing surge in mental health inpatient occupancy/acuity. This need is exacerbated by the Royal Ottawa Hospital's decision to stop providing mental health services for children and youth, a development that will add further strain the Department. To be able to adequately handle the influx of new patients, CHEO will require an additional 4 Pediatric Psychiatrists beyond the 4 positions that were previously requested.

414. Where new or replacement positions have been filled across CHEO, these recruitments are typically either minimally experienced physicians right out of fellowship or International Medical Graduates ("IMGs"), who present their own limitations. As they can only work in Ontario on a restricted academic license that mandates a certain level of scholarly work, IMGs necessarily operate with a reduced ability to provide clinical time.

Additionally, some IMGs eventually choose to work in other provinces with less restrictive licensing. These factors make relying on their recruitment an unsustainable proposition.

415. CHAMO struggles to retain physicians for extended periods of time, resulting in continuing vacancies. While the bridge funding provided some immediate and urgent relief and has been used to approve new recruitments, some of these positions (notably surgical positions in Urology, Neurosurgery, and Plastic Surgery) remain unfilled, principally due to lack of remuneration compared to other centres. At this point, CHAMO can no longer offer sufficient remuneration to recruit at any career stage.

416. Without improved funding, these problems will only worsen. For example, as noted, in the near future, the Royal Ottawa Hospital will cease to provide mental health services for children and youth. This will add further strain to the Department of Psychiatry at CHEO, requiring an addition of 4 Pediatric Psychiatrists (beyond the 4 positions that were previously requested).

417. The situation with respect to after-hours call coverage for inpatient and acute care is also becoming more challenging. Starting this July, the Family Medicine program will be removing their trainees from the inpatient wards during their pediatric rotations. This will reduce the number of trainees available for in-house call to cover the pediatric inpatients and leave significant gaps in the in-house call schedule. As a result, Hospitalists will be essential to meet the after-hours coverage needs.

418. In other CHEO departments, where there are few to no trainees for call coverage, departments have been self-funding hospitalists to support after-hours work. With increasing expectations for safe care after hours, this self-funding has come at great cost to these departments and is not sustainable.

(iii) The Effects of Physician Shortages on Care

419. These physician shortages have led to chronic delays, which have very real adverse impacts on children. At present, more than **60% of new patients** are not seen

by a physician within a safe clinical window, **70% of follow-ups** are not seen within an appropriate window, and every year, over **8,000 patients** are referred for care and not seen at all. There are long wait times for testing, assessment, and care: **9 months** for an ultrasound (standard is 1 month), **6.5 months** for an MRI under sedation (standard is 1 month), and **18 months** for an initial assessment and care for children and youth with complex obesity. CHEO has the **longest MRI wait times** in the province.

420. Shortages have also had a profound effect on surgeries, as seen in the aforementioned **28** OR days that are cancelled every month. This has led to dramatic backlogs and waiting periods. **3,300** children and youth are currently waiting for surgery at CHEO, and **53%** of all surgeries and procedures are not being done within clinically safe recommended windows. For example, children are waiting up to **2 years** to receive corrective back surgery for scoliosis, and ear, nose and throat surgeries have a **14-month** waitlist. When compared to other pediatric care hospitals in Ontario, the urgency of the situation at CHEO becomes even starker. Between September 30, 2023, and October 28, 2024, the number of “Surgical Long Waiters” fell by 10% at SickKids, 29% at McMaster Children’s, and 17% at Children’s Hospital at LHSC. In contrast, CHEO’s numbers increased by **62%**.¹⁶⁶

421. In the Emergency Department, waits can range to as high as **15 hours** to see a physician during the busiest times of the year. Inadequate staffing of inpatient services has led to admitted patients being stuck waiting for up to **24-26 hours** after the decision to admit has been made. These outcomes are a direct result of the **20%** of ED shifts left unfilled due to staffing shortages each month.

422. Additionally, CHEO has had to institute multiple limitations on the care that is provided. Currently, physicians are able to see “lower acuity” patients with significant eating disorders, patients with substance use and addictions issues only if they are in a

¹⁶⁶ See CHAMO Slide Deck, *supra*, BOD VOL 5 TAB 141.

serious enough state to need admission. The hospital is unable to provide timely detection and treatments for patients with cerebral palsy.

423. All of this has direct impact on the children and youth treated at CHEO. Children in the community wait longer than in other regions, and in many cases, longer than adults.¹⁶⁷ Because of the vulnerability of children and the impact gaps in timely care can have on their development, these lapses will have downstream effects on the entire healthcare system for years to come.

424. The Eastern Ontario community has noted the issues at CHEO, resulting in a litany of negative news stories detailing the long wait times and backlogs.¹⁶⁸ These unacceptable outcomes are, in no small part, due to a physician funding arrangement that is insufficient to meet today's urgent patient needs – let alone address the backlogs of care and the demands of a growing region.

(iv) CHAMO's Proposed Solution

425. To address the serious crisis CHEO is facing, CHAMO proposes to attack the root cause of the staffing issues – uncompetitive remuneration. The proposal would allow for an updated version of the AFP that repairs physician remuneration to the 75th percentile, right-sizes pediatric specialty resources, and funds hospitalists. Over 4 years, this AFP will cost \$99 million (\$15 million in year 1, \$28 million in year 2, \$28 million in year 3, and \$28 million in year 4).

¹⁶⁷ Elizabeth Payne, "['Nobody thinks that is OK': Children now waiting longer than adults for almost all health procedures](#)", *Ottawa Citizen* (June 21, 2022) BOD VOL 3 TAB 105.

¹⁶⁸ See: Sadeen Mohsen, "[Toddler waits hours for care as CHEO tops Ontario ER average](#)", *Ottawa Citizen* (December 13, 2024), BOD VOL 3 TAB 106; Josh Pringle, "[This Ottawa hospital has the longest ER wait time to see a doctor in Ontario](#)", *CTV News Ottawa* (December 9, 2024) BOD VOL 3 TAB 107; Anil Jhalli, "[Close to 40,000 kids are waiting for appointments at CHEO](#)", *CityNews Ottawa* (January 26, 2023) BOD VOL 3 TAB 108; Holly McKenzie-Sutter, "[Ontario kids' hospital looks to redeploy staff, use online tools to tackle long waits](#)", *Global News* (October 7, 2022) BOD VOL 3 TAB 109.

426. CHAMO physicians perform a crucial role at CHEO that merits compensation at the 75th percentile. As previously stated, CHEO is the only hub for child and youth health in Eastern Ontario. Beyond providing highly specialized services to young patients, physicians also educate and mentor the future of the specialty and primary care workforce across the region. Additionally, they continually develop new and innovative approaches that can be used to provide the best care for children across the province.

427. In order to meet the unique needs of the hospital, CHAMO specialists require an additional 1-3 years of training beyond what is required for Community specialists. Given CHEO's position in the region, they regularly care for patients with complex, complicated, and rare diseases, and cannot refuse acute referrals – they are the end of the line. All of this means that while CHAMO specialists can easily migrate to the community, the reverse is not true.

428. Compensation at the 75th percentile recognizes all of these factors, provides physicians with remuneration consistent to their special role, and encourages an optimized and stable physician workforce. This will allow CHEO to competitively recruit and retain the highly specialized medical professionals needed to allow children and youth in Eastern and Northeastern Ontario to access care equitable to elsewhere in Ontario.

429. The specific aspects of CHAMO's proposal are as follows:¹⁶⁹

- **Repair:**

OMA proposes updating compensation levels by establishing new notional rates based on the 75th percentile of full-time community physician FFS billings (for those billing over \$150K), with exceptions for radiology and ophthalmology, which would be benchmarked to the median. Where provincial Alternate Payment Plans (APPs) exist, the higher of the APP rate or the 75th percentile should apply. This increased funding is needed to bring physician

¹⁶⁹ OMA, Children's Hospital Academic Medical Organization (CHAMO) Alternate Funding Plan Proposal, March 6, 2024, BOD Vol. 5, Tab 142.

compensation in line with appropriate comparators and help restore CHAMO's ability to recruit and retain physicians in the area of specialized pediatric care.

- **Physician Recruitment Funding:**

CHAMO requires additional recruitment funding to hire 72.5 FTEs for Years 1 and 2 across all seven CHEO departments (separate and apart from the bridge funding previously received from the Ministry, and up from the previously proposed 55.55 FTEs).

Eliminating the Flow-Through Methodology and Fee-for-Service (FFS) Conversion:

Since 2008, CHAMO AFP compensation has been periodically adjusted using flow-through mechanisms intended to maintain parity with community physicians. However, the current approach has inadvertently widened the pay gap, leaving CHAMO physicians undercompensated compared to their community counterparts. The OMA proposes eliminating the existing flow-through methodology and replacing it with target compensation rates by specialty using community benchmarks at the 75th percentile, as discussed above.

As well, historically, a process existed to convert FFS funds when physicians joined or left the AFP. This process is now obsolete and the OMA proposes eliminating the FFS conversion entirely. Instead, when new positions are approved, the CHAMO AFP would be increased directly by the target compensation rate for each specialty.

- **CHAMO AFP Expansion Fund:**

To ensure CHAMO can respond to growing demands, the OMA proposes establishing an annual expansion fund equal to 5% of CHAMO's total AFP contract value. CHAMO would submit requests for funds based on new FTE needs, which the Ministry would release at the notional target rates per specialty. This approach would streamline recruitment and avoid delays associated with the current Expression of Interest (EOI) process.

- **Clinical Assistants, Fellows, and Clinical PhDs:**

Due to restrictions on resident duty hours and the increasing complexity of pediatric care, CHAMO requires stable funding for Hospitalists to maintain safe, 24/7 inpatient coverage. There is also a growing reliance on Clinical Fellows and Clinical PhDs, who currently lack dedicated funding within the CHAMO AFP and are often supported through physician compensation. The OMA is now seeking new funding for 61.2 immediate Hospitalist and PhD positions across all CHAMO departments (up from the lower number

previously requested) – funding which was deferred to this arbitration despite the request for bridge funding for these positions.

- **Shadow Billing Premium Reduction:**

The OMA proposes reducing the shadow billing premium from 53.76% to 25%, with a resulting \$8.2 million in savings that can be reallocated to support other proposals (a savings amount which with additional funding for recruitment would be higher). This proposal is, of course, entirely dependent upon the 75th percentile remuneration proposal being awarded.

- **Adjustment to FFS Billing Thresholds:**

The CHAMO AFP allows some FFS billing for out-of-scope services (e.g., adult care), but the thresholds have not changed despite AFP growth. With more physicians joining CHAMO and increasing FFS code values, the existing thresholds are too low. The OMA proposes a 5% annual increase in FFS billing thresholds to reflect both physician growth and changes to the Schedule of Benefits.

O. Virtual Care Proposal

The OMA proposes to enable the clinically appropriate use of virtual telephone care where video is not accessible, due to technology, lack of patient knowledge or capacity, inability to utilize video technology, or other socio-economic barriers.

To address this issue, the OMA proposes that a telephone consultation by a specialist where clinically appropriate will be paid at the virtual telephone care rate if due to these barriers applying, it is impractical to perform a video or in-person consultation. However, such a telephone consultation would not establish a physician-patient relationship for the purpose of ongoing payment of comprehensive care.

The amount payable for a consultation service rendered by telephone is 85% of the corresponding in-person fee except for mental health consultation services (A195, A190, A795, A695, A197, A198, A191, A192) which will be payable at 95% of the corresponding in-person fee.

*The OMA also proposes to enable physicians practicing in **shared care** models to bill comprehensive virtual care codes, as follows:*

Modify the OHIP Schedule to allow for comprehensive virtual care codes where specialists and GP Focus Practice Physicians (both GPP and GPFP) work in the same comprehensive shared group practice providing shared care.

A comprehensive shared care group practice means a HOCC group, or other groups of physicians practicing together in the same specialty/subspecialty/GP Focus Practice designation, physicians sharing a group billing number, or in a multidisciplinary hospital-based clinic focused on a shared condition or pathology (e.g. thrombosis, hand, burns and spine clinics).

In all cases, the group must practice together with the capacity to provide direct physical encounters in the same hospital or same clinic or facility, with the group being available to provide direct physical encounter coverage, and with all physicians in the group having access to the patient's medical record.

The practice group must also be registered with the MOH in order to be provided with a shared care group billing number.

Eligibility to bill comprehensive virtual care codes in the shared care model require that there be an established physician-patient relationship with another physician within the same practice group who has provided at least one insured service with a direct physical encounter to the patient in the preceding 24 months.

*The OMA also proposes to modify the OHIP Schedule to allow comprehensive virtual care codes to be billed for non-elective virtual care service encounters in **long term-care facilities**, under the following eligibility Criteria for Virtual Care Billing (OHIP Schedule of Benefits):*

- *Non-elective (acute) virtual care encounters: Initiated by a patient or by someone on their behalf (e.g., family or facility staff)*
- *Physician Requirements: Must be conducted by a physician, with support by an LTC-affiliated nurse capable of providing clinical information and physical assessment as required*

COST: \$2.9 million in Year 1 for Shared Care models and \$1.4 million in Year 1 for Long-Term Care Virtual Care Services for a total of \$4.3 million in Year 1.

(i) Background to Virtual Care

430. Following the shift to virtual care compelled by the pandemic, and the resulting recognition of the appropriateness of physicians providing virtual care on an ongoing basis, the 2021-24 PSA introduced a permanent framework for the payment of virtual care services in Ontario (Section B of the 2021-24 PSA).

431. This framework integrated video and telephone under the OHIP insured framework, establishing a basket of services that may be delivered virtually when clinically appropriate. It also emphasized the importance of providing virtual care in the setting of an ongoing physician-patient relationship, which is referred to as “comprehensive virtual care”.

432. In June 2022, when the OMA shared certain member concerns with the Ministry of Health, prior to the implementation of the virtual care framework, the Ministry responded that any changes to the framework would need to be addressed in the next

round of bargaining, including, most particularly, what were referred to as the “unintended consequences” of the new framework.

433. The OMA is now seeking to remove barriers to providing virtual services that may have been excluded, unintentionally or otherwise, from the framework in the 2021 PSA, as well as to improve access to virtual care.

434. There had been concerns expressed by the Ministry that restricting access to virtual care was needed because of a concern that there would be excessive virtual care provided as we emerged from the pandemic. The evidence is entirely to the contrary. For 2023-24, only 16% of services that could have been provided in person and virtually have been provided virtually.

435. As a result, given the demonstrated appropriateness of virtual care being provided to patients by Ontario physicians, the OMA now proposes that the OHIP Schedule be updated to allow for comprehensive virtual care codes where specialists and GP Focus Practice Physicians (both GPP and GPFP) work in the same comprehensive shared group practice providing shared care. The OMA also proposes to modify the OHIP Schedule to allow comprehensive virtual care codes to be billed for non-elective virtual care service encounters in long term-care facilities.

436. Since the Year 1 Arbitration, the OMA has withdrawn its virtual care proposals related to case conferencing and telephone care rate.

(ii) Proposal for *Virtual Care Consultation by Telephone*

437. The OMA proposes to enable the clinically appropriate use of virtual telephone care where video is not accessible, due to technology, lack of patient knowledge or capacity, inability to utilize video technology, or other socio-economic barriers.

438. To address this issue, the OMA proposes that a telephone consultation by a specialist where clinically appropriate will be paid at the virtual telephone care rate if due to these barriers applying, it is impractical to perform a video or in-person consultation.

However, such a telephone consultation would not establish a physician-patient relationship for the purpose of ongoing payment of comprehensive care.

439. The amount payable for a consultation service rendered by telephone is 85% of the corresponding in-person fee except for mental health consultation services (A195, A190, A795, A695, A197, A198, A191, A192) which will be payable at 95% of the corresponding in-person fee.

(iii) Proposal to Enable Physicians Practicing in Shared Care Models to Bill Comprehensive Virtual Care Codes

440. Under the PSA 2021-24 framework, there must be an existing/ongoing patient-physician relationship to provide payment for comprehensive virtual care. In practice, where physicians provide shared care as a group, unless a particular physician who is part of that shared care team has an existing/ongoing patient-physician relationship (defined as the patient having had at least one insured service with a direct physical encounter with that physician in the preceding 24 months), that physician cannot be reimbursed for providing comprehensive virtual care.

441. This type of shared care was previously allowed for all physicians as part of the Ontario Telemedicine Network, under the pre-Covid Virtual Care Program rolled out November 15, 2019 and under the COVID virtual care compensation agreement.

442. There are many examples of shared-care practice models including:

- Community Palliative Care On-Call Program which provides 24 / 7 / 365 care to palliative patients in Ontario;
- The Ottawa Hospital's renal transplant and glomerulonephritis clinics;
- London-based community clinic for diabetes in pregnancy (GDM, Type 1, Type 2, other endocrine disease);
- Toronto practice for obesity medicine with multiple sites;

- Ottawa-based Rapid Referral Cardiac Clinic provides virtual urgent assessments in lieu of admission or ED. The clinic also follows patient closely after discharge to avoid readmission or return to ED;
- General internal medicine physician group providing OB medicine focused on treating patients with medical complications in pregnancy. Initial visits are in person with one physician but follow ups are virtual and may be undertaken by another physician in the group.

443. Moreover, the OHIP Schedule payment rules specifically allow for specialists and GP Focus Practice Physicians in the same practice group to fulfill the separate requirement to provide availability for direct physical encounters in order to be eligible to be paid for comprehensive virtual care. Specifically, the OHIP Schedule states:

Services involving a direct physical encounter must be made available by the physician providing Comprehensive Virtual Care Services, or by the physician's group, within a clinically appropriate time-frame, if it becomes apparent during a Virtual Care Service that a service involving a direct physical encounter is medically necessary, or if at the time of scheduling the service the patient expresses preference for a service involving a direct physical encounter [page A65].

444. The OHIP Schedule further defines "a group", in commentary, as follows:

For the purpose of this provision, with respect to specialist and GP Focused Practice Physicians, a group is defined as: those physicians in the same hospital specialty call rotation, or who are co-located in shared clinical physical space, and have shared access to the patient's medical record. For family and general practice physicians, a group is defined as: Patient Enrollment Model physicians who are signatory or contracted to the same specific group contract (i.e., as identified by the same group billing number), or those physicians who are co-located in a shared clinical physical space and have shared access to the patient's medical record. [page A65]

445. However, the terms of the new Virtual Care Framework under the 2021-24 PSA unjustifiably restrict reimbursement for virtual care when provided in shared care models by specialist and GP Focus Practice Physician groups. For their part, family medicine physicians in a Patient Enrollment Model were not similarly impacted.

446. In the OMA's view, allowing specialists and GP Focus Practice Physicians practicing in shared care models to bill comprehensive virtual care codes would enhance patient access and comprehensive care and decrease wait time for services. It would also reduce the number of consultations claimed for the purposes of establishing a physician patient relationship.

447. As a result, the OMA proposes to enable physicians practicing in shared care models to bill comprehensive virtual care codes, as follows:

Modify the OHIP Schedule to allow for comprehensive virtual care codes where specialists and GP Focus Practice Physicians (both GPP and GPFP) work in the same comprehensive shared group practice providing shared care.

A comprehensive shared care group practice means a HOCC group, or other groups of physicians practicing together in the same specialty/subspecialty/GP Focus Practice designation, physicians sharing a group billing number, or in a multidisciplinary hospital-based clinic focused on a shared condition or pathology (e.g. thrombosis, hand, burns and spine clinics).

In all cases, the group must practice together with the capacity to provide direct physical encounters in the same hospital or same clinic or facility, with the group being available to provide direct physical encounter coverage, and with all physicians in the group having access to the patient's medical record.

The practice group must also be registered with the MOH in order to be provided with a shared care group billing number.

Eligibility to bill comprehensive virtual care codes in the shared care model require that there be an established physician-patient relationship with another physician within the same practice group.

Claims Submission Requirements: Claims for comprehensive virtual care codes must be submitted using the group billing number.

(iv) Proposal Regarding Long-Term Care Virtual Care Services

448. The OMA also proposes to modify the OHIP Schedule to allow comprehensive virtual care codes to be billed for non-elective virtual care service encounters in long term-care facilities.

449. Physicians working in long-term care (LTC) provide broad, family medicine-based oversight to residents who are among the most medically and functionally complex individuals in our health system. Typically, LTC physicians perform rounds in the homes about half a day per week and remain involved between visits through frequent phone interactions with nursing staff. In-person presence is limited, making remote guidance a key part of care delivery.

450. The core responsibilities of LTC physicians are shaped by legislated requirements, including three-month medication reviews, annual physical exams, and annual care conferences. Beyond these, issues documented by RNs during the week are reviewed during scheduled visits, with more pressing concerns being dealt with via telephone calls to the physician throughout the week.

451. Diagnostics in LTC can be constrained. Bloodwork is usually drawn once or twice weekly, and obtaining results takes time. X-rays can be arranged within about a week, though ultrasounds often take longer—sometimes weeks. ECGs typically require up to two weeks for reporting. These delays place added emphasis on clinical judgment and timely decision-making, often based on incomplete information. During weekdays, physician availability is typically from 7:00 a.m. to 5:00 p.m. when physicians are accessible by phone to staff for routine issues. Outside of those hours, most LTC homes rely on on-call group arrangements, ensuring coverage for evenings, weekends, and holidays. Temporary coverage is also common when a physician is away due to illness or vacation.

452. Residents in LTC are overwhelmingly frail and medically complex. As of the Ontario Long Term Care Association's 2019 report,¹⁷⁰ the average resident is 84 years old. Ninety percent have some form of cognitive impairment (64% with a diagnosis of dementia). Most need extensive help with daily activities. Neurological, cardiovascular,

¹⁷⁰ Ontario Long-Term Care Association, "[This is Long-Term Care 2019](#)" (April 2019), BOD VOL 3 TAB 110.

and musculoskeletal conditions are highly prevalent. More than 60% take 10 or more prescription medications, and many require close monitoring for acute issues.

453. Using the Case Mix Index (CMI), a provincial measure of resident acuity and resource needs, from 2004 to 2009, acuity increased by 12.2%. A revised methodology was introduced in 2009, resetting the baseline to 1.0. By March 2020, the CMI had risen to 1.1112, representing an 11.12% increase since 2009—or a 24.7% rise from 2004 when adjusted cumulatively.

454. This growing acuity reinforces the importance of timely medical input. Virtual care offers a critical mechanism for physicians to respond quickly and meaningfully to acute deterioration. It facilitates remote assessments that can often prevent unnecessary hospital transfers and allow for palliative approaches to be provided directly in the home. Virtual interventions, while efficient, are not simple. Many LTC residents may be unable to communicate clearly due to dementia or other causes. History-taking typically relies on staff and chart review, not the resident themselves.

455. Physicians are frequently contacted by RNs to assess deteriorating patients virtually. Through guided physical exams, nurses describe lung and heart sounds, pain localization, and neurological findings while the physician also reviews the chart remotely and speaks with the care team. These assessments, when done with skilled nursing support, can match the depth of in-person evaluations and differ significantly from patient-led virtual visits in the community.

456. Virtual care enables compassionate, context-sensitive decisions that prioritize dignity and align with evolving legislation. Notably, the *Fixing Long-Term Care Act* (FLTCA), enacted in April 2022, added a resident's right to palliative-based care. As such, physicians often reassess care goals in real time during acute events. Broad advance directives may exist, but the specific interpretation of palliation or hospitalization varies with each situation.

457. The OMA's proposal for virtual care for the LTC context is responsive to these concerns.

458. *The OMA proposes to modify the OHIP Schedule to allow comprehensive virtual care codes to be billed for non-elective virtual care service encounters in long term-care facilities, under the following eligibility Criteria for Virtual Care Billing (OHIP Schedule of Benefits):*

- ***Non-elective (acute) virtual care encounters:*** *Initiated by a patient or by someone on their behalf (e.g., family or facility staff)*
- ***Physician Requirements:*** *Must be conducted by a physician affiliated to the LTC home, with support by an LTC-affiliated nurse capable of providing clinical information and physical assessment as required*
- ***Timing:*** *Only eligible for payment outside of regular hours (before 7:00 and after 17:00 on weekdays and all day Saturday, Sunday and holidays) or if rendered during daytime hours (07:00 -17:00 hrs Monday through Friday) requiring sacrifice of office hours*
- ***Billing Exclusion:*** *Virtual care encounters do not count toward the monthly W010 visit requirements*

459. In the OMA's view, if awarded, this proposal would improve access and co-ordination of care to LTC patients for acute episodic events, improve patient access for timely non-elective services in LTC facilities, and help reduce unnecessary LTC transfers to emergency departments, reducing, in turn, emergency department wait times.

P. Manual Review Proposal

The OMA proposes to amend the Claims Adjudication Subcommittee's (CASC) terms of reference as outlined below in order to address concerns around manual review:

COST: \$0.

(i) Background to Manual Review Concerns

460. Over the past decade, physicians have faced increasing challenges receiving payments for their services which result in underpayments to the physician and a backlog of claims. Some of these challenges include payment delays, rejections of payments for the performance of lifesaving complex procedures, inconsistent acceptance and rejection of codes for the same services, and a lack of appropriate billing codes for specific services. Dealing with these issues is not only frustrating, but it also imposes a significant administrative burden on physicians which negatively impacts their availability for patient care. The OMA estimates that loss at 57,000 patient visits annually or the loss of 20 specialists each year. These challenges are causing some physicians to question whether they should continue to perform certain procedures.

461. Some examples of the problems that are arising, based on information received by the OMA from its members, include the following:

- Surgical Oncologist – Specializes in breast cancer care, performing surgeries that require years of additional training and take three times as long as standard procedures. The province refuses to pay for these surgeries.
- Orthopedic Surgeon – Complex surgeries require multiple billing codes, which are automatically flagged for review, delaying payment by months before ultimately being rejected. Considering whether these procedures are worth continuing to offer.
- Urologist – Focuses on complex reconstructive surgeries, which are reimbursed at a lower rate than simpler procedures. Payments often take up to a year, making it difficult to run a practice, pay staff, and provide quality care.

- Otolaryngology Surgeon – Performs advanced surgeries but faces constant delays in payment. Claims must be resubmitted two or three times, creating a massive administrative burden for both the surgeon and their staff.
- Hand and Wrist Surgeon – Performed a 15-hour surgery to reattach four fingers for a patient but was paid nothing. Three years later, the patient has returned to work, yet the surgeon has still not received payment.

462. While billing issues vary across medical and surgical specialties, there are widespread reports from our members that these issues have worsened over time. To gain a deeper understanding of the scope and impact of these billing issues, the OMA conducted a survey of the membership in January 2025.

463. Overall, several trends that impact patient care were reported, including:

- administrative time spent on rejected billings directly reduced the amount of time spent on providing direct patient care;
- instead of reviewing their claim submissions, physicians report that they could have spent this time seeing at least 5 additional patients; and
- physicians who had OHIP claims rejected in the past year are less willing to perform some procedures due to these rejections.

464. Based on the survey results, the OMA estimates that an additional 57,528 patients could have been seen in 2024 if rejected claims were not an issue.

465. In addition, an analysis of OHIP Claims Data for the 2023/2024 fiscal year found that the time it takes for physicians to be compensated for surgeries they perform has substantially increased since FY2020/2021 and has increased the most for more complex surgeries.

(ii) The OMA's Manual Review Proposal

466. The OMA proposes to amend the Claims Adjudication Subcommittee's (CASC) terms of reference as outlined below in order to address concerns around manual review:

Amended Claims Adjudication Sub Committee Terms of Reference

BACKGROUND

The Ministry of Health (MOH) and the Ontario Medical Association (OMA) agree to continue to make every reasonable effort to ensure a timely and consistent process for adjudication of all in-province OHIP physician claims for payment. To that end, the Parties have agreed to establish the MOH/OMA Claims Adjudication Sub-Committee (CASC).

MANDATE

The CASC will review specifically identified claims adjudication issues commonly encountered by multiple physicians and/or by the MOH in order to make recommendations to:

- *Better explain/communicate the claims operational processes;*
- *Improve the accuracy, efficiency and accountability of the operational claims processes;*
- *Support consistency in the process for adjudication of claims;*
- *Improve transparency and understanding of the automated Medical Claims Payment System (MCPS) for physicians by, reviewing, modifying and publishing the “OHIP computer rules” on the internet in an easy-to-read format;*
- *Review and update the explanatory and error codes currently posted on the internet;*
- *Implement ability to track claims under review on the Remittance Advice (RA) report;*
- *Establish 3 months deadline on MOH to respond to billing claims, similar to deadlines on physician claim submissions or payment is made in full;*
- *Establish an Ombudsman role to investigate physician complaints on delayed/declined payments;*

- ***Establish new prior approval process; and***
- ***Review all Independent Consideration agreements approved by the Ministry (current and future) and bring forth recommendations on at least an annual basis to the PPC.***

Common issues addressed by the CASC will typically fall within the following areas unless agreed to by the Parties:

- *The claims submission process:*
 - *In-Province claims for payment*
 - *Reciprocal Medical Billing*
 - *The automated Medical Claims Payment System (MCPS)*
 - *Advance and automated payment process policies for FFS physicians, including pre-payment issues*
 - *Medical Claims Payment System rules (OHIP system “Medical Rules”) for specific examples identified*
 - *Issues with error codes and/or explanatory codes*
 - *Mandatory claims data*
- *The claims adjudication process*
 - *Supporting documentation requested in order to review, adjust, pay, or deny a submitted claim*
 - *Timeliness of payments and responses to RAIs*
 - *Inquiries related to a claims payment decision*
 - *Efficiencies in claims adjudication process (e.g., reducing administrative burden associated with rejected claims)*
 - *Communication between physicians and Claims Services Branch*

Note: The CASC will not resolve individual physician complaints regarding payment processing. Physicians with one-off/singular billing questions or issues will be directed to contact the CSB Connects inquiry system for individual physician billing support and issue resolution.

Agenda items or other issues that are not found to be within scope of these ToR of the CASC will be re-directed to the appropriate forum where possible.

*Where the CASC is unable to achieve consensus on a recommendation, the matter will be referred to the **Physician Payment Committee (PPC)**.*

CASC MEMBERSHIP

The CASC will consist of three members appointed by the OMA and three members appointed by the MOH. The OMA and the MOH will each appoint a Co- Chair from among its members. OMA and MOH program staff will support the CASC.

FREQUENCY OF MEETING

Meetings will be held monthly for the first six months with a focus on the priority items identified in the committee workplan, after which meetings will be quarterly. At the request of either co-chair, resolution of issues requiring immediate attention will be addressed through discussion between the Co-Chairs.

For efficiency, the CASC will also pursue identification and addressing of issues through email correspondence where possible.

PROCESS

The Parties will be responsible for the expenses related to their own representatives and staff. The Parties may temporarily substitute or permanently replace representatives without notice.

REPORTING

The CASC will report and make recommendations to the PPC. The CASC will provide status updates on a regular basis or as requested.

Q. Good Faith Payment Proposal

The OMA proposes to restore the former "Good Faith" payment policy or an equivalent policy, on terms to be discussed and negotiated. Specifically, the OMA seeks the implementation of a good faith payment policy in the following three scenarios.

1) Newborns: Allow all claims made under a Pre-Assigned Health Number (PAHN) for newborns, issued as per guidelines in the "Infant Registration Program Manual for Birthing Hospitals" document, to be eligible for payment for a period of 90 days.

2) Ontario residents who are OHIP eligible but do not have valid health coverage and/or documentation (e.g. unhoused, individuals with other social or health factors affecting ability to obtain health card): Provide a generic billing number to be used for these individuals.

3) Individuals presenting in critical conditions who are unable or who have nobody able to provide any information on their health coverage or related documentation: Provide a generic billing number to be used for these individuals specific to critical conditions.

The proposal aims to ensure physicians are paid for medically necessary services provided to uninsured patients who are OHIP eligible in a hospital or a community where reasonable attempts to validate OHIP coverage have been made.

If the parties have any disputes regarding implementation of the above, these may be referred by either party to William Kaplan, acting as sole mediator/arbitrator, for final and binding determination.

COST: \$0.

(i) Background to Good Faith Concerns

467. Until 1998, Ontario physicians benefitted from a Ministry of Health "Good Faith" payment policy that allowed claims to be paid even if a patient's health number was later found invalid, when the provider could not determine an eligibility problem by looking at the health card at the time of service. Since this policy was discontinued, Ontario physicians have been frustrated by the lack of payment for care they provide in good faith when a patient's health card is invalid but who is otherwise eligible for OHIP coverage or in the case of newborn patients who are given a Pre-Assigned Health Number (PAHN) that can later be deemed invalid after medical services have already been rendered.

468. Health card validity is a matter between the patient and OHIP, yet physicians bear the full financial risk, even though claims processing is controlled by OHIP. Physicians should be compensated in good faith for services rendered to OHIP-eligible patients, as well as for non-deferrable care provided to uninsured individuals. Responsibility for determining and managing eligibility should rest with the Ministry, not with physicians.¹⁷¹

469. The OMA seeks the implementation of a good faith payment policy in the following three scenarios:

- Newborn Rejections and Neonatal Death;
- OHIP Eligible without Valid Coverage or Documentation; and
- Uninsured patients receiving non-deferrable care.

470. With this proposal, the OMA aims to ensure that physicians are paid for medically necessary services provided to uninsured patients who are OHIP eligible in a hospital or a community where reasonable attempts to validate OHIP coverage have been made.

(ii) Newborn Rejections and Neonatal Death

471. Currently, a physician is not able to validate a newborn's Pre-Assigned Health Number (PAHN) at the time of service. Services can be billed under the PAHN until the newborn turns 90 days. However, if the PAHN registration is not completed (e.g. incorrect information entered by parent or hospital staff), services submitted using the PAHN will be rejected with a VH9 (Health Number not registered with MOH) error. The physician will not receive payment for any services billed under the PAHN, despite the registration issue being out of the physician's control.¹⁷²

¹⁷¹ OMA, "OHIP-Eligible Rejected Claims Working Group Recommendations" (September 2024) ["Rejected Claims Working Group"], BOD VOL 3 TAB 111.

¹⁷² Jane Healey, MD, FRCPC, Department of Paediatrics, Trillium Health Partners, "Challenges with the Infant Registration Program for Newborns in Ontario", BOD VOL 3 TAB 112.

472. At present, the Infant Registration Program is complex and involves multiple steps requiring coordination between hospital staff and parents. The process is particularly challenging in complex situations, such as neonatal death, surrogacy, or apprehension by child welfare services. High staff turnover, under-resourcing, and human error frequently lead to registration failures that result in claim rejections for care that is often urgent and complex.

473. As well, once a claim is rejected, the responsibility for resolution rests with the physician. However, correcting these claims is extremely difficult and often unsuccessful due to barriers, such as outdated or incorrect family contact information, language issues, unwillingness of families to share private information, inconsistencies in infant names, and the lack of cooperation from other agencies. In cases of neonatal death, physicians often choose not to pursue registration corrections out of compassion, further contributing to lost income.¹⁷³

474. While the Ministry of Health has made some attempts to improve the situation, including accepting forms with placeholder information and issuing a 2019 memo to hospitals, these efforts have been ineffective and VH9 rejections appear to actually be on the rise due to ongoing system complexity. As well, a 2023 policy change reduced the claims submission window from six months to three. Since PAHNs now expire after 90 days, any delay in converting them into valid health numbers effectively ensures that a claim will be rejected as “stale-dated.” Even when physicians do manage to obtain the updated number, resubmission often requires cumbersome manual processing, further delaying or preventing payment.¹⁷⁴

475. For some physicians, the scale of the problem is significant. For example, one pediatrician had 23% of newborn claims rejected over a two-month period due to VH9 errors, all linked to a specific hospital’s failure to register properly. Another pediatrician

¹⁷³ *Ibid.*

¹⁷⁴ *Ibid.*

reported over \$10,000 in lost income from uncorrectable rejected claims, and a tertiary care physician group, despite dedicated billing support, lost over \$50,000 between 2018 and 2022.¹⁷⁵

476. Ontario's physicians provide urgent care to newborns, including vulnerable or critically ill infants, yet are often going unpaid, especially in cases involving new immigrants, low-income families, and birth tourism. This is a problem that the OMA proposal is intended to resolve.

(iii) OHIP Eligible without Valid Coverage or Documentation

477. Another payment problem arises when Ontario residents are OHIP eligible but do not have a valid health card since it has expired without their knowledge, face socio-economic or other barriers in renewing their card, are unable to prove their status or residence, have no fixed address, have lost documents or have been unable to visit a Service Ontario centre.¹⁷⁶

478. Despite these issues being outside physician control, OHIP denies payment without a valid health card and version code, leaving physicians to absorb the financial risk. This creates ethical and practical dilemmas, particularly in urgent cases where CPSO guidance mandates providing care first and raising coverage/payment questions later.¹⁷⁷ In these situations, physicians often receive no compensation from either OHIP or the patient and must also bear administrative costs to chase payment. In non-urgent cases, denying care or requesting payment up front carries risks of patient conflict, complaints, and delayed care.

¹⁷⁵ *Ibid.*

¹⁷⁶ Rejected Claims Working Group, *supra*, BOD VOL 3 TAB 111.

¹⁷⁷ CPSO, [FAQS for Navigating a System Under Stress](#), updated May 1, 2024, accessed Aug 9, 2024, BOD VOL 3 TAB 113.

479. A further inconsistency arises when patients with invalid OHIP cards remain eligible for other government benefits like ODB, Ontario Works, or ODSP. Yet re-validating OHIP requires a separate, often burdensome, process. These challenges disproportionately affect vulnerable populations and raise serious health equity concerns. There is a need to reduce barriers to care and create fair processes for reimbursement.

480. Partial solutions can be found in other provinces. BC, Alberta, Saskatchewan, and Quebec provide good-faith payment options for emergencies. Some allow retroactive billing when coverage is later reinstated. Provinces like PEI, BC, and Alberta also accept alternate proof of residency, such as mailing addresses from shelters or support organizations.¹⁷⁸

481. Physicians should not be required to provide medically necessary, often life-saving care to OHIP-eligible patients without a path to payment. These issues add to the administrative burden, burnout, and moral distress facing physicians. A good faith payment mechanism is essential when there is a reasonable belief that a patient is OHIP-eligible.

(iv) Uninsured Patients Requiring Non-Deferrable Care

482. A third scenario arises when uninsured individuals present at Ontario hospitals, including in emergency departments, in need of urgent, non-deferable care. These populations may include undocumented residents, temporary residents (such as those on work or study permits) who experience lapses in coverage, uninsured travelers to Canada facing medical emergencies, and individuals experiencing complications or emergencies following elective health tourism or birth tourism. Despite an obligation to provide care, physicians often face challenges to receive payment for the medical services they provide in these situations.

¹⁷⁸ Rejected Claims Working Group, *supra*, BOD VOL 3 TAB 111.

483. In terms of non-deferrable care, the OMA means the following:¹⁷⁹

- Physical or mental health conditions which, if not immediately treated, pose a high probability that the patient will suffer loss of life, limb, or critical organ function;
- Conditions which necessitate admission to hospital for stabilization, until such time as acute inpatient care is no longer required;
- Conditions which require emergency surgery;
- Conditions for which immediate treatment is required to prevent permanent complications (e.g., fractures, burns);
- Labour, delivery, and acute complications of pregnancy, including both maternal and fetal/newborn impacts;
- Conditions with immediate public health implications (including but not limited to many reportable diseases); and
- Presenting symptoms that are clinically suspected to represent any of the above, prior to diagnostic confirmation. This includes the possibility of presentation to outpatient settings. With the exception of public health issues, such conditions would usually require transfer to hospital for diagnosis and treatment.

484. When providing care in these critical situations, physicians should receive payment from OHIP.

(v) The OMA's Good Faith Proposal

485. In response to these situations, the OMA proposes to restore the former "Good Faith" payment policy or an equivalent policy, on terms to be discussed and negotiated. Specifically, the OMA seeks the implementation of a good faith payment policy in the following three scenarios:

1. Newborns: Allow all claims made under a Pre-Assigned Health Number (PAHN) for newborns, issued as per guidelines in the "Infant Registration

¹⁷⁹ *Ibid.*

Program Manual for Birthing Hospitals” document, to be eligible for payment for a period of 90 days.

2. Ontario residents who are OHIP eligible but do not have valid health coverage and/or documentation (e.g. unhoused, individuals with other social or health factors affecting ability to obtain health card): Provide a generic billing number to be used for these individuals.
3. Individuals presenting in critical conditions who are unable or who have nobody able to provide any information on their health coverage or related documentation: Provide a generic billing number to be used for these individuals specific to critical conditions. The proposal aims to ensure physicians are paid for medically necessary services provided to uninsured patients who are OHIP eligible in a hospital or a community where reasonable attempts to validate OHIP coverage have been made.

486. If the parties have any disputes regarding implementation of the above, these may be referred by either party to William Kaplan, acting as sole mediator/arbitrator, for final and binding determination.

R. Technical Fees Proposal

The OMA proposes that technical fees (including Integrated Community Health Service Centre facility costs) be increased to cover the cost of providing diagnostic services and procedures, to allow for future investment in new equipment and to encourage the use of technologies that best serves the needs of Ontario patients.

The OMA proposes an increase of \$70M to the OHIP technical fee pool for each of the remaining three years of the 2024-28 PSA, 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").

The \$70M increase to the technical fee pool would be allocated on the following basis: 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.

The OMA proposes that the parties established a joint MOH-OMA technical fees committee ("TFC") under the auspices of PPC. See below for details.

Cost: \$210 Million Total (\$70 Million in each Year 2, 3, and 4)

(i) Background to Technical Fees Proposal¹⁸⁰

487. Diagnostic services, such as MRIs, X-rays, CT scans, ultrasounds, and ECGs, have a professional fee component, which compensates physicians for interpreting results and a technical fee component, which covers overhead costs like equipment, supplies, facilities, and staff. These technical fees are integral to sustaining diagnostic service delivery and are billed in line with the OHIP Schedule of Benefits and Facility Costs, depending on the service provider and setting.

488. Historically, several efforts have been made to address diagnostic service fees, beginning with the 1997 Physician Services Agreement (PSA) and continuing through numerous working groups and committees. Despite these efforts, many of the

¹⁸⁰ OMA, "Diagnostics Services & The Technical Fee Working Group," presented to Mediator Kaplan, October 2024, BOD VOL 5 TAB 132.

recommendations were never implemented, and diagnostic fee schedules saw minimal updates between 2000 and 2011. In 2005, technical fees were slightly increased by 1%, only to be cut by 2.5% in 2012. Subsequent years brought further reductions, including a 2.65% discount in February 2015 and a 1.3% reduction in October of that same year, specifically targeting technical services.

489. In 2018, the Kaplan board of arbitration directed as follows:

The parties are also directed to continue discussions regarding the OMA's additional technical fees proposals.

Where consensus cannot be reached on technical fees issues, either party may trigger further mediation with the assistance of the board or the Chair.

It is our hope that discussion, mediation and fact finding during this mediation process will set the stage for efficient and productive future processes.

Unfortunately, while the OMA did some internal work in respect of its proposals, there were no substantive bilateral negotiations or discussion.

490. Subsequently, under the 2021-24 PSA, the parties agreed as follows, explicitly recognizing identifying a review of technical fees “as a matter of priority”:

- The parties will jointly participate in the work of the technical fees working group, informed by work the Ontario Medical Association has already begun;

- The Ministry retains the right to propose additions but not deletions to the existing Terms of Reference, attached as Appendix 1;

- For the purposes of the work of this Technical Fees Committee, William Kaplan, as the sole mediator/arbitrator, shall be seized with respect to resolving any issues arising out of the parties' efforts to agree on the terms of reference, to conclude and carry out the terms of reference governing this work, and to resolve any methodological differences concerning factors relevant to determining funding to support the technical component of providing medical services;

- The parties agree that this agreement to refer issues in dispute above to arbitration is without prejudice to either party's position otherwise on the arbitrability of these kinds of issues under the BAF.

- The parties' intention is that the Working Group complete its work by March 31, 2024.

491. The terms of reference for the work of the Technical Fee Working Group, as set out in Appendix 1, are as follows:

Appendix 1 – Technical Fee Working Group Terms of Reference Engaging with the Ministry of Health on the following areas, as appropriate

Continue discussions regarding the OMA's technical fee proposals, as per the 2017 Kaplan Arbitration Award

Planning and Strategies to Address Health Care Needs

Using a planning-based approach to the diagnostic services system, recommend strategies to address access and health care needs with a patient focus – including access in under-serviced areas, new approaches to meet patient needs, addressing capacity and wait lists, improving patient education, educating physicians on referral patterns and guidelines etc.

Funding and Structure

To provide advice and recommendations on the funding and structure for the province-wide diagnostic system based on growth, supply, and changing patient needs. To provide advice and recommendations for the use of any new funding, and for the funding of new diagnostic services.

Quality and Service Standards

To provide advice to strengthen quality assurance practices and guidelines. Using a collaborative approach, develop strategies to move toward a systemic and integrated approach to quality management to support appropriate quality and service standards for diagnostic services.

Compensation of Technical Component

To develop and establish how the technical component of diagnostic services (currently described as technical fees) will be evaluated, compensated, and administered, including establishing a fair costing methodology, and an ongoing review process to reflect that reimbursement is based on fair costing and current service volumes.

Utilization Management

To develop and recommend a province-wide utilization management process for the system, including technical fees. To conduct periodic reviews of utilization and utilization trends and provide advice on appropriate evidence-based utilization management.

New Diagnostic Technologies

To consider and develop a framework for the implementation, distribution, quality management, and funding to support new diagnostic technologies.

Capital and Equipment

To assess and make recommendations concerning equipment acquisition and replacement issues and related equipment standards and quality assurance.

492. Unfortunately, while the OMA was strongly committed to completing the work of the task force prior to the expiry of the 2021-24 PSA, very little bilateral progress has been made. It is abundantly clear that without direction from this board of arbitration, no meaningful progress will be made to achieve a much needed increase in technical fees.

493. To give this Board some context and background concerning the need for increases to technical fees, the following are the submissions of the OMA with respect to technical fees in its 2017-21 PSA arbitration brief. Indeed, what the OMA said then is even more true today, as reimbursement for technical fees has fallen even further behind over the ensuing years.

The Issue

1. *Diagnostic services, other than those provided to hospital inpatients, typically have separate professional and technical fee components. The professional fees listed in the OHIP Schedule are intended to remunerate physicians for providing the service and interpreting its results.*

2. *The technical fees listed in the OHIP Schedule and the Schedule of Facility Fees for Independent Health Facilities are intended to defray the costs associated with the provision of insured diagnostic services. The constituent components of technical fees are:*

- *Preparing the patient for the procedure;*
Performing the diagnostic procedure(s);

- *Making arrangements for any appropriate follow-up care;*
- *Providing records of the results of the procedure to the interpreting physician;*
- *Discussion with, and providing information and advice to, the patient or patient's representative, whether by telephone or otherwise, on matters related to the service;*
- *Preparing, and transmitting, a written, signed and dated interpretive report of the procedure to the referring physician;*
- *Providing premises, equipment, supplies and personnel for all specific elements of the technical and professional components except for the premises for any aspects of the professional component associated with clinical supervision and interpreting the results of the diagnostic procedure.*

3. *While these costs have varied over time due to numerous factors (including inflation and changes in technology), there has been no mechanism in place to provide a systemic understanding of these expenses and the changes to them.*

4. *As described below using various models and studies, the gap between the technical fee and the cost of providing the diagnostic service has grown between 38% and more than 200% over the past 20 years depending on the particular service. This growing gap has been largely ignored and has, in many cases, left physicians subsidizing the cost of providing the service with their professional fees which is neither acceptable nor sustainable. There must be a process/mechanism to ensure that technical fees reflect the true cost of providing the service.*

5. *In the OMA's view, it has become imperative to develop a process to properly measure and reimburse the technical cost¹⁸¹ of diagnostic services which includes a mechanism for the continuous introduction, evaluation and renewal of diagnostic services and of the technical component of those services in all settings (public hospitals, Independent Health Facilities and Out of Hospital*

¹⁸¹ *This initiative is not intended to address simple items such as "tray fees" for minor office-based procedures or for laboratory services provided in physician's offices. Rather, it is intended to address services that generally require a significant capital investment in the equipment required to provide the service or significant operational expenses.*

Premises).

A. Prior Bilateral Findings up to 2008

The Diagnostic Services Committee (DSC) was established under the 2004 Physician Services Agreement as a tripartite advisory body to the Ontario Ministry of Health and Long Term Care (MOHLTC), comprising the OMA, the Ontario Hospital Association and the MOHLTC. In March 2008, it released the Progress and Priorities Report which identified a need for additional funding for

diagnostic services, noting that “Current funding for diagnostic services does not reflect today’s cost and service delivery realities.”¹⁸²

6. The trilateral work of the DSC and its subcommittees in 2007 and 2008 highlighted the enormous gap in funding that existed even then. As part of the DSC’s work, the Task Force on Technical Compensation (TFTC) was established to make recommendations on how the technical component of diagnostic services should be evaluated, compensated and administered. The TFTC’s March 19, 2008 report¹⁸³ to the DSC included a detailed evaluation of the technical fee component for five diagnostic services; X091, X113, X185, X224 and J135 (see Table 1 below).

7. Results of the evaluation indicated that the 2008 fee values (which were greater than the 2017 fee values!) should be increased by **between 32.5% and 289.7%** to appropriately account for the true costs of rendering the diagnostic service depending upon service location and equipment modality.

Table: Task Force on Technical Compensation (TFTC) Summary of Costs for Sample Fee Codes¹⁸⁴

2008	CR IHF	CR IHF	CR	C R	DR IHF	DR IHF	DR	D R
------	-----------	-----------	----	--------	-----------	-----------	----	--------

¹⁸² Diagnostic Services Committee, Progress and Priorities Report, (March 2008) [“DSC 2008 Report”], BOD VOL 3 TAB 114.

¹⁸³ Task Force on Technical Compensation, Report to the Diagnostic Services Committee, (March 19, 2008), BOD VOL 3 TAB 115.

¹⁸⁴ X091 X-ray - Chest, two views; X113 X-ray - Colon - air contrast, primary or secondary, including survey films, if taken; X185 Mammogram – bilateral; X224 X-ray - Knee including patella, three or four views; J135 Diagnostic Ultrasound - Complete abdominal scan; CR - Computed Radiography; DR – Digital Radiography.

Fee Code	Fee ³	GT A	Other Ontario	Academic Hospital	General Hospital	GT A	Other Ontario	Academic Hospital	General Hospital
X091	\$22.45	\$65.03	\$60.62	\$67.26	\$55.77	\$64.83	\$61.30	\$78.44	\$67.64
X113	\$62.85	\$113.72	\$105.65	\$116.82	\$97.74	\$130.76	\$124.44	\$161.38	\$142.99
X185	\$38.10	\$92.41	\$90.57	\$91.50	\$79.14	\$122.41	\$121.66	\$115.75	\$103.86
X224	\$23.50	\$75.54	\$70.03	\$77.31	\$64.63	\$74.95	\$70.58	\$91.58	\$79.79

Fee Code	Current Fee	IHF GTA	IHF Other Ontario	Academic Hospital	General Hospital
J135	\$50.00	\$77.50	\$66.24	\$90.28	\$74.83

B. Further Deterioration since 2008

8. This chronic underfunding has continued to grow with no adjustment over the last two decades despite significant increases in labour, facility and consumable costs. In addition, many of these services have incorporated new technologies that require large investments to maintain acceptable standards of care, such as new PACS/RIS/IT support.

9. To provide a global evaluation of the cost of performing diagnostic services subsequent to the 2008 work of the DSC, the OMA constructed two Technical Fee Medical Economic Indices (TFMEI) (see Table 2 below).

10. The first index (TFMEI-1) is based on expense components for staff salary, office rent/lease, and supplies and equipment, where the component weightings are based on figures presented in TFTC's March 19, 2008 report to the DSC.

11. The second index (TFMEI-2) adds other medical expenses to the components of the TFMEI-1. The weighting of each component is also different and is based on figures presented in the Medicare RBRVS: The Physicians'

Guide 2017.¹⁸⁵

12. Both indices demonstrate that the cost of performing diagnostic services has risen since 2006: by 46% according to the TFMEI-1 and by 36% according to the TFMEI-2.

Table: Technical Fee Medical Economic Index - 1 (TFMEI - 1)

Year	Expense Component			TFMEI*	Index (2006=100)
	Staff Salary	Office Rent	Supplies/ Equipment		
2006	3.0%	3.6%	1.8%	2.44%	100.0
2007	.7%	1.9%	1.6%	5.00%	105.0
2008	15.5%	2.3%	3.9%	8.70%	114.1
2009	12.4%	9.1%	1.5%	6.70%	121.8
2010	2.1%	-3.3%	3.5%	2.38%	124.7
2011	5.3%	2.9%	8.0%	6.44%	132.7
2012	1.4%	0.8%	0.9%	1.12%	134.2
2013	3.6%	-0.5%	2.5%	2.70%	137.8
2014	3.9%	0.3%	1.7%	2.51%	141.3
2015	2.0%	1.5%	1.5%	1.71%	143.7
2016	2.7%	0.3%	0.3%	1.29%	145.6

* TFMEI-1 weightings: 42.2% staff, 7.8% for office rent, 50.0% for medical equipment and supplies. The weightings of each expense component are based on the Task Force on Technical Compensation, Report to the DSC – March 19, 2008, that identified six cost components with significant impact on total technical fee costs. The median proportion was used and expected return on investment was excluded.

¹⁸⁵ American Medical Association, Medicare RBRVS: The Physicians' Guide 2017, (American Medical Association, 2017), pp. 49-53.

Sources

Component	Base Index	Source
<i>Staff Salary</i>	<i>Avg Earnings - Office of Physicians</i>	<i>CANSIM, Average weekly earnings, Ontario; all employees; excluding overtime; offices of physicians</i>
<i>Office Rent</i>	<i>Rental Rate</i>	<i>Cushman & Wakefield, Average of Toronto & Ottawa Rental Rates</i>
<i>Supplies/Equipment</i>	<i>Supplies/Equipment</i>	<i>CANSIM, Canada; medical equipment and supplies manufacturing</i>

Table: Technical Fee Medical Economic Index - 2 (TFMEI - 2)

Year	Expense Component				TFMEI*	Index (2006=100)
	<i>Staff Salary</i>	<i>Office Rent</i>	<i>Other Expenses</i>	<i>Supplies/ Equipment</i>		
2006	3.0%	3.6%	2.1%	1.8%	2.43%	100.00
2007	9.7%	1.9%	1.3%	1.6%	3.86%	103.86
2008	15.5%	2.3%	1.9%	3.9%	6.64%	110.76
2009	12.4%	9.1%	1.0%	1.5%	5.51%	116.86
2010	2.1%	-3.3%	1.9%	3.5%	1.90%	119.08
2011	5.3%	2.9%	2.1%	8.0%	5.36%	125.46
2012	1.4%	0.8%	0.7%	0.9%	1.00%	126.72
2013	3.6%	-0.5%	0.5%	2.5%	2.01%	129.27
2014	3.9%	0.3%	1.6%	1.7%	2.12%	132.00
2015	2.0%	1.5%	0.9%	1.5%	1.53%	134.02
2016	2.7%	0.3%	1.8%	0.3%	1.27%	135.73

* TFMEI-2 weightings: 28.6% staff, 13% for office rent, 20.3% for other expenses and 38.2% for medical equipment and supplies. The weightings of each expense component are based on the Medicare RBRVS: The Physicians' Guide 2017, Table

5.2. Mean Practice Expenses per Hour Spent in Patient Care Activities for Independent Diagnostic Testing Facilities.

Sources

Component	Base Index	Source
<i>Staff Salary</i>	<i>Avg Earnings - Office of Physicians</i>	<i>CANSIM, Average weekly earnings, Ontario; all employees; excluding overtime; offices of physicians</i>
<i>Office Rent</i>	<i>Rental Rate</i>	<i>Cushman & Wakefield, Average of Toronto & Ottawa Rental Rates</i>
<i>Other Expenses</i>	<i>CPI & Pharmaceuticals</i>	<i>1. CANSIM, Consumer price index (CPI), 2005 basket content, Ontario; all-items; 2. CANSIM, Canada; pharmaceutical and medicine manufacturing</i>
<i>Supplies/Equipment</i>	<i>Supplies/Equipment</i>	<i>CANSIM, Canada; medical equipment and supplies manufacturing</i>

C. Technical Fees in Absolute Terms Have Decreased

13. Over time, technical fees have not only failed to keep pace with the increasing costs of providing diagnostic services but have actually decreased in absolute terms by 0.05%.

14. This decrease does not include the additional reduction in technical fees following the Ministry's unilaterally imposed across-the-board payment discounts that have continued since 2012 and now total -4.45%, thereby compounding the problem.

15. The following (Table 3) summarizes technical fee payment changes since 1998:

Table: Technical Fee Changes: 1998 – 2017

Cumulative Technical fee adjustments (1998-2017) = -0.05%

Year	% Change to SOB	Additional Ongoing Discounts	Notes
1998			
1999	1.45%		
2000			
2001			
2002			
2003			
2004			
2005	1.00%		<i>April 1, 2005: 1% ATB ("across-the-board") to tech fees</i>
2006			
2007			
2008			<i>Interim one-time funding (approximately 2%) from 2008 to 2012, unilaterally terminated in 2012</i>
2009			
2010			
2011			
2012	-2.50%		<i>MOH unilaterally terminates interim funding, and further imposed 2.5% technical fee decrease</i>
2013		<i>ATB: -0.5%</i>	<i>April 1, 2013 - 0.5% Payment discount applied to all FFS claims</i>
2014			
2015		<i>ATB: - 3.15%, increased October 1, 2015 to -4.45%</i>	<i>Add'l FFS Payment unilateral discounts: (1) February 1, 2015 - 2.65% (T=3.15%) (2) October 1, 2015 - 1.3% (T=4.45%)</i>
2016			<i>Unilateral discount continues</i>
2017			<i>Unilateral discount continues</i>

(ii) Developments since 2017

494. Since 2017, the gap between actual costs and expenses and the limited amounts provided under the OHIP Schedule to reimburse physicians for these technical fee costs and expenses has only widened.

495. Moreover, despite the direction in the 2017-21 PSA arbitration award, and the more recent bilateral commitment to address technical fee compensation as a priority matter, the history of the parties' attempts to engage bilaterally on improving compensation for technical fees shows that the Ministry has no interest in addressing this matter.

496. The table immediately below presents an evaluation of the cost of performing diagnostic services since 2007 based on OMA constructed Technical Fee Medical Economic Indices ("TFMEI"). Both indices demonstrate that the cost of performing diagnostic services has risen since 2007, by 64.6% according to the TFMEI-1 and by 51% according to the TFMEI-2, as follows:

Table: Technical Fee Medical Economic Indices ("TFMEI"): 2007 – 2024

Year	TFMEI – 1					TFMEI - 2				
	Expense Component			TFMEI*	Index	Expense Component			TFMEI*	Index
	Staff Salary	Office Rent	Supplies/ Equipment			Staff Salary	Office Rent	Supplies/ Equipment		
2007	9.70%	1.90%	1.80%	5.10%	100	3.90%	1.90%	1.80%	2.70%	100
2008	15.50%	2.30%	2.80%	8.20%	108.2	2.60%	2.30%	2.80%	2.70%	102.7
2009	12.40%	9.10%	2.10%	7.00%	115.8	2.00%	9.10%	2.10%	2.60%	105.4
2010	2.10%	-3.30%	9.40%	5.30%	121.9	3.70%	-3.30%	9.40%	6.00%	111.8
2011	5.30%	2.90%	2.60%	3.70%	126.5	1.20%	2.90%	2.60%	2.00%	114
2012	1.40%	0.80%	1.20%	1.30%	128.1	1.40%	0.80%	1.20%	1.30%	115.4
2013	3.60%	-0.50%	2.00%	2.50%	131.3	1.70%	-0.50%	2.00%	1.70%	117.4
2014	3.90%	0.30%	1.40%	2.30%	134.3	2.00%	0.30%	1.40%	1.50%	119.2
2015	2.00%	1.50%	2.10%	2.00%	137	2.70%	1.50%	2.10%	2.30%	121.9

2016	2.70%	0.30%	-0.90%	0.70%	138	1.30%	0.30%	-0.90%	0.10%	122.1
2017	-0.10%	1.90%	0.40%	0.30%	138.4	1.80%	1.90%	0.40%	1.10%	123.4
2018	4.00%	3.30%	2.00%	2.90%	142.5	2.90%	3.30%	2.00%	2.40%	126.4
2019	3.90%	4.30%	0.30%	2.10%	145.6	2.70%	4.30%	0.30%	1.60%	128.5
2020	3.70%	1.10%	-0.50%	1.40%	147.6	7.20%	1.10%	-0.50%	2.90%	132.2
2021	0.40%	3.40%	3.40%	2.10%	150.8	3.50%	3.40%	3.40%	3.50%	136.8
2022	2.20%	0.30%	6.00%	3.90%	156.7	2.20%	0.30%	6.00%	3.90%	142.2
2023	0.30%	0.84%	1.66%	1.02%	158.3	3.22%	0.84%	1.66%	2.25%	145.3
2024	5.56%	2.11%	2.99%	4.01%	164.6	5.25%	2.11%	2.99%	3.87%	151.0

* To calculate TFMEI - staff salary component is given a 42.2% weighting, 7.8% for office rental expense and 50% for medical equipment and supplies.

Weighting of the TFMEI is based on the Task Force on Technical Compensation, Report to the DSC – March 19, 2008, that identified six cost components with significant impact on total technical fee costs. The median proportion was used and expected return on investment was excluded.

Sources:

Component	Base Index	Source
Staff Salary – TFMEI 1	Avg Earnings - Office of Physicians	CANSIM, Average weekly earnings, Ontario; all employees; excluding overtime; offices of physicians
Staff Salary - TFMEI 2	Average Weekly Earnings - Ontario Industrial Aggregate Index	CANSIM, Average weekly earnings, Ontario; all employees; excluding overtime; industrial aggregate excluding unclassified businesses
Office Rent	Rental Rate	Cushman & Wakefield, Average of Toronto & Ottawa Rental Rates
Supplies/ Equipment	Supplies/ Equipment	CANSIM, Canada; medical equipment and supplies manufacturing

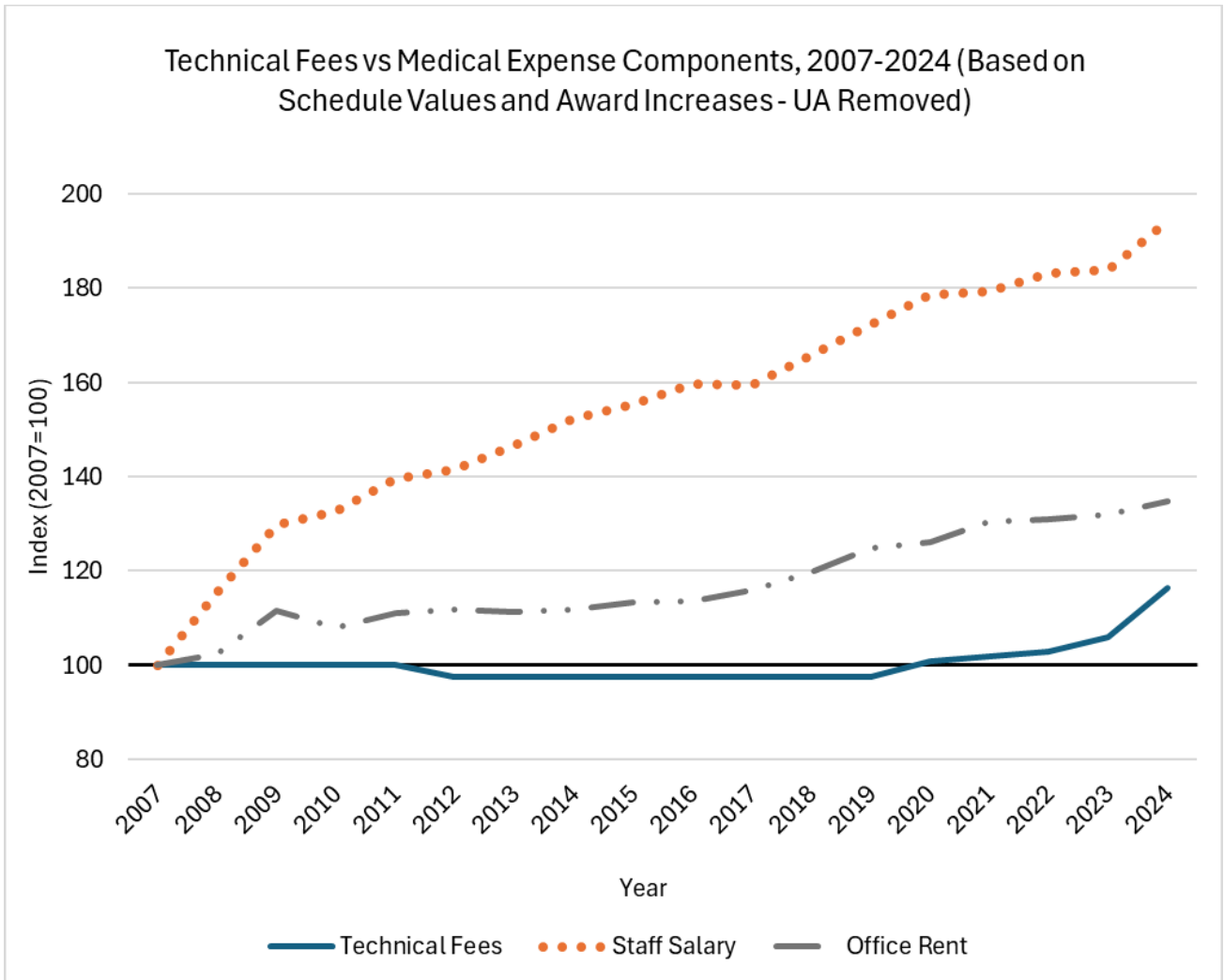
497. The following table presents technical fee increases since 2007. Over the past 17 years, technical fees have failed to keep pace with the increasing costs of providing diagnostic services and have only increased in absolute terms by 16.4%, as follows:

Table: Technical Fee Changes: 2007 – 2024

Year	% Change	Discounts	Comments
2007		H Fee: 7.0%	
2008		H Fee: 7.0%	
2009		H Fee: 7.0%	
2010		H Fee: 7.0%	
2011		H Fee: 7.0%	
2012	-2.50%	H Fee: 7.0%	MOH imposed 2.5% technical fee decrease
2013		H Fee: 7.0% ATB - 0.5%	April 1, 2013 - 0.5% Payment discount applied to all FFS claims
2014		H Fee: 7.0% ATB - 0.5%	
2015		H Fee: 7.0% ATB - 3.15% ATB - 4.45%	Add'l FFS Payment discounts: (1) February 1, 2015 - 2.65% (T=3.15%) (2) October 1, 2015 - 1.3% (T=4.45%)
2016		H Fee: 7.0% ATB - 4.45%	
2017		H Fee: 7.0% ATB - 4.45%	* 0.75% global payment increase (excluding only hospital technical fees and OPIP)
2018		H Fee: 7.0% ATB - 4.45%	* 1.25% global payment increase (excluding only hospital technical fees and OPIP)
2019		H Fee: 7.0%	* 0.5% global payment increase (excluding only hospital technical fees and OPIP) * 0.5% used to remove the 0.5% payment discount from the 2012 PSA* * Elimination of the unilateral 2015 2.65% non-fee for service and 3.95% fee-for service payment discounts

2020	3.54%	H Fee: 7.0%	* 1.0% global payment increase (excluding only hospital technical fees and OPIP) * All technical services will receive a fee increase of 3.54% with the exception of technical services performed in hospital
2021			* 1% global payment increase (excluding only hospital technical fees and OPIP)
2022			* 1% global payment increase (excluding only hospital technical fees and OPIP)
2023	2.01%		* 2.01% permanent increase to SOB, effective April 1, 2023 (reflects compounded value of FY2021/22 & FY2022/23 global payment increases) * 2.8% global payment increase (excluding only hospital technical fees and OPIP).
2024			* 2.8% global payment increase (excluding only hospital technical fees and OPIP) * 9.95% global payment increase (excluding only hospital technical fees and OPIP); 9.95% represents 3% for Year 1 (April 1, 2024 - March 31, 2025) plus additional 6.95% for redress/catch-up.

498. The following figure presents the change in staff salary and office rent expenses, compared to the changes to non-hospital technical fee values for diagnostic services since 2007. Over the past 17 years (2007 to 2024), while staff salaries have increased 94% and office rents have increased 35%, technical fees have increased by 16% (inclusive of the year 3 2021-24 PSA and year 1 2024-28 technical fees increases).



Notes: Hospital technical fees excluded from analysis.

For simplicity, figure does not take into account unilateral discounts from 2013-2015 and subsequent reversal of these discounts.

Sources: CANSIM, Average weekly earnings, Ontario; all employees; excluding overtime; offices of physicians, Cushman & Wakefield, Average of Toronto & Ottawa Rental Rates

(iii) 2021 Beltzner Study on costs associated with technical fees

499. In 2021 the OMA side of the Technical Fees Working Group (“TFWG”) commissioned a study on an approach to evaluate the current cost of providing the technical component of a service in Ontario (report completed in 2022). The accountant selected to complete this report, Mr. Rainer Beltzner (an expert in medical expenses and

cost accounting) is the former chair of the Task Force on Technical Compensation that reported to the trilateral Diagnostics Services Committee (as referred to above).

500. While the 2021-22 Beltzner study worked to establish a costing methodology that could apply broadly to the range of technical services in Ontario, six technical services were fully costed using real world data as a proof of concept. Comparing these values to actual amounts paid for these services provides an understanding of how technical services are funded relative to the cost of providing those services.

501. Of the \$992M in diagnostic technical fees billed in FY2019, Diagnostic Radiology and Cardiology account for approximately 72% of this total, by dollar value. On this basis, the TFWG decided to select two (2) codes primarily billed by Diagnostic Radiology and two (2) billed primarily by Cardiology for study. The remaining two (2) codes were selected from the common technical codes billed by other Specialties. The selection of individual technical fee codes was further informed by the following criteria:

- i) The fee codes selected should be commonly billed and representative of the work typically performed (measured by total payments, service volume, number of physicians, and patient counts).
- ii) Fee codes should be selected that are billed in a variety of care settings (i.e., Independent Health Facility (“IHF”), Hospitals, and private office settings).
- iii) Codes should be selected from different Specialties (noting that not all specialities that bill technical fees can be included in this limited pilot study).
- iv) Codes should have well defined equipment and quality standards.

502. In the OMA-TFWG’s report, Mr. Beltzner provides the following commentary:

“Current costs per procedure are higher than the approved technical fees. The most significant cost increases come from the current cost of technologists (and to some extent the support admin staff) where wage rates have seen significant upward pressures due to the current competitive environment. This is unlikely to

change in the future until more technologists enter the market. Diagnostic equipment has seen increases particularly with respect to cost of repair, maintenance, and software version upgrades. While many peripheral devices (servers, PC's, etc.) have seen cost reduction because of a competitive environment, this is offset by the increased need for system integration, security, and the supporting skill set to support an increasingly complex environment [...]"

The table below shows the difference between the estimated incremental costs of providing a technical service and the technical fee associated with that same service (as of 2022).

Table: Selected Fee Codes: Technical Fees and Estimated Cost of Provision (2022)

Code	Descriptor	Technical Fee (February 2022)	Estimated Cost (February 2022)
G570A	Echocardiography - Complete study - 1 and 2 dimensions - technical component	116.60	118.00
J135B	Diagnostic Ultrasound - Thorax, abdomen and retroperitoneum - Abdominal scan - Complete	50.50	88.01
X091B	Diagnostic Radiology - Chest & Abdomen - Chest - Two views	24.40	37.37
G315A	ECG - Stress Testing - Maximal stress ECG - technical component	45.05	77.51
J310B	Pulmonary Function Studies - Functional residual capacity - Carbon monoxide diffusing capacity by single breath method	22.15	28.48
G455A	Physical Medicine - Needle electromyography and nerve conduction studies - Schedule A - technical component	28.35	79.35

503. The following table shows the “full” procedural costs. The full procedural costs view the procedure as a stand-alone procedure which would apply if a new clinic was

built and equipment bought from scratch, and only used to perform a given procedure. If a new clinic was created, with new equipment, etc., there would not be any question that there would be a substantial loss for a few years.

Table: Full procedural costs associated with provision of select technical services (2022)

	G570A	J135B	X091B	G315A	J310B	G455A
Equipment	\$26.50	\$34.38	\$10.31	\$11.83	\$4.47	\$12.40
Personnel	\$76.08	\$49.06	\$21.66	\$56.88	\$19.74	\$61.91
Space	\$37.10	\$24.53	\$8.22	\$40.60	\$8.45	\$9.32
Other	\$14.56	\$8.01	\$9.16	\$9.72	\$4.72	\$9.75
Total Current Cost Per Procedure	\$154.23	\$115.98	\$49.35	\$119.04	\$37.38	\$93.98
T-Fee Per	\$116.60	\$50.50	\$24.40	\$45.05	\$22.15	\$28.35
Difference Per Procedure	\$37.63 31%	\$65.48 130%	\$24.95 102%	\$73.99 164%	\$15.23 69%	\$65.03 229%

504. The next table shows the ‘incremental’ procedural costs - i.e. if the procedure was added to an already existing operating facility.

Table: Incremental procedural costs associated with provision of select technical services (2022)

	G570A	J135B	X091B	G315A	J310B	G455A
Equipment	\$20.31	\$31.30	\$9.43	\$8.12	\$3.65	\$9.65
Personnel	\$70.43	\$43.41	\$16.01	\$50.32	\$17.51	\$53.39
Space	\$12.71	\$5.30	\$2.77	\$9.35	\$2.99	\$6.57
Other	\$14.56	\$8.01	\$9.16	\$9.72	\$4.34	\$9.75
Total Current Cost Per Procedure	\$118.00	\$88.01	\$37.37	\$77.51	\$28.48	\$79.35
T-Fee Per	\$116.60	\$50.50	\$24.40	\$45.05	\$22.15	\$28.35
Difference Per Procedure	\$1.40 1%	\$37.51 74%	\$12.97 53%	\$32.46 72%	\$6.33 29%	\$51.00 180%

505. More details on costing methodology and cost elements can be found in the TFWG's report, "Cost of Selected Technical Fee Codes: Pilot Study" and "Cost of Selected Technical Fee Codes: Scalable Approach".¹⁸⁶

506. There are a number of specific examples of significantly underfunded technical fees in the Schedule of Fees. The electroencephalograph (EEG) codes (G541 and G540) have been identified by neurologists as being woefully inadequate on a cost recovery basis which potentially may limit service delivery. The simple electromyography (EMG) code G455, identified in the Beltzner study as paying 180% below cost, pays the same as the complex code G471 (\$28.90), which makes little sense given the significantly more technician time required to complete the complex study.

507. In the Nuclear Medicine scintigraphy codes, white blood cell scintigraphy (J883/J884) has a technical fee of \$364.30 and \$320.80, respectively, yet the radiopharmaceutical required to conduct the test has a cost over \$1,000. A number of other scintigraphy studies such as marrow scintigraphy (J881/J882) and lung scintigraphy (J859, J887, J860) face a similar problem. The result is an undue burden on hospital facilities to complete studies that could be done in an independent facility. This exacerbates wait times and system cost.

508. Ultrasound imaging of the musculoskeletal system has an inadequate technical fee. The imaging of a single joint pays the same as a multiple joint study on the same side. Pelvic and gynecological ultrasound despite complexity requiring technician time and associated costs continues to be underfunded.

509. As there currently is no bilateral process to introduce new technical fees there is a backlog of requests from physicians to the OMA and a number of new diagnostics

¹⁸⁶ Technical Fee Working Group Report, "Cost of Selected Technical Fee Codes: Pilot Study" and "Cost of Selected Technical Fee Codes: Scalable Approach". BOD VOL 3 TAB 116.

identified by the Ontario Health Technology Committee (OHTAC) that would benefit from inclusion in the fee schedule.¹⁸⁷

510. At present there are existing technologies completed in hospital that could be implemented in the community except that no billing code exists. Some examples from the field of Neurology include lumbar puncture (Z804) and deep brain stimulation (DBS) for the treatment of Parkinsons disease. Home sleep studies also have no technical fee code and so are unable to be completed outside of a laboratory setting adding to increased cost and patient hardship.

511. The OMA strongly believes that reestablishing a meaningful bilateral structure to ensure the delivery and appropriate funding of technical services is essential to the maintenance of high-quality health care for Ontarians.

(iv) OMA Technical Fees Proposal

512. The OMA proposes that technical fees (including Integrated Community Health Service Centre facility costs) be increased to cover the cost of providing diagnostic services and procedures, to allow for future investment in new equipment and to encourage the use of technologies that best serves the needs of Ontario patients.

513. The OMA proposes an increase of \$70M to the OHIP technical fee pool for each of the remaining three years of the 2024-28 PSA, 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”).

514. The \$70M increase to the technical fee pool would be allocated on the following basis: 25% of funds will be applied to new technologies and 75% of funds will support

¹⁸⁷ List of New Diagnostic Services Requiring a Technical Fee, BOD VOL 3 TAB 117.

an adjustment of existing diagnostic services and procedures, taking into consideration advances in technology and overall cost increases.

Bilateral Technical Fee Committee

515. The OMA proposes that the parties establish 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.

516. 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 planning, quality and service standards, appropriateness, the introduction of new services and technologies and the acquisition and replacement of capital equipment.

(a) PPC Role

517. The OMA proposes that the PPC employ the following framework for the timely introduction of funding to support existing and new diagnostic services and procedures:

1. If the request is for a new fee, the PPC must first recommend the corresponding professional fee. The Section must indicate on the Professional Fee Assessment Form (“PFAF”) if there is an accompanying technical fee. It is not necessary to provide a completed Technical Fee Assessment Form (“TFAF”) with the initial submission.
2. If the request is for a revision of an existing fee, it should be submitted as part of the PPC fee setting/allocation process. The Section cannot present a request to the Technical Fee Committee (“TFC”) directly.
3. If the PPC feels the request is warranted, it is forwarded to the TFC for determination of an appropriate fee.

4. Sections submit their TFAF and supporting documentation to the TFC.
5. Sections present their request(s) to the TFC.
6. TFC submits its recommendations to PPC for final deliberation and inclusion in the PPC final recommendation to the PSC.

S. Physician Health Benefit Program (PHBP) Proposal¹⁸⁸

To account for increased number of participants, increased claim costs resulting from inflation and increased claims utilization, and in order to be able to continue to provide physicians with necessary and stable health insurance benefits, the OMA proposes to further increase the government contribution to the PHBP from \$33.2 million dollars to the following:

- *April 1, 2025: \$34.2M*
 - *April 1, 2026: \$35.7M*
 - *April 1, 2027: \$37.7M*
-

518. The 2004 Physician Services Framework Agreement and 2008 Physician Services Agreement provided for the creation of the Physician's Health Benefit Program ("PHBP"), effective January 1, 2008, which provides Ontario physicians with health insurance coverage (including critical illness, extended health care ("EHC") insurance and an optional health spending account).

519. Until the 2021-24 PSA, the Ministry had provided \$25 million in funding for this program annually since it launched in January 2008, with no funding increases since inception, while program participation grew by 27% and costs increased by 258%.

520. Under the 2021-24 PSA, recognizing the growing cost of providing physicians with insured health benefits, and the growing need for such health benefits particularly during and coming out of the pandemic, the Ministry agreed to make modest improvements to funding of the PHBP, increasing annual funding to \$28.5 million, effective April 1, 2022, and to \$31 million effective April 1, 2023 and, subsequently, to \$33.16 million effective April 1, 2024.

¹⁸⁸ OMA Insurance, "PHBP/OPO Experience and Projections" Presentation, Presented to NTF, May 12, 2025, BOD VOL 5 Tab 149

521. To account for increased number of participants, increased claim costs due to medical inflation, rising drug prices, and greater overall claims utilization – and to ensure the continued provision of necessary and stable health insurance benefits for physicians – the OMA proposes a further increase in the government contribution to the PHBP as follows:

- April 1, 2025 \$34.2M
- April 1, 2026 \$35.7M
- April 1, 2027 \$37.7M

522. The current administration cost of \$325,000 has remained unchanged since the program's inception in 2006. However, this amount is significantly lower than the actual cost to administer the program. As a result, the proposed increase in funding includes raising the administration cost to OMA to \$846,900.

523. This increased government funding is supported by both year over year growth in physicians enrolled in the program (estimated to be 1.9%) but more importantly by the increased costs of providing the benefit under the program, as set out below.

Plan Year	Health Premium Increase	Health & CI Participant Premium Share ⁽¹⁾	Health Spending Account Cost ⁽²⁾	Individual Participant Cost (in \$ millions)
2020/21	15%	30%	\$50	\$18.2M
2021/22	17%	35%	\$50	\$20.4M
2022/23	12%	45%	\$50	\$26.5M
2023/24 ¹	15%	47.5%	\$50	\$33.7M
2024/25 ⁽³⁾	2%	47.5%	\$50	\$38.5M
2025/26 ⁽³⁾	15%	47.5%	\$50	\$42.4M
2026/27 ⁽³⁾	15%	47.5%	\$50	\$49.3M
2027/28 ⁽³⁾	15%	47.5%	\$50	\$57.1M

⁽¹⁾ Effective January 1st

⁽²⁾ Annual Health Spending Account participant cost

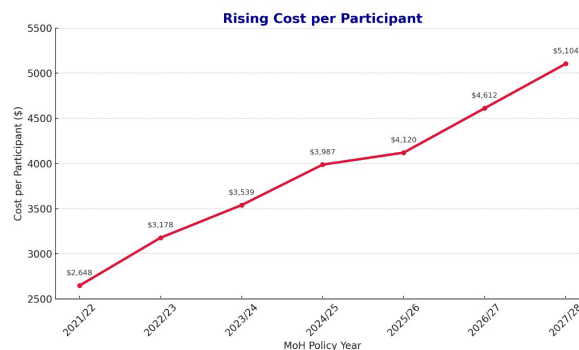
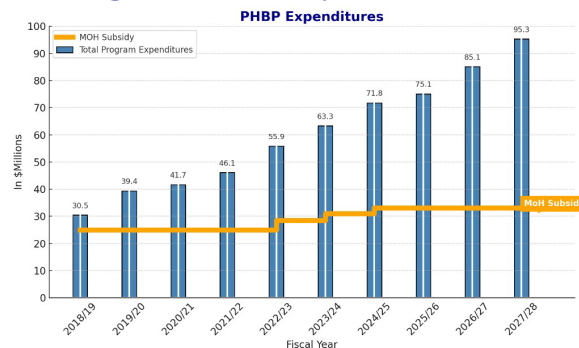
(3) Projected for Plan Years 2024/25 and thereafter

524. Moreover, without the proposed additional Ministry funding support, a \$5.7 million deficit is projected by 2027/2028. With increasing participation, medical inflation and rising drug costs, if no change is made to the current funding (\$33.16 million from the Ministry and 47.5% cost-sharing by physicians effective January 1, 2024) the program will be in a projected deficit of \$5.7 million dollars by the 2027/28 program year.

525. Indeed, at the current Ministry funding level of \$33.16 million dollars, by 2028, the government support will only offset 35% of total plan expenditures, as opposed to 82% in 2018, as illustrated below:

MoH Physician Health Benefit Program Subsidy

- Subsidy increased to \$28.5M in 2023, to \$31M in 2024, and to \$33.16M in 2025
- Participation YoY growth = 1.9% (to 18,670 physicians in 2028)
- Percentage of physicians enrolled in the program remains stable at ~53%
- At the current funding level, by 2028, the subsidy will offset 35% of total plan expenditures, vs 82% for 2018



T. OHIP SCHEDULE OF BENEFITS IMPROVEMENTS

The OMA proposes to allocate \$30 million each year for the Physician Payment Committee (PPC) to address respond to submissions on the gender pay gap such as those set out in Appendix I (see below).

Cost: \$90 Million (\$30 million in each of Years 2, 3, and 4)

(i) Gender Pay Gap Schedule of Benefits Proposal

526. The existence of gender-based disparities in physician payments is well established both internationally¹⁸⁹ and in Ontario.¹⁹⁰ Steffler et al., 2021 studied physician earnings in Ontario using all OHIP billings and found that the unadjusted differences in clinical payments between male and female physicians were 32.8% annually and 22.5% daily. After accounting for practice characteristics, region, and specialty, a 13.5% gender pay gap remained.

¹⁸⁹ Theurl E, Winner H. The male-female gap in physician earnings: evidence from a public health insurance system. *Health Econ.* 2011 Oct;20(10):1184-200. doi: 10.1002/hecl.1663. Epub 2010 Sep 19. PMID: 20853520, BOD VOL 3 TAB 118; Magnusson, C. (2016). The gender wage gap in highly prestigious occupations: a case study of Swedish medical doctors. *Work, Employment and Society*, 30(1), 40-58. <https://doi.org/10.1177/0950017015590760>, BOD VOL 3 TAB 119; Dumontet M, Le Vaillant M, Franc C. What determines the income gap between French male and female GPs—the role of medical practices. *BMC Fam Pract.* 2012;13(1):94. doi:10.1186/1471-2296-13-94, BOD VOL 3 TAB 120.

¹⁹⁰ Buys YM, Canizares M, Felfeli T, Jin Y. Influence of age, sex, and generation on physician payments and clinical activity in Ontario, Canada: an age-period-cohort analysis. *Am J Ophthalmol.* 2019;197:23-35. doi:10.1016/j.ajo.2018.09.003, BOD VOL 4 TAB 121; Cohen M, Kiran T. Closing the gender pay gap in Canadian medicine. *CMAJ.* 2020;192(35):E1011-E1017. doi:10.1503/cmaj.200375, [Cohen & Kiran, 2020], BOD VOL 4 TAB 122; Dossa F, Simpson AN, Sutradhar R, et al. Sex-based disparities in the hourly earnings of surgeons in the fee-for-service system in Ontario, Canada. *JAMA Surg.* 2019;154(12):1134-1142. doi:10.1001/jamasurg.2019.3769, [Dossa et al, 2021] BOD VOL 4 TAB 123; Kralj B, O'Toole D, Vanstone M, Sweetman A. The gender earnings gap in medicine: Evidence from Canada. *Health Policy.* 2022 Oct;126(10):1002-1009. doi: 10.1016/j.healthpol.2022.08.007. Epub 2022 Aug 17. PMID: 35995639, BOD VOL 4 TAB 124.

527. Further, work in Ontario has found that female surgeons receive fewer referrals than male surgeons throughout their career, irrespective of experience¹⁹¹ and that hourly earnings for female surgeons were lower than for male surgeons, all else equal, as female surgeons more commonly perform lower paying procedures per unit of time.¹⁹²

528. One mechanism identified as a potential driver of such gender inequities in specialist billings is referral bias. Chami et al. (2023) found that male specialists in Ontario received more referrals than did female specialists, with males receiving higher average revenue per referral.¹⁹³ While both males and females tended to refer more often to specialists of the same gender, the overall odds of referring to a male specialist remained higher. While the underlying reasons for the bias in referral patterns are not well understood, the evidence seems to suggest that female surgeons experience more severe repercussions from referring physicians after negative surgical outcomes (e.g., patient death) than male surgeons.¹⁹⁴ Other possible explanations for referral bias include the role or preference of patients and hospital administrators, as well as the fact that physician education pathways still remain poorly understood.

529. While the OHIP Schedule itself is theoretically blind to physician gender and other personal physician characteristics, evidence of billing disparities between male and female physicians persists in fee-for-service settings. Studies have shed light on some possible causes of some of the disparity,¹⁹⁵ but many aspects of the pay gap remain unexplained. The type of work physicians do, either through formal specialization (or

¹⁹¹ Dossa et al, 2021, *supra*, BOD VOL 4 TAB 123.

¹⁹² *Ibid.*

¹⁹³ Chami N, Weir S, Shaikh SA, et al. Referring and Specialist Physician Gender and Specialist Billing. *JAMA Netw Open*. 2023;6(8):e2328347. doi:10.1001/jamanetworkopen.2023.28347 [“Chami et al., 2023”], BOD VOL 4 TAB 125.

¹⁹⁴ Sarsons H. [Interpreting Signals in the Labor Market: Evidence from Medical Referrals \[Job Market Paper\]](#). Working Paper, [“Sarsons et al., 2017”] BOD VOL 4 TAB 126.

¹⁹⁵ Chami et al, 2023 *supra*, BOD VOL 4 TAB 125.

through focused practice), and the time spent by those providers can vary by gender.¹⁹⁶ By extension, the OHIP Schedule can result in differing payments per unit of time, even for provision of the same or similar services.

530. The parties explicitly agreed to take steps necessary to achieve gender pay equity in Part D, paragraph 2 of the 2021-24 PSA. To this point, there have been over 50 submissions made to the PPC related to addressing the gender pay gap (note that some submissions involve multiple fee codes). Three examples include:

- New fee for pelvic exam with speculum. Various sections have suggested that this service is under-remunerated when billed using existing assessment codes. The creation of a new code for pelvic exams would help to ensure compensation is better aligned with the complexity and time associated with performing vital services for women's health.
- Alignment of surgical and procedural fee values for services related to male and female reproductive organs. Sections have proposed increasing the value of female genital procedures and surgeries to align with equivalent or similar procedures performed by urologists and general surgeons. OBGYN's are predominantly female, and urologists and general surgeons¹⁹⁷ are predominantly male; equating the fee values of this and other comparable services would improve equity.
- New time-based add on fee to assessment code. The Section on General and Family Practice ("SGFP") has proposed a time based add on fee to A007 for services exceeding 20 minutes in duration. Given the available

¹⁹⁶ Cohen & Kiran, 2020, *supra*, BOD VOL 4 TAB 122; Hedden L, Barer ML, Cardiff K, et al. The implications of the feminization of the primary care physician workforce on service supply: a systematic review. Hum Resource Health 2014;12:32, BOD VOL 4 TAB 127.

¹⁹⁷ Data Source: [OMA, Physician Human Resources in Ontario](#), accessed April 30, 2024. BOD VOL 4 Tab 128

evidence that female physicians spend more time with patients per encounter, this can ensure that the additional time and associated care provided during a long patient encounter is more appropriately remunerated.

531. In order to begin addressing this gender pay gap, the OMA proposes that \$30 million in each of Years 2, 3 and 4 be allocated for PPC to respond to submissions on the gender pay gap, such as those set out in Appendix I, which can be found in the OMA's Book of Documents.¹⁹⁸

¹⁹⁸ Appendix I: Submissions identified as gender pay gap, BOD Vol. 5, Tab 150.

(ii) New Services Resulting From Medical Innovation/Technological Advances Schedule of Benefits Proposal

The OMA proposes to allocate \$30M each year for PPC to respond to submissions on medical innovation/technological advances.

To provide a further overview of the impact of technology and medical innovation, the OMA's submissions from its arbitration brief for the 2017-21 PSA to the Kaplan Board of Arbitration are found below in Appendix II to these submissions.

Cost: \$90 Million (\$30 million in each of Years 2, 3, and 4)

532. Advances in medical innovation and technology continue; however, there has been no formal fee setting process since the 2008 PSA (2011 Funding Allocation) to update the OHIP Schedule to reflect these advancements. In this respect, the 2019 MSPC and 2022 PPC funding allocation timelines and amounts only allowed for the introduction of simple schedule revisions and fee adjustments.

533. As a result, there are many areas within the OHIP Schedule that have not evolved with the changing standards of practice and medical innovation with the result that the OHIP Schedule does not adequately or appropriately describe or compensate the services that are now being rendered.

534. Physicians providing these evolved or new services that are not specifically or clearly listed in the OHIP Schedule have had to find other ways of being remunerated. This may include billing under existing umbrella fee codes or catch-all codes, submitting claims directly to OHIP medical consultants on an independent consideration ("IC") basis (e.g., R990 and R993), billing the patient directly or securing payment from other sources such as academic funding for experimental programs (e.g., APPs, PET Steering Committee).

535. During past fee allocation processes, despite determining that technical fees were out of scope due to the technical fee moratorium, specialties still made submissions to

the PPC and its predecessor the Medical Services Payment Committee (“MSPC”). Some examples brought forward during the Year 1 and 2 fee allocation process that would require establishing a new professional fee in conjunction with a technical fee where appropriate, to reflect new medical innovations, such as:

- 3-dimensional modelling for medical use
- Ultrasound Elastography Evaluation of Liver
- Digital Breast Tomosynthesis
- Ultrasound - Biophysical Profile (BPP)
- Ambulatory EEG monitoring – with quantification of sleep
- Neuromuscular Ultrasound
- Transcranial Doppler Ultrasound – Complete/Limited Study
- Vestibular evoked myogenic potential (oVEMP and cVEMP)
- Video head impulse test ("vHIT)

536. There have been over 50 submissions made to the PPC related to advances in medical innovation and technological advances. Three examples include:

- New fee for repetitive Transcranial Magnetic Stimulation (rTMS)

Repetitive Transcranial Magnetic Stimulation treatment involves the stimulation of the prefrontal cortex with a varying magnetic field, which induces an electric current following the principle of Faraday induction (which states that a rapidly changing magnetic field will induce an electric current in conductive material, with the current strength being proportional to the rate of change of the magnetic field). The application of this rapidly varying magnetic field, and resultant electric current, has been shown to be effective in the treatment of depression and other disorders.

- New fee code for Radiofrequency Ablation for Barrett’s Esophagus

Before the introduction of radiofrequency ablation (RFA) as a safe and effective therapeutic modality for the management of dysplastic Barrett’s

esophagus, patients with high-grade dysplasia or early cancer would undergo surgical resection of the esophagus. RFA is a minimally invasive treatment option that has been proven to be effective in randomized clinical trials in the management of dysplastic Barrett's esophagus.

- Revise fee code G390 (Supervision of chemotherapy for induction phase of acute leukemia or myeloablative therapy prior to bone marrow transplantation) to include "First infusion of bispecific antibodies (such as glofitamab) Chemotherapy for infusion of CART cells".

Cell based therapy, including Chimeric Antigen Receptor T cell (CAR-T) therapy and bio specific, have led to a new era in the therapy of Malignant Hematology. These innovative approaches have yielded unprecedented improvements in the management of acute leukemias, lymphomas and plasma cell dyscrasias and have recently become an integral part therapy of patients in Canada.

537. The OMA proposes to allocate \$30M each year for PPC to respond to submissions on medical innovation/technological advances. To provide a further overview of the impact of technology and medical innovation, the OMA's submissions from its arbitration brief for the 2017-21 PSA to the Kaplan Board of Arbitration are attached as Appendix II, which can be found in the OMA's Book of Documents.¹⁹⁹

¹⁹⁹ Appendix II: Submissions identified as advances in medical innovation/technology, BOD Vol. 5, Tab 151.

(iii) Complexity Of Patient Care Schedule of Benefits Proposal

The OMA proposes to allocate \$30M each year for PPC to respond to submissions on complexity.

Cost: \$90 Million (\$30 million in each of Years 2, 3, and 4)

538. Complexity is one of the explicit factors forming part of the PPC's mandate under Part D of the 2021-24 PSA. Complexity of patient care can be influenced by the patient's age, co-morbidities, chronic health conditions, acuity of an episode (e.g., trauma) and type of medical/surgical intervention. More "complex" patient encounters tend to require additional time, have a higher level of acuity, and involve a greater level of intensity (e.g., knowledge, judgment, technical skill, risk and stress). For the most part, payment under the OHIP Schedule has failed to explicitly address or explicitly recognize complexity in medical, diagnostic or surgical care.

539. In circumstances where physicians see more complex patients, or risk/intensity varies considerably between cases, additional modifiers are necessary to align the payments and the complexity of work performed. In addition, as patient demographics and standards of practice change, the "average" complexity of a service will also increase and thus merit an adjustment to the fee.

540. There have been approximately 170 submissions made to the PPC related to addressing complexity of patient care include. Three examples include:

- Fee increase to Lobectomy and segmentectomy fee codes (M143, M144 and M145). From the epidemiological point of view, early-stage lung cancer is observed more frequently in elderly patients. Thoracic surgeons are projected to operate on older and more frail patients as lung cancer screening becomes more prevalent. This leads to a larger fraction of patients requiring more dedicated care, increasing case complexity,

increasing the length of surgery as well as length of post-surgical stay significantly. This increase in fees should reflect the increasing complexity of this surgical care.

- New psychiatry complexity modifiers. The Section on Psychiatry requested expanding the system already implemented in OHIP Schedule to provide additional “Clinical Care Modifiers” that identify and recognize psychiatric services of higher complexity/intensity/risk. The current Clinical Care Modifiers, K187, K188 and K189, recognize periods of high risk and remunerate at a premium. K187 and K188 each provide the respective psychiatric services with a 15% premium, which is combinable to 30% if the conditions for both Clinical Care Modifiers are met. Psychiatry proposes expanding this system to include other markers of high complexity/intensity/risk.
- Revise payment rules to E682 (Pump bypass - graft of major vessel other than ascending aorta for the purpose of cardiopulmonary bypass or ventricular assist device) to be applicable with coronary artery repair and ventricular assist devices (fee codes R743 and R701-704). This is performed on complicated cardiac surgical patients who are unable to be accessed through traditional ascending aortic technique (e.g., axillary artery approach) where the bulk of the work is the dissection and isolation of the vessel and/or implantation of cardiac assist devices.

541. The OMA proposes to allocate \$30M each year for PPC to respond to respond to submissions on complexity such as those set out in Appendix III, in the OMA’s Book of Documents.²⁰⁰

²⁰⁰Appendix III: Submissions identified as complexity of patient care, BOD Vol. 5, Tab 152.

(iv) Fee Schedule Modernization Proposal

The OMA proposes to allocate \$45M each year for PPC to respond to submissions on fee schedule modernization

Cost: \$135 Million (\$45 million in each of Years 2, 3, and 4)

The OMA further proposes to establish a Schedule Modernization and Review Panel with a mandate to develop a new, modernized Schedule of Benefits. The new Schedule would be submitted to the Parties for consideration during the 2028 Physician Services Agreement (PSA) negotiations.

542. The Schedule of Benefits was first established in May 1978. Since then, the Schedule has not undergone any substantive comprehensive, systematic review. There have been attempts, such as the Resource-Based Relative Value Schedule (RBRVS) Commission of Ontario which was established in May 1997 and the OMA's Central Tariff Committee (CTC) annual "Sectional Review" process that was held in 2007 and 2008; CTC was place in abeyance in November 2008.

543. The need for reviewing and modernizing the Schedule was again recognized in the 2021 PSA, where the parties agreed to establish an ongoing Physician Payment Committee (PPC) tasked with this mandate. The parties also agreed that the work of the PPC be aligned with the FAIR relativity model that emphasizes modernizing the Schedule as its foundational step to address intra-sectional relativity.

544. The parties explicitly committed to modernizing the OHIP schedule in Part D2 of the 2021-24 PSA which includes making changes to better reflect contemporary practice, and may include the addition, revision or deletion of Schedule language and/or fee codes, having regard to such factors as time, intensity, complexity, risk, technical skills and communication skills required to provide each service.

545. As part of this process, codes may be deleted if they do not reflect current practice or are claimed for unintended purposes. New codes may be introduced to better reflect

the service being rendered or to better reflect current practice. Code descriptors may also be revised to reflect current practice.

546. Introducing new fee codes, while at the same time deleting outdated codes and/or revising existing codes to properly describe the service rendered, is expected to allow for appropriate claim submissions, improved monitoring and control, reduction in claim rejections and audits, and better tracking of the services provided.

547. There have been over 220 submissions made to the PPC related to fee schedule modernization. Some examples include:

- Revise emergency department weekend and holiday visit fees to include Friday evenings. Many Emergency Department Alternate Funding Agreements (EDAFAs) count their Friday evening shifts as part of the weekend coverage for the purposes of shift equity as well as to calculate the base pay rate for shifts. In addition, other after-hours premiums currently already apply to Friday evenings (e.g., E409 and E410).
- Revise A020/A021 Complex dermatology assessment/consultation payment requirements to clarify applicable medical indications for billing these fee codes and to better capture language changes in the evolution in clinical practice and pathology seen by medical dermatologists.

548. The OMA proposes to allocate \$45M each year for PPC to respond to respond to submissions on fee schedule modernization such as those out in Appendix IV, included in the OMA's Book of Documents.²⁰¹

549. In order to address the need for a comprehensive and systematic review of the schedule of benefits, the OMA also proposes to establish a Schedule Modernization and Review Panel with a mandate to develop a new, modernized Schedule of Benefits. The

²⁰¹ Appendix IV: Submissions identified as schedule modernization, BOD VOL 5 Tab 153

new Schedule would be submitted to the Parties for consideration during the 2028 Physician Services Agreement (PSA) negotiations.

550. The primary directive of the PPC's fee setting/allocation process is to implement compensation increases to the Schedule of Benefits. This occurs on an annual cycle where OMA Constituencies are invited to submit fee proposals. This results in a slow, piecemeal approach to modernizing the Schedule and provides few opportunities to make substantive and comprehensive changes, partly due to the need for resources to develop such a proposal and the challenges of complex costing or implementation. As a result, the OMA proposes a dedicated body to deal with Fee Schedule Modernization.

551. The proposed terms of reference for this Panel are as follows:

Terms of Reference

1. Purpose / Mandate

1. The Parties agree to establish a Schedule Modernization and Review Panel (the Panel, henceforth) with a mandate to develop a new, modernized Schedule of Benefits. The new Schedule will be submitted to the Parties for consideration during the 2028 Physician Services Agreement (PSA) negotiations.

2. Scope of Work

- 2. Specific responsibilities that the Panel will undertake include:*
- Developing work plan for approval by the Physician Payment Committee (PPC) within 60 days from the date of finalized 2024 PSA;*
 - Providing quarterly updates to PPC;*
 - Submit a complete modernized Schedule of Benefits by October 1, 2027.*

3. Core Principles

3. *All proposed changes must remain within the existing funding envelope of each OHIP Specialty. Any additional funding for the new Schedule of Benefits will be discussed as part of the 2028 PSA negotiations. To ensure the integrity of the process, the parties agree that the information provided and exchanged during the course of this process will not be used or relied upon for any other purpose whatsoever.*

4. *In its work, the Panel will invite submissions from each OHIP specialty to modernize its part of the Schedule and bring its own fee codes into relativity.*

5. *Specifically, and as appropriate, the submissions will include:*
 a. *addition, deletion and revision of fee codes (to reflect current medical practice, simplify and harmonize the Schedule.*
 b. *fee relativity within each OHIP specialty (to properly account for time and intensity of each service, where intensity encompasses complexity, risk, technical skills, and communication skills required to provide each service).*

6. *The Panel will review the submissions from the OHIP specialties and amalgamate all proposals into the new Schedule. In this work, the Panel may establish working groups and consult with relevant committees, jurisdictions, and other stakeholders.*

4. Authority

7. *The Taskforce is an advisory committee reporting to the Physician Payment Committee. It has the authority to establish working groups to review and modernize different parts of the Schedule.*

5. Membership

8. *The Panel will be composed of 3 members selected by the Parties using the skill-based approach.*

9. *The Panel will be fully supported by the OMA and MOH staff as it relates to administrative, analytical, research and subject matter needs.*

10. *The Panel may also engage external stakeholders and experts, as required.*

6. Term

11. *The Panel will have a fixed term, commencing within 30 days from the date of the Year 2, 3, and 4 arbitration award and ending on March 31, 2028.*

(v) Medical Specialties Consultation Time-Based/Complexity Proposal

The OMA proposes that targeted funding be allocated towards to recognize specialists for care of complicated patients that take a greater amount of time due to complexity, with the Physician Payment Committee (PPC) directed to undertake this work.

COST: \$35 Million

552. Complexity of patient care can be influenced by the patient's age, co-morbidities, chronic health conditions, acuity of an episode (e.g., trauma) and type of medical/surgical intervention. More "complex" patient encounters tend to require additional time and involve a greater level of intensity (e.g., knowledge, judgment, technical skill, risk and stress). For the most part, the OHIP Schedule of Benefits has failed to keep pace with growing complexity and patient acuity.

553. The initial determination of a fee reflects the work provided by the typical physician for the typical case. However, in clinical practice, some physicians see more complex groups of patients due to specific expertise, referral bias, etc., so, risk/intensity may vary considerably between cases. Changes in the standard of practice, medical comorbidities and patient demographics may also evolve over time leading to increased complexity.

554. Physicians today are increasingly seeing patients with more complex physical, mental and social needs than was previously the case. For physicians on the front lines, increased patient complexity means increased workloads and increased pressures on their already packed clinical schedules alongside their ongoing concerns about ensuring quality of care in an overburdened system.

555. It is recognized that although complexity may be difficult to define, measurement of time to perform a service correlates with increasing complexity. As such additional modifiers to the base service may be needed to align payments with the complexity of work performed.

556. As part of the Physician Payment Committee's (PPC) fee setting allocation process, a number of sections brought forward proposals related to time-based consultation visit fees, to better capture time and therefore complexities relative to the fee value. For example, when considering gender pay equity, studies show female and non-binary physicians spend more time

with patients performing certain services and consultation payments make up a greater proportion of total professional billings for female specialists than their male counterparts--27.1% versus 24.9%, respectively. The fact that female and nonbinary physicians spend longer time with patients to perform the clinical service due to factors such as referral bias, patient preference of specific provider, etc., leads to income disparity and unfairly penalizes certain physicians. The PPC has recognized this issue but has not been able to date to implement necessary change.

557. The OMA is seeking to recognize additional time needed to provide care to complicated patients. This proposal aligns with the 2021 PSA agreement to proceed with the FAIR relativity model which identifies time per service as a crucial variable in establishing standardized intra and inter sectional relativity. Furthermore, the proposal could be used as a proof of concept in the evaluative process for other time-based proposals (e.g., assessment fees). As such, the proposal modernizes the OHIP Schedule, which is a shared mutual objective of the OMA and Ministry.

558. Accordingly, the OMA proposes as follows:

The OMA's proposal is intended to,

- 1. compensate medical specialists for the work and effort involved in providing care to more complicated patients that take a greater amount of time beyond the standard time to complete a full consultation*
- 2. modernize and streamline the OHIP Schedule by deleting medical specialty time-based extension consultation fee codes and repurposing the funding towards a new time base consultation extension fee*
- 3. Establish an add-on extension fee billed after minimum time threshold met for specialty specific consultation*

The OMA proposal is for \$35 million of targeted funding to be allocated towards this initiative, with the Physician Payment Committee (PPC) directed to undertake this work. The PPC is to conduct section consultations to evaluate and establish (a) a base consultation time for each medical specialty and (b) an add on fee payable after a set minimum time threshold billable for each additional 15 minutes. The PPC is to consider similar payment structures that exist in the OHIP Schedule, such as K001 and K630 (Appendix1) and other jurisdictions, such as Alberta's complex patient consultation time-based modifier (CMXC30).

Appendix I: K630 Psychiatric consultation extension OHIP Schedule payment rules

Appendix II: Lists of medical specialty time-based consultation fee codes

Appendix I: Schedule Payment Rules for K630 Psychiatric consultation extension

OHIP Schedule of Benefits, page A171 (effective April 1, 2024)

Psychiatric consultation extension

This service is eligible for payment for an extension to the consultations listed in the table below when the physician is required to spend an additional period of consecutive or non-consecutive time on the same day with the patient and/or patient's relative(s), patient's representative or other caregivers.

Note:

The time unit measured excludes time spent on separately billable interventions.

K630 Psychiatric consultation extension..... per unit 117.40

Payment Rules:

1. *K630 is a time based service. Time is calculated based on units - Unit means ½ hour or major part thereof - see General Preamble GP7 for definitions and time-keeping requirements.*
2. *K630 is limited to a maximum of six units per patient per physician per day.*
3. *K630 is payable in accordance with the following rules:*

Consultation	Minimum time with the patient before the start time for the first unit of K630	Minimum time required for consultation service + 1 unit of K630 to be payable	[Commentary: Minimum time required for consultation service + 2 units of K630 to be payable
A190, C190, W190	90 minutes	106 minutes	136 minutes
A195	60 min	76 min	106 min
A197 – sole service	60 min	76 min	106 min
A198 – sole service	60 min	76 min	106 min

A197 + A198 same patient same day	120 min	136 min	166 min
A695, C695, W695	120 min	136 min	166 min
A795, C795, W795	90 min	106 min	136 min
A895, C895, W895	60 min	76 min	106 min
A191	60 min	76 min	106 min
A192	60 min	76 min	106 min
A191+ A192 same patient same day	120 min	136 min	166 min]

Appendix II: Lists of medical specialty time-based consultation fee codes

Fee Code	Description	Fee value	Time
A/C600	Cardiology (60) - Comprehensive cardiology consultation	\$310.45	75
A/C/W400	Community Medicine (05) - Comprehensive community medicine consultation	\$240.55	75
A/C710	Critical Care Medicine (11) - Comprehensive critical care medicine consultation	\$310.45	75
A/C/W150	Endocrinology & Metabolism (15) - Comprehensive endocrinology consultation	\$310.45	75
A/C/W220	Genetics (22) - Special genetic consultation	\$310.45	75
A/C/W775	Geriatrics (07) - Comprehensive geriatric consultation	\$310.45	75
A/C/W460	Infectious Disease (46) - Comprehensive infectious disease consultation	\$310.45	75
A/C/W130	Internal (13) - Comprehensive internal medicine consultation	\$310.45	75
A/C/W160	Nephrology (16) - Comprehensive nephrology consultation	\$310.45	75
A/C/W180	Neurology (18) - Special neurology consultation	\$310.45	75
A/C/W260	Pediatrics (26) - Special pediatric consultation	\$310.45	75
A/C/W425	Physical Medicine & Rehabilitation (31) - Comprehensive physical medicine and rehabilitation consultation	\$310.45	75

A/C470	<i>Respiratory Disease (47) - Comprehensive respiratory disease consultation</i>	\$310.45	75
A/C590	<i>Rheumatology (48) - Comprehensive rheumatology consultation</i>	\$310.45	75
A/C/W190	<i>Psychiatry (19) - Special psychiatric consultation</i>	\$310.45	75
A/C/W795	<i>Psychiatry (19) - Geriatric psychiatric consultation</i>	\$310.45	75
A/C/W223	<i>Genetics (22) - Extended special genetic consultation</i>	\$401.30	90
A/C/W770	<i>Geriatrics (07) - Extended comprehensive geriatric consultation</i>	\$401.30	90
A/C/W682	<i>Neurology (18) - Extended special neurology consultation</i>	\$401.30	90
A/C/W662	<i>Pediatrics (26) - Extended special pediatric consultation</i>	\$401.30	90
A/C/W667	<i>Pediatrics (26) - Neurodevelopmental consultation</i>	\$401.30	90
A/C/W695	<i>Psychiatry (19) - Neurodevelopmental consultation</i>	\$414.35	90

(vi) Surgical Unbundling Pre- and Post-Operative Care Proposal

The PPC proposes revising the surgical preamble to allow for pre- and post-operative care to be billed with surgical cases, to better capture time and complexities in the attendance of patients before and after surgical procedures, and during patient recovery in a hospital setting.

This would address equity between routine procedures (e.g., day surgery) versus same procedure on a more complex patient requiring hospitalization; patients in hospital are there for a reason, often as a result of a complication or unforeseen circumstance and should be remunerated accordingly.

COST: \$19.8 Million

559. Currently, pre- and post-operative care and visits are bundled together for billing purposes as an element of many surgical services. Surgical unbundling refers to the practice of billing separately for specific pre- and post-operative services from the surgical procedure itself. Surgical unbundling is necessary to ensure that physicians are compensated for providing these pre- and post-operative care services, by more appropriately capturing time and complexities in the attendance of patients before and after surgical procedures, and during patient recovery in a hospital setting. In the OMA's view, recognizing the evolution of surgical practice in a hospital setting by appropriate compensation is important in maintaining a full range of surgical services and promoting retention of surgeons in hospital settings

560. The bilateral PPC (OMA and Ministry) has agreed on the following proposal and costing. Implementation depends on the Board awarding allocation of targeted funding for this initiative.

561. This proposal would also modernize the schedule to reflect changes in the management of non-operative patients who end up having surgery (pre-operative rules are antiquated)

562. During the last fee setting allocation process, a number of surgical sections proposed and supported revising the surgical preamble in this manner.

563. The bilateral PPC had deferred its decision until cost estimates could be examined and affected Sections had an opportunity to provide feedback. The bilateral PPC estimated cost implications is about \$20 million. See **Appendix I** for estimated cost implications by specialty. See **Appendix II** for Technical methodology notes.

Appendix I: Surgical Unbundling: Estimated Cost implications

Table 1: Total cost implications: Pre- and Post with % surgical billings

Network	OHIP Specialty	Post-Op Care estimated cost	Pre-Op Care estimated cost	Total Estimated cost (Pre & Post-Op Care)	% of Surgical Billings
Surgical	01-Anaesthesiology	\$1,120	\$5,921	\$7,041	0.1%
Surgical	03-General Surgery	\$3,830,532	\$980,879	\$4,811,411	3.0%
Surgical	04-Neurosurgery	\$1,426,662	\$212,050	\$1,638,712	3.8%
Surgical	06-Orthopaedic Surgery	\$5,919,344	\$973,616	\$6,892,961	3.9%
Surgical	08-Plastic Surgery	\$364,956	\$86,580	\$451,536	0.9%
Surgical	09-Cardiac Surgery	\$1,545,520	\$217,551	\$1,763,071	5.1%
Surgical	17-Vascular Surgery	\$829,735	\$129,850	\$959,585	6.5%
Surgical	20-Obstetrics & Gynaecology	\$99,757	\$46,935	\$146,692	0.2%
Surgical	23-Ophthalmology	\$17,852	\$131,317	\$149,169	0.1%
Surgical	24-Otolaryngology	\$292,044	\$38,350	\$330,394	1.1%
Surgical	35-Urology	\$499,391	\$79,011	\$578,401	1.5%
Surgical	64-General Thoracic Surgery	\$457,232	\$47,569	\$504,801	3.9%
Total Surgical		\$15,284,146	\$2,949,628	\$18,233,774	2.2%
Diagnostic	33-Diagnostic Radiology	\$403,178	\$121,014	\$524,192	5.3%
Total Diagnostic		\$403,178	\$121,014	\$524,192	5.3%
GP/FP	GP-1 Family: Capitation	\$23,361	\$5,227	\$28,588	0.3%
GP/FP	GP-2 Family: FFS	\$32,289	\$91,461	\$123,750	0.5%
GP/FP	12-Emergency Medicine	\$223,417	\$6,134	\$229,551	1.2%
Total GP/FP		\$279,613	\$102,995	\$382,607	0.8%
Medical	02-Dermatology	\$5,174	\$8,388	\$13,562	0.1%
Medical	11-Critical Care Medicine	\$64,208	\$11,554	\$75,762	3.4%
Medical	13-Internal and Occupational Medicine	\$11,531	\$6,323	\$17,854	0.1%
Medical	18-Neurology	\$64,123	\$6,453	\$70,576	4.0%
Medical	26-Paediatrics	\$3,587	\$899	\$4,486	0.4%
Medical	41-Gastroenterology	\$104,927	\$41,022	\$145,949	0.3%
Medical	47-Respiratory Disease	\$30,475	\$10,323	\$40,798	2.3%
Medical	60-Cardiology	\$171,255	\$156,228	\$327,482	2.8%
Total Medical		\$456,716	\$241,562	\$698,278	0.6%
Grand Total		\$16,423,653	\$3,415,199	\$19,838,852	2.0%

Table 2: Total cost implications with % of Allocation

Network	OHIP Specialty	Total Estimated cost (Pre & Post-Op Care)	\$ Allocation (Apr. 1, 2026)	% of Allocation
Surgical	01-Anaesthesiology	\$7,041	\$34,351,508	0.0%
Surgical	03-General Surgery	\$4,811,411	\$35,027,053	13.7%
Surgical	04-Neurosurgery	\$1,638,712	\$4,407,401	37.2%
Surgical	06-Orthopaedic Surgery	\$6,892,961	\$22,679,444	30.4%
Surgical	08-Plastic Surgery	\$451,536	\$9,213,483	4.9%
Surgical	09-Cardiac Surgery	\$1,763,071	\$3,601,258	49.0%
Surgical	17-Vascular Surgery	\$959,585	\$3,756,712	25.5%
Surgical	20-Obstetrics & Gynaecology	\$146,692	\$47,895,909	0.3%
Surgical	23-Ophthalmology	\$149,169	\$10,038,007	1.5%
Surgical	24-Otolaryngology	\$330,394	\$9,605,353	3.4%
Surgical	35-Urology	\$578,401	\$11,863,846	4.9%
Surgical	64-General Thoracic Surgery	\$504,801	\$3,007,418	16.8%
Total Surgical		\$18,233,774	\$195,447,392	9.3%
Diagnostic	33-Diagnostic Radiology	\$524,192	\$47,238,734	1.1%
Total Diagnostic		\$524,192	\$57,625,756	0.9%
GP/FP	GP-1 Family: Capitation	\$28,588	\$55,246,784	0.1%
GP/FP	GP-2 Family: FFS	\$123,750	\$234,514,283	0.1%
GP/FP	12-Emergency Medicine	\$229,551	\$27,479,873	0.8%
Total GP/FP		\$382,607	\$318,626,068	0.1%
Medical	02-Dermatology	\$13,562	\$8,494,549	0.2%
Medical	11-Critical Care Medicine	\$75,762	\$10,756,432	0.7%
Medical	13-Internal and Occupational Medicine	\$17,854	\$71,793,831	0.0%
Medical	18-Neurology	\$70,576	\$20,349,025	0.3%
Medical	26-Paediatrics	\$4,486	\$40,600,400	0.0%
Medical	41-Gastroenterology	\$145,949	\$8,966,118	1.6%
Medical	47-Respiratory Disease	\$40,798	\$14,645,170	0.3%
Medical	60-Cardiology	\$327,482	\$32,584,625	1.0%
Total Medical		\$698,278	\$344,331,185	0.2%
Grand Total		\$19,838,852	\$916,030,401	2.2%

Appendix II: Technical methodology notes*Data sources:*

- MOH datafiles, Fee-For-Services & Shadow Billing claims FY2023
- CIHI DAD base table FY2023

*Definitions & notes:*Length of stay for pre-operative care

- Days before surgery is defined as the number of days between date of surgery and date of patient admissions to the hospital.

- Only days 1 & 2 prior to surgery date are considered for pre-operative care.
- Day of surgery does not count as a day in pre-operative care.
- Whenever another service was provided on days 1 & 2 before the surgery date, no additional visit was costed for that encounter.
- Added E083 to subsequent visit fees.

Length of stay for post-operative care

- Days After Surgery is defined as the number of days between date of surgery and date of patient discharge from hospital.
- Post-operative care is calculated as days 3 through 14, excluding the day of discharge.
- Discharge dates are from CIHI DAD base table (FY2023), or date of C124 OHIP claim (FY2023), or date on which the patient was pronounced dead A/C771, or A/C777 OHIP claims (FY2023).
- Records with missing discharge date (as per note above), were proxied to follow a similar length of stay as those with a discharge date, by specialty.
- First two days after surgery are already billable and are not calculated in the estimated cost.
- Added E083 to subsequent visit fees.

Data sample

- Analysis restricted to surgical procedures, excluding E-add on codes, Obstetrical P codes, surgical Z codes and J codes.
- Analysis restricted to service location 'HIP' or whenever a hospital number (hospnum) was available and the service location was not 'HDS', 'HOP', 'IHF', or 'HED'.
- Analysis restricted to whenever an admission date was available, and the admission date occurred before the surgery date.
- Where two surgical procedures are rendered on a patient within a 14-day time period, the first surgical procedure is excluded when calculating length of stay for post-operative care.
- Date of surgery and date of admission are from MOH data files, FFS and SB claims, FY2023.
- List of excluded group numbers (gnums):
- 0K72', '4K72', '3K72', '9K72', '5K02', '5K82', '4K50', '3K50', '9K50', '6K50', '5K54', '8K54', '7K54', '2K54', '1K54', '0K54', '4K54', '3K54', '9K54', '6K54', '5K53', '8K53', '7K53', '2K53', '1K53', '0K53', '4K53', '3K53', '9K53', '6K53', '5K59', '8K59', '7K59', '2K59', '1K59', '0K59', '3K59', '4K59', '6K59', '8K72', '9K59'.
- Surgical Billings in the calculation of % Surgical Billings includes all surgical codes for which post-operative care was calculated, and the add-ons that could be billed with them.

U. Community Physicians Overhead Support Proposal

The OMA proposes a new fee code to help ease physician overhead costs in the community, set at \$5, payable as an add-on for in-person assessments and consultations provided in community practices, up to a maximum of 40 payments per day per physician.

- *Community practice – physicians working in an independent community-based clinic where the physician(s) are responsible for the overhead costs (including physicians who are associates of the practice).*
- *Excluded:*
 - o *Services provided in a hospital*
 - o *Services provided under an employment contract*
 - o *FHO physicians – given targeted funding for modernized FHO improvements.*

Cost: \$80 Million in Year 3

564. Community-based physicians experience greater challenges in meeting their overhead payments due to their smaller scale, lack of institutional support, and competitive market dynamics. Unlike hospital-based practices, office-based physicians are solely responsible for covering costs such as rent, staffing, equipment, electronic medical records (EMRs), and supplies—expenses that have grown rapidly in recent years without corresponding adjustments in OHIP professional fees. Managing these overhead costs effectively is, however, essential for community physicians to maintain financial sustainability while providing quality care to their patients. Additionally, the financial burden of office overhead disproportionately affects new and female physicians, especially during periods such as maternity leave.

565. The OMA's community-based overhead proposal addresses this growing concern in a time of escalating costs.

566. Underlying this proposal is a concern that the current fee-for-service model fails to reflect the true cost of providing outpatient care. Historically, OHIP fees were designed to include overhead expenses; however, cost increases have significantly outpaced fee adjustments. This imbalance has reduced the portion of physician compensation meant for professional services, placing many practices at financial risk.

567. Failure to address these overhead concerns could result in a decline of community-based services, pushing more patients toward already strained hospitals. Addressing the overhead burden for community-based practices is not only a matter of fairness but one of preserving equitable access to care across the province.

568. Numerous provinces have introduced a “Business Cost” fee that is in recognition of this additional overhead, as follows:

British Columbia Business Cost Premium

British Columbia offers the Business Cost Premium (BCP) which is a payment to help eligible physicians cover the rising rent, lease, or ownership costs of a community-based office.

The BCP is a percentage premium currently paid on fees for Consultation, Visit, Counselling, and Complete Examination services, when provided in-person or by Telehealth in a community-based office in an eligible geographical location. Pre-2022 the British Columbia BCP pays an additional 5% of eligible services for those in the City of Vancouver (up to \$60 per day), 4% in Metro Vancouver and Victoria (up to \$48 per day), and 3% in all other communities (up to \$36 per day).

The 2022 British Columbia Physician Services Agreement allows for more than 100% increase in the BCP: Annual funding for the Business Cost Premium will be increased by:

- (A) \$40 million to \$75.7 million per year for Fiscal Year 2023/24; and*
- (B) a further \$9 million to \$84.7 million per year for Fiscal Year 2024/25 and subsequent Fiscal Years.*

Alberta Business Cost Program

The Alberta Business Cost Program (BCP) supports practices where increased business costs are having an impact on stability and attractiveness, including family practice and other groups in like circumstances.

The Alberta BCP is designed to be available across the province. All physicians who provide visit services in an office-based setting are eligible to receive payments through a fee modifier of \$3.59 on select office visit and consultation codes up to a maximum of 50 payments per day per physician.

Manitoba Community-Based Practice Supplement

Manitoba has recently introduced a new community-based practice support supplement that will provide a payment per in-person patient encounter starting October 1, 2023. This new tariff is being introduced to recognize the escalating clinic costs that can be associated with in-person visits in a community setting. Community based practice supplement, paid at \$3.50, may be claimed in addition to an office/ home visit where practice expenses are incurred. A maximum of fifty (50) claims may be claimed per physician in any twenty-four period.

569. The OMA proposes a new fee code to help ease physician overhead costs in the community, set at \$5, payable as an add-on for in-person assessments and consultations provided in community practices, up to a maximum of 40 payments per day per physician:

- *Community practice – physicians working in an independent community-based clinic where the physician(s) are responsible for the overhead costs (including physicians who are associates of the practice).*
- *Excluded:*
 - *Services provided in a hospital*
 - *Services provided under an employment contract*
 - *FHO physicians – practice costs addressed through modernized FHO*

570. Implementing a business or overhead fee for physicians in Ontario will help provide financial stability and encourage in-person care, following the approach of similar models introduced in British Columbia, Manitoba, and Alberta.

V. Canadian Medical Protective Association

571. The parties have agreed that the current terms for CMPA will continue, and the current agreement in Appendix H of the 2012 PSA will now continue until March 31, 2028, and will remain in full force and effect and will not be altered, deleted or added to without agreement of the parties and unless changed as a result of the negotiation, mediation or arbitration of the renewal 2028-2032 PSA.

W. Payment Delay and Ministry Payment Infrastructure: The Need to ensure proper and timely implementation of negotiated and awarded compensation increases

572. The OMA is committed to ensuring timely payments to physicians of any increases awarded as part of the 2024 PSA. The OMA requests that the Board remain seized to address any implementation issues that arise, including with respect to delayed payments.

573. The OHIP Medical Claims Payment System (MCPS) started over 50 years ago, with the complexity of the system processes increasing as the policy structure, payment models and claims administration have evolved. The MCPS is one of the largest health insurance systems in North America, comprising of 60+ subsystems, 4.3 million lines of COBOL code, and over 600 databases. It performs a variety of functions including adjudication, payment, eligibility, assessment, reporting and electronic submission and distribution.

574. Unfortunately, the OHIP payment system has not been sufficiently modernized so as to keep up with the imperative of ensuring payments are made to physicians in a timely manner. No doubt, the complexity and variety of payment models and structures has evolved considerably, but this has only revealed considerable gaps in the system's ability to meet the Ministry's payment obligations as agreed to by the OMA and the Ministry. Regardless of whether payment delays or errors are a result of outdated systems (hardware or software) or programming limitations, it is reasonable to expect that the Ministry will take necessary steps to ensure that payments are made in accordance with agreed to parameters.

575. However, physicians have been facing increasing challenges in receiving payment for their services, including significant payment and adjudication delays, which result in underpayments to the physician and a backlog of claims and payments. Some of these challenges include payment delays and rejections for lifesaving complex procedures, inconsistent acceptance of codes, and a lack of appropriate billing codes for specific services. Dealing with these issues is causing significant administrative

burden which decreases physician availability for patient care. What's more concerning is that due to these challenges in receiving remuneration, some physicians are questioning whether they should continue performing certain procedures.

576. To gain a deeper understanding of the scope and impact of these billing issues, in January 2025 the OMA conducted a survey of its membership. This was the highest response rate of any survey previously conducted by the OMA including over 2500 responses (response rate of 15.6%), underscoring the widespread importance, impact and severity of the problem which indicated that 90% of the more than 2,500 respondents had rejections from OHIP in 2024.

577. Overall, several trends that impact patient care were observed, including:

- 65.5% of all respondents mentioned that the administrative time spent on rejected billings directly reduced the amount of time spent on providing direct patient care.
- 54% of all respondents mentioned that instead of reviewing their claim submissions, they could have spent this time seeing at least 5 additional patients.
- 47.9% of respondents who had OHIP claims rejected in the past year are less willing to perform some procedures due to billing rejections.

578. Based on the survey results, and with the assumption that the results are representative of the survey population, we estimate that an additional 57,528 patients could have been seen in 2024 if rejected claims were not an issue.

579. Below are some of the recent examples of payment delays or errors resulting from the MCPS:

- On October 25, 2024 as per the Supplementary Year 3 and Year 1 Implementation Agreement, the parties agreed to specific timelines for issuing payments. The agreement specifically committed Ministry to take retroactive payments of 9.95% increase to physicians for services rendered from April 1, 2024 to December 31, 2024. The parties agreed

that this payment was to be made in May 2025. Due to system limitations, the Ministry was only able to issue retroactive lumpsum payments for a period of April to October of 2024, with payment for the remaining two months still outstanding. This delay in payment impacted all Fee-for-Service physicians.

- Payments for the new acuity modifier under the FHO capitation model, which were initially to be made effective April 1, 2025 according to the Ministry's own info-bulletin, have been delayed at least until August, 2025.
- As part of the OMA and Ministry of Health 2021-24 PSA Year 3 implementation and 2024-28 procedural agreement, the Parties agreed that the 2023-24 contract year payment to physicians will be increased by 2.8% for all physician payments set out in Section 21(a) of the Binding Arbitration Framework (BAF) (save for hospital technical fees, OMA Priority Insurance Plan (OPIP), and Virtual Urgent Care Centres and Temporary Locum Program). Despite the specific exclusion of hospital technical fees, in November 2024, the Ministry applied lump sum retroactive payments to hospital-based technical fees. What made matters worse, these incorrectly applied payments were flowed to individual physicians' bank accounts, resulting in the Ministry needing to recover over \$10M from over 4,000 physicians. Due to system limitations, the Ministry was not even able to provide physicians appropriate accounting of the overpayment, so physicians were being asked to accept financial adjustments without a clear breakdown of how the overpayment was calculated.
- As per the Supplementary Year 3 and Year 1 Implementation Agreement, the Ministry committed to issuing relativity-based prospective payments to all physicians starting in April 2025. Although the Ministry was able to issue

these payments to some payment models (i.e., Alternate Payment Plans), payments to all Fee-for-Service physicians did not start until the June Remittance Advice.

- With respect to various APPs, while the Ministry agreed to pay the 9.95% increases arising from this board's September, 2024 year 1 award "as soon as practicable", those increases have still not been received, i.e. over nine months since the arbitration award. Indeed, the year 3 2.8% increase, which was negotiated in February 2024, has still not been fully paid to all physician groups.

580. The MCPS system also prevents Ministry from issuing appropriate reporting to groups receiving funding that would allow them to distribute lump sum funds to participating physicians. This often results in groups receiving funds from the Ministry but being unable to flow funds to participating physicians. One example of this is when lumpsum payments flowed to over 8,000 academic physicians funded through Academic Health Sciences Centres AFP. Another example is when funds flowed to Laboratory Physicians or physicians funded through the Northern Specialist APP.

581. Additionally, system issues and delays are not unique to payments made through the MCPS. Physicians funded through other Ministry processes experience similar or worse delays in receiving funding from the Ministry. For example, over 10,000 physicians funded through Alternate Payment Plans often receive retroactive payments months, or even years, after payments are made to Fee-for-Service physicians. To illustrate, psychiatrists funded through Assertive Community Treatment Teams or through psychiatric sessional funding have yet to receive increases awarded to physicians in 2023/24.

582. Clearly, the OMA and, more importantly, the physicians it represents, have experienced ongoing frustration and financial disruption and other consequences in the repeated failure by the Ministry of Health to meet agreed upon dates for implementation and payout of increases to their compensation resulting from arbitration awards or

settlements reached by parties. While the Ministry and the OMA have been able to agree on PSA increase implementation timetables, the Ministry has been unable to meet some of those timetables. In the result, members have had to bear the burden of not receiving payments that they expected and were entitled to expect to receive in a timely manner. Not only does this adversely and unreasonably affect physician financial and tax planning and cash flow, but it also erodes member confidence in the OMA's capacity and credibility.

583. As a result, the OMA requests, as is normal and customary, that this Board of Arbitration remain seized with respect to any issues arising from the implementation of this Award, including the time frame within which increased payments are to be made and received. In the result, either party will be able to ask the Board for its assistance and direction on implementation, with the OMA reserving its right to seek appropriate remedies (e.g. interest) in the event that the Ministry fails to meet agreed upon or directed implementation dates, particularly where the Ministry is unable to provide justification for any delay, or otherwise where the delay is unreasonable and unwarranted.