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

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

(the "Ministry")

- and –

THE ONTARIO MEDICAL ASSOCIATION

("the OMA")

BEFORE THE BOARD OF ARBITRATION:

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

May 6, 7 and 8, 2024

BOOK OF EXHIBITS OF THE MINISTRY OF HEALTH

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Tab	Exhibit
1	Framework Appendix for Negotiation, Mediation and Arbitration
2	Significant Expansion of Medical School Education
3	OMA Rep Rights Agreement
4	Background of Physician Services Budget
5	2021 – 2024 Physician Services Agreement (MOS) reached February 10, 2022
6	2021 – 2024 PSA Year 3 Implementation and 2024-28 Procedural agreement reached February 22, 2024
7	*The Ministry of Health and Long Term Care and Ontario Medical Association*, February 18, 2019
8	Additional Investment outside those negotiated in the 2021-2024 PSA
9	2024 Ontario Budget: Building a Better Ontario
10	Line-by-Line Review of Ontario Government Expenditures, 2018
11	Firms' inflation expectations and price-setting behaviour in Canada: Evidence from a business survey, February 27, 2023
12	Methodological Notes on the British Columbia – LFP Model – Calculation of Proportion of Total Time Worked
13	Clinical Evaluation of Artificial Intelligence and Automation Technology to Reduce Administrative Burden in Primary Care, March 28, 2024
14	CRA – T4 Data by Age Group 20-65 for 2022 Tax Year
15	Workload and Population Analysis back to 2005/2006
16	The Induced Productivity Decline Hypothesis: More Physicians, Higher Compensation and Fewer Services, 2021
17	Long-term trends in the work hours of physicians in Canada, 2024
18	Trends in prevalence of chronic disease and multimorbidity in Ontario, Canada, 2021
19	Extension agreement for Government & OPSEU Unified, 2017

20	Extension agreement for Government & AMAPCEO, 2017
21	*The Crown and OSSTF and ETFO* Award, February 9, 2024
22	*The Crown and OPSEU Unified,* January 21, 2024
23	*The Crown and AMAPCEO,* January 26, 2024
24	Methodological Notes on the Calculation of Each Provincial Payment Model
25	Methodological Notes on the Overhead Analysis

EXHIBIT 1

BETWEEN

THE ONTARIO MEDICAL ASSOCIATION
(The "OMA")

- and -

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO, AS REPRESENTED BY THE MINISTER OF HEALTH AND LONG -TERM CARE
(The "MOHLTC")

1. The parties have agreed to the attached amendments to the Representation Rights Joint Negotiation and Dispute Resolution Agreement. The "Framework Appendix For Negotiation, Mediation and Arbitration" will become the new Appendix A and will replace the previous Appendix A known as "Joint Process".

2. Both negotiating teams unanimously agree to recommend acceptance of the "Framework Appendix For Negotiation, Mediation and Arbitration", together with the additional agreed matters, for ratification to their principals.

Dated at Toronto, Ontario, this 16th day of May, 2017

For the OMA

For the Government

FRAMEWORK APPENDIX FOR NEGOTIATION, MEDIATION AND ARBITRATION (HEREAFTER THE "FRAMEWORK APPENDIX")

(Note: This will be the new Appendix A to the Representation Rights and Joint Negotiation and Dispute Resolution Agreement (RRJNDRA))

BILATERAL NEGOTIATIONS

1. Unless the parties agree otherwise, each Physician Services Agreement (PSA) will be for a term of four years. The arbitration board will not have authority to change the four-year term, unless the parties agree otherwise.

2. The parties will commence bilateral negotiations for renewal of a PSA at least 180 days before the expiry of the PSA, or as otherwise agreed to by the parties.

3. The parties may propose such terms and conditions for renewal, with or without modifications, of the PSA then in effect, without restrictions on the scope of matters the parties may include in a PSA in the negotiation and mediation process outlined below. The terms and conditions of a PSA negotiated under this Framework Appendix, and any terms and conditions relating to a matter falling with the scope of arbitration under s. 21, will remain in full force and effect, and will not be altered, deleted or added to, without agreement of the parties.

4. Both parties will negotiate in good faith and make every reasonable effort to negotiate a PSA.

5. The parties will make timely disclosure to each other of any data, materials or other information that is reasonably relevant to the issues in dispute throughout the negotiation, mediation and arbitration processes outlined in this Appendix. Issues related to disclosure will be decided by the chair of the arbitration board, unless at the time of the referral of the dispute for determination, the chair has not been appointed, in which case it may be referred to and will be determined by the Referee.

6. Upon the expiry date of a PSA, the terms and conditions of the PSA, and any terms and conditions relating to a matter falling within the scope of arbitration under s. 21, will remain in full force and effect, and will not be altered, deleted or added to without the agreement of the parties, and unless changed as a result of the negotiation, mediation or arbitration of a renewal PSA.

SELECTION OF MEDIATOR/APPOINTMENT OF NOMINEES

7. Before the conclusion of 30 days from the commencement of negotiations, the parties will attempt to reach agreement on a mediator/arbitrator (who shall also be the chair of the arbitration board), unless the parties have agreed to separate individuals to serve as mediator and arbitration board chair respectively, in which case the parties will agree to both.

8. If at any time thereafter, the parties are unable to agree to a mediator/arbitrator (or to a mediator and arbitration board chair where they have agreed to use separate individuals), either party may request that the Chief Justice of Ontario, determine the mediator/arbitrator, or mediator and arbitration board chair. In such circumstances, both parties will provide 3 names to the Chief Justice for mediator/arbitrator, or three names for mediator and three names for arbitration board chair if the parties have agreed to use separate individuals). If the same individual(s) have been proposed by both parties, the Chief Justice will appoint one of the agreed upon individuals. If there is no overlap, after consulting with the parties in such manner as the Chief Justice sees fit, the Chief Justice will appoint an individual (or individuals) either from one of the lists provided by the parties, or such other individual(s) as the Chief Justice determines. The lists will remain confidential to the parties and the Chief Justice.

9. Each party will appoint its nominee to the arbitration board within 15 days of the commencement of mediation. A party may substitute another person to serve as its nominee at any time prior the commencement of any arbitration hearing.

10. Once the mediator/arbitrator, or mediator, have been agreed to or appointed, the mediator, in consultation with the parties, will schedule dates for mediation so as to ensure that the timeframes for mediation contemplated by this Framework Appendix are met to the extent reasonably possible. The mediator will conduct the mediation without nominees, unless otherwise agreed by the parties.

11. Once the arbitration board has been agreed to or appointed, the chair of the arbitration board, in consultation with the nominees and the parties, will schedule dates so as to ensure that the timeframes for binding interest arbitration contemplated by this Framework Appendix are met to the extent reasonably possible.

MEDIATION

12. Either party may give notice to the other to trigger the mediation process, after the parties have been bargaining for at least 60 days, unless the parties agree otherwise.

13. Where either party has given notice to trigger the mediation process, the mediator will meet with the parties in order assist them to reach a renewal PSA on all matters in dispute. The first mediation session will take place within 30 days of the referral to mediation.

14. The mediator will determine the procedures and rules governing the mediation process, after consulting with the parties. The mediator is not competent or compellable as a witness before an arbitration board, or any other court or tribunal, respecting any information or material furnished to or received by the mediator while involved in assisting the parties to reach a PSA.

15. The Parties will engage in mediation for no less than 60 days after the mediation commences, before either party may refer to the dispute to binding interest arbitration. However, if the mediator determines that the parties are at an impasse at any time, the mediator may declare an impasse, in which case the dispute will be immediately be referred to arbitration.

16. Where a matter is referred to arbitration, after consulting with each other, both parties will provide a list of issues in dispute to the other party, and to the arbitration board, within 15 days.

BINDING INTEREST ARBITRATION

17. The arbitration board shall be composed of the nominees of the parties, and the mediator/arbitrator (who will be the chair of the arbitration board), subject to any different agreement by the Parties.

18. Absent an agreement of the parties, the method of binding interest arbitration to be used shall not be final offer selection. In particular, unless the parties agree otherwise, the arbitration board may, on any issue or issues, select either party's proposal, choose a middle ground, or issue any award that it determines is appropriate in the circumstances.

19. (a) The board of arbitration will be deemed to be an arbitrator under the *Arbitration Act, 1991*, and this Appendix constitutes an agreement to arbitrate under the *Arbitration Act, 1991*.

(b) The parties agree to contract out of the following provisions of the *Arbitration Act, 1991* and agree that these provisions do not apply to the binding interest arbitration process under this Framework:

(i) ss. 10(4) (no election of chair);

(ii) s. 35 (the arbitrator can also mediate);

(iii) s. 45 (no appeal);

(iv) s. 54 (no power to award costs);

(v) s. 56 (no assessment of arbitrator costs by a party); and

(vi) s. 57 (no interest on arbitral awards).

20. The parties expect that the arbitration board will render its final award within 60 days after the last day of hearing. If the arbitration board determines that it requires additional time, the chair will advise the parties.

Scope of Arbitration

21. The following issues fall within the jurisdiction of the arbitration board for inclusion in a PSA:

(a) Any new or existing fee or payment (including any proposed change to a fee or payment) payable by the MOHLTC or other Ministry (or successor Ministry or government agency) to a physician for providing a service under the OHIP Schedule of Benefits, the Health Insurance Act, or under any other statute, regulation, arrangement, agreement or program providing for physician compensation for the delivery of medical services to patients.

This includes the detailed list of the payments currently made to physicians attached as Appendix A, and includes those payments made to physicians known as fee-for-service (FFS) payments, alternate payment plans (APPs) and alternate funding plans (AFPs), primary health care (including physician compensation in FHTs such as the blended salary model and FHT sessional fees), hospital on-call coverage (HOCC) and sexually transmitted disease (STD) services, compensation for CHC and AHAC physicians, flow-through top up for public health physicians, and physicians in divested psychiatric hospitals and assertive community treatment teams; and payments to physicians for services under the Ontario Telemedicine Network program.

(b) Subject to section 23(a), the requirements or conditions that a physician must meet in order to be paid for an insured service on a fee-for-service basis.

(c) Activities or accountabilities under a non-fee-for-service agreement (including any proposed change to an activity or accountability), and any amount to be paid for any such activity or accountability.

(d) With respect to the PSB:

(i) what components are to be included in the PSB, with the condition that all of the following components must be included in the PSB:

1. the detailed list of the payments currently made by the MOHLTC to physicians attached as Appendix A, including those payments made to physicians known as fee-for-service (FFS) payments, alternate payment plans (APPs) and alternate funding plans (AFPs), primary health care (including physician compensation in FHTs such as the blended salary model and FHT sessional fees), hospital on-call coverage (HOCC) and sexually transmitted disease (STD) services, compensation for CHC and AHAC physicians, and flow-through top up for public health physicians, and physicians in divested psychiatric hospitals and assertive community treatment teams;

2. Payments for clinical services paid by other ministries;

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

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

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

(e) After 2023, payments to subsidize physicians for a portion of their fees to the Canadian Medical Protective Association (CMPA) or other malpractice insurance. The provisions in the 2012 PSA related to payments to subsidize physicians for a portion of their fees to the CMPA will continue to apply until the end of 2023.

(f) Electronic medical records (where required by legislation, government, a government agency or program, or the terms of a non-fee for service agreement);

g) Physician benefits and benefit programs, including physician health benefits and paid pregnancy or parental leave, which shall be part of the PSB as per section 21(d)(i)1.

(h) With respect to the existing, previously agreed to specialist or primary care boilerplate provisions the parties agree that if the Government proposes to change the specialist or primary care boilerplate provisions based on a change to generally applicable government financial or accountability directives, and the parties cannot reach agreement about such changes, the arbitration board has jurisdiction to determine whether these provisions should be changed and, if so, on what terms. In addition, where either party claims that there has been a material change justifying an alteration of these provisions, the arbitration board will have jurisdiction to determine whether such material change has occurred, and if so, whether the provisions should be changed and if so on what terms.

Despite the foregoing paragraph, unless the parties agree otherwise, the arbitrator does not have jurisdiction to alter the termination provisions that are found in the specialist and primary care boilerplate provisions.

(i) Any matters set out in s. 5, s. 26, s. 27, s. 28, and s. 32.

22. Subject to those matters that are arbitrable under s. 21, the parties agree that the Government of Ontario has the right to make decisions about health care policy, which elements of the health care system will be funded on behalf of the people of Ontario, and how that system is organized, funded and delivers health care.

23. For greater certainty, the following matters do not fall within the scope of arbitration:

(a) The government's decision, after consultation with the OMA through the PSC:

(i) to add new fee codes under the OHIP Schedule of Benefits;

(ii) to delist a fee code (provided there is no "nil" billing code for such delisted fee code); or

(iii) to modify or restrict coverage or eligibility criteria for payment under a fee code, based on the government's determination that coverage or eligibility is not medically necessary (provided there is no "nil" billing code for such modified coverage or eligibility)

For clarity, the amount of the payment for new or modified fee codes would be arbitrable.

(b) Government funding for non-clinical services, except to the extent that the funding is provided as part of a non-fee for service alternate

payment or funding model, in which case it is deemed to be arbitrable under s. 21;

(c) Government funding for non-physician services;

(d) Resident loan interest relief programs;

(e) Pensions;

(f) Physician compensation for the assisted reproduction program until March 31, 2021, at which time it shall be arbitrable under section 21;

(g) Physician services paid through the Workplace Safety and Insurance Board; and

(h) Subject to paragraph section 21, any issue related to the impact on a physician's compensation by a third party for which the government is not responsible.

24. The jurisdiction of the arbitration board set out in s. 21 above also applies in the period following the determination of the PSA, in circumstances where i) a new service is added to the OHIP Schedule of Benefits, ii) a new non-fee-for-service agreement (including an APP, AFP, primary care agreement or government program) is proposed, and an impasse is reached in negotiating the agreement, or iii) either party terminates an existing agreement in accordance with the terms and conditions of that agreement, and an impasse is reached in negotiating a successor or replacement agreement. For clarity, the parties agree that either party may terminate an agreement in accordance with the terms of that agreement.

Criteria for Arbitration

25. In making a decision or award on any matters falling within the scope of arbitration, the arbitration board shall take into consideration the following factors and any other factors it considers relevant:

(a) The achievement of a high quality, patient-centred sustainable publicly funded health care system;

(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.

Process of Arbitration

26. With respect to those issues within the scope of arbitration involving changes to physician compensation and the PSB, the arbitration board will proceed as follows, taking into consideration the factors outlined in section 25:

(a) Determine:

(i) any changes to physician compensation in each year of the agreement;

(ii) what components are to be included in the PSB, as set out in section 21(d)(i);

(iii) the baseline of the PSB or of separate components of the PSB, as set out in s. 21(d)(ii);

(iv) any changes to the PSB in each year of the agreement (separate and apart from any change to the PSB that results from the determination made under s. 26(a)(i)), as set out in s. 21 (d)(iii).

The parties agree that the total change to the PSB in each year of the agreement will be the compounded total of any changes determined under s 26(a)(i) (changes to physician compensation) and s. 26(a)(iv) (changes to PSB);

(b) Determine the consequences, if any, as set out in s. 21(d)(iv);

(c) If the arbitration board considers it appropriate, it may, in respect of any year of the agreement, determine an amount to be subject to distribution/allocation based on evidence-based relativity, evidence-based appropriateness, evidence-based value considerations, and any other factors set out in s. 25;

(d) If the arbitration board determines an amount in s. 26(c) to be distributed/allocated, the parties will meet to negotiate the distribution/allocation of that amount based on the factors set out in s. 26(c). Either party may give notice to the other party to trigger mediation on this issue, at any time during this negotiation. Unless the parties agree otherwise, the mediator shall be the chair of the arbitration board;

(e) If the parties enter into a negotiation/mediation under s. 26(d), either party may refer the distribution/allocation issues that are unresolved to the arbitration board 60 days after negotiations commenced, or such other timeframe as the parties may agree. The arbitration board will determine the distribution/allocation of the amount determined under s. 26(c) based on the factors set out in s. 26(c).

Joint Oversight of the PSB for the term of the agreement

27. If a determination is made under section 26(b) that there is a limit on PSB expenditures in any year of the PSA for which the OMA is responsible, the parties will attempt to agree at the PSC on the steps to take to manage expenditures beyond those for which the government is responsible. If the parties cannot reach agreement, either party may refer their differences to the arbitration board, which will have authority to decide on the steps, if any, required to manage expenditures consistently with any such limit.

28. The parties agree that, separate and apart from any determination made under s. 26(a)(i) or s. 26(a)(iv), the parties will make changes to the PSB where:

(a) The Ministry makes a policy decision to change the scope of an existing service, or to provide a new or different service or program to Ontarians; or

(b) There is an unforeseeable event beyond the control of either party that materially impacts the PSB.

If the parties cannot reach agreement on the changes contemplated by this section, either party may refer the issue to the arbitration board, which will have authority to determine the changes.

Expert Advisors as a Resource

29. At any stage in the proceeding, the arbitration board may, on its own motion or at the request of either party, appoint an expert advisor to provide independent advice and report to it on specific issues.

29.1 The arbitration board may require the parties to give the expert advisor any relevant information and documents.

29.2 Any report prepared by the expert advisor for the arbitration board shall be given to the parties.

29.3 At the request of a party or the arbitration board, the expert advisor shall, after making the report, participate in a hearing and be questioned by the parties, who may also present evidence of any other expert on the subject matter of the report.

29.4 For clarity, the arbitration board will communicate to the parties any expert reports on which it may rely in making a decision.

Decision

30. A decision of the majority of the members of the arbitration board shall be the decision or award of the arbitration board. Absent a majority decision, the decision of the chairperson shall be the decision or award of the arbitration board.

31. Any decision or award rendered by the arbitration board is final and binding upon the Parties, and shall, together with any agreed items, constitute the PSA between the parties.

32. The arbitration board shall decide all matters in dispute between the parties falling within the scope of arbitration, and any other matter which in the opinion of the arbitration board is necessary to conclude a PSA in respect of those matters that have been submitted to arbitration, and shall remain seized to make findings or orders to give effect to its award, and if necessary to finalize the document which shall constitute the PSA.

33. The parties will share costs of the mediator/arbitrator (or chair of the arbitration board) equally, except that each party will be separately responsible for the cost of its nominees.

REFEREE AND ENFORCEMENT OF FRAMEWORK APPENDIX AND OTHER AGREMEENTS

34. The parties agree that the Referee under this Framework Appendix will be XX. If XX or any successor Referee to XX is unable or unwilling to serve, the parties will attempt to agree on a successor Referee, failing which the

process for appointing the Chair of an arbitration board will apply, with any necessary modifications.

35. The Referee, once appointed, shall remain in place until a new PSA is concluded, will remain seized in respect of any dispute arising while the Referee was appointed, and may be reappointed for the term of the next PSA.

36. The Parties agree to submit any dispute or difference between them over the interpretation, application, administration or alleged violation of this Framework Appendix to the Referee, except for roles that are specifically described in this Framework Appendix framework as belonging to the mediator or arbitrator. For further clarity, the arbitrator will be responsible for issues relating to scope (under s. 21).

37. The Referee will be deemed to be an arbitrator under the *Arbitration Act, 1991*, and this Appendix constitutes an agreement to arbitrate under the *Arbitration Act, 1991*. The parties agree to contract out of s. 35 (arbitrator can also mediate), s. 45 (no appeal), s. 54 (no power to award costs), s. 56 (no assessment of arbitrator costs by a party), and s. 57 (no interest on arbitral awards).

38. The Referee will have the authority to order any remedy he or she deems just and appropriate, but has no jurisdiction to amend the provisions of any agreement between the parties or any award issued by an arbitration board. The parties expect that the Referee will render a final award within 30 days of the last day of the hearing. If the Referee determines that additional time is needed, the Referee will advise the parties accordingly.

39. Other than as specified above as falling within the authority of the arbitration board determining the PSA, the Parties agree to submit any dispute or difference between them over the interpretation, application, administration or alleged violation of the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement, a Physician Service Agreement, or any other agreement falling within the scope of binding interest arbitration under this Framework Appendix, to the PSC. If the dispute or difference cannot be resolved by the PSC within 30 days, either party may refer the dispute or difference to the Referee, who will have all the powers and authority of an arbitrator under the Arbitration Act, 1991. The Referee will have the authority to order any remedy he or she deems just and appropriate, but has no jurisdiction to amend the provisions of any agreement between the parties or any award issued by an arbitration board.

NO STRIKE ACTION

40. The OMA, and its legally constituent elements, will not threaten, condone or encourage Strike Action by physicians for whom it has representation rights under this Framework Appendix.

41. No physician represented by the OMA will threaten or engage in Strike Action.

42. "Strike Action" is defined as any withdrawal, restriction or limitation of physician services to patients by two or more physicians undertaken in combination or in concert or in accordance with a common understanding for the purpose of pressuring the government with respect to any matters covered by this Framework Appendix or with respect to government funding, policy, legislation or regulatory measures.

    "Strike Action" does not include a withdrawal, restriction or limitation of services to patients where the action was undertaken in the normal course of practice, or actions that involve expression of concerns about issues (such as petitions, letter writing campaigns, media campaigns, public protests, or information materials in the reception area of a physician's office).

43. The MOHLTC may refer any alleged Strike Action to the Referee for a determination and remedy. If requested by the MOHLTC, the Referee shall conduct an expedited hearing.

TRANSITIONAL PROVISIONS

44. With respect to the first PSA under the Framework Appendix, the parties agree that:

    (a) term will be 4 years, April 1, 2017 to March 31, 2021;

    (b) in reaching its decision, the arbitration board cannot rely on the terms and conditions of the unratified 2016 tPSA, nor can either party rely on the unratified 2016 tPSA or on its terms and conditions in support of any proposal it may make with the mediator or to the arbitration board, but the parties can refer to the fact that a tPSA was negotiated in 2016 and that it was not ratified;

    (c) bargaining will be in accordance with the Framework Appendix, and will commence the later of 30 days after ratification by both parties or by September 1, 2017, with any necessary modifications to the terms and timelines set out in the Appendix. Upon ratification of this Framework Appendix, the existing terms and conditions relating to a matter falling with the scope of arbitration under s. 21 will remain in full force and effect, and will not be altered, deleted or added to, without agreement of the parties,

and unless and until changed as a result of the negotiation, mediation or arbitration of a the first PSA under this Framework Appendix.

ADDITIONAL AGREED MATTERS:

a) **Charter Challenge**

- the Charter litigation can continue.

- the parties can refer to the binding arbitration agreement in the litigation

- the OMA acknowledges that the government has granted the binding arbitration agreement to resolve bargaining disputes between the parties, and agrees that this does not constitute acceptance by the government of the claims in their litigation, and in particular, any claim to a right to binding arbitration under section 2(d) of the charter

- the government agrees that the binding arbitration agreement does not prejudice the OMA's position in its Charter litigation that there is a right to binding arbitration under section 2d of the Charter.

b) Remove the concept of "deemed OMA agreement" in the RRJNDRA, by removing last two sentences, so that paragraph 7 reads as follows in its entirety:

"All current template and ancillary agreements, any future template and ancillary agreements, will include the OMA as a party and signatory to such agreements (and any amendments thereto).

c) Amend paragraph 21 of the RRJNDRA, by adding the following:

"This agreement, including the Appendices, is perpetual."

Appendix A – Detailed list of payments currently made by MOHLTC that must be included in the PSB

Fee-For Service (FFS)

i) Professional Fees and Technical Fees, Health Care Payment (HCP) Claims, Ontario Registered Physicians

- Automated FFS-Based Premiums Included

ii) Other Non-Claims Programs;

- Mental Health Psychiatric Stipend
- Paediatric Stabilization
- Rural Medicine Investment Program
- Physician On-Call Program
- Northern Physician Retention Initiative
- Clinical Decision Unit Pilot Project

Hospital On Call Coverage (HOCC) / Sexually Transmitted Disease (STD)

i) Hospital On Call Coverage (HOCC), including CPOC, POC and CCC on-call
ii) Sexually Transmitted Diseases

Primary Health Care

i) Primary Care Core Payments

- Family Health Network (FHN) Base Rate Capitation
- Family Health Organization (FHO) Base Rate Capitation
- Comprehensive Care Capitation Fee
- Family Health Group (FHG) 10% Comprehensive Care Premium
- Access Bonus
- Income Stabilization
- Office Practice Administration
- Physician Collaboration
- Rurality Gradient Premium
- General Practitioner Special Premiums
- House Calls
- Blended FFS Shadow Billing
- Q-Codes
- Special Premiums
- Group Management and Leadership Payment

ii) Other

- Special Patient Populations
- GP Focused Practice Models
- Rural and Northern Physician Group Agreements
- Group Health Centre
- First Nations Agreement
- Institutional Substitution Program
- Health Care Connect physician payments
- AHAC and CHC
- Other physician clinical services: sessional, stipend, stabilization, supplement or top-up payments to physicians
- Locum payments and payments to physicians under recruitment and retention programs for clinical services
- Flow-through top up for public health physicians

Alternative Payment Plans (APP)/Academic Health Science Centres (AHSC), including all of their physician payment components

- Specialist Physicians - APP Including ACT
- APPs for specialist services
- EDAFA
- Academic Health Science Centres
- Physician Benefit Programs (Physician Health Benefits and Pregnancy/Parental Leave Benefits)
- Top-up for Laboratory Physicians
- Shelter health APPs

EXHIBIT 2

Significant Expansion in Medical School Education

Through the 2022 and 2023 Ontario Budgets, Ontario announced a significant expansion of medical school education, adding 449 postgraduate seats to the medical education system over a six year period (2023 to 2028). Of these, 270 will be allocated to family medicine. This expansion involves adding positions to Ontario's six existing medical schools and the creation of a medical school at Toronto Metropolitan University.

Through the 2024 Budget (Page 86), Ontario announced the creation of a medical school at York University, primarily focused on training family doctors. This school would add a further 102 postgraduate seats.

EXHIBIT 3

Memorandum of Agreement

Between:

The Ontario Medical Association
("OMA")

-and-

Her Majesty the Queen in Right of Ontario
as Represented by the
Minister of Health and Long-term Care
("Minister")

WHEREAS the Minister is charged with responsibility for the administration and stewardship of health care in Ontario;

AND WHEREAS the OMA is recognized as the exclusive representative of physicians practicing in Ontario;

AND WHEREAS physicians in Ontario exercise their right to freedom of association under section 2(d) of the *Charter* through the OMA, and the OMA seeks an agreement with the Minister that would provide for a process of meaningful consultation and dialogue;

AND WHEREAS the Parties seek to describe how they will consult and negotiate meaningfully and in good faith with each other in respect of Physician Services Agreements and compensation for physician services;

AND WHEREAS the OMA and Minister wish to continue to work together in a relationship based upon mutual respect, trust, consultation and co-operation in order to improve health care in the Province of Ontario;

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

The Parties have come to the following agreement:

General

1. The OMA is recognized as the exclusive representative of physicians practicing in Ontario.

2. This Agreement describes the OMA's representation rights with respect to the negotiation of physician compensation for physician services funded in whole or in part, directly or indirectly, by the Minister.

   It is understood that this Agreement does not apply to:

   (a) Physicians employed by or appointed to provide services directly to the Government of Ontario, including those represented by the Association of Physicians and Dentists in Public Service; or

(b) Physicians represented by The Professional Association of Internes and Residents of Ontario (PAIRO).

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

4. The Minister will negotiate all template agreements (and amendments) with the OMA. A "template agreement" is a funding agreement, as determined by the Parties, that the Minister intends to offer to more than one group of physicians for acceptance as a standard form of agreement.

5. The Minister may not deal directly with a Physician Group in respect of negotiating ancillary agreements (or amendments) if a majority of the Physician Group elects to have the OMA act as its representative in those negotiations.

   An "ancillary agreement" is either: (i) a unique agreement that provides funding to a specific group of physicians on a non-fee-for-service basis or blended model that is not a template agreement; or (ii) a template agreement when it is applied to and entered into with a specific group of physicians.

6. The Minister will notify the OMA of all expressions of interest that it receives from physicians respecting an ancillary agreement, or of any amendment to such an agreement, so that the OMA may contact the physicians to advise them of the availability of OMA representation.

7. All current template and ancillary agreements, any future template and ancillary agreements, will include the OMA as a party and signatory to such agreements (and any amendments thereto). The OMA will provide the Ministry with an executed copy of such an agreement no later than 7 days after receiving from the Ministry a copy of such an agreement that is ready for execution. The OMA would be deemed to have executed the agreement if it does not provide the Ministry with an executed copy no later than 7 days after receiving an agreement that is ready for execution.

8. The Minister acknowledges the role that the OMA plays on behalf of physicians in providing the Government of Ontario with advice about health care policy and system issues affecting physicians. The Minister will continue to consult with the OMA to seek its advice about significant health care policy and system issues that affect physicians.

   It is understood that this Agreement does not restrict the Government of Ontario from seeking advice from others about health care policy or health care system matters, nor does it restrict the Government of Ontario from setting its budget for the funding of the health care system or physician services.

Physician Services Committee

9. The OMA and Minister agree to continue the Physician Services Committee ("PSC"), and further agree that matters arising from this agreement and the continuing development and strengthening of their relationship will be considered at the PSC.

10. The PSC will continue to provide a broad and structured process for regular liaison and communication between the Ministry and the OMA.

11. The mandate and terms of reference of the PSC are set out at Appendix "B" to this agreement.

Dispute Resolution under this Agreement

12. If the OMA and the Minister have a disagreement regarding any of the following aspects of their relationship, either party may refer the disagreement to the PSC for consideration:

    - the interpretation or application of this agreement;
    - the interpretation or application of a Physician Services Agreement, or any proposed amendments to a Physician Services Agreement during the term of that agreement;
    - any proposed amendments to template or ancillary agreements; or
    - any other aspect of the parties' relationship that is not subject to a dedicated dispute resolution mechanism

13. In the event that a dispute is referred to the PSC in accordance with article 12 of this agreement, the PSC will make recommendations to the Parties respecting the resolution of the dispute.

14. The PSC may enlist the support of an agreed upon facilitator to assist it in its consideration of the dispute, and to help the parties reach a resolution in this regard.

15. (a) During the operation and administration of a Physician Services Agreement, the Parties may be called upon to make decisions which may adversely affect the specific interests of a particular group of physicians represented by the OMA. If that occurs, and bearing in mind that the OMA has an obligation to represent all physicians for the purpose of this Agreement, and the affected group believes that the OMA has not fulfilled its representation obligation, the matter will first be referred to the PSC for consideration. If the matter is not resolved, it will be referred to a qualified person appointed by the PSC after consultation with the affected group, as a fact finder and mediator to assist the Parties.

    (b) Failing resolution through fact-finding and mediation, the mediator will prepare a written recommendation for resolution that will be provided to the Parties and the affected group for their consideration. If the matter remains unresolved after two weeks from the date the recommendation was provided, the recommendation will be made public and the affected group may then use any other available dispute resolution process.

Amending Procedure

16. Either the OMA or Minister may seek to amend this agreement by providing the other party with written notice of its proposed amendment(s).

17. Upon receiving such notice, the parties will make every reasonable, good faith effort to promptly reach agreement respecting the proposed amendment.

18. If the parties are unable to reach an agreement respecting the proposed amendment within 60 days of the written notice, then either party may refer the dispute to a special committee of the PSC for consideration.

19. The special committee will make recommendations to the parties regarding the resolution of the dispute within 30 days of the referral.

20. The special committee may enlist the support of an agreed upon facilitator to assist it in its consideration of the dispute, and to help the parties reach a resolution in this regard.

Term

21. This agreement will come into force on the date that the Minutes of Settlement abandoning Ontario Superior Court of Justice (Divisional Court) Court File No. 344/12 are executed.

Appendix "A"

JOINT PROCESS

Phase One: Negotiation and Facilitation

1.1 The Parties will commence negotiations at least four months before the end of the term of a Physician Services Agreement or as otherwise agreed to by the Parties. The Parties will agree on a Facilitator and Conciliator for the purposes of this Joint Process prior to or at the beginning of the negotiation process.

The Parties will agree on a period of time that is no greater than 120 days during which they will negotiate bilaterally without assistance.

At any time after that period of time, either party may request the appointment of a Facilitator. The parties may also agree to appoint a Facilitator during the period of bilateral negotiations.

The Facilitator will be an individual with expertise in the Ontario health care system who will be able to advise and guide the parties in their negotiations.

1.2 The Facilitator will determine the procedures and rules governing the facilitation process in consultation with the parties. All proceedings with the Facilitator are to be strictly confidential.

1.3 On or before the 14th day (or a later date as determined by the Facilitator in consultation with the parties) following the Facilitator's appointment, if the parties have not reached an agreement, then the Facilitator will issue written recommendations ("Recommendations") to the parties. The Recommendations will be confidential between the parties and may not be disclosed by either party without the other party's express written consent or as otherwise provided in this Agreement.

1.6 The parties will reconvene within 14 days of receipt of the Recommendations to continue their negotiations and to seek to reach an agreement.

Phase Two: Conciliation

2.1 If the parties have not reached an agreement within 14 days (or such longer period as agreed to by the parties) of the receipt of the Recommendations, then either party may request the appointment of a neutral conciliator ("Conciliator") to assist in the resolution of all outstanding issues.

2.2 Following the appointment, the Conciliator may review and consider the Recommendations.

2.3 The Conciliator will determine the procedures and rules governing the conciliation process in consultation with the parties. All proceedings with the Conciliator are to be strictly confidential.

2.4 On or before the 14th day (or such later date as determined by the Conciliator in

consultation with the parties) following the Conciliator's appointment, if the parties have not reached an agreement, then the Conciliator will issue a written report ("Report") to the parties outlining the parties' respective positions on the issues in dispute and making recommendations to resolve these issues. This Report will be a public document.

2.5 The parties will reconvene within 14 days of receipt of the Report to continue their negotiations and to seek to reach an agreement. The parties will engage in negotiations for a period of no less than 10 days (or such longer period as agreed to by the parties).

General

3.1 The parties agree to participate in this process in good faith and to make all reasonable efforts to reach an agreement.

3.2 Neither party will seek to end the negotiations prior to the conclusion of the two phases of the Joint Process as outlined above.

3.3 The Minister will not advise the Government of Ontario to unilaterally implement proposals prior to the completion of the Joint Process described above.

Appendix "B"

PHYSICIAN SERVICES COMMITTEE

Membership

Each Party will appoint a core membership supplemented from time to time as needed by temporary members with particular expertise or authority.

Co-Chairs

Each of the Parties will appoint a co-chair.

Relationship-Building

The PSC will continue training in relationship building and conflict resolution, as the Parties consider necessary.

Agenda Setting

The agenda of the PSC will be set by the co-chairs of the PSC.

Funding

Each Party will fund its own members and their own administration costs of the PSC.

Meetings

The PSC will normally meet twice a month.

Mandate

The mandate for the PSC is to make recommendations to the Parties as follows:

- To build and sustain a strong positive relationship between the Government of Ontario and the medical profession;
- To receive and consider reports and recommendations as set out in a Physician Services Agreement;
- To advise the Parties in connection with the changing role of physicians within the health care system, including possible improved models of delivery of and compensation for services;
- To develop recommendations, either on its own initiative or as a result of reports and recommendations received from committees reporting to it, to the Minister and the OMA leading to the enhancement of the quality and effectiveness of medical care in Ontario;
- To participate in the dispute resolution processes in accordance with this or other agreements between the Minister and the OMA;
- To consider matters referred to it by either the Minister or OMA.

Committees

The Parties plan to rely on ad hoc working groups and committees to work on various mutual initiatives as determined from time to time.

EXHIBIT 4

BACKGROUND OF PHYSICIAN SERVICES BUDGET

The Physician Services Budget (PSB) expenditures are mostly attributable to the Ontario Health Insurance Plan (OHIP) which insures medically necessary physician, laboratory, prescribed practitioner and some hospital services for eligible Ontarians and fall within Vote Item 1405-1 of the provincial budget.

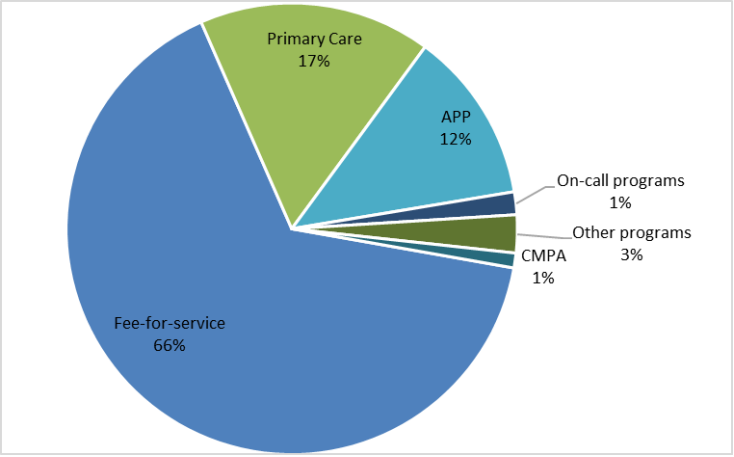
PSB expenditures can be divided into the following broad categories:

Fee-for-Service (FFS)	Physicians submit claims for payment for each service rendered based on the Schedule of Benefits (SOB).
Primary Care (PC)	Primary care physicians working in capitation model are paid based on terms set out in contractual agreements and may be non-FFS (salary, capitation) or a blend of FFS and non-FFS. Primary care physicians submit "shadow claims" based on the SOB to document services rendered to patients.
Alternative Payment Plans (APP) / Academic Health Science Centers (AHSC)	Group-based payments to specialist physicians based on terms set out in contractual agreements. Includes a variety of payment models.
On-Call programs	Payments to physicians for providing on-call coverage.
Other programs	Payments to physicians for other programs/initiatives including Underserviced Area Programs, locum programs, and fertility services.
Canadian Medical Protective Association (CMPA)	Payments to subsidize physicians for a portion of their fees to the CMPA.

In the 2022-23, expenditures in each PSB category were as follows:

Figure 3.1: 2022-23 PSB Expenditures

PSB Category	Payments ($M)
Fee-for Service	10,334.3
Primary Care	2,622.5
APP	1,936.0
On-Call Programs	257.6
Other Programs	427.8
CMPA	165.8
Total	15,744.0



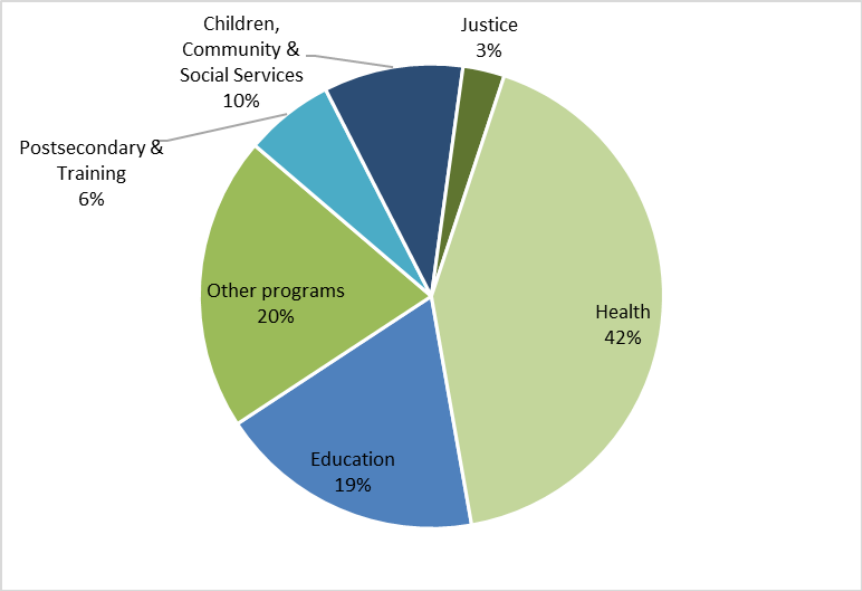
A detailed of summary of program-specific expenditures for 2022-23 is appended below.

At present, the Ministry is forecasting PSB expenditures will increase to $16,985 million in 2023-24.[1]

Currently, the health sector comprises 43% of program spending by the Ontario government.[2]

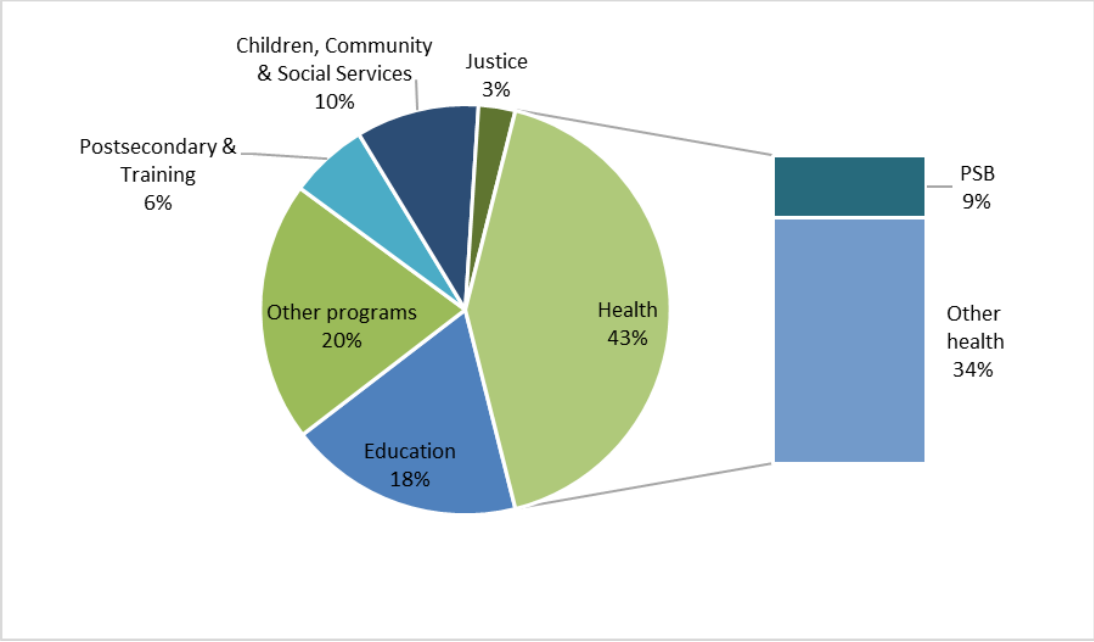
[1] Based on Q1 and Q2 expenditures with claims assessed as of February 2, 2024.
[2] Ontario Ministry of Finance. *Annual Report and Consolidated Financial Statements 2022-2023.*

Figure 3.2: Ontario Program Spending by Sector, 2022-23



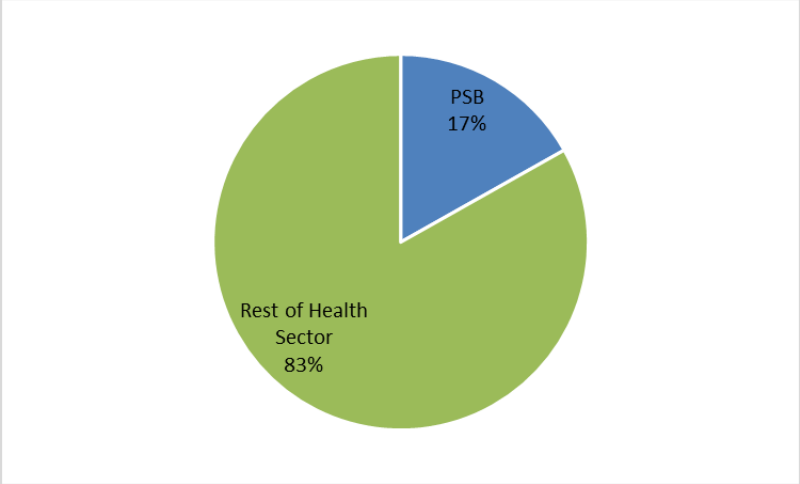
In 2022-23, Physician Services Budget expenditures represented approximately 9% of all program spending.

Figure 3.3: PSB as a percentage of all Ontario Program Spending



Within Ontario's health sector budget, the PSB currently consumes roughly 17% of available funding.

Figure 3.4: PSB as a percentage of Ontario's Health Sector Budget



APPENDIX A – 2022-23 PHYSICIAN SERVICES BUDGET – PROGRAM SPECIFIC EXPENDITURES

Program/Payment	2022-23
CHAMO	$67,261,346
HSC AFA	$149,606,045
SEAMO	$146,494,681
Community Pain Program	$732,756
Hamilton Academic Paediatrics Association	$37,772,426
Hamilton RGP - McMaster, RMA	$3,493,919
Kensington Anesthesia Demonstration Project	$1,493,725
London Academic Paediatrics Association	$16,446,102
London Neurosurgery	$4,332,243
London Paediatrics Association (Surgery)	$6,044,860
Mount Sinai Neonatal	$3,739,928
Ottawa Regional Perinatal Program	$1,587,503
Ottawa RGP	$2,646,927
Southwestern RGP	$3,723,103
St Joseph, London - Regional NICU	$1,872,093
Surrey Place	$989,922
The Donwood Institute	$509,373
The Toronto Hospital Anaesthesia Association	$121,540
Toronto Hosp - Abort	$370,726
Toronto RGP	$1,087,448
University of Ottawa Paediatric Associates	$700,212
Vascular Surgeons Group	$4,638,192
Women's Health Centre	$679,238
Academic Medical Organization of Southern Ontario-London Health Sciences Centre	$47,210,838
Baycrest Centre for Geriatric Care	$2,063,436
Bloorview Kids Rehab	$4,402,106
Bruyere Academic Medical Organization	$11,071,270
Centre for Addiction and Mental Health	$4,182,987
Hamilton Academic Health Sciences Organization - Hamilton Health Sciences Centre	$49,630,677
Montfort Hospital	$6,932,089
MSH-UHN	$61,244,879
Northern Ontario School of Medicine	$14,440,384
Royal Ottawa Health Care Group	$2,975,484
St. Michael's Hospital Medical Services Association - St. Michael's Hospital	$25,127,946
Sunnybrook Health Sciences Centre	$25,363,679
The Ottawa Hospital Academic Medical Organization - The Ottawa Hospital	$36,396,951
University of Ottawa Heart Institute	$6,913,727
University of Ottawa, Department of Family Medicine	$949,301
University of Toronto Department of Family and Community Medicine	$2,482,222
University of Western Ontario - Department of Family Medicine and Dentistry	$1,034,604

Women's College Hospital Academic and Medical Services Group	$6,000,813
710-GLOBAL FUNDING	$44,480,968
711-2004 AGRMT (FT)	$117,497,783
712-HOLIDAY PREMIUM	$7,099,491
713-SEASONAL PREM	$2,595,920
714-2008 AGRMT (FT)	$134,319,585
715-BLENDED PREMIUM	$2,796,887
716-SPECIALIST SB	$42,673
Anaesthesia Care Team	$6,236,322
Frail & Elderly	$12,894,476
Geneticists	$1,374,595
Infectious Diseases	$4,235,910
Almonte Obstetrics and Gynecological Physician Group	$1,137,930
Breslau Physiotherapy	$589,701
Child and Adolescent Multidisciplinary Psychiatry Services (CHAMPS)	$109,456
Dryden Anaesthesia	$883,855
Fort Frances Anaesthesia	$915,626
Goderich Cardia Rehab Grp	$41,591
Kenora Anaesthesia	$1,037,089
Kenora Internal Medicine Physician Group	$2,268,498
Kenora Psychiatry	$1,317,841
Lakeridge Health Paediatric Associates	$2,827,618
Leamington Obstetric and Gynaecologic Physician Group	$1,003,834
Midland Obstetrics and Gynecological Physician Group	$508,392
Northeastern Ontario Regional Surgical Network	$1,598,358
Neonatology Associates of Windsor	$1,126,385
NW Ontario Neurosurgical Group Practice	$1,337,944
NW Ontario Regional Surgical Network	$4,227,911
Owen Sound Obstetrics Associates	$2,349,422
Simcoe Muskoka Paediatric Mental Health Physician Group	$576,270
Quinte Health Care Paediatric Services	$1,625,195
Regional Consulting Paediatric Associates of Timmins and District	$1,121,061
Regional Consulting Paediatrics - Chatham	$1,713,333
Regional Consulting Paediatrics - North Bay	$1,717,338
Regional Consulting Paediatrics - Orillia	$2,393,171
Regional Consulting Paediatrics - Owen Sound	$1,362,593
Regional Consulting Paediatrics - Stratford	$1,444,233
Regional Consulting Paediatrics - Sudbury	$2,591,727
Regional Pediatrics Consulting - Barrie	$3,045,876
Sioux Lookout Anaesthesia	$1,020,774
St. Thomas-Elgin Paediatric Group	$286,644
Sudbury Neurosurgical Associates	$1,782,621

Sudbury Vascular Surgery	$1,436,460
Sudbury-Algoma (Psych)	$852,319
Thunder Bay Physiotherapy	$1,003,625
Thunder Bay Regional Consulting Paediatricians	$2,854,250
West Park Health Care Ctr	$1,402,565
Alexandra Marine and General Hospital	$1,584,758
Almonte General Hospital	$1,545,568
Anson General Hospital ED - Iroquois Falls	$1,211,920
Arnprior & District Memorial Hospital	$1,546,441
Bingham Memorial Hospital	$855,583
Blind River District Health Centre	$1,372,861
Bluewater Health - Charlotte Eleanor Englehart Site	$1,542,855
Campbellford Memorial Hospital	$1,999,878
Carleton Place & District Memorial Hospital	$1,489,463
Deep River and District Hospital	$1,549,709
Dryden Regional Health Centre	$1,386,110
Espanola General Hospital	$1,722,288
Four Counties Health Services Corporation	$1,374,168
Glengarry Memorial Hospital	$1,813,315
Grey Bruce Health Services - Lion's Head Site	$1,221,820
Grey Bruce Health Services - Markdale Site	$1,467,101
Grey Bruce Health Services - Meaford Site	$1,569,073
Grey Bruce Health Services - Southampton Site	$1,634,623
Grey Bruce Health Services - Wiarton Site	$1,490,064
Haldimand War Memorial Hospital	$2,103,053
Haliburton Highlands Health Services Corporation - Haliburton Site	$1,376,560
Haliburton Highlands Health Services Corporation - Minden Site	$1,901,622
Hanover & District Hospital	$1,689,736
Hôpital Général de Hawkesbury & District General Hospital Inc.	$1,759,058
Hôpital Notre-Dame Hospital (Hearst)	$1,335,501
Huron-Perth Healthcare Alliance Clinton Public Hospital Site - ED	$1,111,047
Kemptviille District Hospital	$1,764,772
Kirkland and District Hospital	$1,409,586
Lake of the Woods District Hospital	$2,026,043
Lakeridge Health Corporation - Port Perry Site	$1,698,852
Lennox & Addington County General Hospital Association	$1,884,539
Mattawa General Hospital Inc.	$1,592,759
Muskoka Algonquin Healthcare - Huntsville	$1,853,101
Niagara Health System - Douglas Memorial Hospital	$1,692,657
Niagara Health System - Port Colborne	$2,112,157
North Wellington Health Care Corporation - Mount Forest Site	$1,512,680
North Wellington Health Care Corporation - Palmerston Site	$1,342,769
Perth and Smiths Falls District Hospital - Perth Site	$1,815,862

Perth and Smiths Falls District Hospital - Smiths Falls Site	$1,751,591
Quinte Healthcare Corporation - Bancroft Site	$1,603,636
Quinte Healthcare Corporation - Picton Site	$1,881,409
Renfrew Victoria Hospital	$1,824,469
Riverside Health Care Facilities, Inc.	$1,604,855
Seaforth Community Hospital	$1,348,254
Sensenbrenner Hospital - Kapuskasing	$1,456,814
Services de santé de Chapleau Health Services	$887,565
Sioux Lookout Men-Ya-Win Health Centre	$1,801,203
Smooth Rock Falls Hospital Corporation	$855,699
South Bruce Grey Health Centre - Chesley Site	$934,173
South Bruce Grey Health Centre - Durham Site	$1,338,490
South Bruce Grey Health Centre - Kincardine Site	$1,663,306
South Bruce Grey Health Centre - Walkerton Site	$1,243,067
South Huron Hospital Association	$1,444,740
South Muskoka Memorial Hospital (Bracebridge)	$1,693,738
St. Francis Memorial Hospital Association	$1,597,316
St. Joseph's General Hospital Elliot Lake	$1,745,827
St. Marys Memorial Hospital	$1,349,781
Chatham Kent Health Alliance - Wallaceburg	$1,901,475
Temiskaming Hospital	$1,593,300
The Alexandra Hospital Ingersoll	$1,692,565
The Groves Memorial Community Hospital	$1,540,724
The Lady Minto Hospital	$1,336,462
The Listowel Memorial Hospital	$1,477,243
The West Haldimand General Hospital	$1,653,545
The West Nipissing General Hospital	$1,638,279
Uxbridge Cottage Hospital	$1,494,612
West Lincoln Memorial Hospital	$1,774,097
West Parry Sound Health Centre	$1,874,742
Winchester District Memorial Hospital	$2,068,064
Wingham and District Hospital	$1,351,043
Mackenzie ER Physician Association	$52,851
THP Mississauga Emergency Association	$52,851
Southlake Regional Health Centre - Newmarket Hospital	$52,851
Scarborough Centenary Hospital Emergency Medical Association	$6,945,219
St. Jospeh's Health Centre Emergency Physicians Association	$52,851
Brampton Civic Hospital Emergency Physicians Business Group	$52,851
Etobicoke General Hospital Emrgency Group	$52,851
Bluewater Health - Norman Site	$4,807,774
Brantford General Hospital	$5,294,023
Brockville General Hospital	$2,661,980
Cambridge Memorial Hospital	$3,861,598

Collingwood General & Marine Hospital	$2,925,797
Cornwall Community Hospital - Community Site	$4,068,412
Georgian Bay General Hospital (Midland)	$3,485,143
Grand River Hospital	$6,463,083
Grey Bruce Health Services - Owen Sound Site	$3,001,746
Guelph General Hospital	$4,959,950
Halton Health Care - Georgetown Site	$3,573,224
Halton Healthcare Services Corporation - Milton Site	$5,294,583
Halton Healthcare Services Corporation - Oakville Trafalgar Memorial Site	$7,029,113
Hamilton Health Sciences Corporation	$7,719,656
Hamilton Health Sciences Corporation - McMaster Site Pediatrics	$3,783,941
Headwaters Health Care Centre - Orangeville Site	$3,706,656
Hôpital Montfort	$4,456,291
Hôpital régional de Sudbury Regional Hospital	$5,852,787
Hotel-Dieu Grace Hospital - Hotel-Dieu Site	$4,421,193
Humber River Hospital - Wilson	$11,624,021
Lakeridge Health Corporation - Bowmanville Site	$3,086,398
Erie Shores HealthCare	$2,693,949
London Health Sciences Centre - CHWO/Westminster Site	$4,209,122
London Health Sciences Centre - University Site	$4,741,765
London Health Sciences Centre - Victoria Hospital	$6,284,515
Markham Stouffville Hospital ED - Markham	$8,799,843
Mount Sinai Hospital	$4,118,473
Niagara Health System - Welland County General Hospital	$3,290,622
Norfolk General Hospital	$2,296,274
North Bay General Hospital	$4,187,459
North York General Hospital	$10,999,545
Northumberland Hills Hospital	$3,140,809
Orillia Soldiers' Memorial Hospital	$3,948,372
Pembroke Regional Hospital	$2,891,981
Peterborough Regional Health Centre	$6,717,751
Queensway Carleton Hospital	$6,901,558
Quinte Health Care Corporation - Belleville Site	$3,529,489
Quinte Healthcare Corporation - Trenton Site	$2,950,974
Rouge Valley Health System - Ajax-Pickering - Site	$4,962,000
Sault Area Hospital	$4,871,934
St. Joseph's Health Care London	$2,776,162
St. Mary's General Hospital	$5,446,860
St. Michael's Hospital	$6,811,235
St. Thomas Elgin General Hospital	$5,152,026
Stevenson Memorial Hospital - Alliston	$2,907,714
Stratford General Hospital	$2,876,531
Strathroy Middlesex General Hospital	$2,505,554

Sunnybrook and Women's College Health Sciences Centre	$6,454,547
The Credit Valley Hospital	$10,553,756
The Ottawa Hospital - Civic Campus	$7,053,998
The Ottawa Hospital - General Campus	$6,779,797
Chatham Kent Health Alliance - Chatham	$3,266,731
The Ross Memorial Hospital	$3,257,166
The Royal Victoria Hospital	$7,741,495
The Scarborough Hospital - General Division	$6,217,728
The Scarborough Hospital - Grace Campus	$4,325,643
Thunder Bay Regional Health Sciences Centre	$9,713,250
Timmins and District Hospital/l'hopital de Timmins et du district	$3,871,081
Toronto East General and Orthopaedic Hospital Inc.	$9,295,818
University Health Network	$10,255,520
Windsor Regional Hospital	$4,628,970
Woodstock General Hospital Trust	$4,440,651
Top Up Program for Laboratory Medicine APP ULC	$55,023,415
DPPH top up program	$14,725,419
Mental Health Sessional funding	$41,970,967
Public Health Top Up	$4,605,199
Cochrane Northern Specialists	$110,713
Elliot Lake Specialist Group	$878,513
General Surgeons of Sudbury Regional Hospital	$3,022,721
Kenora Medical Specialists	$332,923
North Bay Specialist Coalition	$8,289,496
Northwestern Ontario Medicine Specialists Association	$3,683,429
Parry Sound Specialist Group	$1,578,589
Sault Area Hospital Anaesthesia Group	$1,414,836
Sault Multi-specialty Group	$5,857,186
Sudbury Anaesthesia Group	$6,548,202
Sudbury Orthopaedic and ENT Group	$2,706,290
Sudbury Psychiatry Group	$2,493,466
Sudbury Regional Hospital Med Surg Group	$4,360,769
Superior Surgical Group	$1,871,118
Temiskaming Specialists Group	$732,750
The Kirkland Lake Specialty Group	$423,198
Thunder Bay Anaesthesia Associates	$2,086,068
Thunder Bay Critical Care Group	$1,136,165
Thunder Bay Multispecialty Group	$4,620,372
Thunder Bay Orphan Specialists Association	$1,843,881
Thunder Bay Orthopaedic Surgeons	$1,923,231
Timmins Medical Specialists	$3,268,675
Medical Oncology	$152,723,061
Ontario GynOncology	$18,883,058

Radiation Oncology	$41,014,254
Hamilton Health Sciences Corp - General Site	$680,323
Hotel-Dieu Grace Hospital - Hotel-Dieu Site (Windsor)	$479,280
London Health Sciences Centre - South Street Site	$667,529
Ottawa Gen Trauma	$482,627
St. Michael's Hospital	$482,627
Sudbury General Trauma	$485,182
Sunnybrook & Women's College HSC Trauma	$478,093
Thunder Bay Regional Hospital	$480,071
700-GERIATRIC GA	$5,836,376
701-GERIATRIC IA	$16,786,970
702-CHILD <30 DAYS	$4,996,826
703-CHILD >=30D<1YR	$2,928,271
704-CHILD 1YR <2YR	$1,559,122
705-CHILD 2YR <5YR	$2,994,498
706-CHILD 5YR <16YR	$6,344,257
717-GP PSYCH PREM	$3,575,364
718-ANAES AGE <29DY PREMIUM	$21,020
719-ANAES AGE <1 YR PREMIUM	$67,710
720-ANAES AGE 1-8YR PREMIUM	$788,121
721-ANAES AGE 70-79 PREMIUM	$3,701,406
722-ANAES AGE 80+YR PREMIUM	$4,778,684
723-AH EV AGE <29DY PREMIUM	$3,741
724-AH EV AGE <1 YR PREMIUM	$5,862
725-AH EV AGE 1-8YR PREMIUM	$31,433
726-AH EV AGE 70-79 PREMIUM	$196,074
727-AH EV AGE 80+YR PREMIUM	$401,292
728-AH NT AGE <29DY PREMIUM	$1,052
729-AH NT AGE <1 YR PREMIUM	$1,493
730-AH NT AGE 1-8YR PREMIUM	$7,270
731-AH NT AGE 70-79 PREMIUM	$34,802
732-AH NT AGE 80+YR PREMIUM	$58,604
733-FPA- SPORTS MEDICINE	$149,789
734-FPA- ALLERGY	$364
735-FPA- PAIN MGMT	$816,708
736-FPA- SLEEP MEDICINE	$1,594
737-FPA- ADDICTION MEDICINE	$204,185
738-FPA- GERIATRICS	$29,675
739-GERIATRIC GRA	$209,941
740-GERIATRIC HOUSE CALL	$685,223
Professional Fees: Other	$9,172,167,031
Technical Fees: Other	$314,212,787
Professional Fees: Community Lab	$83,291,775

Technical fees: Hospital	$295,658,172
Technical fees: IHF	$495,048,199
Paediatric Stabilization	$5,203,091
Psychiatric Stipend	$30,459,028
Clinical Decision Unit (CDU)	$4,410,543
Professional Fees: OTN	$67,617,030
Rural Medicine Investment Program (RMIP)	$4,775,033
Complex Continuing Care On-Call (CCC)	$1,678,312
Community Palliative On-Call (CPOC)	$5,218,909
Hospital On-Call Coverage (HOCC)	$239,766,839
Physician On-Call	$10,888,383
565-ACCESS BONUS RECONCILIATION	-$103,680
665-ACCESS BONUS RECONCILIATION	-$471,158
680-AFTER-HOURS INCENTIVE PREMIUM	$26,731
110-BLENDED FEE-FOR-SERVICE PREMIUM	$94,022,009
165-AFTER HOURS ON CALL COVERAGE PYMT	$107,600
170-OFFICE PRACTICE ADMIN PAYMENT	$7,686,227
220-GMLP	$6,641,809
230-PREVENTIVE CARE BONUS PAYMENT	$60,867,300
235-CRC SCREEN TEST COMPLETION PAYMENT	$8,620
260-HOSPITAL	$13,494,167
270-LABOUR AND DELIVERY	$2,843,667
300-OFFICE PROCEDURES	$4,250,667
320-PALLIATIVE CARE	$11,777,000
340-HOME VISITS	$5,176,073
358-COMPLEX HOUSE CALL ASSESSMENT 20%	$607,765
359-HOUSE CALL ASSESSMENT PREMIUM 85%	$425,275
360-PRENATAL	$8,950,400
370-LONG TERM CARE	$5,281,417
380-PC-SMI	$7,521,200
430-RURALITY GRADIENT PREMIUM	$4,802,426
431-RURALITY GRADIENT ADJUSTMENT	$36,000
495-BASE PAYMENT	$68,812,365
496-ADMIN. PAYMENT	$3,428,476
497-GROUP ADMIN. PAYMENT	$1,681,010
498-ON CALL AFTER HOURS PAYMENT	$434,796
560-ACCESS BONUS PAYMENT	$13,478,008
570-COMPREHENSIVE CARE CAPITATION PYMT	$400,329,842
571-COMPREHENSIVE CARE CAPITATION ADJ	-$1,631,330
572-COMP CARE CAPITATION DISCOUNT	-$4,556,952
580-BASE RATE PAYMENT	$1,361,352,978
581-BASE RATE PAYMENT ADJUSTMENT	-$4,288,364
660-ACCESS BONUS PAYMENT	$140,040,800

672-BASE REMUNERATION PAYMENT	$12,346,130
673-BENEFITS PAYMENT	$2,469,226
674-LOCUM REMUNERATION PAYMENT	$617,306
90-HIV COMPENSATION LEVEL	$224,422
Professional Fees: FHG premium	$46,169,620
Aboriginal Health Access Centres (AHAC) Indigenous Interdisciplinary Primary Care Teams (IIPCT)	$19,077,108
Community Health Centre (CHC)	$112,193,615
GHC	$26,118,291
New Graduate Entry Program	$759,141
RNPGA 1	$28,790,089
RNPGA 2	$11,908,737
Sioux Lookout	$20,046,224
WEENEEBAYKO AREA HEALTH AUTHORITY	$5,793,189
Assertive Community Treatment Teams (ACTT) top up	$4,687,678
Consent and Capacity Board & Ontario Review Board	$2,466,684
Family Health Team – Family Health Team (FHT) Sessionals	$8,462,287
EDLP, NSLP, RFMLP	$30,626,949
Pregnancy & Parental Leave Benefit	$12,841,838
Physician Health Benefit Program	$28,500,000
Sexually Transmitted Infections (STI)	$1,812,423
Tuberculosis for Uninsured Persons (TB-UP)	$84,520
MAG fee codes	$164,464
MCCSS fee codes	$5,444,369
Telestroke	$737,340
Physician Collaboration - NP Led Clinics and PCNP	$1,248,746
Northern Physician Retention Initiative	$6,382,976
Northern RRRI	$9,159,250
NS Physician Outreach	$121,502
Psychiatry Outreach	$3,180,999
Visiting Specialist Program	$6,158,565
741- Hospitalist Premium	$16,144,045
742- Internal Medicine Premium	$7,622,305
Q Codes	$99,211,233
Fertility Services	$36,136,275
Thunder Bay Vascular Surgery Group	$546,210
St. Michael's Hospital Emergency Department Psychiatry Group	$132,613
Health Sciences North Sudbury ICU	$210,000
Headwaters Health Care Paediatric Group	$825,884
Tillsonburg District Memorial Hospital Emergency Group	$1,195,250
Woodstock Hospital Peadiatrics Group	$115,103
St. Joseph's Healthcare Hamilton Emergency Physician Group	$10,570
Brant Community Healthcare Paediatric Group	$230,009

Georgian Bay General Hospital Anaesthesia Group	$125,105
Temporary Locum Program (formerly CTSLPE)	$27,210,040
Canadian Medical Protective Association (CMPA) subsidies	$165,790,000
Total (incl. CMPA)	**$15,743,952,248**

EXHIBIT 5

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MEMORANDUM OF SETTLEMENT

THE ONTARIO MEDICAL ASSOCIATION
(The "OMA")

-and-

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO, AS REPRESENTED BY THE MINISTER OF HEALTH
(The "MOH")

WHEREAS the Ontario Medical Association (hereafter the "OMA') and the Ministry of Health (hereafter the "MOH") are parties to an agreement that recognizes the OMA as the exclusive representative of physicians practicing in Ontario ("OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement" or "RRA");

WHEREAS the OMA and the MOH have entered into the "Framework Appendix for Negotiation, Mediation and Arbitration" wherein the OMA and the MOH shall negotiate Physician Services Agreements ("PSA");

AND WHEREAS the OMA and the MOH have now concluded their negotiations for the PSA for the period April 1, 2021-March 31, 2024;

NOW the undersigned unanimously agree to recommend ratification of the attached Memorandum of Settlement to their principals as full and complete settlement of all issues between the parties for the April 1, 2021 – March 31, 2024 PSA.

THE PARTIES FURTHER AGREE that all other issues not addressed in the Memorandum are hereby withdrawn without prejudice to the positions of the parties.

Dated at Toronto, this 10th day of February, 2022

FOR THE MOH

Joshua Tepper _____

_____

Teresa Buchanan _____

Gillian Kernaghan _____

_____

Lynn Guerriero _____

FOR THE OMA

Paul Rosenbrin _____

_____

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Contents

A. FINANCIAL AGREEMENT 4

1. General 4
2. Years 1 and 2 Compensation Increases 4
3. Year 3 Compensation Increases and Gain Sharing 8
4. Year 3 HOCC Funding 10
5. Year 3 APP Funding 11
6. Committee Process 13
7. Dispute Resolution 14

SCHEDULE A – PREGNANCY AND PARENTAL LEAVE AND PHYSICIAN HEALTH BENEFIT PROGRAM/OPIP 15

1. Pregnancy and Parental Leave Benefit Program 15
2. OMA Priority Insurance Program 16

SCHEDULE B – HOCC 17

SCHEDULE C - APPS 20

1. General APP Review Process 20
2. Establishment of Hospitalists APP 21
3. Specific Agreed APP Repair and Other Initiatives 22
   a) London Neurosurgery Group 22
   b) Northwest and Northeast Regional Surgical Networks 22
   c) Ontario Telestroke Program 22
   d) Rural and Northern Physician Group Agreement 23
   e) Vascular Surgeons Thunder Bay 25
4. Additional APP Implementation Processes 26
   a) Laboratory Physicians (LMFFA) 26
   b) Genetics, Infectious Disease and Geriatrics 27
   c) Emergency Department Alternate Funding Agreement 27

B. VIRTUAL CARE 29

1. Preamble 29
2. Definitions 30
3. Payments 31

4. Premiums, Management Fees and Other Add-Ons 33
5. Payment Parameters 37
6. Primary Care 44
7. Virtual Care in Specialist Physician Contracts (Alternate Payment plan (APP) and Alternate Funding Plan (AFP) Agreements) 45
8. Virtual Urgent Care Centres 45
9. Implementation 46
Appendix A – List of Eligible Fee Codes for Virtual Care: Comprehensive Virtual Care Services 47
Appendix B – List of Eligible Fee Codes for virtual care: Limited Virtual Care Services 62
10. Secure Messaging proof-of-Concept Pilot 63
C. PRIMARY CARE 69
1. Managed Entry 69
2. Complexity 71
3. After-Hours 72
4. Aspirational Parameters for FHO Weekly Patient Access and for Virtual/In-person Split for FHO and Other Primary Care Physicians 74
5. Weekend Access (A888 Equivalent) for Patients – FHO 75
6. Increase Mandatory Group Size 75
7. FHO Group Maximum Roster 76
8. CCM and FHN Migration 76
9. Walk-in Clinics 77
10. Change the Maximum FFS Pooling from Group to Individual Physicians 77
11. Enhanced FHO Group Coverage 78
12. FHO After-Hours Exemptions 79
13. Modernized Booking Process for FHO and FHN Enrolled Patients 80
D. SCHEDULE OF BENEFITS FEE ADJUSTMENTS AND MODERNIZATION 81
E. FAIR RELATIVITY MODEL 83
F. APPROPRIATENESS WORKING GROUP 84
1. Continuation of the AWG 84
G. TECHNICAL FEES 86
H. EXTENSION OF CANADIAN MEDICAL PROTECTIVE ASSOCIATION (CMPA) AGREEMENT 89

I. CLAIMS SUBMISSION TIMELINE AND ADJUDICATION PROCESS 90
J. DATA SHARING 91
K. MEMORANDUM OF UNDERSTANDING REGARDING DURATION OF PSA UNDER FRAMEWORK 94

A. FINANCIAL AGREEMENT

The parties acknowledge the necessity, created by the COVID-19 pandemic, to work cooperatively toward optimizing access and the delivery of quality health care to the citizens of Ontario.

1. General

The parties agree that the economic structure of this PSA is entered into without prejudice to either party's position in any future bargaining, mediation or arbitration respecting the relationship between price/other compensation adjustments and PSB expenditures.

2. Years 1 and 2 Compensation Increases

1. For the 21/22 contract year:

A lump sum equivalent to a 1.0 percent increase to all physician payments set out in Section 21(a) of the Binding Arbitration Framework (BAF), except hospital technical fees and OPIP. This 1% lump sum payment shall be paid to physicians in the month of February 2023 on the date that reflects the physician's regular payment schedules.

2. For the 22/23 contract year:

A lump sum equivalent to a 2.01 percent increase [reflecting the 1 percent increase for 21/22, and a further 1 percent for 22/23, compounded] to all physician payments set out in Section 21(a) of the BAF.

The year 2 lump-sum payment shall be applied as a 2.01% percentage increase to all physician payments, except hospital technical fees, OPIP, and pregnancy and parental leave. This 2.01% increase will be implemented April 1, 2022, prospectively on a monthly basis, and will be flowed through to non-fee for service payments as soon as is practicable.

This adjustment will not be applied on the increases to "Specific Agreed APP repair and Other Initiatives" set out in paragraph 3 of Schedule C to this Agreement.

3. The lump-sum payments in paragraphs 1 and 2 above will result in a permanent compounded 2.01 percent adjustment to physician payments set out in Section 21(a) of the BAF, which will be permanently allocated to physicians effective April 1, 2023, on the following basis.

The permanent 2.01% compounded increase will be calculated on a base of 2019-2020 expenditures plus 3.5446% (which reflects the previously awarded increases under the 2017-21 PSA) and will be permanently allocated as follows:

a. 1/4 of the global increase will be allocated to each section or physician grouping on an equal percentage amount; and

b. 3/4 of the global increase will be allocated to each section or physician grouping based on the hybrid CANDI-RAANI score.

Specifically, the allocations to each section or physician grouping will be made on the basis of the table and note set out below, and implemented on April 1, 2023, and flowed through to non-fee for service payments as soon as is practicable:

Physician Section/Group		Fee Increase April 1, 2023
00_1	GP-1	1.7817%
00_2	GP-2	2.6186%
00_3	GP-3	3.3385%
1	Anaesthesiology	1.1899%
2	Dermatology	2.0202%
3	General Surgery	2.1876%
4	Neurosurgery	1.7271%
5	Community Medicine	2.0742%
6	Orthopaedic Surgery	1.7271%
7	Geriatrics	2.7081%
8	Plastic Surgery	1.8967%
9	Cardiac Surgery	1.2089%
12	Emergency Medicine group	2.0524%
13	Internal and Occupational Medicine	2.4107%
15	Endocrinology	1.8383%
16	Nephrology	1.7005%
17	Vascular Surgery	2.1527%
18	Neurology	2.8012%
19	Psychiatry	3.0540%
20	Obstetrics & Gynaecology	2.7081%
22	Genetics	2.4107%
23	Ophthalmology	0.5186%
24	Otolaryngology	1.7817%
26	Paediatrics	2.4107%
28	Laboratory Medicine group	1.6231%
31	Physical Medicine & Rehabilitation	2.5753%
33	Diagnostic Radiology	1.0826%
34	Radiation Oncology	1.2089%
35	Urology	1.5982%
41	Gastroenterology	0.8916%
44	Medical Oncology	1.5736%
46	Infectious Disease	2.8012%
47	Respiratory Disease	2.5753%
48	Rheumatology	2.1527%
60	Cardiology	1.5257%
61	Haematology	2.3334%
62	Clinical Immunology	1.8673%
63	Nuclear Medicine	2.1187%
64	General Thoracic Surgery	2.3716%

Note: The parties agree that for the 2021-22 and 2022-23 increases, the permanent increases to the Northern Ontario Academic Medical Association (NOAMA) AFP, Academic Health Science Centre (AHSC) AFP, On-Call Programs and non-hospital technical fees will be 2.01%. For 2023-24, the amount of the permanent increase for the NOAMA AFP, AHSC AFP, On-Call Programs and non-hospital technical fees will be equal to the prospective compounded adjustment described in paragraph 8, after the provisions of paragraph 8(a) and (b) are applied.

4. The determination of how to apply the allocations in paragraph 3 above within each section or physician grouping, and to non-fee for service contracts or programs, will be made through the process outlined in the parties' agreement on "Schedule of Benefits Fee Adjustments and Modernization". This determination will be made by October 1, 2022.

5. In addition to the year 1 and year 2 compensation increases set out above, and effective April 1, 2022, the parties agree to the following:

a) increase the funding for pregnancy and parental leave and for OPIP on the terms set out in Schedule A to this agreement; and

b) increase the funding for "Specific Agreed APP repair and Other Initiatives" set out in paragraph 3 of Schedule C to this Agreement, on the terms specified therein.

3. Year 3 Compensation Increases and Gain Sharing

6. For the 2023/2024 contract year, payments to physicians will be determined on the following basis:

a. If actual PSB expenditure in year 3 is between $16.1759 billion and $15.8587 billion, the difference will be allocated entirely to physicians,

and, in addition:

b. If actual PSB expenditure in year 3 is less than $15.8587 Billion, the difference between the actual PSB expenditure and $ 15.8587 Billion will be allocated 75 percent to physician payments, and 25 percent to government.

7. There shall be no financial liability for physicians if PSB expenditure is above $16.1759 Billion.

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

Step 1

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

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

Step 2

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

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

9. The determination of how to apply the allocations in paragraph 8 c) and d) above within each section or physician grouping, and to non-fee for service contracts or programs, will be made through the process outlined in the parties' agreement (in Part D of this PSA) on "Schedule of Benefits Fee Adjustments and Modernization". This determination will be made by October 1, 2024

10. The parties acknowledge that the increases described in paragraph 8(a) and (b) above in respect of HOCC and APPs cannot be permanently implemented on April 1, 2023. Lump-sum payments to account for this delay will be paid as described in paragraphs 18(a) and 19 (a) and (b) below.

11. Consistent with and following the Committee process set out at paragraph 21 below, the parties will work together to see that the increases described in paragraph 8 (c) and (d) above will first be paid on a lump-sum basis, where such lump sum is allocated in the same proportions as set out in the table following paragraph 3 above, and consistent with the approach set out in the note following that table, retroactive to April 1, 2023, to cover the time period until the permanent compounded increases to each section or physician grouping are implemented on April 1, 2025. Payments for the fiscal year 2023-24 will be covered in two lump sums. The first payment will be made in August 2024, and will be flowed through to non-fee for service payments as soon as is practicable thereafter. A second and final completion payment for fiscal year 2023-24 will be made as soon as practicable after the final 2023-24 PSB expenditure is known. For certainty, either party may refer

any dispute over these retroactive payments to William Kaplan, acting as sole mediator/arbitrator, for a final and binding determination for the purposes of this paragraph.

12. In accordance with the completion of the work to be undertaken by the Physician Payment Committee set out under Part D, “Schedule of Benefits Fee Adjustments and Modernization”, any permanent compensation increases contemplated by paragraph 8 (c) and 8(d) above will be implemented by April 1, 2025, or such earlier date as the parties may agree, and will be flowed through to non-fee for service payments as soon as is practicable thereafter. The parties further agree that the lump sum payment to cover the period from April 1, 2024 through to the implementation of the permanent increase will be paid to physicians in the same proportions as set out in the table at paragraph 3, and consistent with the approach set out in the note following paragraph 3, no later than August, 2025, and will be flowed through to non-fee for service payments as soon as is practicable thereafter.

4. Year 3 HOCC Funding

13. Effective April 1, 2023, up to $12.5 million will be made available to groups applying for on-call program funding, subject to the terms and conditions set out in schedule B to this agreement. This additional funding will be treated as part of existing funding for the purpose of paragraph 8(a) above.

14. The parties agree that, pursuant to the formula for determining additional HOCC funding set out in paragraph 8 above, up to $75 million dollars of permanent additional HOCC funding will be targeted to a revised burden-based HOCC payment and accountability structure agreed to by the parties, in accordance with the terms and process set out in Schedule B. The allocation of this funding will be subject to a reserve of up to 10% (at the discretion of the Ministry) of the estimated new funding available for HOCC pursuant to the formula set out above, and as determined by the December 15, 2023 PSB expenditure estimate arrived at through the parties work set out in paragraph 21. The parties

will make final decisions on this revised HOCC program in a timely manner, in order to enable the submission of applications as outlined in Schedule B. For the purposes of this paragraph, any dispute between the parties can be submitted by either party to William Kaplan, acting as sole mediator/arbitrator, to make directions as to timeliness and otherwise to provide for a final and binding determination of any issues as set out in Schedule B.

15. The commitment to permanent additional funding as determined by the parties in paragraph 14 above will be guaranteed in accordance with paragraph 18 below.

5. Year 3 APP Funding

16. The parties agree that, pursuant to the formula for determining additional APP funding set out in paragraph 8 above, up to $50 million dollars will be targeted for additional permanent funding for new APPs and for expansion of existing APPs, pursuant to the process set out in paragraphs 1 and 2 of Schedule C. The allocation of this funding will be subject to a reserve of up to 10% (at the discretion of the Ministry) of the estimated new funding available for APPs pursuant to the formula in paragraph 8 above, and as determined by the December 15, 2023 PSB expenditure estimate arrived at through the parties work set out in paragraph 21. This does not include any new or expanded APPs described in paragraph 22 below. The parties will make such decisions as are practicable to enable allocations of funding to APPs on or before December 2023, for intended implementation where possible within the third year of this agreement. For the purposes of this agreement, any dispute between the parties with respect to the allocation of funding to an existing APP or a new APP (including any disputes over timing or costs) can be submitted by either party to William Kaplan, acting as sole mediator/arbitrator, to make directions as to timeliness and otherwise to provide for a final and binding determination of any issues arising under this paragraph.

17. The commitment to permanent additional funding as determined by the parties in paragraph 16 above will be guaranteed in accordance with paragraph 19 below.

18. The parties agree to review the actual expenditures for HOCC as follows:

a) Any funding established under this Agreement for HOCC, which is not spent on the revised HOCC burden-based system and new payment structure between April 1, 2023, and the date that the revised HOCC system is implemented, will be paid as expeditiously as is practicable to physicians on a lump sum basis in accordance with the year 3 allocations to each section or physician groupings;

b) If the permanent annualized increased expenditure for HOCC, as determined one year after HOCC implementation, is less than the amounts that were allocated pursuant to the formula set out in paragraph 8 above, including any unspent reserve amount, the HOCC payments to physicians will be both retroactively and permanently adjusted based on the amount of the unspent funding, unless the parties agree otherwise, to ensure the value of third year permanent physician payments have been adjusted in accordance with Paragraphs 6, 10 and 11.

19. The parties agree to review the actual expenditures for APPs as follows:

a) Any unexpended new funding for APPs as determined under the formula set out in paragraph 8 above for increased APP funding, arising in the period between April 1, 2023 and March 31, 2024, will be paid as expeditiously as is reasonably practical to physicians on a lump sum basis in accordance with the year 3 allocations to each section or physician groupings.

b) Any unexpended new funding for APPs as determined under the formula in paragraph 8 above for increased APP funding arising in the period between April 1, 2024 and October 1, 2024 will be paid as expeditiously as is reasonably practical to physicians on a lump sum basis in accordance with the year 3 allocations to each section or physician groupings.

c) If the permanent annualized increased expenditure for APPs, as determined as of October 1, 2024, is less than the amounts that were allocated pursuant to the formula in paragraph 8 above, including any unspent reserve funding, the parties agree to expeditiously allocate the unspent funding on new or expanded APPs, unless the parties agree otherwise, to ensure the value of third year permanent physician payments have been adjusted in accordance with Paragraph 6, 10 and 11.

20. For the purposes of this agreement, any dispute arising under paragraph 18 or 19 can be submitted by either party to William Kaplan, acting as sole mediator/arbitrator, for a final and binding determination.

6. Committee Process

21. Following ratification, the parties will establish a committee that will meet on a quarterly basis, or on such other regular basis as they determine, to review the expenditure calculations. Through this committee, the parties will agree to a best estimate of the year 3 (2023-2024) PSB expenditures in accordance with paragraph 6 by December 15, 2023.

22. Any agreements reached by the Government with respect to any new physician payment program or addition to an existing program which was not the subject of a proposal by the OMA during the negotiations leading to the agreement for the 2021-2024 PSA will not be included in calculating the total PSB expenditure for the purposes of paragraph 6 above, unless the parties specifically agree otherwise.

23. The parties further agree to continue the Appropriateness Working Group as amended by this Agreement without any identified or required monetary target or any dispute resolution process. To this end, they will engage in an ongoing review to determine whether they can further reduce the provision of medically unnecessary, or inappropriate services through payment rule changes (including, but not limited to, modifying or specifying indications for treatment), delisting of a service (without prejudice to the Ministry's rights under the BAF) and/or other changes to

the schedule of benefits as are responsive to, among other things, the determination of appropriateness/inappropriateness, and/or through physician peer comparisons/review and physician/patient education. This may also include mechanisms for operationalizing recommendations regarding appropriateness/inappropriateness.

7. Dispute Resolution

24. For the purposes of this Financial Agreement, any issue with respect to the interpretation, application or administration of this agreement will be submitted to William Kaplan, acting as sole mediator/arbitrator, in place of the referee provided for under the Binding Arbitration Framework, for a full and final determination on an expedited basis, with the exception of paragraph 23 above.

SCHEDULE A – PREGNANCY AND PARENTAL LEAVE AND PHYSICIAN HEALTH BENEFIT PROGRAM/OPIP

1. Pregnancy and Parental Leave Benefit Program

Effective any leave commencing as of April 1, 2022

Increase weekly maximum to $1300:
The parties agree to increase the benefit payment maximum of $1,035 per week to $1,300 per week

Increase reimbursement rate from 50% to 75%:
The parties agree to increase the benefit calculation of the physician's average weekly gross eligible earnings in Ontario from 50% to 75% in the 12-month period immediately preceding the leave start date

Length of Leave
The parties agree that there will be 17 weeks of combined pregnancy and parental leave for all parents, i.e., those giving birth, or otherwise becoming a parent (including adoption, surrogates) and including stillbirth

Increase to maximum gross eligible earnings
The parties agree that an eligible physician who is receiving benefits from the Pregnancy and Parental Leave Benefit Program may earn gross eligible earnings up to $1,300 a week without deduction during the course of their leave.

Initiation of Leave
The parties agree that pregnancy or parental leave may be initiated within 12 months of the child joining the parent, and must be completed within the 12 months of the child joining the parent.

Timing of Leave
The parties agree that pregnancy or parental leave does not have to be taken consecutively, but must be taken for no less than two weeks at a time.

Exceptions
The current exceptions in the pregnancy and parental leave benefit program will continue, as reflected in the Ministry's Pregnancy and Parental Leave Benefit Program Guidelines, which can be found here: https://www.health.gov.on.ca/en/pro/programs/parentalleave/#:~:text=The%20Pregnancy%20and%20Parental%20Leave,to%20a%20maximum%20of%20%241%2C035.45.

2. OMA Priority Insurance Program

The Ministry agrees to enhance the Ministry contribution to the OMA Priority Insurance Program's (OPIP), by increasing their annual funding to $28.5 million, effective April 1, 2022, and to $31 million effective April 1, 2023.

SCHEDULE B – HOCC

1. Upon ratification, the parties will invite applications from new groups of physicians who have been excluded from receiving Hospital On-Call Coverage (HOCC) funding under the HOCC funding moratorium, as well as, those physicians who have been limited in accessing funding under the following programs: Community Palliative On-Call (CPOC), Complex Continuing Care (CCC) On-Call and Long Term Care Home Physician On-Call (POC). The parties also agree that groups of less than five that provide the same level of uninterrupted call as groups of five or more will receive the rate payable to groups of five. Up to 12.5 million dollars of new funding will be made available for these purposes, with payments for these new groups and for groups of less than five to commence effective April 1, 2023.

2. A time-limited joint Ministry/OMA HOCC working group will be established for the purposes of designing for implementation a burden based HOCC program to replace the existing HOCC program. The joint working group will consult with relevant stakeholders (e.g. OH and OHA). The burden based HOCC program will be modelled on commonly recognized levels of call intensity that will be agreed upon by the parties. Among the things the working group will consider are the potential levels such as those set out below:

   Level A: Attending physician required to be on site for the entire on call period for both in-patient services and the Emergency Department (in common language, ‘in-house call’)

   Level B: Attending physician responding to hospital calls, both urgent and non-urgent for both in-patient services and the Emergency Department, from an off-site location with high potential for in person attendance to provide urgent patient services (in common language, ‘home call with possibility of conversion to in-house’)

   Level C: Attending physician responding to hospital calls, both urgent and non-urgent via any means of communication (telephone, video, asynchronous communication) from hospital staff, residents or other physicians, with low likelihood to come to hospital (in common language, ‘home call only’)

Level D: Attending physician responding to hospital calls, non-urgent via any means of communication (telephone, video, asynchronous communication) from hospital staff, residents or other physicians, with very low likelihood to come to hospital (in common language, 'call-in only')

3. Applications for this new burden based HOCC program must be received, for joint Ministry and OMA review, by December 31, 2023 with the intention of implementation prior to April 1, 2024.

4. For the purposes of paragraphs 1, 2 and 3 above, William Kaplan, acting as sole mediator/arbitrator, is seized to resolve any dispute between the parties, including any disputes over costing, without prejudice to either party's position otherwise on the arbitrability of these kinds of issues under the BAF.

5. The Ministry recognizes the introduction of the Cortellucci Vaughan Hospital as a net new hospital to Ontario's health system, and to provide an additional $2.3M in net new HOCC funding to support Mackenzie Health's on-call program, which funding will be in addition to the determination of any compensation adjustments provided for under this physician services agreement.

6. The parties have separately agreed to replace the existing HOCC Agreement Preamble with the following, which will also be incorporated in the restructured HOCC program, and will take those steps as are necessary steps to implement this change:

> *"Whereas:*
>
> *The Ministry and the OMA negotiated the Hospital On-Call Coverage Program (HOCC Program) to provide compensation from the Ministry to physicians for rendering insured health care services to insured persons. The Minister is authorised to conduct such negotiations under section 12 of the Commitment to the Future of Medicare Act, 2004*

Under section 2(1) of the Health Insurance Act (HIA), the Minister is responsible for the administration and operation of the Ontario Health Insurance Plan (OHIP) and is the public authority for Ontario under the Canada Health Act (Canada). Under section 2(2) of the HIA, the Minister is authorized to enter into arrangements to pay physicians on a basis other than fee for service, and this Agreement sets out the terms of such an arrangement for the HOCC Program.

This Agreement sets out the terms under which physicians are eligible to receive funding from the Ministry for providing insured health care services to insured persons at the Hospital as set out in the HOCC Program, and it includes provisions for the administration by the Hospital of the distribution of funding. All payments under this Agreement are made by the Government of Ontario to physicians under OHIP as established by the HIA for the benefit of insured persons of Ontario."

SCHEDULE C - APPS

Note: APP contracts will also receive flow through increases as determined in the normal course.

1. General APP Review Process

The Parties agree to establish a joint working group to evaluate and determine the incremental additional cost of proposals for new APPs, and of proposals for adding physicians into existing APPs, for the purposes of allocating any funding set out for APPs under the terms of this agreement.

Requests for the expansion of existing APPs or the creation of new APPs will be submitted to the Ministry. The Ministry will include OMA contact information to assist in the development of an APP request application in the instructional materials provided to groups. Further, the Ministry will, once all documentation has been received, send the complete request to the OMA, and will advise the group accordingly. Factors to consider in making a determination on the merits of the creation of a new APP or the expansion of an existing APP include:

a. The changes in demand for physician services under the APP (volume and acuity)
b. Wait times and changes in wait times over time
c. Alignment with hospital volume projections
d. Changes in practice and new technologies
e. A multi-year HR plan for the Group
f. Alignment with clinical needs
g. Alignment with community needs
h. Sustainability and appropriateness of current compensation model

Each approved APP will include the following:

i. Number of FTEs approved

ii. Funding per FTE

iii. Incremental Cost (Funding per FTE minus FFS billing)

The Ministry and OMA may consult with other relevant health sector stakeholders, such as Ontario Health, as it deems appropriate.

Any dispute between the parties with respect to the allocation of funding to an existing APP or with respect to a new APP can be submitted by either party to William Kaplan, acting as sole mediator/arbitrator, who is seized to resolve any dispute between the parties, including any disputes over costing and timing, without prejudice to either party's position otherwise on the arbitrability of these kinds of issues under the BAF.

2. Establishment of Hospitalists APP

As a priority matter, the parties agree to establish a Hospitalist Medicine APP Working Group to design a Hospitalist Medicine APP to be available for intended implementation by April 1, 2023.

The Working Group's mandate will include the following:

- An agreed upon policy rationale/framework for a Hospitalist APP
- Broad principles for a new hospitalist APP
- What sections and/or specialties would be eligible for a hospitalist contract
- What regional and/or hospital specific elements of a Hospitalist APP need to be considered (e.g. small, rural, northern, academic, community, etc.)
- Program eligibility requirements, including inclusion and exclusion criteria
- The form of a template agreement to support a Hospitalist APP including associated accountabilities
- Parameters for a Hospitalist APP compensation structure and an appropriate rate/price to support a Hospitalist APP.

In carrying out this mandate, it is expected that the following be undertaken: a jurisdictional scan, subject matter expert interviews and OHIP billing and fee code data analysis including special visits premiums.

For the purposes of this agreement, William Kaplan, acting as sole mediator/arbitrator, is seized to resolve any dispute between the parties including any disputes over costing, without prejudice to either party's position otherwise on the arbitrability of these kinds of issues under the BAF.

3. Specific Agreed APP Repair and Other Initiatives

In addition to any APP funding increases based on the year 3 compensation adjustments, the parties agree to the following:

a) London Neurosurgery Group

The parties agree to increase the base rate paid under the APP by $39,000, and to increase the service encounter premium to 26.07%, effective April 1, 2022.

b) Northwest and Northeast Regional Surgical Networks

The parties confirm the interim base compensation rate is now permanent and agree to increase the amount paid on all OHIP approved services to 33.53% effective April 1, 2022 for a maximum of 12 FTEs in Northwest and 8 FTEs in Northeast.

c) Ontario Telestroke Program

The parties agree to increase the first call stipend to $1,500, and the second call stipend to $500, effective April 1, 2021.

In agreeing to the above, the parties acknowledge that the existing transitional compensation currently in place will end upon ratification of this agreement. Further, the retroactive payment of the above back to April 1, 2021 will be net of this existing transitional compensation.

d) Rural and Northern Physician Group Agreement

i) Partial FTEs – Amend the agreement to replace the definition of “RNPGA Physician” to include both full and partial FTE physicians, and to provide for the following items in the existing RNPGA agreement to be pro-rated for partial FTEs:

2.1 Base Rate

2.1.1 Overhead

2.3 Payment for Specialized Services

ii) Succession Planning – 3 months of overlap funding for a newly recruited physician and a departing physician.

iii) Base Rate Increase - Increase the base rate by 4% effective April 1, 2022, and a further 4% effective April 1, 2023.

iv) Complement Review - The Ministry and OMA will establish a time-limited bilateral working group which includes representation from select stakeholders (ex. NOSM, CRaNHR, affiliated interprofessional teams, other physician services and primary care providers, etc.), whose objectives would be to establish a methodology and implement an RNPGA complement review for all RNPGA communities. This work will be completed by December 31, 2022 for implementation April 1, 2023. The complement review would include review of other existing health human resources and make reference to community population need and health system opportunities/barriers to develop evidence-based recommendations to the parties.

The time-limited bilateral working group would develop complement review criteria. Criteria that may be considered include:

(1) stability of contract type
(2) minimum complement
(3) teaching and training requirements
(4) ED visit volumes
(5) administrative burden
(6) community staffing needs
(7) demographics and population morbidity
(8) whether the group is associated with a FHT
(9) obstetrical care requirements
(10) the needs of women physicians in terms of sustainable workload
(11) migration patterns, and
(12) maintaining patient choice of physician.

The Ministry and OMA shall agree on: (i) the parties included in the time-limited bilateral working group, (ii) the complement review criteria to be applied and iii) the application of such criteria to determine RNPGA complement. For the term of this Physician Services Agreement, any dispute arising from the working group with respect to (i) or (ii) or (iii) above or any of the recommendations arising out of the working group can be referred by either party to William Kaplan, acting as sole mediator/arbitrator, who is seized to resolve any dispute between the parties with respect to the above. The parties agree that this agreement to refer issues in dispute above to arbitration is without prejudice to either party's position on the arbitrability on these issues.

vi) Pay out Unused Respite locum days – On an annual basis, a physician may elect to be paid for up to 5 unused Locum Days, at the HFO Rural Family Medicine Locum Program (RFMLP) daily stipend rate. For a claim to be payable, the physician must provide documentation to demonstrate that reasonable efforts were made to find coverage. This includes the physician providing documentation that shows they contacted Ontario Health, confirming the vacancy was posted

and exploring any responses. Any claim for payout must be made within 3 months following the end of the applicable year. For clarity, any additional unused days will be banked in accordance with paragraph 6.2 of the RNPGA contract.

e) Vascular Surgeons Thunder Bay

Effective April 1, 2022, the establishment of a new APP with a base of $465,529 per FTE, and with a 21.76% premium on shadow billed claims for 3 FTEs.

4. Additional APP Implementation Processes

a) Laboratory Physicians (LMFFA)

The Ministry and the OMA have previously agreed to streamline the current funding model into a single payment structure administered through OHIP.

The work to develop a funding model was initiated by the Physician Services Committee and a Laboratory APP Working Group. This group was struck with representatives of the Section of Laboratory Medicine, OMA staff, the Ministry and the OHA. The mandate of the Working Group is to develop a cost neutral funding model that would streamline the current, cumbersome Laboratory Medicine Funding Framework Agreement (LMFFA) process.

The parties agree to continue to work on developing a permanent APP funding model for Laboratory Medicine through the work of the Laboratory Medicine APP Working Group, and to complete this work by December 1, 2023.

It is expressly understood that the development of an APP will first require resolution of many complex issues, including a shared understanding of the current method and various sources of funding, the definition of “cost neutral” in the context where other sources of revenue may inform current physician compensation, the ongoing role, if any, of direct to hospital funding for physician compensation and consideration of existing employment and pension arrangements of some physicians.

The parties agree that in addition to his general authority under paragraph 24 of this Financial Agreement, William Kaplan, acting as mediator/arbitrator, also has the authority to determine any unresolved disputes in the development of this APP. The parties agree that this agreement to refer issues in

dispute above to arbitration is without prejudice to either party's position on the arbitrability on these issues.

For clarity, William Kaplan's jurisdiction, as arbitrator, is contingent upon the Ministry and the hospitals reaching agreement on the funding reallocation needed to establish the APP.

b) Genetics, Infectious Disease and Geriatrics

The parties agree to continue to work on developing permanent APP funding models for Geriatrics, Genetics and Infectious Diseases by December 1, 2023 using the funding previously committed from the 2008 PSA and any flow-through funding from prior years.

For the purposes of this agreement, William Kaplan, acting as sole mediator/arbitrator, is seized to resolve any dispute between the parties with respect to the above. The parties agree that this agreement to refer issues in dispute above to arbitration is without prejudice to either party's position on the arbitrability on these issues.

c) Emergency Department Alternate Funding Agreement

The parties agree to establish a bilateral Emergency Department Working Group (EDWG) with a mandate to review and recommend amendments to ED AFA models. This includes an agreement to conduct a Ministry of Health funded updated Predictor of Workload in the Emergency Room (POWER) study. This study will occur when the parties, in consultation with the Emergency Services Advisory Committee, agree there is a sufficient change in the COVID-19 pandemic impacts on Ontario's emergency departments such that it is safe for researchers to proceed and conditions return to a more stable baseline. The EDWG is seized with concluding its work by October 1, 2023, or such other date that will allow the work to be completed so that the parties may then immediately hold discussions regarding any issues that either party may have with respect to implementation. In order to achieve this target

date, the parties agree that in addition to his general authority under paragraph 24 of this Financial Agreement, William Kaplan, acting as mediator/arbitrator, also has the authority to issue any order or direction that may assist the parties in respect of the bilateral work contemplated above.

B. VIRTUAL CARE

1. Preamble

The parties recognize the critical role played by Ontario physicians throughout the COVID-19 pandemic, providing patients with timely, safe and equitable access to high quality care.

The parties are committed to continuing to support virtual care beyond the temporary virtual care K-codes, to improve patient access to medically appropriate care while also ensuring good patient experiences and outcomes, accountability and value for money. Virtual care will allow physicians to offer new modalities of service delivery that can optimize care for patients and allow for appropriate and timely access.

The parties have agreed, in furtherance of this commitment, to integrate video and telephone service, under the OHIP insured framework in a manner that ensures clinically appropriate, high-quality patient care, while acknowledging the importance of in person care when clinically indicated or requested by the patient. The Ministry will be relying on the essential role and judgement of physicians in striking the appropriate clinical balance between providing in-person and virtual care, always mindful of the principles that guide medical practice and the needs of the people we serve.

The new Virtual Care Model agreed to below is intended to be the next step in integrating virtual care into the Ontario health care system. The parties are committed to gathering data and evidence relating to the impact of Virtual Care Services on quality and accessibility and delivery of care, access to in person services, and utilization (expenditures) of physician services. As a result, the Ministry and the OMA will work together to navigate the ongoing development of virtual care in Ontario. The parties recognize that it is essential that physicians do their part to choose which aspects of practice are appropriate to provide virtually, and to achieve the parties' shared interest in promoting high-quality, responsive patient care.

To appropriately reflect and remunerate the types of services being provided virtually, it is proposed that the Schedule of Benefits be amended to insure Virtual Care Services provided by synchronous video or phone, as set out below and in Appendices.

2. Definitions

For the purpose of this virtual care payment structure, an existing/ongoing patient-physician relationship is defined as follows:

a) Where the patient has had at least one insured service with a direct physical encounter with the physician (Family Physician or Royal College specialist physician ("a specialist")) in the preceding 24-months; or

b) Where a physician provides services to a patient who has signed the Ministry's Patient Enrolment and Consent to Release Personal Health Information form and is enrolled to that physician or another physician within the same group (who is signatory/locum to a Ministry alternate funding plan agreement); or

c) Where a specialist or GP focus practice physician provides an eligible insured consultation by video; or

d) Where a physician provides any of the following services:
   - A920 – Medical management of early pregnancy - initial service by video or phone,
   - A945 – Special palliative care consultation by video,
   - C945 – Special palliative care consultation by video,
   - A680 – Initial assessment - substance abuse by video,
   - C680 – Initial assessment - substance abuse by video,
   - NEW fee codes Www1-Www3 – Midwife-Requested Assessments (MRAs) by video.
   - A802 Extended midwife-requested genetic assessment by video
   - A801 Comprehensive midwife-requested genetic assessment by video

- A800 Midwife-requested genetic assessment by video
- A253 Optometrist-Requested Assessment (ORA) by video
- A256 Special optometrist-requested assessment by video

e) Comprehensive Virtual Care Services – These are video and telephone services insured and payable under fee codes listed in Appendix A, when rendered in the context of an existing/ongoing patient-physician relationship as defined above and where in the physicians' professional opinion, the person's care and support requirements can be effectively and appropriately delivered by video or telephone.

f) Limited Virtual Care Services – These are video and telephone services insured and payable outside of an existing/ongoing physician patient relationship under new fee codes Xxxx listed in Appendix B and where in the physicians' professional opinion, the person's care and support requirements can be effectively and appropriately delivered by video or telephone. Telephone services are only eligible for payment in this instance when the patient indicates that they cannot participate in the service by video.

3. Payments

a) Where a comprehensive virtual service set out in Appendix A is provided by a physician using video, payment will be on par with the in person service.

b) Where a comprehensive virtual service set out in Appendix A is provided by a physician using telephone, payment will be at 85% of the amount of the in person service except as set out in c) below.

c) K007 GP psychotherapy, K005 primary mental health, K197 individual out-patient psychotherapy, and K198 outpatient psychiatric care provided by telephone will be paid at 95% of the amount for an in person service.

d) Where a limited virtual care service (Xxx1) is provided by video the amount paid will be $20.

e) Where a limited virtual care service (Xxx2) is provided by telephone (and in accordance with the limitation set out above) the amount paid will be $15.

f) The following new fee codes will be established at the following rates and are only payable when provided by video.

- Www1 Midwife Requested Assessment (MRA) – when rendered virtually: $111.70 (A813 equivalent)
- Www2 Midwife Requested Special Assessment (MRSA) – when rendered virtually: $186.95 (A815 equivalent)
- Www3 Midwife-Requested Anaesthesia Assessment (MRAA) – when rendered virtually: $106.80 (A816 equivalent)
- Zzz1 GP Focused practice designated consultation – when rendered virtually: $84.45 (A005 equivalent)
- Zzz2 GP Focused practice designated repeat consultation – when rendered virtually: $45.90 (A006 equivalent)
- Zzz3 GP Focused practice designated limited consultation – when rendered virtually: $72.10 (A905 equivalent)
- Zzz4 GP Focused practice designated special consultation – when rendered virtually: $144.75 (A911equivalent)
- Zzz5 GP Focused practice designated comprehensive consultation – when rendered virtually: $217.15 (A912 equivalent)

Note:

- Xxx1 and Xxx2 include at a minimum, history-taking and medically appropriate exam to arrive at a diagnosis and provide an appropriate management plan.
- Www1, www2 and www3 are subject to the same conditions as A813/A815/A816, except for a general assessment (where applicable) which is replaced by a relevant history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function.

- Zzz1, zzz2, zzz3, zzz4 and zzz5 are consultations rendered by designated GP focused practice physicians who complete a relevant history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function. Otherwise, these services are subject to the same conditions as A005/A006/A905/A911/A912).

4. Premiums, Management Fees and Other Add-Ons

a) The following premium payments will be applied when the qualifying service is provided virtually:

Fee Code	Premium	Rate
E060	Post renal transplant assessment premium	25% of virtual fee paid
E078	Chronic disease assessment premium	50% of virtual fee paid
E080 (video only)	First visit by primary care physician after hospital discharge	$25.25
K187	Acute post-discharge community psychiatric care	15% of virtual fee paid
K188	High-risk community psychiatric care	15% of virtual fee paid
K189 (video only)	Urgent community psychiatric follow-up	$216.30
Q012	Primary care after-hours fee	30% of virtual fee paid
Q016	CCM after-hours fee	30% of virtual fee paid
Q017	HIV after-hours fee	30% of virtual fee paid
Q018	GP focus – COE1 after-hours fee	30% of virtual fee paid
Q020	Serious mental illness premium: special payment for mental health services	$1,000-$2,000

Q021	Serious mental illness premium: special payment for mental health services	$1,000-$2,000
Q042 (video and phone)	Smoking cessation counselling fee	$7.50
E079	Smoking cessation: Initial discussion with patient, to eligible services	$13.22 for phone and $15.55 for video
Q150	FOBT distribution and counselling fee	$7.00
Q152	Colorectal cancer screening test completion fee	$5.00
xxxx	Age-based fee premiums	10-30%
xxxx	Focused practice psychotherapy premium	17% of virtual fee paid
xxxx	Internal medicine office assessment premium	12% of virtual fee paid
-	FHG in-basket premium	10% of virtual fee paid

b) Management fees

Management fees are monthly or annual fees paid in lieu of or in addition to regular FFS billing that are paid when specific minimum requirements have been met.

Where Schedule requirements are met, those services continue to be payable under existing fee codes regardless of whether the requirements are met by insured services involving a direct physical encounter or insured Virtual Care Services.

Management fees are generally intended to compensate physicians for the management and supervision of specific patients/conditions, which generally includes any and all services related to monitoring the patient's condition (e.g., discussion with and providing advice to the patient, and coordination, provision, documentation of ongoing management, etc.).

The majority of services that have previously contributed to minimum requirements for Management Fees (i.e., in-person assessments, consults, visits) are included as eligible Virtual Care Services under this agreement. (i.e., the fee codes in Appendix A). Virtual Care Services will contribute towards minimum requirements for Management Fees, the same as in-person assessments, consults and visits do currently. As such, they do not need to be added to the list of eligible services for virtual care.

Monthly and Annual Management Fees in the Schedule – Virtual Care Services Will Contribute Toward Requirements

- K045 – Endocrinology & Metab/Internal Med – Diabetes management
- K046 – Endocrinology & Metab/Internal Med – Diabetes team management
- Q040 – at least one K030 in person
- K119 – Paediatric developmental assessment incentive
- K481 – Rheumatoid arthritis management
- K682/K683/K684 – Monthly management of OAMP

Diabetic Management Assessment

- In order to bill a virtual K030 an in person K030 must have been billed in the preceding 12 months.

c) Other telephone/virtual/indirect services in the schedule of benefits

Fee codes in the Schedule that already include payment for any telephone or other indirect services provided in the specified time period are not included in appendix A and may be billed as usual.

Where “telephone, fax or e-mail” is currently specified, the parties agree to amend the Schedule language to indicate “telephone or otherwise” to align with the descriptions of other services in the Schedule. For example, this would apply to Opioid Management (K682, K683, K684), Diabetes Monthly Management (G500, G514, G520), and Management and supervision of outpatient continuous nerve block infusion or outpatient palliative epidural infusion (G064).

Below is a list of codes that fall under this category

- G063 – Initiation of outpatient continuous nerve block infusion
- G064 – Management and supervision of outpatient continuous nerve block infusion or outpatient palliative epidural infusion
- G098 – Transfusion support weekly fee
- G100 – Haemophilia infusion weekly fee
- G101 – Home/self-care ventilation weekly fee
- G271 – Anticoagulant supervision
- G334 – Telephone supervisory fee for ovulation induction with human menopausal gonadotropins or gonadotropin-releasing hormone (not eligible for payment same day as visit), to a maximum of 10 per cycle)
- G382 – Supervision of chemotherapy
- G388 – Management of special oral chemotherapy, for malignant disease
- G500 – Diabetes monthly management – month in which insulin injections (2 or more daily) or insulin by pump is initiated; or month in which initial assessment by a specialist of a diabetic patient treated with insulin injections (2 or more daily) or insulin by pump occurs, 1 or more
- G511 – Telephone management regarding a patient receiving palliative care at home
- G512 – Weekly palliative care case management fee
- G514/G520 – Diabetes monthly management – each additional month (1-3 contacts); or each additional month (4+ contacts)
- G860-G866 – Chronic dialysis weekly team fee
- K313 – Physiatric management
- K034 – Telephone reporting – specified reportable disease to a MOH
- K071 – Acute home care supervision (first 8 weeks)
- K072 – Chronic home care supervision (after 8th week)
- K077 – Geriatric telephone support
- K090/K091 – Pre-op and post-op medical management of bariatric surgery

- K480 – Physician to allied professional telephone consultation (rheumatology)
- K708/K709/K710 - Multidisciplinary cancer conferences
- K121/K700/K704/K701/K702/K703/K707/K124/K705/K706 - Case conferences
- K730/K731/K734/K735 Physician/NP to physician telephone consultations
- K732/K733/K736/K737 Critical telephone consultation
- U025/U023/U026/U021/U235/U233/U236/U231 – E-assessments
- K738/K739 – E-consultations

5. Payment Parameters

a) Existing Schedule Requirements

Existing requirements in the Schedule (aside from a direct physical encounter with the patient) will apply to virtual care services, including the existing constituent and common elements, and the specific elements, of providing an insured service.

b) Appropriateness

Virtual Care Services are not eligible for payment where it is not medically appropriate to provide the services without a direct physical encounter. Where a patient requests a virtual visit (is not willing to present in-person, despite the physician's advice and availability), this would be payable using the appropriate fee code for the service that can be completed virtually. However, if before the Virtual Care Service has been completed, the patient agrees to and does present for a direct physical encounter for the same concern, the Virtual Care Service is not eligible for payment (i.e., only the service with a direct physical encounter is eligible for payment).
If during the course of a Virtual Care Service it becomes apparent that the service cannot be appropriately completed without a direct physical encounter, the Virtual Care service is not eligible for payment (only the service with a direct physical encounter is eligible for payment).

c) Verified Virtual Visit Solution

Video services are not eligible for payment when performed using a non-verified virtual visit solution (not listed on Ontario Health's public list of verified solutions). The current list can be found at https://www.ontariohealth.ca/our-work/digital-standards/virtual-visits-verification-standard/vendor-list.

d) Geographic Location

Virtual Care Services are only insured if the physician and patient are physically located in Ontario at the time the Virtual Care Services is provided.

e) Existing Virtual Services

Virtual Care Services are not eligible for payment if substituted for existing services which already include telephone or other virtual communications listed in the Schedule (e.g., G271 anticoagulant supervision by telephone and G382 supervision of chemotherapy). Physicians will only be paid for the service using the fee code that most accurately describes the service provided.

f) Availability

In-person services must be made available by the physician providing comprehensive Virtual Care Services, or by the physician's group, within a clinically appropriate timeframe, if it becomes apparent during a Virtual Care Service that an in-person visit is medically necessary, or if at the time of scheduling the service the patient expresses preference for an in-person visit.

For Royal College specialist and GP focus 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 physicians a group is defined: PEM 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.

g) Services Not Listed in Appendices

All other insured services that are rendered by video or phone to insured persons and that are not listed in Appendix A as Comprehensive Virtual Care Services, not defined under the new fee code for Limited Virtual Care Services listed in Appendix B, or not included in the codes listed in paragraph 4(c) above, are not eligible for payment.

h) Documentation

Virtual Care Services are not eligible for payment unless the delivery modality is documented on the patient's medical record.

i) Change in modality, greater part rule

If during the course of a Virtual Care Service the modality changes (for example, a phone service transitions into a video service), physicians may claim the modality that represents the greater part (more than 50%) of the time spent providing the Virtual Care Service. For time based services, the combined time of both modalities will represent the total time of the service.

j) Initiation by patient or follow up

Virtual Care Services are not eligible for payment unless initiated by the patient or the patient's representative, or the service represents a medically necessary follow-up to a visit initiated by the patient or the patient's representative.

For clarity, administrative staff may co-ordinate appointments and organize care in a manner analogous to in-person encounters without violating this condition. Similarly, medically necessary follow-up services may be organized by the provider (or by their staff) without violating the condition. However, a physician-initiated call to “check-in” on a patient would not be eligible for payment, nor would any telephone calls or video encounters conducted for administrative purposes (such as to inform patients of clinic closures or the availability of remote services).

Furthermore, services are not eligible for payment when initiated by the physician (or the physician’s staff) without a clear and medically necessary reason for doing so. For example, the communication of normal lab work, unless medically necessary (in so far as the clinical management of the patient is altered) should not be billed.

Physician-initiated communication to provide advice or guidance regarding a previously rendered service is also not separately eligible billable. A common example of this would occur when a patient is provided with a prescription along with instruction to fill it only upon receipt of a positive test result. The call to inform the patient of the test result is not eligible for payment as it would be considered a Specific Element of the initial (refer to: item F, GP 15, Schedule of Benefits).

As a general rule, the provider should consider whether the remote encounter would have occurred in their “in-person” practice. In circumstances where an in-person encounter would not have taken place, it is unlikely that a claim for a virtual service could be supported.

Consultations, which arise from requests from other providers, would not violate the condition in so far as the patient would have assented to the referral as part of their discussion with the referring provider.

k) Supervision of trainees:

Virtual Care Services are not eligible for payment unless personally rendered by the physician or rendered in accordance with the payment rules regarding supervision of post graduate medical trainees (SOB, GP79 to GP84 with schedule amendments as agreed to by the parties).

The parties agree to the following amendments to General Payment Rule 5 (GP81):

Payment Rules

A. General

….

5. The following services are not eligible for payment to the Supervising Physician when rendered by a Medical Trainee:

a. Case Conferences;

b. Multidisciplinary Cancer Conferences;

c. Provider-to-provider services, including:

    1. Telephone Consultations;

    2. E-Consultations; and

    3. E-Assessments.

d. Virtual Care Services when provided to Hospital Inpatients or patients in an Emergency Department.

The parties agree to the following amendments to definitions (GP79-GP80):

Amendments to the Definition of Supervision (GP79)

Definitions:

For the purposes of this section of the Schedule only, the following Definitions apply:

Supervision:

Supervision is performed by the Supervising Physician and includes the responsibility to guide, observe and assess the educational activities of the Medical Trainee and assures the quality of an insured service while being rendered by the Medical Trainee.

Supervision is only performed:

a. in person, by telephone, or videoconference, the method being consistent with the acuity of the service being rendered by the Medical Trainee as well as the Medical Trainee's level of competence;

….

[Commentary:

The Supervising Physician and the Medical Trainee must be physically present in Ontario.]

Amendments to the Definition of Time-Based Services (GP80):

Definitions:

….

Time-Based Services A Time-Based Service is an insured service described as Psychotherapy, Psychiatric and Counselling, Interviews, Hypnotherapy, Psychiatric Care and Primary Mental Health Care.

l) Minimum time requirements

Only time spent communicating with the patient related to the provision of care is eligible to contribute to minimum time requirements.

m) Referrals for Consultations

Amend Schedule requirements/commentary for all insured consultation services – pg. GP16 of SOB, as follows:

[Commentary 1: Where the visit leading to the referral for consultation has occurred virtually, it would be expected that the referring physician has an established relationship with the patient and that the clinical issue leading to the referral has been assessed in-person within the previous 12 months.]

[Commentary 2: The request would ordinarily also include appropriate clinical information, such as the reason for the referral for consultation, present and past history, physical findings and relevant test results and reports.]

n) Hospital inpatients and LTC Residents

Virtual Care Services are not eligible for payment for services provided to hospital inpatients or LTC residents unless the following requirements have been met:

- The physician is not the patient's assigned MRP for routine care.
- The local hospital/LTC facility does not have a physician on staff and present in the community with the expertise to render the needed service, as verified and documented by the referring physician in the patient’s permanent medical record.
- An in-person assessment by the referring physician must be completed within the 30 days preceding a virtual in-patient specialist consultation to confirm the need for a consultation.

6. Primary Care

a) Core Services:

All new family practitioner Virtual Care Services will be introduced as core services and in-basket for all Primary Care Models. Existing core services selected as eligible for virtual care will remain in basket. These Virtual Care Services would be compensated at the shadow billed rate.

Primary Care Models: Family Health Network, Family Health Organization, Group Health Centre, Rural and Norther Physicians Group Agreement, Blended Salary Model, St. Joseph's Health Centre, Weeneebayko Area Health Authority, GP Focus HIV, GP Focus Care of the Elderly, GP Focus Palliative, Toronto Palliative Care Agreement, Inner City Health Associates (excludes Family Health Groups and Comprehensive Care Models included in Fee for Service).

b) Outside Use:

Virtual Care Services will contribute towards outside use and will be negated for all Primary Care Models with an Access Bonus Payment, at an amount equal to the payment made for outside virtual care services.

c) Premiums, Management Fees and Other Add-Ons:

Premiums, management fees and other add-ons (i.e., after-hours premiums, automated age premiums etc.) are eligible for payment with Virtual Care Services, as set out above. Additionally, Virtual Care Services will contribute towards any thresholds for premiums, management fees or add-ons, as set out above.

d) No Group pooling of Virtual Care Services

Virtual care services will contribute to a physicians' individual fee for service billing ceilings under PEM agreements, with respect to services provided to non-enrolled patients.

e) Requirement for After-Hours:

After-hours must be available to patients in-person, similar to weekday services. The add-on After-Hours Premiums in primary care will be eligible for payment when Virtual Care services are provided during after-hours, on the terms set out above.

7. Virtual Care in Specialist Physician Contracts (Alternate Payment plan (APP) and Alternate Funding Plan (AFP) Agreements)

Virtual Care Services performed by APP/AFP physicians will be shadow billed using the group's applicable shadow billing group number and will be paid at the applicable shadow billing premium rate for that group number.

8. Virtual Urgent Care Centres

Physicians delivering services at an Ontario Health approved pilot Virtual Urgent Care Centre (VUCC) would continue to submit claims using the K-codes until September 30, 2022.

In the event that the decision is made that VUCC shall remain in place beyond this date, the parties will meet to discuss and conclude negotiations with respect to terms and level of payments to physicians in VUCC. In the event the parties are unable to reach agreement, William Kaplan sitting alone will remain seized of this issue.

9. Implementation

a) General

On June 6, 2021 the parties agreed to extend the temporary K Codes used to compensate physicians for Virtual Care (K080, K081, K082, K083), as well as payments for specific premiums/management fees, until September 30, 2022. The terms and conditions for virtual care set out in this agreement will come into effect on September 30, 2022. Should the implementation of those terms and conditions not be completed by September 30, 2022, the K-codes will be further extended as required to enable full transition to this new model of virtual care.

b) Ontario Virtual Care Program

Video visits delivered through OVCP will be transitioned into the OHIP insured framework in accordance with the pricing structure, rates and payment parameters outlined above, and not until such structure, rates and payment parameters are in place.

Appendix A – List of Eligible Fee Codes for Virtual Care: Comprehensive Virtual Care Services

Fee Code	Descriptor	Modality
Services Eligible for Payment When Rendered by Video or Phone		
A001A	MINOR ASSESS. - F.P./G.P.	Video/Phone
A007A	INTERMED.ASSESS/WELL BABY CARE-F.P./G.P./PAED.	Video/Phone
A008A	MINI ASSESSMENT	Video/Phone
A013A	SPECIFIC ASSESS. - ANAES.	Video/Phone
A014A	PARTIAL-ASSESS. -ANAES.	Video/Phone
A020A	DERMATOLOGY - COMPLEX DERMATOLOGY ASSESSMENT	Video/Phone
A023A	SPECIFIC ASSESS. - DERM.	Video/Phone
A024A	PARTIAL-ASSESS. -DERM.	Video/Phone
A033A	SPECIFIC ASSESS. - GEN. SURG.	Video/Phone
A034A	PARTIAL-ASSESS. -GEN. SURG.	Video/Phone
A043A	SPECIFIC ASSESS. - NEURO-SURG.	Video/Phone
A044A	PARTIAL-ASSESS. -NEUROSURG.	Video/Phone
A051A	COMMUNITY MEDICINE- COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A053A	MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A054A	MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A058A	PARTIAL ASSESSMENT	Video/Phone
A063A	SPECIFIC ASSESS. - ORTHO-SURG.	Video/Phone
A064A	PARTIAL-ASSESS. -ORTHO. SURG.	Video/Phone
A071A	GERIATRICS - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A073A	MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A074A	MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A078A	PARTIAL ASSESSMENT	Video/Phone
A083A	SPECIFIC ASSESS. - PLASTIC SURG.	Video/Phone
A084A	PARTIAL-ASSESS. -PLASTIC SURG.	Video/Phone
A093A	SPECIFIC ASSESS. - CARDIO. & THOR. SURG.	Video/Phone
A094A	PARTIAL-ASSESS. -CARDIO. & THOR. SURG.	Video/Phone
A113A	NEUROLOGY - COMPLEX NEUROMUSCULAR ASSESSMENT	Video/Phone
A131A	INTERNAL MEDICINE - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A133A	MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A134A	MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A138A	PARTIAL-ASSESS. -INT- MED.	Video/Phone
A151A	ENDOCRINOLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone

A153A	ENDOCRINOLOGY & METABOLISM - MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A154A	ENDOCRINOLOGY & METABOLISM - MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A158A	ENDOCRINOLOGY & METABOLISM - PARTIAL ASSESSMENT	Video/Phone
A161A	NEPHROLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A163A	NEPHROLOGY - MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A164A	NEPHROLOGY - MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A168A	NEPHROLOGY - PARTIAL ASSESSMENT	Video/Phone
A173A	VASCULAR SURGERY - SPECIFIC ASSESSMENT	Video/Phone
A174A	VASCULAR SURGERY - PARTIAL ASSESSMENT	Video/Phone
A181A	NEUROLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A183A	MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A184A	MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A188A	PARTIAL-ASSESS. -NEUROL.	Video/Phone
A193A	SPECIFIC ASSESS. -PSYCHIATRY	Video/Phone
A194A	PARTIAL-ASSESS. -PSYCH.	Video/Phone
A203A	SPECIFIC ASSESS. -OBS.& GYN.	Video/Phone
A204A	PARTIAL-ASSESS. -OBS. & GYN.	Video/Phone
A221A	GENETIC MINOR ASSESSMENT	Video/Phone
A233A	SPECIFIC ASSESS. - OPHTH.	Video/Phone
A234A	PARTIAL ASSESS. -OPHTH.	Video/Phone
A243A	SPECIFIC ASSESS. - OTO.	Video/Phone
A244A	PARTIAL ASSESS. -OTOL.	Video/Phone
A261A	MINOR ASSESS. - PAED.	Video/Phone
A262A	LEVEL 2 - PAEDIATRIC INTERMEDIATE ASSESSMENT	Video/Phone
A263A	MEDICAL SPECIFIC ASSESSMENT-PAED	Video/Phone
A264A	MEDICAL SPECIFIC RE-ASSESSMENT-PAED	Video/Phone
A283A	LABORATORY MEDICINE MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A284A	LABORATORY MEDICINE PARTIAL ASSESSMENT	Video/Phone
A310A	MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A311A	PHYSICAL MEDICINE AND REHABILITATION - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A313A	MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A318A	PHYSICAL MEDICINE-PARTIAL ASSESSMENT	Video/Phone
A338A	DIAGNOSTIC RADIOLOGY - MINOR ASSESSMENT	Video/Phone
A340A	MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A341A	RADIATION ONCOLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A343A	MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A348A	RADIATION ONCOLOGY-PARTIAL ASSESSMENT	Video/Phone

A353A	SPECIFIC ASSESS. - UROL.	Video/Phone
A354A	PARTIAL ASSESS. -UROL.	Video/Phone
A365A	DIAGNOSTIC RADIOLOGY - SPECIAL INTERVENTIONAL RADIOLOGICAL CONSULTATION	Video/Phone
A411A	GASTROENTEROLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A413A	MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A414A	MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A418A	PARTIAL ASSESS. -GASTROENT.	Video/Phone
A441A	MEDICAL ONCOLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A443A	MEDICAL ONCOLOGY - MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A444A	MEDICAL ONCOLOGY - MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A448A	MEDICAL ONCOLOGY - PARTIAL ASSESSMENT	Video/Phone
A461A	INFECTIOUS DISEASE - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A463A	INFECTIOUS DISEASE - MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A464A	INFECTIOUS DISEASE - MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A468A	INFECTIOUS DISEASE - PARTIAL ASSESSMENT	Video/Phone
A471A	RESPIRATORY DISEASE - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A473A	MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A474A	MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A478A	PARTIAL ASSESS. -RESP. DIS.	Video/Phone
A480A	RHEUMATOLOGY - COMPLEX RHEUMATOLOGY ASSESSMENT	Video/Phone
A481A	RHEUMATOLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A483A	MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A484A	MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A488A	PARTIAL ASSESS. -RHEUMATOL.	Video/Phone
A510A	PHYSICAL MEDICINE AND REHABILITATION - COMPLEX NEUROMUSCULAR ASSESSMENT	Video/Phone
A511A	PHYSICAL MEDICINE AND REHABILITATION -COMPLEX PHYSIATRY ASSESSMENT	Video/Phone
A570A	RESPIRATORY DISEASE - COMPLEX RESPIRATORY ASSESSMENT	Video/Phone
A601A	CARDIOLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A603A	MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A604A	MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A608A	PARTIAL ASSESS. -CARDIOLO.	Video/Phone
A611A	HAEMATOLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A613A	MEDICAL SPECIFIC ASSESSMENT	Video/Phone

A614A	MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A618A	PARTIAL ASSESS. -HAEMATOL.	Video/Phone
A621A	CLINICAL IMMUNOLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A623A	MEDICAL SPECIFIC ASSESSMENT	Video/Phone
A624A	MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A628A	PARTIAL ASSESS. -CLIN. IMMUNOL.	Video/Phone
A632A	NUC. MED. - MINOR ASSESSMENT	Video/Phone
A633A	NUCLEAR MEDICINE-SPECIFIC ASSESSMENT	Video/Phone
A638A	NUCLEAR MEDICINE-PARTIAL ASSESSMENT	Video/Phone
A643A	SPEC.ASSESS. - GEN.THORACIC SURGERY	Video/Phone
A644A	PARTIAL ASSESS.IN OFFICE-GEN.THORACIC SURGERY	Video/Phone
A661A	PAEDIATRICS - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video/Phone
A760A	ENDOCRINOLOGY & METAB - COMPLEX ENDOCRINE NEOPLASTIC DISEASE ASSESSMENT	Video/Phone
A917A	FOCUSED PRACTICE ASSESSMENT - SPORTS MEDICINE	Video/Phone
A920A	MEDICAL MANAGEMENT OF EARLY PREGNANCY - INITIAL VISIT	Video/Phone
A927A	FOCUSED PRACTICE ASSESSMENT - ALLERGY	Video/Phone
A937A	FOCUSED PRACTICE ASSESSMENT - PAIN MANAGEMENT	Video/Phone
A947A	FOCUSED PRACTICE ASSESSMENT - SLEEP MEDICINE	Video/Phone
A957A	FOCUSED PRACTICE ASSESSMENT - ADDICTION MEDICINE	Video/Phone
A967A	FOCUSED PRACTICE ASSESSMENT - GERIATRICS	Video/Phone
H313A	REHABILITATION COUNSELLING	Video/Phone
K002A	INTERVIEWS-RELATIVES ON BEHALF OF PATIENT PER 1/2 HOUR	Video/Phone
K003A	INTERVIEW ON BEHALF OF PATIENT (CASLEG.GUARD) PER 1/2HR.	Video/Phone
K004A	FAMILY PSYCHOTHERAPY-2/MORE MEMBERS-PER 1/2HR.	Video/Phone
K005A	INDIVIDUAL CARE PER 1/2 HR	Video/Phone
K007A	IND. PSYCHOTHERAPY PER HALF HOUR - GP	Video/Phone
K008A	DIAG.INTERVIEW W/CHILD &/OR PARENT-PER 1/2HR.	Video/Phone
K010A	PSYCHOTHERAPY-GROUP-PER MEMBER PER1/2HR 7TH TO 9TH HR	Video/Phone
K012A	GROUP PSYCHOTHERAPY-FOUR PEOPLE PER 1/2 HR PER MEMBER	Video/Phone
K013A	COUNSELLING-ONE OR MORE PEOPLE-PER 1/2HR.	Video/Phone
K014A	COUNSELLING-FOR DONOR/RECIP/RECIP FAMILIES REORGAN TRANSPLA	Video/Phone
K015A	COUNSELLING-RELATIVE ON BEHALF OF PT.SEE PARA.B20 (C)	Video/Phone
K016A	GENETIC ASSESSMENT	Video/Phone
K019A	GP/FP - K019 - 2 PEOPLE	Video/Phone
K020A	GP/FP - K020 3 PEOPLE	Video/Phone
K022A	HIV PRIM CARE INDIVID CARE 1/2 HR OR MAJOR PART	Video/Phone

K023A	PALLIAT CARE SUPPORT INDIVID CARE 1/2 HR OR MAJOR PART	Video/Phone
K024A	GENERAL/FAMILY PRACT. - GR. PSYCHOTHERAPY - 5 PEOPLE	Video/Phone
K025A	GENERAL/FAMILY PRACT. - GR. PSYCHOTHERAPY - 6 TO 12 PEOPLE	Video/Phone
K028A	SEXUALLY TRANSMITTED DISEASE (STD) COUNSELING	Video/Phone
K029A	INSULIN THERAPY SUPPORT	Video/Phone
K030A	DIABETIC MANAGEMENT ASSESSMENT (DMA)	Video/Phone
K033A	COUNSELLING - 1 PT/YR/UNIT	Video/Phone
K037A	FIBROMYALGIA/CHRONIC FATIGUE SYNDROME CARE	Video/Phone
K039A	SMOKING CESSATION FOLLOW-UP	Video/Phone
K040A	GROUP COUNSEL - 2 & PTS WITH NO K013/K040X3	Video/Phone
K041A	GROUP COUNSEL - 2 & PTS. WITH NO K013/K040X3	Video/Phone
K044A	GENETIC FAMILY COUNSELLING	Video/Phone
K122A	INDIVIDUAL DEVELOPMENTAL AND/OR BEHAVIOURAL CARE	Video/Phone
K123A	FAMIILY DEVELOPMENTAL AND/OR BEHAVIOURAL CARE	Video/Phone
K140A	CHRONIC DISEASE SHARED APPOINTMENT-2 PATIENTS	Video/Phone
K141A	CHRONIC DISEASE SHARED APPOINTMENT-3 PATIENTS	Video/Phone
K142A	CHRONIC DISEASE SHARED APPOINTMENT-4 PATIENTS	Video/Phone
K143A	CHRONIC DISEASE SHARED APPOINTMENT-5 PATIENTS	Video/Phone
K144A	CHRONIC DISEASE SHARED APPOINTMENT-6-12 PATIENTS	Video/Phone
K195A	FAMILY PSYCHOTHERAPY-OUT-PATIENTS (2 OR MORE MEMBERS)	Video/Phone
K196A	FAMILY PSYCHIATRIC CARE OUT-PATIENT	Video/Phone
K197A	INDIVIDUAL OUT-PATIENT PSYCHOTHERAPY	Video/Phone
K198A	PSYCHIATRIC CARE OUT-PATIENT	Video/Phone
K203A	GROUP PSYCHOTHERAPY OUT-PATIENT-4 PEOPLE	Video/Phone
K204A	GROUP PSYCHOTHERAPY OUT-PATIENT-5 PEOPLE	Video/Phone
K205A	GROUP PSYCHOTHERAPY OUT-PATIENT-6-12 PEOPLE	Video/Phone
K206A	GROUP PSYCHOTHERAPY OUT-PATIENT-ADDITIONAL UNITS	Video/Phone
K208A	GROUP PSYCHOTHERAPY OUT-PATIENT-2 PEOPLE	Video/Phone
K209A	GROUP PSYCHOTHERAPY OUT-PATIENT-3 PEOPLE	Video/Phone
K222A	GENETIC CARE-PATIENT OR FAMILY	Video/Phone
K623A	GP/FP/PSYCHIATRY - FORM 1 - APPLICATION FOR PSYCHIATRIC ASSESSMENT	Video/Phone
K680A	SUBSTANCE ABUSE-EXTENDED ASSESSMENT	Video/Phone
K887A	GP/FP - CTO INITIATION INCLUDING COMPLETION OF THE CTO FORM AND ALL PRECEDING CTO SERVICES DIRECTLY RELATED TO CTO INITIATION PER UNIT	Video/Phone
K888A	GP/FP - CTO SUPERVISION INCLUDING ALL ASSOCIATED CTO SERVICES EXCEPT THOSE RELATED TO INITIATION OR RENEWAL PER UNIT	Video/Phone

K889A	GP/FP - CTO RENEWAL INCLUDING COMPLETION OF THE CTO FORM AND ALL PRECEDING CTO SERVICES DIRECTLY RELATED TO CTO RENEWAL PER UNIT	Video/Phone
P005A	ANTENATAL PREVENTATIVE HEALTH ASSESSMENT	Video/Phone
Services Eligible for Payment When Rendered by Video Only		
A015A	CONSULT. - ANAES.	Video
A016A	RE-CONSULT. - ANAES.	Video
A025A	CONSULT. - DERM.	Video
A026A	RE-CONSULT. - DERM.	Video
A035A	CONSULT. - GEN. SURG.	Video
A036A	RE-CONSULT. - GEN. SURG.	Video
A045A	CONSULT. - NEURO-SURG.	Video
A046A	RE-CONSULT. - NEURO-SURG	Video
A050A	SPECIAL COMMUNITY MEDICINE CONSULTATION	Video
A055A	COMMUNITY MEDICINE CONSULTATION - OFFICE	Video
A056A	REPEAT CONSULTATION	Video
A065A	CONSULT - ORTHO-SURG.	Video
A066A	RE-CONSULT - ORTHO-SURG.	Video
A075A	CONSULTATION	Video
A076A	REPEAT CONSULTATION	Video
A085A	CONSULT - PLASTIC SURG.	Video
A086A	RE-CONSULT - PLASTIC SURG.	Video
A095A	CONSULT - CARDIO. & THOR. SURG.	Video
A096A	RE-CONSULT - CARDIO. & THOR. SURG.	Video
A130A	COMPREHENSIVE INTERNAL MEDICINE CONSULTATION	Video
A135A	CONSULT - INTERNAL MED.	Video
A136A	RE-CONSULT - INTERNAL MED.	Video
A150A	COMPREHENSIVE ENDOCRINOLOGY CONSULTATION	Video
A155A	ENDOCRINOLOGY & METABOLISM - CONSULTATION	Video
A156A	ENDOCRINOLOGY & METABOLISM - REPEAT CONSULTATION	Video
A160A	COMPREHENSIVE NEPHROLOGY CONSULTATION	Video
A165A	NEPHROLOGY- CONSULTATION	Video
A166A	NEPHROLOGY - REPEAT CONSULTATION	Video
A175A	VASCULAR SURGERY - CONSULTATION	Video
A176A	VASCULAR SURGERY - REPEAT CONSULTATION	Video
A180A	NEUROLOGY - 75 MINUTE CONSULT	Video
A185A	CONSULT - NEUROL.	Video
A186A	RE-CONSULT - NEUROL.	Video
A190A	SPECIAL PSYCHIATRIC CONSULTATION	Video

A191A	CONSULT INTERVIEW W/ CAREGIVER OF PAT 65 YRS+ OR W/ DEMENTIA	Video
A192A	CONSULT INTERVIEW PATIENT 65 YRS+ OR LESS WITH DEMENTIA	Video
A195A	CONSULT - PSYCHIATRY	Video
A196A	RE-CONSULT - PSYCHIATRY	Video
A197A	CONSULT-INTERVIEW WITH PARENTS-PSYCHIATRY	Video
A198A	CONSULT-INTERVIEW WITH CHILD-PSYCHIATRY	Video
A205A	CONSULT - OBS.& GYN.	Video
A206A	RE-CONSULT - OBS.& GYN.	Video
A220A	GENETICS - 75 MINUTE CONSULT	Video
A223A	GENETICS - 90 MINUTE CONSULT	Video
A225A	CONSULTATION	Video
A226A	REPEAT CONSULTATION	Video
A235A	CONSULT - OPHTH.	Video
A236A	RE-CONSULT - OPHTH.	Video
A245A	CONSULT - OTO.	Video
A246A	RE-CONSULT - OTO.	Video
A253A	OPTOMETRIST-REQUESTED ASSESSMENT (ORA)	Video
A255A	ENDOCRINOLOGY & METABOLISM - LIMITED CONSULTATION	Video
A256A	SPECIAL OPTOMETRIST-REQUESTED ASSESSMENT	Video
A260A	PAEDIATRICS - 75 MINUTE CONSULT	Video
A265A	CONSULT - PAED.	Video
A266A	RE-CONSULT - PAED.	Video
A275A	INFECTIOUS DISEASE - LIMITED CONSULTATION	Video
A285A	CONSULT - PATHOL./MICROBIOL./MED.BIOCH.	Video
A286A	RE-CONSULT/LT- CONSULT-PATHOL./MICROBIOL./MED.BIOCH.	Video
A315A	CONSULT - PHYS. MED. & REHAB.	Video
A316A	RE-CONSULT - PHYS. MED. & REHAB.	Video
A325A	LIMITED CONSULTATION	Video
A335A	CONSULT - DIAG. RADIOLOGY	Video
A345A	CONSULT - RADIATION ONCOLOGY	Video
A346A	RE-CONSULT - RADIATION ONCOLOGY	Video
A355A	CONSULT - UROL.	Video
A356A	RE-CONSULT - UROL.	Video
A375A	LIMITED CONSULTATION - GERIATRICS	Video
A385A	LIMITED CONSULT - NEUROL.	Video
A395A	LIMITED CONSULT - PSYCHIATRY	Video
A400A	COMPREHENSIVE COMMUNITE MEDICINE CONSULTATION	Video
A405A	COMMUNITY MEDICINE LIMITED CONSULTATION-OFFICE	Video

A415A	CONSULT - GASTROENTEROLOGY	Video
A416A	RE-CONSULT - GASTROENTEROLOGY	Video
A425A	COMPREHENSIVE PHYSICAL MEDICINE & REHABILITATION CONSULT	Video
A435A	LIMITED CONSULT - INTERNAL MED.	Video
A445A	MEDICAL ONCOLOGY - CONSULTATION	Video
A446A	MEDICAL ONCOLOGY - REPEAT CONSULTATION	Video
A460A	COMPREHENSIVE INFECTIOUS DISEASES CONSULTATION	Video
A465A	INFECTIOUS DISEASE - CONSULTATION	Video
A466A	INFECTIOUS DISEASE - REPEAT CONSULTATION	Video
A470A	COMPREHENSIVE RESPIRATORY DISEASES CONSULTATION	Video
A475A	CONSULT - RESPIRATORY DISEASE	Video
A476A	RE-CONSULT - RESPIRATORY DISEASE	Video
A485A	CONSULT - RHEUMATOLOGY	Video
A486A	RE-CONSULT - RHEUMATOLOGY	Video
A515A	LIMITED CONSULT - PHYS. MED. & REHAB.	Video
A525A	LIMITED CONSULT - CLINICAL IMMUNOLOGY	Video
A545A	LIMITED CONSULT - GASTROENTEROLOGY	Video
A565A	LIMITED CONSULT. - PAED.	Video
A575A	LIMITED CONSULT. - RESPIRATORY DISEASE	Video
A586A	REPEAT CONSULT	Video
A590A	COMPREHENSIVE RHEUMATOLOGY CONSULTATION	Video
A595A	LIMITED CONSULT. - RHEUMATOLOGY	Video
A600A	COMPREHENSIVE CARDIOLOGY CONSULTATION	Video
A605A	CONSULT. - CARDIOLOGY	Video
A606A	RE-CONSULT. - CARDIOLOGY	Video
A615A	CONSULT. - HAEMATOLOGY	Video
A616A	RE-CONSULT. - HAEMATOLOGY	Video
A625A	CONSULT. - CLINICAL IMMUNOLOGY	Video
A626A	RE-CONSULT. - CLINICAL IMMUNOLOGY	Video
A635A	NUCLEAR MEDICINE-CONSULTATION	Video
A636A	NUCLEAR MEDICINE-REPEAT CONSULTATION	Video
A645A	GENERAL THORACIC SURGERY-CONSULTATION	Video
A646A	REPEAT CONSULTATION – IN OFFICE - GEN. THORACIC SURGERY	Video
A655A	LIMITED CONSULT. - HAEMATOLOGY	Video
A662A	PAEDIATRICS - 90 MINUTE CONSULT	Video
A665A	PRENATAL CONSULT. - PAED.	Video
A667A	NEURODEVELOPMENTAL CONSULTATION - OFFICE	Video
A675A	LIMITED CONSULT.CARDIOLOGY	Video

A680A	GP/FP - ADDICTION MEDICINE INITIAL ASSESSMENT -INITIAL ASSESSMENT – SUBSTANCE ABUSE	Video
A682A	EXTENDED SPECIAL NEUROLOGY CONSULTATION	Video
A695A	PSYCHIATRIC NEURODEVELOPMENTAL CONSULTATION	Video
A735A	NUCLEAR MEDICINE-DIAGNOSTIC CONSULTATION	Video
A745A	LIMITED CONSULT. - RADIATION ONCOLOGY	Video
A765A	CONSULT (MED. SPECIALIST) PATIENT 16 YEARS OF AGE AND UNDER	Video
A770A	GERIATRIC 90 MINUTE CONSULT	Video
A775A	COMPREHENSIVE GERIATRIC CONSULT	Video
A795A	GERIATRIC PSYCHIATRY CONSULTATION	Video
A800A	GENETICS - MIDWIFE-REQUESTED GENETIC ASSESSMENT	Video
A801A	COMPREHENSIVE MIDWIFE-REQUESTED GENETIC ASSESSMENT	Video
A802A	GENETICS - EXTENDED MIDWIFE-REQUESTED GENETIC ASSESSMENT	Video
A835A	SPECIAL NUCLEAR MEDICINE CONSULTATION	Video
A845A	MEDICAL ONCOLOGY - LIMITED CONSULTATION	Video
A865A	NEPHROLOGY - LIMITED CONSULTATION	Video
A921A	MEDICAL MANAGEMENT OF EARLY PREGNANCY - SUBSEQUENT VISIT	Video
A935A	PREAMBLE-SPECIAL SURGICAL CONSULT.	Video
A945A	GEN./FAM.PRACT.SPECIAL PALLIATIVE CARE CONSULTATION	Video
C010A	GP/FP - SUPPORTIVE CARE - PER VISIT	Video
C013A	ANAESTHESIA - SPECIFIC ASSESSMENT	Video
C014A	ANAESTHESIA - SPECIFIC RE-ASSESSMENT	Video
C015A	ANAESTHESIA - CONSULTATION	Video
C016A	ANAESTHESIA - REPEAT CONSULTATION	Video
C020A	DERMATOLOGY - COMPLEX DERMATOLOGY ASSESSMENT	Video
C023A	DERMATOLOGY - SPECIFIC ASSESSMENT	Video
C024A	DERMATOLOGY - SPECIFIC RE-ASSESSMENT	Video
C025A	DERMATOLOGY - CONSULTATION	Video
C026A	DERMATOLOGY - REPEAT CONSULTATION	Video
C033A	GENERAL SURGERY - SPECIFIC ASSESSMENT	Video
C034A	GENERAL SURGERY- SPECIFIC RE-ASSESSMENT	Video
C035A	GENERAL SURGERY- CONSULTATION	Video
C036A	GENERAL SURGERY- REPEAT CONSULTATION	Video
C043A	NEUROSURGERY - SPECIFIC ASSESSMENT	Video
C044A	NEUROSURGERY - SPECIFIC RE-ASSESSMENT	Video
C045A	NEUROSURGERY - CONSULTATION	Video
C046A	NEUROSURGERY - REPEAT CONSULTATION	Video

C051A	COMMUNITY MEDICINE - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C053A	COMMUNITY MEDICINE - MEDICAL SPECIFIC ASSESSMENT	Video
C054A	COMMUNITY MEDICINE - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C055A	COMMUNITY MEDICINE - CONSULTATION	Video
C063A	ORTHOPAEDIC SURGERY - SPECIFIC ASSESSMENT	Video
C064A	ORTHOPAEDIC SURGERY - SPECIFIC RE-ASSESSMENT	Video
C065A	ORTHOPAEDIC SURGERY - CONSULTATION	Video
C066A	ORTHOPAEDIC SURGERY - REPEAT CONSULTATION	Video
C071A	GERIATRICS - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C073A	GERIATRICS - MEDICAL SPECIFICAL ASSESSMENT	Video
C074A	GERIATRICS - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C075A	GERIATRICS - CONSULTATION	Video
C076A	GERIATRICS - REPEAT CONSULTATION	Video
C083A	PLASTIC SURGERY SUBSEQUENT VISITS - SPECIFIC ASSESSMENT	Video
C084A	PLASTIC SURGERY - SPECIFIC RE-ASSESSMENT	Video
C085A	PLASTIC SURGERY - SUBSEQUENT VISITS - CONSULTATION	Video
C086A	PLASTIC SURGERY - SUBSEQUENT VISITS - REPEAT CONSULTATION	Video
C093A	CARDIAC SURGERY - SPECIFIC ASSESSMENT	Video
C094A	CARDIAC SURGERY - SPECIFIC RE-ASSESSMENT	Video
C095A	CARDIAC SURGERY - CONSULTATION	Video
C096A	CARDIAC SURGERY - REPEAT CONSULTATION	Video
C113A	NEUROLOGY - COMPLEX NEUROMUSCULAR ASSESSMENT	Vide
C130A	INTERNAL MEDICINE - COMPREHENSIVE INTERNAL MEDICINE CONSULTATION	Video
C131A	INTERNAL MEDICINE - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C133A	INTERNAL MEDICINE - MEDICAL SPECIFIC ASSESSMENT	Video
C134A	INTERNAL MEDICINE - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C135A	INTERNAL MEDICINE - CONSULTATION	Video
C136A	INTERNAL MEDICINE - REPEAT CONSULTATION	Video
C150A	ENDOCRINOLOGY & METAB - COMPREHENSIVE ENDOCRINOLOGY & METAB CONSULTATION	Video
C151A	ENDOCRINOLOGY & METAB - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C153A	ENDOCRINOLOGY & METAB - MEDICAL SPECIFIC ASSESSMENT	Video
C154A	ENDOCRINOLOGY & METAB - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C155A	ENDOCRINOLOGY & METAB - CONSULTATION	Video
C156A	ENDOCRINOLOGY & METAB - REPEAT CONSULTATION	Video

C160A	NEPHROLOGY - COMPREHENSIVE NEPHROLOGY CONSULTATION	Video
C161A	NEPHROLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C163A	NEPHROLOGY - MEDICAL SPECIFIC ASSESSMENT	Video
C164A	NEPHROLOGY - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C165A	NEPHROLOGY - CONSULTATION	Video
C166A	NEPHROLOGY - REPEAT CONSULTATION	Video
C173A	VASCULAR SURGERY - SPECIFIC ASSESSMENT	Video
C174A	VASCULAR SURGERY - SPECIFIC RE-ASSESSMENT	Video
C175A	VASCULAR SURGERY - CONSULTATION	Video
C176A	VASCULAR SURGERY - REPEAT CONSULTATION	Video
C180A	NEUROLOGY - SPECIAL NEUROLOGY CONSULTATION	Video
C181A	NEUROLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C183A	NEUROLOGY - MEDICAL SPECIFIC ASSESSMENT	Video
C184A	NEUROLOGY - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C185A	NEUROLOGY - CONSULTATION	Video
C186A	NEUROLOGY - REPEAT CONSULTATION	Video
C190A	PSYCHIATRY - SPECIAL PSYCHIATRIC CONSULTATION	Video
C193A	PSYCHIATRY - SPECIFIC ASSESSMENT	Video
C194A	PSYCHIATRY - SPECIFIC RE-ASSESSMENT	Video
C196A	PSYCHIATRY - REPEAT CONSULTATION	Video
C203A	OBSTETRICS AND GYNAECOLOGY - SPECIFIC ASSESSMENT	Video
C204A	OBSTETRICS AND GYNAECOLOGY - SPECIFIC RE-ASSESSMENT	Video
C205A	OBSTETRICS AND GYNAECOLOGY - CONSULTATION	Video
C206A	OBSTETRICS AND GYNAECOLOGY - REPEAT CONSULTATION	Video
C220A	GENETICS - SPECIAL GENETIC CONSULTATION	Video
C223A	GENETICS - EXTENDED SPECIAL GENETIC CONSULTATION*	Video
C225A	GENETICS - CONSULTATION	Video
C226A	GENETICS - REPEAT CONSULTATION	Video
C233A	OPHTHALMOLOGY - SPECIFIC ASSESSMENT	Video
C234A	OPHTHALMOLOGY - SPECIFIC RE-ASSESSMENT	Video
C235A	OPHTHALMOLOGY - CONSULTATION	Video
C236A	OPHTHALMOLOGY - REPEAT CONSULTATION	Video
C243A	OTOLARYNGOLOGY - SPECIFIC ASSESSMENT	Video
C244A	OTOLARYNGOLOGY- SPECIFIC RE-ASSESSMENT	Video
C245A	OTOLARYNGOLOGY - CONSULTATION	Video
C246A	OTOLARYNGOLOGY - REPEAT CONSULTATION	Video
C255A	ENDOCRINOLOGY & METAB- LIMITED CONSULTATION	Video
C260A	PAEDIATRICS- SPECIAL PAEDIATRIC CONSULTATION	Video
C263A	PAEDIATRICS - MEDICAL SPECIFIC ASSESSMENT	Video

C264A	PAEDIATRICS - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C265A	PAEDIATRICS - CONSULTATION	Video
C266A	PAEDIATRICS - REPEAT CONSULTATION	Video
C275A	INFECTIOUS DISEASE - LIMITED CONSULTATION	Video
C283A	LABORATORY MEDICINE - MEDICAL SPECIFIC ASSESSMENT	Video
C285A	LABORATORY MEDICINE - CONSULTATION	Video
C286A	LABORATORY MEDICINE - LIMITED CONSULTATION	Video
C311A	PHYSICAL MEDICINE AND REHABILITATION - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C313A	PHYSICAL MEDICINE AND REHABILITATION - MEDICAL SPECIFIC ASSESSMENT	Video
C314A	PHYSICAL MEDICINE AND REHABILITATION - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C315A	PHYSICAL MEDICINE AND REHABILITATION - CONSULTATION	Video
C316A	PHYSICAL MEDICINE AND REHABILITATION- REPEAT CONSULTATION	Video
C325A	GENETICS - LIMITED CONSULTATION	Video
C335A	DIAGNOSTIC RADIOLOGY - CONSULTATION	Video
C341A	RADIATION ONCOLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C343A	RADIATION ONCOLOGY - MEDICAL SPECIFIC ASSESSMENT	Video
C344A	RADIATION ONCOLOGY - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C345A	RADIATION ONCOLOGY - CONSULTATION	Video
C346A	RADIATION ONCOLOGY - REPEAT CONSULTATION	Video
C353A	UROLOGY - SPECIFIC ASSESSMENT	Video
C354A	UROLOGY - SPECIFIC RE-ASSESSMENT	Video
C355A	UROLOGY - CONSULTATION	Video
C356A	UROLOGY - REPEAT CONSULTATION	Video
C365A	DIAGNOSTIC RADIOLOGY - SPECIAL INTERVENTIONAL RADIOLOGICAL CONSULTATION	Video
C375A	GERIATRICS - LIMITED CONSULTATION	Video
C385A	NEUROLOGY - LIMITED CONSULTATION	Video
C395A	PSYCHIATRY - LIMITED CONSULTATION	Video
C411A	GASTROENTEROLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C413A	GASTROENTEROLOGY - MEDICAL SPECIFIC ASSESSMENT	Video
C414A	GASTROENTEROLOGY - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C415A	GASTROENTEROLOGY - CONSULTATION	Video
C416A	GASTROENTEROLOGY - REPEAT CONSULTATION	Video
C425A	PHYSICAL MEDICINE AND REHABILITATION - COMPREHENSIVE PHYSICAL MEDICINE AND REHABILITATION CONSULTATION	Video
C435A	INTERNAL MEDICINE - LIMITED CONSULTATION	Video

C441A	MEDICAL ONCOLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C443A	MEDICAL ONCOLOGY - MEDICAL SPECIFIC ASSESSMENT	Video
C444A	MEDICAL ONCOLOGY - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C445A	MEDICAL ONCOLOGY - CONSULTATION	Video
C446A	MEDICAL ONCOLOGY - REPEAT CONSULTATION	Video
C460A	INFECTIOUS DISEASE - COMPREHENSIVE INFECTIOUS DISEASE CONSULTATION	Video
C461A	INFECTIOUS DISEASE - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C463A	INFECTIOUS DISEASE - MEDICAL SPECIFIC ASSESSMENT	Video
C464A	INFECTIOUS DISEASE - MEDICAL SPECIFIC RE- ASSESSMENT	Video
C465A	INFECTIOUS DISEASES - CONSULTATION	Video
C466A	INFECTIOUS DISEASE - REPEAT CONSULTATION	Video
C470A	RESPIRATORY DISEASE - COMPREHENSIVE RESPIRATORY DISEASE CONSULTATION	Video
C471A	RESPIRATORY DISEASE - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C473A	RESPIRATORY DISEASE - MEDICAL SPECIFIC ASSESSMENT	Video
C474A	RESPIRATORY DISEASE - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C475A	RESPIRATORY DISEASE - CONSULTATION	Video
C476A	RESPIRATORY DISEASE - REPEAT CONSULTATION	Video
C480A	RHEUMATOLOGY - COMPLEX RHEUMATOLOGY ASSESSMENT	Video
C481A	RHEUMATOLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C483A	RHEUMATOLOGY - MEDICAL SPECIFIC ASSESSMENT	Video
C484A	RHEUMATOLOGY - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C485A	RHEUMATOLOGY - CONSULTATION	Video
C486A	RHEUMATOLOGY - REPEAT CONSULTATION	Video
C510A	PHYSICAL MEDICINE AND REHABILITATION - COMPLEX NEUROMUSCULAR ASSESSMENT	Video
C511A	PHYSICAL MEDICINE AND REHABILITATION - COMPLEX PHYSIATRY ASSESSMENT	Video
C515A	PHYSICAL MEDICINE AND REHABILITATION - LIMITED CONSULTATION	Video
C545A	GASTROENTEROLOGY - LIMITED CONSULTATION	Video
C565A	PAEDIATRICS - LIMITED CONSULTATION	Video
C570A	RESPIRATORY DISEASE - COMPLEX RESPIRATORY ASSESSMENT	Video
C575A	RESPIRATORY DISEASE - LIMITED CONSULTATION	Video
C585A	LABORATORY MEDICINE - DIAGNOSTIC CONSULTATION	Video
C586A	LABORATORY MEDICINE - REPEAT CONSULTATION	Video
C590A	RHEUMATOLOGY - COMPREHENSIVE RHEUMATOLOGY CONSULTATION	Video

C595A	RHEUMATOLOGY - LIMITED CONSULTATION	Video
C600A	CARDIOLOGY - COMPREHENSIVE CARDIOLOGY CONSULTATION	Video
C601A	CARDIOLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C603A	CARDIOLOGY - MEDICAL SPECIFIC ASSESSMENT	Video
C604A	CARDIOLOGY - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C605A	CARDIOLOGY - CONSULTATION	Video
C606A	CARDIOLOGY - REPEAT CONSULTATION	Video
C611A	HAEMATOLOGY - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C613A	HAEMATOLOGY - MEDICAL SPECIFIC ASSESSMENT	Video
C614A	HAEMATOLOGY - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C615A	HAEMATOLOGY - CONSULTATION	Video
C616A	HAEMATOLOGY - REPEAT CONSULTATION	Video
C623A	CLINICAL IMMUNOLOGY - MEDICAL SPECIFIC ASSESSMENT	Video
C624A	CLINICAL IMMUNOLOGY - MEDICAL SPECIFIC RE-ASSESSMENT	Video
C625A	CLINICAL IMMUNOLOGY - - CONSULTATION	Video
C626A	CLINICAL IMMUNOLOGY - REPEAT CONSULTATION	Video
C635A	NUC. MED. - CONSULTATION	Video
C643A	GENERAL THORACIC SURGERY - SPECIFIC ASSESSMENT	Video
C644A	GENERAL THORACIC SURGERY - SPECIFIC RE-ASSESSMENT	Video
C645A	GENERAL THORACIC SURGERY - CONSULTATION	Video
C646A	GENERAL THORACIC SURGERY - REPEAT CONSULTATION	Video
C655A	HAEMATOLOGY - LIMITED CONSULTATION	Video
C661A	PAEDIATRICS - COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT	Video
C662A	PAEDIATRICS - EXTENDED SPECIAL PAEDIATRIC CONSULTATION - SUBJECT TO THE SAME CONDITIONS AS A662	Video
C665A	PAEDIATRICS - PRENATAL CONSULTATION	Video
C667A	PAEDIATRICS - NEURODEVELOPMENTAL CONSULTATION	Video
C675A	CARDIOLOGY - LIMITED CONSULTATION	Video
C680A	GP/FP - ADDICTION MEDICINE INITIAL ASSESSMENT – SUBSTANCE ABUSE	Video
C682A	NEUROLOGY - EXTENDED SPECIAL NEUROLOGY CONSULTATION	Video
C695A	PSYCHIATRY - NEURODEVELOPMENTAL CONSULTATION	Video
C735A	NUC. MED. - DIAGNOSTIC CONSULTATION	Video
C745A	RADIATION ONCOLOGY - LIMITED CONSULTATION	Video
C760A	ENDOCRINOLOGY - COMPLEX ENDOCRINE NEOPLASTIC DISEASE ASSESSMENT	Video
C765A	MEDICAL SPECIALIST (13, 15, 16, 34, 41, 44, 46, 47, 48, 60, 61, 62) - CONSULTATION, PATIENT 16 YEARS OF AGE AND UNDER	Video
C770A	GERIATRICS - EXTENDED COMPREHENSIVE GERIATRIC CONSULTATION	Video

C775A	GERIATRICS - COMPREHENSIVE GERIATRIC CONSULTATION	Video
C795A	PSYCHIATRY - GERIATRIC PSYCHIATRIC CONSULTATION	Video
C845A	MEDICAL ONCOLOGY - LIMITED CONSULTATION	Video
C865A	NEPHROLOGY - LIMITED CONSULTATION	Video
C895A	PSYCHIATRY - CONSULTATION	Video
C935A	SPECIAL SURGICAL CONSULTATION (03, 04, 06, 08, 09, 17, 20, 23, 24, 35, 64)	Video
C945A	GP/FP - SPECIAL PALLIATIVE CARE CONSULTATION	Video
K630A	PSYCHIATRIC CONSULTATION EXTENSION	Video
W025A	DERMATOLOGY - CONSULTATION	Video
W026A	DERMATOLOGY - REPEAT CONSULTATION	Video
W075A	GERIATRICS - CONSULTATION	Video
W076A	GERIATRICS - REPEAT CONSULTATION	Video
W130A	INTERNAL & OCCUPATIONAL MEDICINE - COMPREHENSIVE INTERNAL MEDICINE CONSULTATION	Video
W150A	ENDOCRINOLOGY & METAB - COMPREHENSIVE ENDOCRINOLOGY & METAB CONSULTATION	Video
W155A	ENDOCRINOLOGY & METAB - CONSULTATION	Video
W156A	ENDOCRINOLOGY & METAB - REPEAT CONSULTATION	Video
W165A	NEPHROLOGY - CONSULTATION	Video
W185A	NEUROLOGY - CONSULTATION	Video
W190A	PSYCHIATRY - SPECIAL PSYCHIATRIC CONSULTATION	Video
W196A	PSYCHIATRY - REPEAT CONSULTATION	Video
W235A	INTERNAL AND OCCUPATIONAL MEDICINE - CONSULTATION	Video
W236A	INTERNAL AND OCCUPATIONAL MEDICINE - REPEAT CONSULTATION	Video
W275A	INFECTIOUS DISEASE - LIMITED CONSULTATION	Video
W310A	PHYSICAL MEDICINE AND REHABILITATION - LIMITED CONSULTATION	Video
W355A	UROLOGY - CONSULTATION	Video
W356A	UROLOGY - REPEAT CONSULTATION	Video
W375A	GERIATRICS- LIMITED CONSULTATION	Video
W395A	PSYCHIATRY - LIMITED CONSULTATION	Video
W425A	PHYSICAL MEDICINE AND REHABILITATION - COMPREHENSIVE PHYSICAL MEDICINE AND REHABILITATION CONSULTATION	Video
W435A	INT & OCC MED - LIMITED CONSULTATION	Video
W465A	INFECTIOUS DISEASE - CONSULTATION	Video
W466A	INFECTIOUS DISEASE - REPEAT CONSULTATION	Video
W510A	PHYSICAL MEDICINE AND REHABILITATION - COMPLEX NEUROMUSCULAR ASSESSMENT	Video
W511A	PHYSICAL MEDICINE AND REHABILITATION - COMPLEX PHYSIATRY ASSESSMENT	Video
W515A	PHYSICAL MEDICINE AND REHABILITATION - CONSULTATION	Video

W516A	PHYSICAL MEDICINE AND REHABILITATION - REPEAT CONSULTATION	Video
W535A	OPHTHALMOLOGY - CONSULTATION	Video
W770A	GERIATRIC - EXTENDED COMPREHENSIVE GERIATRIC CONSULTATION	Video
W775A	GERIATRICS - COMPREHENSIVE GERIATRIC CONSULTATION	Video
W795A	PSYCHIATRY - GERIATRIC PSYCHIATRIC CONSULTATION	Video
W895A	PSYCHIATRY - CONSULTATION	Video
NEW: Www1	MIDWIFE-REQUESTED ASSESSMENT (MRA)	Video
NEW: Www2	MIDWIFE-REQUESTED SPECIAL ASSESSMENT (MRSA)	Video
NEW: Www3	MIDWIFE-REQUESTED ANAESTHESIA ASSESSMENT (MRAA)	Video
NEW: Zzz1	GP FOCUSED PRACTICE DESIGNATED CONSULTATION	Video
NEW: Zzz2	GP FOCUSED PRACTICE DESIGNATED REPEAT CONSULTATION	Video
NEW: Zzz3	GP FOCUSED PRACTICE DESIGNATED LIMITED CONSULTATION	Video
NEW: Zzz4	GP FOCUSED PRACTICE DESIGNATED SPECIAL CONSULTATION	Video
NEW: Zzz5	GP FOCUSED PRACTICE DESIGNATED COMPREHENSIVE CONSULTATION	Video

Appendix B – List of Eligible Fee Codes for virtual care: Limited Virtual Care Services

Fee Code	Descriptor	Modality
NEW: Xxx1	LIMITED VIRTUAL CARE SERVICE - VIDEO	Video
NEW: Xxx2	LIMITED VIRTUAL CARE SERVICE - PHONE	Phone

10. Secure Messaging proof-of-Concept Pilot

The OMA understands that the Ministry will be establishing a pilot for asynchronous messaging, on the terms set out below. Both parties agree that the price and compensation structure of this pilot is without prejudice to either party's position as to the appropriate compensation and other terms for any future agreed or arbitrated OHIP insured model for asynchronous messaging, and will not be relied on in any future mediation or arbitration by either party.

a) Proposed Initiative

Introduce a time-limited pilot compensation model for Secure Messaging (SM) (as uninsured services) within the Ontario Virtual Care Program (OVCP) as a proof-of-concept (PoC) for the purposes of increasing access to care and gathering further evidence on the use of SM on a larger scale in Ontario than has been possible to date.

The SM PoC will be introduced for a period of 2 years (e.g. October 1, 2022 to September 31, 2024) within OVCP. Physicians will be provided with 3 months' notice prior to the launch of the PoC in order to register within OVCP. All physicians part of OVCP upon the commencement of the PoC will be eligible to enroll in the PoC.
The proposed remuneration model has leveraged insights from the Enhanced Access to Primary Care (EAPC) pilot and generally aligns with the remuneration principles for phone and video Virtual Care Services. The SM Service will be introduced within OVCP to allow physicians to resolve patient health issues via asynchronous secure messages when clinically appropriate within an existing patient-provider relationship (see remuneration model for details).

b) Eligibility Requirements and Payment Rules

Introduce a secure messaging proof-of-concept for a period of 2 years (e.g., October 1, 2022 to September 31, 2024) within the OVCP. The following eligibility requirements and payment rules would apply:

i. Physicians may participate if they:

- Are OVCP registrants.
    - SM Service will not be limited to any type of physician; however, remuneration will reflect the physician's payment model.
    - Physicians will be given 3 months' notice prior to PoC launch to allow them to join OVCP.
    - Physicians registered in OVCP by the start of the PoC will be able to enroll in the PoC.
    - OVCP physicians must enroll in the PoC within the first 3 months of the PoC (e.g., by December 31, 2022).
- Agree to participate in review and evaluation of SM billing activity within the PoC to inform lessons learned from the PoC structure.
- Agree to bill for the SM Service only within the scope of the PoC (i.e., not permitted to charge patients directly for any SM service).
- All PoC eligible SM Services must be accompanied by a claim submission.

c) Physicians (both family physicians and specialists) will be eligible for SM Service remuneration if offered within an existing/ongoing patient-physician relationship, which is defined as:

i. The patient having had at least one insured service with a direct physical encounter with the physician (Family Physician or Royal College specialist physician) in the preceding 24-months, or

ii. Where a physician provides services to a patient who has signed the Ministry's Patient Enrolment and Consent to

Release Personal Health Information form and is enrolled to that physician or another physician within the same group (who is signatory/locum to a Ministry alternate funding plan agreement)

d) For payment purposes the SM Service must be personally rendered by the physician.

e) Both the physician and patient must be physically located in Ontario at the time the SM Service is provided.

f) The SM Service must be initiated by the patient or the patient's representative, or if the SM Service represents a medically necessary follow-up to an in-person or virtual visit initiated by the patient or the patient's representative.

g) The SM Service must be documented on the patient's medical record.

h) Premiums, management fees, and other add-ons are not payable with the SM Service. Additionally, the SM Service will not contribute towards any thresholds for premiums, management fees, or add-ons.

i) In-person or appropriate alternate Virtual Care Services (e.g., phone or video) must be made available by the physician providing the SM Service within a clinically appropriate timeframe if it becomes apparent during the SM Service that an in-person or alternative virtual visit is medically necessary.

j) Physicians will only be compensated for the SM Service that is provided through virtual visit solutions that have received verified status for secure messaging through the Virtual Visit Verification process led by Ontario Health.

k) Two months prior to implementation of the SM Service within OVCP, the Ministry and Ontario Health will assess the status of the list of verified solutions to ensure there is a sufficient list of

vendors whose solutions support secure messaging functionality (in addition to videoconferencing):

i. Minimum of 15 verified solutions are publicly listed, including larger vendors, such as: Zoom, MS Teams, Telus, Cisco Webex, VivifyGo, and SeamlessMD.

If the list has not met these requirements, the Ministry will target communication to the larger vendors and provide clear timelines for upcoming billing policy changes to OVCP to encourage their participation.

Implementation details will be discussed at a later date.

l) Remuneration

i. Definition

"SM Service" is defined as a thread of secure messages (i.e., greater than one message and encompassing all messages related to the original health issue), transmitted between a patient or patient representative and a participating physician using a verified virtual visit solution (verified for secure messaging functionality) that originates from a single asynchronous health service.

A SM Service is a communication method in which a patient or patient representative and physician exchange messages about a particular medical issue

Each SM Service involves a minimum of one message sent by both the physician and patient or patient representative.

ii. Details

Payment Type	List of Eligible (Billable) SM Services	List of Ineligible (Non-Billable) SM Services	Physician Pay Rate
SM Service Management Payment Flat fee paid to physicians who achieve a minimum number of asynchronous secure message threads as permitted in the PoC within the SM Service per month/ physician.	Asynchronous secure messages with a patient or patient representative about the patient's health issues that are clinically appropriate to resolve via SM	Messages that: - Communicate test results - Pertain to scheduling visits or conducting other administrative tasks - Renew prescriptions	Monthly Management Fee Payment Tiers[1]: - Minimum 15 SM Services = $150 per month - Minimum 30 SM Services = $300 per month - Minimum 45 SM Services = $450 per month
1 For physicians in a capitated payment model, the SM Service will be considered an excluded uninsured service and will be paid at the primary care shadow billed rate. For further details on primary care enrollment models and specialist APP & AFP specific rules, see below.			

m) Secure Messaging in Primary Care Enrolment Models (PEMs)

Secure messaging for physicians in primary care models listed below will be an excluded non-core service with the pricing reflective of the primary care shadow billed rate.

Primary Care Models: Family Health Network, Family Health Organization, Group Health Centre, Rural and Northern Physicians Group Agreement, Blended Salary Model, St. Joseph's Health Centre, Weeneebayko Area Health Authority, GP Focus HIV, GP Focus Care of the Elderly, GP Focus Palliative, Toronto Palliative Care Agreement, Inner City Health Associates (excludes Family Health Groups and Comprehensive Care Models included in Fee for Service).

All locum physicians, Family Health Group (FHG), and Comprehensive Care Model (CCM) signatory providers will be treated as Fee for Service physicians and receive the full SM Service Management Payment amount in the SM proof-of-concept (i.e., $300 if the minimum of 30 SM services/month is achieved).

Weekday Access for Patients – FHO: Secure messaging services will not contribute to minimum weekly patient encounters.

n) Secure Messaging in Specialist Physician Contracts (APP & AFP Agreements)

Secure Messaging performed by APP/AFP physicians will be shadow billed using the applicable shadow billing group number and will be paid at the applicable shadow billing premium rate for that group number.

C. PRIMARY CARE

1. Managed Entry

Effective April 1, 2022, the Ministry agrees to increase the FHO complement by 480 physicians per year.

Registration of 40 new physicians into FHO models each month in two streams:

- 20 per month in a prioritized stream for those seeking to 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;
- 20 physicians per month in the regular stream (all applications not prioritized) which will be processed on a first come, first served basis;
- Any unused spots from one stream will shift to the other stream to be filled in that month;
- Any unused spots can be rolled over to subsequent months;
- 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 FHO model pursuant to these provisions.
- Income stabilization will be made available on the same terms as previously bilaterally agreed.

For the 2022-23 year only, these numbers will be increased by 20 per month in the prioritized stream (extra 240 total). For greater clarity,

- Any of these spots that go unused will shift to the other stream to be filled in that month; and

- Any of these spots that go unused can be rolled over to subsequent months.

The parties understand that this issue is resolved without prejudice to the issue of the arbitrability of managed entry pursuant to the Binding Arbitration Framework, and that no Board of Arbitration under the BAF shall draw any inference with respect to the issue of arbitrability arising out of this Agreement.

The parties further agree that the managed entry process will continue through to the completion of the next round of negotiations (including negotiation, mediation and arbitration). At the same time, both parties agree that by so agreeing, the Ministry does not consent to its continuation after the completion of the next negotiation, mediation and arbitration process unless the parties agree otherwise.

Managed Entry: Guidelines for Approval of New FHOs

To better support team-based care and access for patients during regular hours and after-hours it is important for patients to know where to go when faced with a medical issue regardless of whether their enrolling physician is available. Co-location of all physicians in a group, or close proximity of those physicians, assists in this goal.

As a result, where new FHO locations are being approved, the following guidelines apply to the determination of close proximity:

- If all physicians in a group cannot be in the same location, there should be no less than 3 physicians in each location.
- Close proximity is defined as the FHO's locations being within a 5km radius of one another, where a RIO score is 0.
- In areas with a RIO score of 1 or more, consideration will be given to applications from groups who cannot locate within 5 km due to infrastructure limitations or any other relevant factors, having regard to the primary health care needs of the community. Any application not granted can be referred to PSC co-chairs for resolution.

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

Regardless of the number of locations, to ensure that patients know the hours of service of their physician group, the hours of service (daytime, after-hours and weekends) will be posted in the office, on telephone answering machines, on-line and shared with Ontario Health (including so that it could be made available on the Ontario Health website).

In addition, the new group must have a shared EMR that provides all physicians in the group access to the medical records of Enrolled Patients (per Section 9.2 of the FHO Agreement).

2. Complexity

Repurposing of Preventive Care Bonus for Colorectal Cancer, Mammography and Pap Smear for FHN and FHO (with Proration of Influenza and Childhood immunizations preventative care bonuses for FHN and FHO physicians with rosters less than 1,000 patients) effective April 1, 2023, or such later date as the CIHI grouper capitation system comes into effect if it is delayed beyond April 1, 2023. The financial results achieved by this repurposing

would be redirected, together with the financial results from the change to fee-for-service pooling in paragraph 10 below, to adjusting the current age-sex based capitation rates to include a new risk-adjustment model based on the CIHI's Population Grouping Methodology. To facilitate this work, a bilateral Diagnostic Risk-adjusted Acuity Modifier Advisory Group will be established and tasked with implementing a capitation system informed by the CIHI grouper by no later than April 1, 2023. William Kaplan, sitting as sole/mediator arbitrator, will be seized to settle any disputes.

3. After-Hours

a) Effective three months after ratification, and subject to the provisions of After-Hours Exemptions, the Group will commit to providing evening (Monday to Thursday starting at or after 5 pm but no later than 7 pm for a minimum three hour consecutive block), and weekend (Friday evening, Saturday or Sunday) 3 hour consecutive blocks for scheduled and unscheduled patients.

b) If a FHO is required to provide one block of weekend coverage, that block will be on Saturday or Sunday. If two weekend blocks are required, they may be scheduled any time on Saturday or Sunday, provided there is no overlap between the blocks. If three weekend blocks are required, the FHO may schedule those blocks on Friday evening, Saturday or Sunday, provided there is no overlap between the blocks. Where four or more weekend blocks are required, one block must be provided on a Saturday, and one block on Sunday, and any remaining blocks as determined by the FHO, provided there is no overlap between the blocks.

c) Each FHO must provide 1 block on each weekday evening (Monday to Thursday) for scheduled and unscheduled visits.

The parties agree to revise the required after-hours and weekend blocks per week by group size as set out below, effective three months after ratification.

*The current contract requirements will apply for groups of less than 6 during the transition period.

	After-Hours			
FHO Group Size (# of Phys)	**Current Requirement**	**Total Evening and Weekend Required** * Effective 3 months after ratification	**Required Evenings** Effective 3 months after ratification	**Required Weekends** Effective 3 months after ratification
1		5	4	1
2		5	4	1
3	3	5	4	1
4	4	5	4	1
5-7	5	5	4	1
8-9	5	6	5	1
10-14	7	8	6	2
15-19	7	9	6	3
20-24	8	10	7	3
25-29	8	11	8	3
30-39	10	14	10	4
40-49	10	15	11	4
50-59	10	16	11	5
60-74	10	17	12	5
75-99	15	22	16	6
100-199	20	30	24	6
200+	25	35	29	6

4. Aspirational Parameters for FHO Weekly Patient Access and for Virtual/In-person Split for FHO and Other Primary Care Physicians

Effective three months after ratification, for FHOs, for every 1300 enrolled patients (i.e., on a pro-rated basis), FHO physicians are encouraged to meet or exceed the following parameters:

- 88 face-to-face and virtual patient encounters weekly, with 60 per cent or more being face to face patient encounters.
- Since this is a group endeavor, the averaging would be measured quarterly (over a three-month period) for the entire group

Services to be provided by the enrolling physician or another physician (including contracted physicians and physician residents) in the enrolling group.

Services are those provided to the FHO's enrolled patients, including shadow billing (in-basket) and out of basket services.

Patient encounters provided as above (including virtual encounters that are medically indicated) to be rendered to the patient or patient representative

Includes enrolled patients of the group only

For non-FHO primary care physicians (Family Health Networks, Group Health Centre, Rural and Northern Physicians Group Agreement, Blended Salary Model, St. Joseph's Health Centre, Weeneebayko Area Health Authority, Sioux Lookout Regional Physicians Services Agreement, GP Focus HIV, GP Focus Care of the Elderly, GP Focus Palliative, Toronto Palliative Care Agreement, Inner City Health Associates, Shelter Health Network, Sherbourne Physicians Group, Family Health Groups, and Comprehensive Care Model), they are encouraged to have 60% or more of their weekly patient encounters on an in-person as opposed to a virtual basis. Since this is a group requirement, the averaging would be measured quarterly (over a three-month period) for the entire group.

The failure to meet these aspirational parameters will form no part of any decision which has any economic or other contractual consequence for any group listed above, including contract termination.

5. Weekend Access (A888 Equivalent) for Patients – FHO

To support increased access to scheduled weekend visits, effective three months after ratification, there will be a newly created code Qxxx of equivalent price to A888 that can be billed by FHO physicians for providing services to their groups' enrolled patients for unscheduled visits on Saturday, Sunday or Holidays, so long as the physician offers at least three scheduled visits for each three hour Saturday, Sunday or Holiday block.

6. Increase Mandatory Group Size

a) Minimum size for new FHOs established after April 1, 2022 will be 6 physicians.

b) Reasonable notice to be provided to all current FHO groups with less than 6 physicians to require implementation to a minimum size of 6 no later than 12 months following ratification.

c) Notwithstanding (ii), existing FHOs of less than 6 physicians will be permitted to continue as such, provided the FHO agrees to implement and maintain the same access requirements, including "after-hours" and weekend access, as FHOs with at least 6 physicians, and provide such agreement, in writing, no later than 12 months following ratification.

d) Guidelines will be agreed to by the parties, or failing such agreement, determined by William Kaplan, acting as sole mediator/arbitrator, permitting FHOs of fewer than 6 physicians in rural, remote or underserviced communities. The Guidelines will also establish the circumstances under which these FHOs can switch their compensation model to the RNPGA model, where requested by physicians.

7. FHO Group Maximum Roster

a) Effective three months after ratification, average FHO roster sizes should generally be no greater than 2400 patients on average per physician.

b) The practices of existing FHOs with an average roster size of greater than 2400 patients will be reviewed jointly by OMA and MOHLTC representatives. If it is determined that these practices are structured and operating to comply with their contractual obligations, they will continue as such. Any practice which does not comply with those obligations will be provided with an appropriate opportunity to become compliant. If the practice does not meet the obligations within the time specified or any extension agreed to by the parties, appropriate steps will be taken to reduce the average roster size per physician to 2400 or such other larger number as the parties agree, within such time period as is agreed by the parties, and in compliance with CPSO policies for reducing patients in a practice.

c) Any dispute with respect to any of the issues related to mandatory roster size will be determined by William Kaplan acting as sole mediator/arbitrator on an expedited basis.

8. CCM and FHN Migration

If the Ministry ceases to offer CCM and FHN as available options, the parties agree that current CCM and FHN physicians may stay in these models but not recruit new physicians except on a replacement basis where the replacement physician takes the roster from the replaced physician. The CCM model will continue to be available as a transitional model for physicians who have applied to become a FHO and are on the waiting list.

9. Walk-in Clinics

a) The OMA and Ministry will work together to develop a framework that will enable and ultimately require walk-in clinics to communicate back to the patient's primary physician with respect to the reason for the visit, as well as the diagnosis and treatment, if any. This applies to both in-person and virtual services.

b) The OMA and Ministry will develop a process for communication with patients who regularly use walk-in clinics to understand why they do so, and how they could be best encouraged to engage in a continuity of care environment, through enrolment with a comprehensive primary care provider, or where they are already enrolled with their own rostered practice. This applies to both in-person and virtual services.

10. Change the Maximum FFS Pooling from Group to Individual Physicians

a) Effective April 1, 2023, eligible primary care groups will no longer pool their fee for service limits at the group level, but have it applied at the physician level instead.

b) Exemptions could be requested and provided through negotiations with the Ministry where and if it is identified as necessary, and if they cannot be agreed resolved by William Kaplan acting as sole mediator/arbitrator.

c) The savings will be repurposed to support the complexity modifier set out in paragraph 2 above.

11. Enhanced FHO Group Coverage

Effective three months after ratification, if a patient's regular physician is not available during weekday hours, the FHO will ensure all enrolled patients presenting with a time-sensitive condition are offered the option of seeing another FHO physician (whether face to face or virtually as clinically appropriate) on the same or next day, or an after-hours clinic that day or the following day. This requirement may be delegated to an allied health provider affiliated with the FHO if clinically appropriate.

FHOs are encouraged to consider including the following illustrative examples as time sensitive conditions:

a) significant new or worsening pain (including pain caused by recent injury),
b) new onset or change in symptoms of infection including fever, rashes, gastrointestinal changes, urinary changes, respiratory changes,
c) exacerbation in chronic conditions (for example back pain, heart disease, lung disease or abdominal or gynecological disease),
d) concerns regarding pregnancy and newborns and infants,
e) decompensation in mental health or substance use, or
f) time sensitive prescriptions that cannot be managed in other ways,

but would not include:

a) annual health exams and preventative screening visits,
b) completion of forms (for example tax disability, insurance, school trips/camp), or
c) routine follow up of chronic physical and mental health conditions.

12. FHO After-Hours Exemptions

Effective 3 months after ratification, the group exemption from after-hours coverage for physicians in a FHO, where more than 50% of physicians provide specified services, will be replaced as follows:

a) There will be an individual exemption from after-hours coverage where more than 50% of physicians in a group provide the following "Exemption Services" after 5 pm weekdays and/or on weekends:

    i) Regular public hospital emergency room coverage; and/or;
    ii) Public hospital anaesthesia on-call services on a regular basis; and/or;
    iii) Obstetrical deliveries outside of regular office hours; and/or
    iv) Regular after-hours care of hospital in-patients; and/or
    v) Provision of palliative care as indicated by at least 4 palliative care patient home visits per week averaged over a 3 month period (tracking mechanism to be jointly developed); and/or
    vi) Provision of services in a LTC/nursing home (for non-enrolled patients) as demonstrated by at least 10 patient visits per week averaged over a 3 month period (tracking mechanism to be jointly developed); and/or
    vii) Complex continuing care on-call as established by a call schedule in a complex continuing care facility.

b) In addition to the exemptions set out above, Northern and Rural FHO groups are contractually required to have at least 50% of their physicians maintain active in-patient hospital privileges; as a result, Northern and Rural FHO groups are required to provide no more than 5 after-hours blocks.

c) The FHO will be required to provide the total after-hours and weekend coverage for the group, based on the FHO group physician size after removing the exempt physicians, as per the requirements set out in the after-hours and weekend chart in paragraph 3 above.

d) In order to qualify for the after-hours exemption the individual physician must be engaged in the services listed above in (i), (ii), (iii), and (iv) for at least 6 hours per week or provide service as specified in (v) and (vi), or be on call as specified in (vii).

13. Modernized Booking Process for FHO and FHN Enrolled Patients

To ensure that patients know the hours of service of their physician's group, the hours of service (daytime, after-hours and weekends), will be posted in the office, on telephone answering machines, on-line and shared with Ontario Health (including so that it could be made available on the Ontario Health website).

All FHOS and FHNs will endeavor to have an online booking system available for their patients by March 31, 2023 and are encouraged to communicate with Ontario Health in achieving this objective. Ontario Health has developed service standards which are available at: https://www.ontariohealth.ca/our-work/digital-standards/online-appointment-booking-standard.

All other primary care models are also encouraged to have an online booking system available for their patients and could also be communicating with Ontario Health in this regard.

D. SCHEDULE OF BENEFITS FEE ADJUSTMENTS AND MODERNIZATION

1. The bilateral work done through these negotiations to introduce virtual care services into the Schedule of Benefits represents the next step in modernizing the insured physician services available in Ontario. This change will expand the modalities available to physicians to deliver services and the ways all Ontarians can access care.

2. The Parties agree to continue the work of modernizing the fee schedule by establishing an ongoing Physician Payment Committee (PPC), which would absorb the functions of and replace the Medical Services Payment Committee (MSPC). The mandate of the PPC will be to make recommendations on an annual basis to the PSC regarding:

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

(ii) “modernizing” the existing Schedule of Benefits on a revenue neutral basis, which may include addition, revision and 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, as well as flow-through and any other financial changes to non-fee for service contracts and to other programs.

In carrying out its mandate, the PPC will take such steps as are necessary to achieve gender pay equity, and to address medical innovation/technological advances. To that end, among other things, the parties agree that the work of the PPC will be aligned with the parties’ bilateral work on the FAIR relativity model.

3. Both parties will nominate their members to the PPC within 30 days of ratification.

4. Once constituted, the PPC will:

(i) Immediately commence the work necessary to make recommendations to PSC regarding the 2.01 per cent April 1, 2023 price adjustment, which is set out at paragraph 3 of the Financial Agreement, across existing fee codes. These recommendations to PSC will be made no later than October, 2022; and

(ii) No later than January 1, 2024, commence the work necessary to make recommendations to PSC regarding the allocation of the permanent fee increase in respect of the year 3 adjustment, which is described at paragraphs 8 c) and 8 d) of the Financial Agreement across existing fee codes. These recommendations to PSC will be made no later than October 1, 2024.

Any dispute arising at the PPC in regards to any of the above will first be referred to PSC for resolution. If PSC is unable to find a resolution, the issue can be referred by either party to William Kaplan who, sitting as a sole mediator/arbitrator, will remain seized for the duration of this PSA to resolve these disputes under the terms of the BAF.

E. FAIR RELATIVITY MODEL

The parties confirm their mutual agreement to proceed with the FAIR relativity model. The objective of this model is to achieve relativity between specialties (or other physician groupings as appropriate), as measured through hourly compensation adjusted by overhead and education. The next steps of this process, including the finalizing of the methodology for proceeding with FAIR (e.g., how to calculate overhead, measure education, determine hourly rates, etc.) remains under active consideration between the parties. The parties further agree to the mutual goal that this work will be completed in time for implementation under the next PSA.

F. APPROPRIATENESS WORKING GROUP

1. Continuation of the AWG

In order to satisfy any outstanding AWG requirements of the Kaplan Arbitration Award dated February 18, 2019, the parties agree to the following:

1. The parties, through their respective AWGs, will meet jointly to attempt to agree on a resolution of the following outstanding proposals which have been the subject of prior discussions at the AWG. These proposals will be considered consistent with the provisions of paragraph 7 of the Appendix to the Kaplan Award:

    - Conduct Haemorrhoidectomy Only When Necessary
    - Decrease Ear Tube Insertion (Tympanostomy) for the Treatment of Chronic Otitis Media in Children
    - Hysterectomy for Menstrual Bleeding and Fibroids
    - Revise description of cast/brace codes
    - Fecal Immunochemical Testing
    - Colonoscopy for constipation
    - Decrease Surgical Intervention for Early Stages of Dupuytren`s Contracture
    - Eye Injections for the Treatment of Neovascular Age-Related Macular Degeneration
    - Improving care for patients with chronic pain by transitioning to a multidisciplinary model
    - Electromyogram (EMG) and Nerve Conduction Study (NCS) Testing
    - Screening colonoscopy consults

2. The parties also agree to include in their considerations the Final Submission of the Expert Panel on Cardiac Testing.

3. The parties will make every effort to conclude their discussions on the proposals in paragraph 1 above no later than 6 months following the date of ratification of this Agreement or such longer period as mutually agreed upon.

4. Any outstanding issues may be referred to the Kaplan Board of Arbitration for final and binding determination.
5. The parties agree that the process set out herein represents full and complete satisfaction of the requirements under the Kaplan Award.

G. TECHNICAL FEES

In the Kaplan Arbitration Award dated February 18, 2019, the Board ordered the following:

> The parties [were] also directed to continue discussions regarding the OMA's additional technical fees proposals.
>
> Where consensus [could not] be reached on technical fees issues, either party [could] trigger further mediation with the assistance of the board of the Chair.
>
> It [was hoped] that discussion, mediation and fact-finding during this [mediation] process will set the stage for efficient and productive future processes.

In furtherance of that award, the parties agree to the following as a matter of priority upon the ratification of this agreement:

- 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.

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.

H. EXTENSION OF CANADIAN MEDICAL PROTECTIVE ASSOCIATION (CMPA) AGREEMENT

The parties agree to continue the current agreement on Canadian Medical Protective Association (Appendix H of the 2012 PSA) for the duration of this PSA i.e., March 31, 2024. For greater certainty, this extension includes an annual increase of Physician contributions of 2.1% annually.

It is further agreed that, consistent with paragraph 6 of the Binding Arbitration Framework Agreement, the CMPA agreement 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 PSA.

I. CLAIMS SUBMISSION TIMELINE AND ADJUDICATION PROCESS

1. The Ministry has advised the OMA of its intent to amend Regulation 22/02 of the *Health Insurance Act (HIA)* to adjust the claims submission period for submitting in-province accounts for insured services to the Ministry from 6 months to 3 months.

2. The parties acknowledge that in many cases, the reason physician claims are rejected are outside of the control of the physician. Accordingly, the parties agree to the following:

    a. Claims submitted within 3 months from the date of service ("the prescribed timeframe") that are rejected to a physician's Claims Error Report may be corrected and resubmitted after the prescribed time frame. In such cases, the physician must provide supporting documentation to demonstrate that the original claim was submitted within the prescribed timeframe. Provided physicians correct the error and resubmit the original claim through the stale dated folder and email the original error report to ClaimsManagement@ontario.ca along with the claim identifying data, then the claim will regularly be paid within the next 2 remittance advice periods.

    AND

    b. The submission period for Remittance Advice Inquiries (RAIs) will be changed from the current 4 month maximum from the date of the Remittance Advice (RA) to 7months from the date of the RA.

IMPLEMENTATION

This change to the claims submission period will take effect on April 1, 2023, for services rendered on or after April 1, 2023. The Ministry will provide physicians with at least 6 months notice prior to implementation (i.e., notification by October 1, 2022) to support effective transition.

J. DATA SHARING

Agreement on data sharing

1. The Parties agree to amend the schedule to their agreement on data-sharing as follows:

    a) Addition of the following administrative claims databases, to be updated on a quarterly basis:
        - National Rehabilitation Reporting System (NRS)
        - Continuing Care Reporting System (CCRS)
        - Ontario Mental Health Reporting System (OMHRS)
        - Home Care Database (HCD)

    b) Change in the frequency of submission (from annually to quarterly) of the following databases:
        - NACRS
        - CIHI Discharge Abstract Database

    c) The MOH will provide the total payments and the number of physicians (or FTE, if available) for the following contracts and programs, on an annual basis.
        - Community Health Centre
        - Aboriginal Health Access Centre
        - Aboriginal Family Health Teams
        - Indigenous Interprofessional Primary Care Team
        - Sioux Lookout Regional Physician Services Inc.
        - Group Health Centre
        - Northern Physician Retention Initiative
        - Return of Service Programs
            - International Medical Graduates
            - Physician Repatriation
            - Physician Re-entry
            - Resident Loan Interest Relief Program
        - Northern Rural Recruitment and Retention Initiative
        - Rural Medicine Investment Program
        - Visiting Specialist Program
        - Rural Family Medicine Locum Program
        - Northern Specialist Locum Programs
        - Emergency Department Locum Program

- Clerkship Travel Program
- Hospital Pediatric Stabilization Program
- Mental Health Programs
    - Sessionals
    - Stipends
    - Ontario Psychiatric Outreach Program
- Application Based Contracts
    - Frail & Elderly
    - Geneticists
    - Infectious Diseases
    - ACT
    - ACT – Cataract Demo
- Laboratory Medicine Funding Framework Agreement (LMFFA)
- Clinical Decision Unit (CDU)
- Physician Collaboration Funding
    - NP Led Clinics
    - NP Demonstration
    - PCNP
- Ottawa Paediatric Locum
- Sexually Transmitted Infections
- Tuberculosis for Uninsured Persons (TB-UP)
- Northern Physician Retention Initiative
- Final Year Medical Student Bursary
- Hospital Pediatric Stabilization Program
- Divested Provincial Psychiatric Hospitals (DPPH)
- Assertive Community Treatment Teams (ACTT)

2. The parties will negotiate a new Data Sharing Agreement to:

    a) better reflect the data needs of the OMA by adding the data and frequencies listed in #1 above,

    b) amalgamate the existing (2005) agreement with the various amendments that have been added since then, and

    c) update the language to reflect the current legislative privacy requirements of the MOH.

3. The parties will work together to establish a process for enhanced regular reporting of physician level payment and workload (e.g., FTE, hours worked, etc.) data from alternative payment models and programs to the MOH. This data, once anonymized, will subsequently be shared with the OMA on a fiscal year basis commencing no later than the 2022/23 Fiscal Year data.

4. The parties agree to establish a bilateral working group to:

    a) Agree on a framework for revising the OMA data sharing agreement to reflect current data sources and update language to reflect modern regulations.

    b) Define a minimum dataset for enhanced regular reporting of physician level payment and workload data to the MOH (subsequently to be shared with the OMA). This minimum reporting dataset will apply to all physician programs and contracts where physician level data is not currently available in existing MOH datasets.

    c) Discuss approaches and potential technical solutions that programs and organizations can use to easily submit the required data in the minimum dataset. Besides improving the ease of data submission, the platform will also include measures to ensure that standardized, high quality data is submitted. The solution should be agile enough to easily accommodate new programs and changes in existing programs.

In addition to what is specifically provided above, William Kaplan will remain seized, acting alone, with respect to any disputes between the parties as to the interpretation, application and implementation of this agreement.

K. MEMORANDUM OF UNDERSTANDING REGARDING DURATION OF PSA UNDER FRAMEWORK

1. Pursuant to paragraph 1 of the Framework Agreement, the parties have agreed to a renewal agreement to the PSA for a three (3) year period namely April 1, 2021 to March 31, 2024.

2. The provisions of the Framework Agreement and the timelines set out therein with respect to future bilateral negotiations, mediation and arbitration will continue to apply in respect of the negotiations for the PSA for the period commencing April 1, 2024.

3. For greater certainty, bilateral negotiations for the PSA commencing April 1, 2024 will commence at least 180 days before March 31, 2024, and the next PSA will be for a four year period April 1, 2024 to March 31, 2028.

EXHIBIT 6

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OMA AND MINISTRY OF HEALTH 2021-24 PSA YEAR 3 IMPLEMENTATION AND 2024-28 PROCEDURAL AGREEMENT

Except as agreed to herein, this implementation and procedural agreement is entered into without prejudice to the position of either party with respect to the negotiation, mediation and arbitration for the 2024-28 Physician Services Agreement (PSA). It is further agreed that this agreement is subject to approval by the parties' respective principals, such approval to be sought as expeditiously as possible.

WHEREAS the OMA and the MOH (the 'parties') entered an agreement that was freely negotiated and ratified for a Physician Services Agreement (PSA) in effect until March 31, 2024 (the '2021-24 PSA').

AND WHEREAS the parties have begun negotiations for a new four-year PSA (the '2024-28 PSA'), for the period of April 1, 2024, to March 31, 2028;

AND WHEREAS the 2021-24 PSA agreement provided for a 2023-24 ('Year 3') expenditure estimation and reconciliation process, pursuant to which the parties met bilaterally in December 2023 and January 2024 to engage in interest-based discussions for the purposes of implementing the Year 3 agreement;

AND WHEREAS in the course of the Year 3 implementation discussions, the parties recognized the value of an expeditious resolution of the Year 3 expenditure estimate and implementation;

AND WHEREAS the parties also commenced discussions regarding the benefit of a more timely conclusion of year one of the 2024-28 PSA than is currently scheduled by the arbitration board;

AND WHEREAS the parties mutually recognize the value of ongoing intensive mediation/arbitration for Years 2, 3 and 4 of the 2024-28 PSA given the importance, complexity and wide range of outstanding issues between the parties;

THEREFORE, in recognition of the parties' shared interests in reaching a timely and final conclusion of Year 3 (2023-24) of the 2021-24 PSA, and of Year 1 (2024-25) of the 2024-28 PSA, the parties hereto agree as follows:

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Year 3

1. The parties agree to implement Section **A. Financial Agreement - Year 3 Compensation Increases and Gain Sharing** of the 2021-24 PSA as follows:

   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).

Year 3 Implementation Approach

2. The interim implementation of the 2021-24 PSA Year 3 payment will be as follows:

   a. For the 2023/24 contract year:

      A lump sum equivalent to a 2.8% increase as per paragraph 1a above. This lump sum payment will be paid as soon as practicable with a targeted date of October 1, 2024.

   b. For the 2024/25 contract year:

      The 2.8% percent increase to physician payments as per paragraph 1a above will be implemented prospectively as an across-the-board increase to fee-for-service payments with a target implementation date of the June 2024 Remittance Advice (RA) and will flow through to non-fee-for-service payments as soon as practicable. These payments made to physicians will apply to all services provided in 2024/25, as outlined in paragraph 1a above, and include any required payments retroactive to April 1, 2024, until the implementation of the up to 40 million dollars in HOCC payments as outlined in paragraph 4 below.

3. The 2.8% increase provided for under paragraph 1a will result in a permanent 2.8% increase to physician payments (reduced by any year 3 HOCC funding expended under paragraph 4) to be implemented effective April 1, 2025, in the manner set out below:

   This permanent increase will be calculated on a base of 2022-2023 expenditures as defined in the 2021-24 PSA and as mutually agreed by the Parties. This permanent increase will be allocated to physician payments as provided under the

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2021-24 PSA through the PPC process as follows:

a. 1/4 of the global increase will be allocated to each section or physician grouping on an equal percentage basis; and

b. 3/4 of the global increase will be allocated to each section or physician grouping based on the hybrid CANDI-RAANI score, to be updated by the parties.

These increases will also flow through to non-fee for service payments as soon as is practicable.

4. The parties agree that there is no remaining or unexpended APP funding under paragraph 16 of the 2021-24 PSA Financial Agreement. However, with respect to HOCC funding, in view of the ongoing work required to continue to develop and implement a burden-based HOCC system, up to $40 million will be made available out of the Year 3 increase to be used to provide funding to new groups who have applied under paragraph 3 of Schedule B of the 2021-24 PSA, and who meet the eligibility criteria for HOCC funding under the existing HOCC rules. This interim funding will commence at the same time as the implementation of the price increase under paragraph 12(a) below. The parties further agree that the issue of additional funding required to implement the burden-based HOCC system will be negotiated and if necessary arbitrated as part of the Year 1 targeted funding under the 2024-28 PSA mediation and arbitration process.

2024-28 PSA Negotiations

5. The parties expressly acknowledge that, subject to the exception noted in paragraph 6 below, the 2.8% Year 3 increase provided for under paragraphs 1 to 3 above cannot be relied upon by either party at mediation or arbitration. The parties further agree that, in any future mediation or arbitration, the OMA will not rely on the Ministry's agreement to make the payment under paragraph 1a in support of any argument that, (a) in so doing, the Ministry has accepted there is any valid claim for additional price or compensation rate increases relating the 2021-24 period beyond those expressly contemplated by the original freely negotiated agreement between the parties (including any claim related to Bill 124); or (b) as evidence of a necessity to recruit and retain physicians; or (c) in support of a claim for a "catch-up" payment to physicians based on any factors, including those found in the Binding Arbitration Framework (BAF), inflation, burnout, administrative burden, population growth or other settlements or awards in any other sector, including the health care sector, in Ontario or Canada.

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Similarly, subject to the exception noted in paragraph 6, the Ministry will not rely on the OMA's agreement to the payment under paragraph 1a to argue that (a) the OMA has accepted that such payment is sufficient or adequate to meet any claim for additional price or compensation rate increases relating to the 2021-24 period beyond those expressly contemplated by the original freely negotiated agreement between the parties (including any claim related to Bill 124); or (b) that such payment is sufficient or adequate to address the necessity to recruit and retain physicians; or (c) that such payment is sufficient or adequate to address the claim for a "catch-up" payment to physicians based on any factors, including those found in the Binding Arbitration Framework (BAF), inflation, burnout, administrative burden, population growth or other settlements or awards in any other sector, including the health care sector, in Ontario or Canada.

For greater clarity, the Year 3 adjustment will be deemed to be part of the original settlement and not referenced at mediation or arbitration by either party in any special or unique fashion.

6. Despite paragraph 5, the MOH is not precluded from relying on or pointing to the 2021-24 PSA price increases, including the Year 3 increase under paragraph 1a, at mediation or at arbitration, in response to any position or argument advanced by the OMA that the Year 1 price increase should include additional price increases in respect of the 2021-24 period as per 7(a) below, based on any of the factors described in paragraph 5 above. Nor does anything in paragraph 5 preclude the OMA from advancing the position or argument that the Year 1 price increase should include additional price increases in respect of the 2021-24 period based on any of the factors described in paragraph 5 above.

7. The parties agree that the mediation/arbitration for the 2024-28 PSA will be bifurcated into two procedural steps:

    a. Year 1, if necessary, will be referred to the Board of Arbitration on May 6, 7 and 8 (with the opportunity if either party requests for further reply argument on June 5 or 6) for binding arbitration in accordance with the terms of the BAF, amended procedurally for the purposes of this agreement on a one-time basis as set out herein; and

    b. Upon the conclusion of the hearing, the parties will continue to use the existing mediation and arbitration dates, and any additional dates that may be required,

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to conclude Years 2, 3 and 4 of the 2024-28 PSA.

The Parties will continue to meet to formulate a focused agenda for the mediation process that takes place prior to the Year 1 arbitration.

8. In deciding the Year 1 price increase, the board of arbitration will determine:

   a. the quantum, if any, of the additional price increase to be awarded, including in respect of years 1, 2 and 3 of the 2021-24 PSA, in Year 1 of the 2024-28 PSA, based on the factors set out in paragraph 5 above; and

   b. separate and apart from a) above, the quantum of the normative price increase to be awarded for Year 1 of the 2024-28 PSA.

9. For the 2024-28 PSA, unless the parties agree to a different proportion, and subject to the Year 1 implementation provisions set out in paragraph 12 below, the total price increases in year 1 will be divided as follows:

   a. Seventy percent (70%) of the price increase awarded in Year 1 will be allocated to each section or physician grouping.

   b. The remaining thirty percent (30%) of the price increase will be allocated to permanent price increases in the form of targeted investments (e.g. Hospital On-Call Coverage (HOCC), pay for performance initiatives, family medicine initiatives, emergency medicine initiatives, APPs or AFPs, technical fees adjustments, gender pay gap initiatives, medical innovation and technology advances, patient complexity initiatives, fee schedule modernization, overhead expenses, locum/underserviced area/CME/skill optimization initiatives, retention initiatives, physician extenders, initiatives relating to the increased administrative burden on physicians, or benefit increases). The examples of targeted investments set out above are not an exhaustive list. For greater clarity, the inclusion of the list above is not determinative of either parties' support for such an initiative or in respect of either parties' position about the arbitrability of the initiatives.

10. Upon the conclusion of 2024-28 PSA Year 1 negotiations or award, the parties will work bilaterally to conclude an agreement on the implementation of the targeted investments. This work will be done in conjunction with the parties' Year 2-4 negotiations and mediation. This approach to Year 1 is without prejudice to the position of either party regarding the future allocation, if any, of price increases

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between general fee increases and targeted price increase investments in years 2,3 and 4 of the 2024-28 PSA.

11. In the event that the parties are unable to reach a consensus on allocation or costing with respect to the targeted investments (or cannot agree whether a particular change is a targeted or non-targeted price increase), any dispute may be referred to the Board of Arbitration as part of the conclusion of the Years 2-4 arbitration, but the Board of Arbitration may not alter the 70/30 ratio applicable to Year1 as set out above. However, the parties may agree that certain targeted investments may, on agreement, be included as part of the May/June Year 1arbitration.

12. The Year 1 price increase will be implemented as follows:

    a. The entire price increase under the Year 1 2024-28 PSA will be implemented prospectively as an across-the-board increase to the fee-for-service payments identified in paragraph 1a above, with a target date of the RA in the month 90 days following the issuance of the arbitration decision, and will flow through to non-fee-for-service payments as soon as practicable.

    b. A lump sum payment equal to the entire increase awarded for Year 1 for the earlier period from April 1, 2024 through to the implementation date under paragraph 12(a), will be paid as soon as practicable following the arbitration award with a target date of October 2024.

    c. To the extent practicable, the permanent year 1 non-targeted price increases will be implemented at the same time as the April 1, 2023, price increases under Year 3 of the of the 2021-24 PSA i.e. April 1, 2025, and in any event no later than October 1, 2025. These increases will be calculated on a base of 2023-2024 expenditures as described in paragraph 1a and will be allocated to physician payments through the PPC process to each section or physician grouping. The distribution as between across the board increases and relativity increases will be determined in such manner as the parties agree or, failing agreement, as the board of arbitration awards, with the relativity portion to be based on the most current hybrid CANDI-RAANI score. These increases will also flow through to non-fee for service payments as soon as is practicable.

    d. Any unexpended portion of the targeted price increases will continue to be paid to physicians as a separate payment on the monthly Remittance Advice

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(RA), until such time as each targeted increase is implemented or unless the parties agree otherwise.

13. While mediation and, if necessary, arbitration over EDAFA funding under the 2024-28 PSA continues, the parties acknowledge that in their discussions to date, the parties have agreed that the existing Emergency Department Alterative Funding Agreement (EDAFA) temporary surge funding will be maintained at the current rate of 5% for the period of April 1, 2024, to March 31, 2025. This is without prejudice to the position of either party regarding a) whether or not surge funding should be funded out of any targeted price increases, b) the sufficiency of the 5% amount, c) the duration of any surge funding, and d) the arbitrability of any of these issues. However, to the extent they are arbitrable, these issues may be determined by the board of arbitration in awarding the terms of the 2024-28 PSA, in accordance with the BAF and the terms of this agreement.

14. Unless otherwise modified for the purposes of this one-time agreement above, the Parties reserve all rights as per the terms of the BAF.

15. William Kaplan will be seized to resolve any disputes arising under this agreement, and continues to remain seized to resolve any disputes arising in respect of the matters set out in Schedule B and paragraphs 2 and 4 of Schedule C of the Financial Agreement of the 2021-24 PSA, and Sections C, D, F and G of the 2021-24 PSA.

February 22, 2024

FOR THE OMA

Dr. Nikolina Mizdrak

Dr. Atul Kapur

Dr. David Nerenberg

Dr. Winnie Wong

Dr. Patrick Conlon

FOR THE MINISTRY

Teresa Buchanan

Dr. Andy Smith

Dr Jeff Tyberg

Dr. Darren Cargill

EXHIBIT 7

IN THE MATTER OF AN ARBITRATION

BETWEEN:

The Ministry of Health and Long Term Care

And

The Ontario Medical Association

Before: William Kaplan, Chair
Dr. Kevin Smith, MOHLTC Nominee
Ron Pink, QC, OMA Nominee

Appearances

For the MOHLTC: Robert Reynolds

Craig Rix
Hicks Morley
Barristers & Solicitors

Bob Bass
Michele White
Bass Associates

For the OMA: Howard Goldblatt
Steven Barrett
Colleen Bauman
Adriel Weaver

Goldblatt Partners
Barristers & Solicitors

The matters in dispute proceeded to a hearing in Toronto on May 24, 25, October 22, 23, 24, November 26, December 18, 19, 20, 2018 and January 13 & 20, 2019.

Introduction

In June 2018, the Ontario Medical Association (hereafter "OMA") and the Ministry of Health and Long Term Care (hereafter "the Ministry") entered into a Binding Arbitration Framework (hereafter "BAF"). The BAF established an independent consensually selected board of arbitration, and one that was given the mandate to determine and decide outstanding issues respecting the content of the Physicians Services Agreement (hereafter "PSA") for the period April 1, 2017 to March 30, 2021. The BAF provided for the adjudication of outstanding issues in phases. In general, and at issue in this Phase One award, are the following:

1. The OMA proposal for redress in respect of both across-the-board and targeted cuts to payments and programs beginning in 2015 and still continuing;
2. The OMA proposal for fee increases;
3. The OMA proposals for Academic Health Sciences Centres;
4. The OMA proposals for the Northern Ontario School of Medicine;
5. The OMA proposal for additional increases to and a process for reviewing technical fees;
6. The OMA proposal for redress resulting from changes to federal legislation governing physician incorporation;
7. The Ministry proposal for a hard cap on the Physician Services Budget (hereafter "PSB");
8. The Ministry proposal for cuts to certain radiology, ophthalmology and cardiology fees; and,
9. Proposals by both the OMA and the Ministry respecting the delivery of primary care particularly through Family Health Organizations (FHOs).

These outstanding issues proceeded to hearings beginning in 2018 and ending in early 2019. A long list of consequential issues, for example, relativity, and other outstanding matters, remain to be decided in subsequent phases of this process, or as agreed by the parties.

In the meantime, consistent with Section 6 of the BAF, any other compensation term falling within the scope of arbitration under Section 21, together with any other existing term or condition, remain in full force and effect and cannot be altered, deleted, or added to without the agreement of the parties. We remain seized should there be any dispute on these issues.

Criteria for Decision-Making

Section 25 of the Binding Arbitration Framework sets out the following decision-making criteria:

In making a decision or award on any matters falling within the scope of arbitration, the arbitration board shall take into consideration the following factors and any other factor it considers relevant:

(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 reasonable, or otherwise the most reliable data available.

Discussion

No single one of these factors has been accorded primacy; but it seems to us that at the centre of our 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. Needless to say, the other criteria are directly relevant to the achievement of these objectives. Sustainability is to be given a broad reading: appropriateness, value for money, timely access, accountability for results; but it obviously also encompasses economic reality and an appreciation, gleaned from several of the other criteria, that, while ability to pay is not specifically identified, there are funding limitations. We also recognize that Ontario physician compensation accounts for approximately 22% of the Ministry budget. Indeed, in 2016-2017, Ontario spent nearly $56 billion (including capital) delivering health care in the province. Caution in increasing expenditures is obviously called for together with acknowledgement that fiscal resources are not infinite and that an increase in one area – for example, physician compensation – will have an impact in others.

The Board has paid extremely careful attention to the parties' submissions on projected economic growth and the economic conditions as well as the future fiscal prospects of the province. Without question, whenever possible and appropriate, and following best practices, substantial savings and efficiencies need to be introduced into the health care system to ease expenditure growth pressures (separate and apart from delivery reforms). Both parties have important responsibilities in this respect, including working collaboratively, especially in the area, as discussed further below, of "appropriateness" where real opportunity exists to

dramatically reduce costs. But it is worth emphasizing that physician compensation, and practices, is just one piece of a much larger puzzle and achieving sustainability involves a much broader approach.

Any OMA or Ministry proposal not directly dealt with in this award is deemed dismissed.

Award

The imposition of a hard cap on the PSB would have implications on other issues in dispute and so it needs to be the first issue addressed.

Ministry Proposal for Hard Cap on PSB

The PSB reflects the value of publicly insured services provided to patients by Ontario doctors. It is based on both price – the cost of services – and quantity – the number of services. Growth in the number of services is known as "utilization". The parties disagree about the factors underlying increases in utilization.

The Ministry takes the position that, while population growth and aging are important, physician behaviour is a major driver of PSB growth, in particular inappropriate tests, treatments and procedures, a situation exacerbated by the fact that Ontario physicians, on average, are working less and seeing fewer patients but billing more (with billing amounts completely disproportionate to, and out of sync with, price increases). The Ministry, therefore, asked us to impose a hard cap on the PSB, but one subject to a 1.9% utilization increase plus

any price increases. As the 2017/18 and 2018/19 contract years have passed, the Ministry proposes that the PSB be increased by 1.9% utilization amount for contract years 2019/20 and 2020/21.

In the Ministry's view, absent a hard cap and a specified utilization growth number, it would be impossible to obtain physician agreement on reducing or eliminating inappropriate practices as economic outcomes would be affected: stated somewhat differently, physician financial interests threatened. In addition to a hard cap with a 1.9% growth amount which the Ministry asserted took into consideration all of the growth factors identified in the BAF, it also proposed that a joint committee be established to identify inappropriate or overused physician services, or physician payments, with an identified target savings amount, together with an arbitral backstop in the event the parties are unable to agree.

OMA Response to Ministry Proposal for Hard Cap on PSB

The OMA categorically rejects a hard cap and the proposed 1.9% utilization amount, one which it notes, in any event, is based solely on population and aging, an unduly and self-evidently restrictive approach completely skewing the result and one completely at odds with the factors the parties deemed relevant and memorialized in the BAF. The OMA takes the position that, by any fair measure, when all of the relevant factors are addressed, utilization is a multiple of this 1.9% number.

In the OMA's submission, relevant factors include not just population growth and aging, but chronic disease prevalence, increasing patient complexity, technological change and innovation, entry of new physicians, patient preferences, expectations and demands, and other factors too numerous to enumerate. All of these factors, like those catalogued in the BAF, are not just accepted by the parties, but are also widely acknowledged in the literature. More fundamentally, the OMA categorically rejected the assertion that Ontario physicians were deliberately providing inappropriate care to increase incomes, a claim it characterized as baseless and unsupported by any evidence whatsoever. It takes issue with Ministry's claims – described as inflated and without compelling evidentiary foundation – about billings increases, days worked and patients seen by pointing to methodological and other concerns about the presented data – data it also described as misleading and incomplete.

The OMA also rejected the assertion that Ontario physicians should be responsible – which they would be if a hard cap was instituted – for increased utilization. Stated somewhat differently, if the Ministry hard cap proposal was accepted, Ontario doctors would be responsible for any physician spending exceeding the PSB by the proposed 1.9% amount plus normative increases. Any expenditure in excess of this amount would be the financial responsibility of Ontario doctors. The OMA acknowledges, however, Ontario physician responsibility for assessing appropriateness – ensuring that services are actually necessary – providing quality and value, and actually addressing over valued services, underuse, overuse and misuse without, of course, compromising timely and quality patient access.

Decision - PSB

In our view, the Ministry is responsible for the PSB including growth. Apart from the intrinsic unfairness of a hard cap and an unpersuasive and, in our estimation, discounted utilization number, both the PSB and its growth are the responsibility of government. Replication and identification of the appropriate comparators – key interest arbitration criteria – buttress this conclusion. No other Canadian jurisdiction enforces a hard cap (caps in New Brunswick and Quebec are not applied). If the Ministry wishes to limit the insured physician services patients receive, it can readily do so. What it cannot do is achieve this outcome by requiring Ontario doctors to subsidize public services. That would be the direct result of the imposition of a hard cap. Accordingly, we reject a hard cap. As such, any debate about the utilization increase amount is rendered moot.

Decision - Appropriateness

While we have dismissed the Ministry request for a hard cap, it is incumbent upon us to address appropriateness – a real issue and a shared concern and one falling squarely within our responsibility to ensure a patient-centred sustainable publicly funded health care system. There is no shortage of guidance: for example, the *2017 Choosing Widely Recommendations*. The fact is that it is entirely within the purview of the Ministry to delist inappropriate and medically unnecessary services. There is an accountability framework providing a mechanism for audit and recovery of unauthorized payments for medically unnecessary services (Physician Payment Review Board) and to the extent it, and other audit mechanisms, require modernization and streamlining, that is a matter that is the immediate responsibility of government and it is one

that needs to be promptly addressed – by government in consultation with the stakeholders. To give just one example, there is evidence that less than 4% - 441 – of Ontario's 11,448 family doctors are responsible for ordering nearly 40% of tests considered low value. Surely, this is a matter worth investigating and, to the extent that the testing is inappropriate, correcting through peer review, audit and enforcement. We cannot state this strongly enough.

Indisputably, and the parties agree about this, it is their shared responsibility to ensure not just quality of care, but the right care at the right time in the right place by the right provider. *Choosing Wisely Canada* and the *CIHI – The Canadian Institute of Health Information* – together estimate that as much as 30% of medical services in Canada are unnecessary and inappropriate. There is self-evidently a real opportunity to achieve significant changes while remaining faithful to the mission. We have heard submissions from both parties on the amount of changes and the process they each propose for identifying where those changes might be found. Having regard to their respective submissions, we have determined that the parties are to establish a joint committee, to be referred to as the Appropriateness Working Group (AWG) with the following parameters:

AWG

(1) For contract year 19/20, a committee of the MOHLTC and OMA will be established to discuss and establish evidence informed amendments to payments by eliminating or restricting inappropriate or overused physician services, or physician payments.

For purposes of the 19/20 contract year, the committee will endeavor to achieve a settlement by May 1, 2019 with changes totaling $100 million for the period of June 1, 2019 to March 31,

2020. If no settlement is achieved, this Board of Arbitration shall remain seized, and will hold hearings with an award by June 1, 2019 that will identify the changes totaling $100 million.

If the committee is able to achieve a settlement with changes totaling greater than $100 million in 19/20, the additional amount in excess of the $100 million shall be counted towards the 20/21 savings achievement outlined in paragraph 2 below.

(2) For contract year 20/21, the committee will endeavor to achieve a settlement by September 30, 2019 on changes totaling a further $360 million for the period of April 1, 2020 to March 31, 2021. If no settlement is achieved, this Board of Arbitration shall remain seized, and will hold hearings with an award by January 1, 2020 that will identify the changes totaling a further $360 million.

Furthermore, based on the submissions of the parties, and their narrowing of the differences between them in mediation to which the Chair of this Board was a party, the details and process for the committee forms part of and is attached as an Appendix to this award.

Redress – The OMA Position

Certainly the most contentious outstanding issue to come before us – and one that has, for years, negatively impacted the relationship between the parties – is the matter of redress.

Some historical context is important. In brief, and discussed further below, the last increase to physician compensation occurred in 2011. In 2012, a Physician Services Agreement (hereafter "the 2012 PSA Settlement") was reached. It was both negotiated and ratified by the parties. It reflected economic restraint, including an agreed-upon 0.5% across-the-board fee reduction**,** and provided for recognition of the OMA as the exclusive bargaining representative of Ontario physicians: *The OMA Representation Rights and Joint Negotiation and Dispute Resolution*

Agreement. It also contained a future dispute resolution mechanism but one that nevertheless allowed unilateral government action if there was an impasse following facilitation and conciliation. That is what happened when bargaining for a new PSA began in January 2014 and could not be successfully concluded.

In brief, the parties could not resolve their differences and following facilitation (Dr. David Naylor) and conciliation (The Hon. Warren Winkler), the Ministry, in 2015, imposed unilateral cuts that can be generally described as follows: 3.95% on fee for service, and 2.65% on non-fee for service. It is the reversal of these cuts that the OMA describes as redress (together with the 0.5% reduction agreed to in the 2012 PSA Settlement). The redress being sought is for all of these amounts, described as "across-the board payment discounts", as well as certain targeted fee and program cuts. The OMA estimates that these cuts, taken together, total more than $700 million annually – direct reductions in physician incomes.

The OMA observes – and details about broader sector collective bargaining outcomes were referred to – that, while other publicly funded groups faced wage restraint in and after 2009, the depth and continuing impact of the Ministry's unilateral cuts, in marked contrast, continue to this day to adversely affect physician income. Moreover, the OMA points out that, while Ontario doctors continue to be subjected to these unilaterally imposed cuts, physicians in other provinces have without exception received some form of compensation increase. It was important to remember, the OMA argued, that while some increases were received in 2004 and

2008, they were not, as the Ministry described them, “exceptional and extraordinary” but the response to market forces and other factors following years of cost containment and restraint.

From the perspective of the OMA, and to quote its words, these cuts are “stolen money” as they were unilaterally imposed by the Ministry in the absence of any fair and independent process for resolving physician compensation disputes. In general, the OMA seeks that the across the board payment discounts be ended effective April 1, 2017 by the restoration of the cut amounts effective the commencement date of the PSA settled by this award, and that the value of the targeted and program cuts be returned to each speciality, also effective April 1, 2017, for allocation – the OMA has detailed proposals on point – subject to the agreement of the Ministry, or determination by the arbitration board. Other program cuts requiring redress include resumption of Managed Entry into FHOs– 80 Physicians per month in 2018-2019 and 40 per month in subsequent years, reintroduction of Income Stabilization – to align with Managed Entry, increased payment of the Acuity Modifier and removal of the moratorium on Hospital On-Call Coverage (HOCC), and other changes.

The OMA – Fee Increases

In terms of fee increases namely, across the board payments, the OMA seeks 1.4% annually for all fee for service and non-fee for service payments for the for the three-year period 2014-2015 to 2016-2017 (i.e. for the period prior to the commencement of the PSA settled by this award, on the basis that there were no normative increases given in those years), for a total of 4.2% (4.26 % compounded) effective April 1, 2017, and then 2.6% in each year of the four years of

the term of the PSA settled by this award. These amounts, the OMA argued, were justified in recognition of no actual increase since 2011 and by reference to comparators, increasing practice costs including rising overhead (as much as 30% of income), positive economic conditions and projections, including losses suffered by inflation between 2015-2017 and other factors detailed in the OMA submissions.

Redress – The Ministry Position

The Ministry categorically rejected the OMA case for redress. Its review of the negotiation history between the parties – detailed at length and in great detail in its submissions – led it to conclude, and urge upon the arbitration board, the conclusion that there was no "stolen money," and no legitimate claim for redress. At various points over the course of a long relationship between the parties, increases have been implemented; and at other times, there has been economic restraint. What was new, in the Ministry's submission following its chronological review, was any claim for redress following cost containment.

The truth of the matter was, in the Ministry's estimation, that the rollbacks were justified after years of extraordinary increases (including over the 2008 recession when elsewhere in the broader public sector virtually every other group of publicly funded employees were affected by significant wage restraint). Rebalancing through measured adjustments to reflect economic reality did not create a case for redress. There was no absence of due process; the agreed-upon process was followed. By any measure physician compensation in Ontario was generous; the

rates competitive. There was no case for catch-up and no legitimacy whatsoever in the claim for redress.

Indeed, after years of increases, up to and including in 2011, rebalancing was necessary as physician incomes had accelerated, galloped really, at an excessive, indeed far from normative pace. In the meantime, the negotiation process was the one that the parties had agreed upon in the 2012 PSA Settlement. The OMA may not like the facilitation and conciliation recommendations – but they arose out of a process that it had agreed to and it was one in which the OMA was represented by experienced counsel and one, in the circumstances, that could not, therefore, be fairly described as unilaterally imposed. No other group, the Ministry pointed out, received payments to recover "lost earnings" during wage restraint. The Ministry strongly urged the arbitration board to reject the OMA redress request.

The Ministry – Fee Increases

Insofar as normative increases were concerned, the Ministry proposed 1% annual increases in years two, three and four of the PSA, with the exception of Cardiology, Radiology and Ophthalmology (where it is seeking certain fee reductions). Limited increases of this nature were justified, the Ministry argued, when Ontario physician income was compared with physician income in other provinces (Ontario doctors are paid more; Alberta doctors, for example, have recently agreed to a reopener with rollbacks), and when considered alongside other Ontario public sector and broader public sector settlements, not to mention income outcomes when measured against the Consumer Price Index and the Industrial Aggregate Index,

to name just two. It was also necessary, the Ministry argued, to bear in mind that the Ministry provided Ontario doctors with significant income supports, benefits and subsidies, including for example, CMPA membership fees. There was, moreover, no recruitment or retention issue: Ontario was the number one choice for residency, both by doctors trained in the province and those who received their training outside of it. The Ministry rejected the OMA assertion of a 30% overhead cost – this figure was the result of small sample size and flawed survey methodology. Survey participants clearly understood that their self-interest would be maximized by overstating their overhead and thereby understating income. The actual number, the Ministry suggested, was closer to 20% and did not, in any event, support the OMA's monetary demands.

Decision – Redress and Fee Increases

Redress

The OMA asserts that the 2012 PSA Settlement, which contained an agreed-upon .5% discount on all physician payments was never intended to be permanent. However, in our view, this negotiated outcome cannot properly be included in any redress claim as it was voluntarily agreed upon. If the parties had wished to sunset it, they could have easily done so, and it is factually and legally significant that they did not.

The Ministry observes that no other group has received redress or catch-up for lost earnings, and we agree that it would not be proper to award amounts in lieu of what might have been negotiated but for wage restraint and unilateral Ministry action. Accordingly, we reject the

OMA claims for compensation for periods prior to the commencement of the PSA settled by this award. However, we do accept the case for redress. Some further discussion is in order.

If fee reductions were temporary and then restored, there would be no case for redress (and this has happened in the past). The difference here, however, is that the Ministry actually reduced existing compensation, as is indicated on physician billing statements, and has continued to do so for years. Doctors did not have their incomes frozen, but uniquely were the only group to have their compensation cut, and these cuts continue. The billing rates remain the same, but a deduction is imposed. This is not wage restraint normally given expression in a freeze, and while it is not fairly described as "stolen money" it is confiscatory absent agreement, and the facilitation and conciliation process, undoubtedly conducted in good faith, was followed by unilateral action. Absent a binding and independent process for the adjudication of differences – as found in the BAF that governs here – it simply cannot be said that unilateral action taken after a failed conciliation is fair. It cannot constitute agreement.

Fee Increases

From the Ministry perspective, compensation paid to Ontario doctors was fair, generous and competitive. The OMA disagrees pointing out that there has been a net decline in earnings when the comparators were examined, and a strong case for major increases made when the usual interest arbitration criteria and economic and labour relations indicators were applied (as set out in detail in its brief and reply brief). In addition, the OMA takes the position that the Ministry vastly underestimated overhead costs, while seeking credit for contributions, for

example, to malpractice insurance was completely inappropriate as that was a widely accepted feature across the country of physician compensation.

As noted above, the Ministry proposed 1% for some, but not all, doctors in years two, three and four, with targeted decreases in fees for certain specialists, while the OMA proposed a compounded 4.2% upon commencement of the PSA and 2.6% each year without any restrictions thereafter (along with various other economic improvements), and no targeted fee cuts.

We cannot accept either proposal. Ontario doctors have had their compensation frozen, while their counterparts in other jurisdictions have seen increases. Nevertheless, there is no case to be made for the extraordinary increases the OMA proposes, especially when a total compensation approach is adopted and account is taken of awarded redress. Across the board increases must, under the BAF, be fair and reasonable, and in our view, this can be achieved with an award that is partially reflective of sectoral outcomes during the term of the PSA, but also reflective of other aspects of this award, both in terms of proposals for redress that have been awarded and proposals of the Ministry to moderate increases.

(Parenthetically, the matter of overhead costs is of concern given the delta between the Ministry and OMA estimates. On the one hand, the Ministry's methodology raises concerns, but there are also flaws in the results relied on by the OMA (they are largely self-reported and some of the underlying assumptions raise more question than answers among other issues). We

believe that the parties must jointly collaboratively and comprehensively address this issue prior to their next PSA. An objective and professional study could actually determine what overhead costs were in different practice models and specialities.)

Accordingly, we award across the board increases and redress as follows:

(1) Effective April 1, 2017

For the 17/18 contract year, a 0.75% compensation adjustment to physician payments set out in Section 21(a) of the Binding Arbitration Framework (BAF), For greater clarity, this shall include all payments set out in Appendix A of the BAF, but will exclude OPIP. For further clarity, these increases will apply to office based technical fees and facility fees, but not to hospital technical fees.

(2) Effective April 1, 2018

For the 18/19 contract year, a 1.25% compensation adjustment to physician payments set out in Section 21(a) of the BAF. For greater clarity, this shall include all payments set out in Appendix A of the BAF, but will exclude OPIP. For further clarity, these increases will apply to office based technical fees and facility fees, but not to hospital technical fees.

(3) Effective April 1, 2019

For the 19/20 contract year, a 1.0% compensation adjustment to physician payments set out in Section 21(a) of the BAF. For greater clarity, this shall include Appendix A of the BAF, but will exclude OPIP. For further clarity, these increases will apply to office based technical fees and facility fees, but not to hospital technical fees.

A portion of this adjustment will be applied to remove the 0.5% payment discount under the 2012 PSA, and will not be subject to distribution or allocation under Phase 2.

In addition, the 2.65% for non-fee for service and 3.95% for fee-for service 2015 payment discounts will be removed (the "redress compensation adjustment"). These adjustments will also not be subject to distribution or allocation under Phase 2.

(4) Effective April 1, 2020

For the 20/21 contract year, a 1.0% compensation adjustment to physician payments set out in Section 21(a) of the BAF. For greater clarity, this shall include all payments set out in Appendix A of the BAF, but will exclude OPIP. For further clarity, these increases will apply to office based technical fees and facility fees, but not to hospital technical fees.

Except as specifically noted above, the distribution of the fee increases we have awarded is subject to relativity adjustments. The parties have agreed that in years one and two the PSA settled by this award that this distribution is governed by the terms of the parties' interim relativity agreement. The board remains seized in respect of years three and four should the parties be unable to agree, and this matter can proceed in the next phase of these proceedings.

Other Compensation Matters

While we have concluded that there should be redress, as set out above, for the across-the-board payment discounts applied to both the fee for service and the non-fee for service payments, we have decided not to order the reversal or amelioration of any of the earlier targeted cuts directed to certain fees and schedules. We have also rejected the Ministry's proposals for targeted fee reductions aimed at radiology, ophthalmology and cardiology and the OMA's incorporation redress proposal. In our view, our focus in ordering redress for the unilateral across the board fee reductions, together with the compensation adjustments that we have ordered, reflects an appropriate overall outcome for the 2017-21 PSA.

Finally, as the parties move on to now resolving the relativity issues between them in terms of the normative increase we have awarded, we believe it is appropriate for us to indicate that, at this time, we would not be inclined as a board of arbitration to direct that the fees or compensation paid to some groups should be reduced, in order to increase the fees or compensation paid to other groups, whether on relativity grounds or otherwise. Rather, at this stage of the parties' relationship, and subject to being persuaded otherwise, given the history over the past several years, we do not believe that this is a time for any further reductions to physician compensation. To be clear, we are not precluding the parties from making submissions on this issue if they wish to do so.

Primary Care

The MOHLTC believes that the FHO model is broken and requires immediate substantial change. The OMA, acknowledging the need for some change, made its proposals contingent on further increasing the number of FHO physicians through Managed Entry (together with income stabilization) and proposed that the parties jointly examine the need for any additional modifications.

There is, in our view, a clear and immediate need for greater patient access to their FHO physician. There are approximately 11 million people in the province currently rostered in comprehensive payment models of which the FHOs are front and center. At the same time, the Ministry has raised serious and far-reaching access issues, and while capitation is intended to pay for primary patient care, alternatives such as walk-in clinics, and FHO physician

unavailability, challenge the system and its sustainability. Capitation is intended to pay for primary patient care, so that inappropriate use of alternatives such as walk-in clinics, or any failure of FHO physicians to provide sufficient access, threaten to undermine the principled basis upon which the entire foundation rests. To elaborate: under the FHO model, a FHO physician receives a capitation amount for the care of a FHO patient. What that means is that FHOs, adjusted for size and population, must provide ready access, and not just during regular working hours. Moreover, the evidence establishes that many FHO rostered patients, for whatever reason, obtain health care from walk-in clinics; health care that is, in the result, publicly paid for twice (and there is no communication between the clinic and the FHO aggravating an already intolerable situation). In our view, this cannot continue as a feature of a publicly funded sustainable health care system

However, at this time, we are not prepared to award any of the OMA or Ministry primary care proposals. Considerable progress toward change, including improved access for residents of Ontario, was achieved during the mediation phase of the proceedings. We are all of the view, however, that a further process of focused discussions could, and would, prove productive. Members of the arbitration board would be willing, if requested, to facilitate or mediate these discussions.

Accordingly, we award the following:

Multi-Stakeholder Primary Care Working Group

The parties will establish a Multi-Stakeholder Primary Care Working Group, reporting to the PSC, and composed of an equal number of OMA and MOHLTC members. The PSC may also appoint stakeholder representatives to the Committee.

The Working Group will examine into and make recommendations regarding access and quality issues, walk-in clinics, complexity modifiers for both capitated and non-capitated practices, and such other issues as either party identified during bargaining or as they may agree to address.

The Working Group will endeavour to make recommendations to PSC by July 1, 2020. Where both parties agree, they may request the Chair or the board's ongoing assistance.

Academic Health Sciences Centre and NOSM Proposals

The innovation fund under the AHSC AFP will be increased by an additional 7.5 million dollars effective April 1, 2019, and by a further 2.5 million dollars effective April 1, 2020 (for a total increase of 10 million dollars).

The compensation adjustments to the NOSM and AHSC AFPs flowing from Section 2 above will increase the existing NOSM and AHSC funding, and will not be subject to distribution or allocation under Phase 2.

In addition, the parties are directed to continue discussions regarding the other aspects of the OMA's NOSM and AHSC proposals, in particular for rightsizing and repair.

Where consensus cannot be reached on AHSC or NOSM issues, either party may trigger further mediation with the assistance of the board or the Chair.

Technical Fees Proposals

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.

Conclusion

At the request of the parties, we remain seized with respect to the implementation of this award. Finally, we are releasing this award to counsel on February 18, but in order for counsel to review it and advise their respective clients, we are directing that this award be embargoed and not be made public until 4 pm on February 19, 2019.

Dated at Toronto this 18th day of February 2019.

"William Kaplan"

William Kaplan, Chair

"Dr. Kevin Smith"

Dr. Kevin Smith, Ministry Nominee

"Ron Pink"

Ron Pink, QC, OMA Nominee

APPENDIX - APPROPRIATENESS WORKING GROUP (AWG) AND PROCESS

1. The parties will establish a joint Appropriateness Working Group (AWG) composed of:

   (a) Four (4) representatives from the Ministry of Health; and

   (b) Four (4) representatives from the OMA.

   The AWG will be co-chaired, with each of the Ministry and OMA selecting one of their respective members to act in this position (the Co-Chairs).

2. The purpose of the AWG is to promote the parties' shared commitment to the use of evidence and best practices, in order to improve the quality of patient care by reducing the provision of medically unnecessary or inappropriate medical services without compromising patient access to medically necessary services.

3. In determining whether a service is medically unnecessary or inappropriate, the AWG will be guided by the best available evidence. This could include Health Quality Ontario reports and recommendations, Health Technology Assessments, peer reviewed literature, Choosing Wisely Canada recommendations, consultations with both physicians and experts in the field being examined, any provincial, national or international guidelines for high quality patient care, clinical care standards and principles of professional practice.

4. In carrying out its mandate, the AWG will initially focus on, but not be limited to, the Ministry appropriateness proposals, tabled during the 2017-18 negotiations and mediation process.

5. The Ministry or the OMA may identify additional proposals for appropriateness changes, aimed at identifying medically unnecessary or inappropriate provision of services which are unrelated to meeting clinical needs.

6. The AWG may, in carrying out its mandate, consult with such additional outside parties, organizations and expert panels on an ad hoc basis as the committee considers helpful. The AWG will also consult relevant OMA sections impacted by the proposals under consideration.

7. The AWG will seek to reach agreement on reducing the provision of medically unnecessary or inappropriate services through payment rule changes (including modifying or specifying the indications for treatment), de-listing of a service and/or other rule changes as are responsive to the determination of appropriateness/inappropriateness, and/or through physician peer comparisons/review and physician/patient education. This may also include mechanisms for operationalizing recommendations regarding appropriateness/inappropriateness. However, there is no

scope for the AWG or the arbitration board to set, change or reduce fees for the provision of individual services.

8. The parties will determine the value of the changes arising from the process set out in paragraph 7, which will be deemed to be equal to the difference between the amount paid for the service in the prior fiscal year under the previous payment coverage/rule, and what would have been paid had the revised payment coverage/rule been in effect in that prior fiscal year. By way of example, if a rule change is made, the total value of the change will be equal to the amount that would have been paid for the service in the prior fiscal year had the payment rule change been in effect. If a service is delisted, the total value of the change will be equal to the amount paid for the service in the prior fiscal year. For peer review/comparison and educational changes, the parties will use best efforts to determine the value of the expected changes in the provision of medically unnecessary/inappropriate services. In any case, failure to reach agreement on the value of any changes as determined in accordance with this paragraph will be determined by the board of arbitration. The parties will work together to implement processes in an effort to achieve the expected outcomes.

9. For purposes of the 19/20 contract year, the committee will endeavor to achieve a settlement by May 1, 2019 on the matters set out in paragraph 7 and 8 totaling $ 100M for the period of June 1, 2019 to March 31, 2020. If no settlement is achieved, the Kaplan Board of Arbitration shall remain seized, and will hold hearings with an award by June 1, 2019 that will identify the changes totaling $ 100 million.

10. For the purposes of the 20/21 contract year, the committee will endeavor to achieve a settlement by September 30, 2019 on the matters set out in paragraphs 7 and 8 totaling a further $360 million for the period of April 1, 2020 to March 31, 2021. If no settlement is achieved, the Kaplan Board of Arbitration shall remain seized, and will hold hearings with an award by January 1, 2020 that will identify the changes totaling a further $ 360M.

11. For further clarity, the totals to be achieved as a result of paragraph 9 and 10 above are $480 million.

12. It is understood that if changes of more $100 million are agreed to/awarded in 19/20, the 20/21 amount will be reduced by the excess.

13. In making its determination under paragraphs 9 and 10, the Board of Arbitration may not order that services be delisted absent agreement. Where the parties agreed to delisting changes, the value of those changes determined in accordance with paragraph 8 will be included in the annual total.

14. In the course of its deliberations, the AWG may refer specific appropriateness proposals to an Expert Panel for review. This would involve convening an expert group to provide recommendations, based on appraisals of the evidence, and will typically occur when

the AWG cannot come to a consensus. The AWG will then consider the information/recommendation(s).

15. Any dispute with respect to procedural issues relating to the operation of the AWG, or an Expert Panel, including timelines, will be determined by the chair of the Board of Arbitration.

16. The parties will fund their appointed members of the AWG and provide necessary secretariat support.

EXHIBIT 8

Additional Investment outside those negotiated in the 2021-2024 PSA

The Ministry also implemented/committed additional improvements outside the PSA during the term of the agreement totaling an estimated $35.2 million dollars. Investments largely occurred in the creation or expansion of alternative funding plans (AFP's), i.e. additional opportunities for physicians to be compensated through alternative funding plans and not price increases.

Additional Investments	**Start date**	**2022-23 expenditures**
New groups/contracts		
St. Michael's Hospital Emergency Department Psychiatry Group	2021-22	$132,613
Health Sciences North Sudbury ICU	2021-22	$210,000
Headwaters Health Care Paediatric Group	2021-22	$825,884
Tillsonburg Emergency Department Group	2022-23	$1,195,250
Woodstock Hospital Pediatrics Group	2022-23	$115,103
St. Joseph's Healthcare Hamilton Emergency Physician Group	2022-23	$10,570
Brant Community Healthcare Paediatric Group	2021-22	$230,009
Georgian Bay General Hospital Anaesthesia Group	2022-23	$125,105
Expansion of existing groups/contracts		
Thunder Bay Regional Consulting Paediatrics	2021-22	$462,688
SEAMO Brockville Obstetrics	2021-22	$167,000
London Paediatric Surgical APP	2021-22	$201,556
London Academic Paediatric Associates	2021-22	$386,286
West Park Healthcare APP	2021-22	$526,637
Sudbury Regional Consulting Paediatrics	2021-22	$562,432
Lakeridge Health Ajax-Pickering site	2021-22	$811,451
Centre for Addictions and Mental Health (CAMH) Psychiatric ED	2021-22	$475,621
Stratford Regional Consulting Paediatric	2021-22	$200,573
CHAMO Clinical Assistants	2021-22	$1,547,010
SEAMO Providence Transitional Care Centre funding	2021-22	$583,926
CHC Kawartha Lakes & De dwa da dehs nye>s	2021-22	$534,816
Matawa Health Co-operative	2021-22	$1,646,020
CHC International Agricultural Workers	2021-22	$145,485
SEAMO AHSC AFP - Internal Medicine	2022-23	$3,725,590
Hamilton Health Sciences Centre AHSC AFP (HAHSO) Burns Unit	2022-23	$957,788

NE Ontario GP Anaesthesia	2022-23	$1,844,571
Bruyere AHSC AFP Family Med and Physiatry FTE	2022-23	$848,000
London Academic Paediatric Associates Genetics FTE	2022-23	$165,682
Hamilton Academic Paediatric Associates (HAPA)	2022-23	$1,029,571
London Health Sciences Centre Paediatric Anaesthesia	2022-23	$1,844,000
Orillia Soldiers Memorial Hospital GP Anaesthesia	2022-23	$614,857
Kenora Chiefs Advisory/All Nations Health Partners OHT APP	2022-23	$255,000
Southwestern Ontario Aboriginal Health Access Network (SOAHAC)	2022-23	$272,784
Total		**$22,653,878**

Below is a list of additional investments/initiatives that began in 2023-24, currently estimated that $12.6M total will be spent in fiscal 23/24.

2023-24 Additional Investments
RNPGA Complement Review
Provincial Oncology Agreement
Sensenbrenner Hospital GPA
Lady Minto Hospital & MIC's GPA
Hopital Notre-Dame Hospital GPA
Hawkesbury and District Anaesthesia Associates
RNPGA Contract Exceptions Requested
GP Focused Care Of the Elderly AFP
GP Focused Palliative Care AFP
Shelter Health Network
Homeless Shelter Agreement AFP
Periwinkle Health Home (Kingston CHC expansion)
St. Joseph's Health Centre

EXHIBIT 9

Ontario

The Honourable
Peter Bethlenfalvy
MINISTER OF FINANCE

Building a Better Ontario

2024 ONTARIO BUDGET



Budget Papers

For general inquiries regarding *2024 Ontario Budget: Building a Better Ontario* please call:

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Bâtir un Ontario meilleur : Budget de l'Ontario 2024

Delivering on Our Plan to Build Ontario

Over the past six years, as our economy and population have grown, our government has been delivering on our plan to build Ontario.

Like the rest of the world, Ontario continues to face economic uncertainty due to high interest rates and global instability.

These challenges are putting pressure on Ontario families, as well as public finances. High inflation, high Bank of Canada interest rates and the high cost of the federal carbon tax have pushed costs up. Households are struggling.

Faced with these challenges, other governments might choose to raise taxes, reduce investments in services or download costs on municipalities. Our government is taking a different approach. We are continuing to invest in Ontario's people and communities. We are doing what's needed to get it done.

Our plan is rebuilding Ontario's economy. We are keeping costs down by holding the line on new taxes as we build the infrastructure our growing province needs.

Because for too long, Ontario was left behind.

Under previous governments, over 300,000 manufacturing jobs were lost.

Previous governments failed to adequately build roads, highways, bridges and public transit. After decades of a chronic lack of funding, Ontario's economy loses billions of dollars each year from the high cost of gridlock.

Previous governments let the cost of energy spiral out of control.

Our government was elected on a plan to fix these problems. We were elected on a plan to rebuild Ontario's economy and bring back good-paying manufacturing jobs. We were elected to build roads, highways and public transit. We were elected to keep costs down for Ontario workers and families.

Now, more people are working than ever before.

Now, shovels are in the ground on new roads, highways and the largest public transit expansion in North America.

Now, Ontario is leading the future of affordable, safe and clean nuclear energy.

We're sticking to our plan. We're getting it done.

Rebuilding Ontario's Economy

From the day we first took office, our government has been on a mission to rebuild Ontario's economy.

We're keeping taxes low, cutting red tape and investing in workers.

Despite challenging economic headwinds, we are attracting record investment to Ontario.

Over the last three years, Ontario created almost 900,000 net new jobs, the fastest growth on record.

In Northern Ontario, we are advancing the building of all-season roads to the Ring of Fire to bring prosperity to First Nations and Northern communities. We are unlocking the economic potential of the critical minerals that will help power Ontario's electric vehicle battery supply chains. Minerals mined in Ontario will power electric vehicles built in new Ontario factories by Ontario workers, purchased in Ontario and around the world.

In Hamilton, ArcelorMittal Dofasco is making a $1.8 billion investment to replace its coal-fed coke ovens and blast furnaces with new, low-emission technology. And in Sault Ste. Marie, Algoma Steel is investing $700 million in a low-emission electric arc furnace.

In St. Thomas, Volkswagen's $7 billion investment in its first overseas electric vehicle battery cell plant is creating 3,000 good-paying manufacturing jobs.

In Windsor, the NextStar Energy EV battery plant will support 2,500 Ontario workers, with more than $5 billion invested in Ontario.

And in Loyalist Township, Umicore is creating 600 new direct jobs with a $2.7 billion investment.

In fact, Ontario is the only place in North America where five of the largest auto manufacturers have set up shop. In addition, Volkswagen is establishing its first overseas electric vehicle battery cell manufacturing plant in Ontario.

This success is not an accident. It is a direct result of our government's plan to rebuild Ontario's economy by investing in workers and keeping taxes low.

These investments and our economy are powered by one of the cleanest grids in North America. Our government is leading the future of nuclear energy by building the first grid-scale small modular reactors in Canada. At the same time, we are supporting the refurbishment of the Bruce, Darlington and Pickering Nuclear Generating Stations with pre-development work also underway for a new large-scale nuclear plant at the Bruce nuclear site.

As part of a pragmatic plan that includes natural gas, investing in and bringing online more clean nuclear energy will fix the mistakes of past governments' energy policies with sensible policies that support economic growth and keep costs down for people and businesses.

Building Infrastructure, Highways and Transit in Your Community

Rebuilding Ontario's economy demands that we build the infrastructure needed to support our growing communities.

Ontario's Plan to Build includes the most ambitious capital plan in the province's history, with $190.2 billion over the next decade to support growing businesses, families and newcomers.

To help municipalities meet their housing targets and get shovels in the ground, we are increasing funding for infrastructure so municipalities can build more homes.

That includes $1 billion in our new Municipal Housing Infrastructure Program and $825 million for the Housing-Enabling Water Systems Fund. The $1.2 billion Building Faster Fund is also helping municipalities build new homes.

To help Ontario communities grow and thrive, we are introducing the new $200 million Community Sport and Recreation Infrastructure Fund to support new and upgraded sport and recreation facilities to support the health and well-being of children, families and seniors across Ontario.

In addition, we successfully negotiated our historic new deal with the City of Toronto, providing new tools, resources and funding to support the City's recovery through growth.

Across Ontario, we are building new roads and highways. We are leading the largest expansion of public transit in North America.

In Windsor-Essex County, shovels are in the ground to expand Highway 3, with planning underway to build a new interchange connecting Highway 401 to Lauzon Parkway. Now, we are helping to build a new interchange at Banwell Road and E.C. Row Expressway to support population growth and the development of the NextStar Energy electric vehicle battery plant.

In Ottawa, we are designing a new interchange at Highway 416 and Barnsdale Road to support South Ottawa's growing population.

We are also moving forward with critical projects that will get people and goods across the GTA moving again, including building Highway 413 and the Bradford Bypass and advancing work on Highway 7 in Markham to Brock Road, through Pickering.

As part of our government's historic transit expansion, we are bringing back two daily weekday train trips on the Milton GO Line and moving forward with our plan to provide two-way, all-day GO service to Milton.

We have also added year-round GO train service to Niagara.

We are bringing fast and reliable transit to downtown Mississauga and Brampton by expanding the Hazel McCallion Light Rail Transit Line, including a two-kilometre extension and loop through to Confederation Parkway.

Work is well underway on four priority subway projects in the GTA, including the Ontario Line, three-stop Scarborough Subway Extension, Yonge North Subway Extension into York Region, and the Eglinton Crosstown West Extension, and planned connection to Pearson International Airport, one of the largest employment areas in Canada.

In order to attract more investment in the province's infrastructure, our government introduced the Building Ontario Fund, which will help build more projects in areas like clean energy generation, long-term care and student housing.

Starting with an allocation of $3 billion, the fund will create opportunities for pension funds to put their members' investments to work right here in Ontario.

This Plan to Build is the most ambitious in Ontario's history, but it is also necessary to lay the groundwork for Ontario's long-term growth. Our government will continue to invest to support the success of Ontario workers, families and businesses for years to come.

Working for Workers

Ontario's workers are central to *Ontario's Plan to Build*. They are our greatest asset and the reason that people want to invest in Ontario.

We are investing in our workers to help them get the skills they need to train for the in-demand jobs of the future in key areas like health care and the skilled trades.

Since our government launched the Skills Development Fund in 2021, we have trained more than 500,000 workers for better jobs and bigger paycheques, including carpenters, plumbers and health care personnel through nearly 600 training projects.

Through an additional $100 million in the Skills Development Fund this year, we will continue to help job seekers advance their careers.

We are also investing more than $62 million in two of the province's foundational skilled trades programs to help young people explore future careers in the skilled trades. This includes over $21 million to expand the Ontario Youth Apprenticeship Program and $42 million to launch 100 pre-apprenticeship training projects around the province that will help young people acquire firsthand job experience.

Our workers deserve sustainable pensions. This is why we are taking action to implement a target benefit framework that would help protect the retirement security of workers in the skilled trades and other occupations. It would help employees move from employer to employer while keeping the same pension, and they could even see their savings invested in projects right here in Ontario.

Our plan ensures that as Ontario and its economy grow, so do workers' paycheques.

Keeping Your Costs Down

Bank of Canada interest rate hikes, high inflation and the federal carbon tax have made life challenging for Ontario families. As families are feeling the pinch on their household budgets, our government refuses to increase taxes or pass on additional costs.

We acted early to keep costs down and we are continuing to support Ontario families.

At a time when the federal government is set to raise the carbon tax even further, we are proposing to extend the gas tax and fuel tax cuts until December 31, 2024, saving Ontario households $320 on average since July 2022.

We are also supporting families and students across Ontario by extending the tuition freeze at Ontario's publicly assisted colleges and universities for at least three more years. Since the freeze was first implemented in 2019, we have saved university students an estimated $1,600 and college students an estimated $350 each year.

We are also saving daily transit users on participating systems an average of $1,600 each year through One Fare, which eliminates double fares across transit systems throughout the Greater Golden Horseshoe.

We are standing up for drivers by banning new road tolls on 400-series highways in Ontario, and we have frozen driver's licence and photo card fees, saving drivers an estimated $66 million over the next five years.

We are putting money back in people's pockets by refunding eligible licence plate renewal fees paid since March 2020 for nearly 8 million vehicle owners in Ontario. We also eliminated licence plate renewal fees and plate stickers on a go-forward basis.

And our government is helping more seniors access financial assistance by indexing the Guaranteed Annual Income System (GAINS) benefit to the rate of inflation for the first time in Ontario's history. We are also expanding the annual income eligibility threshold, meaning about 100,000 more low-income seniors in Ontario will receive payments.

This year, our government froze the beer basic tax indexation and the LCBO mark-up rates for another two years and is proposing to scrap the 6.1 per cent on-site wine basic tax, making it easier for businesses and providing potential savings for consumers.

These measures will help keep more money in the pockets of Ontario families at a time when they need it most.

Better Services for You

We believe in investing in better services that make people's lives easier and more convenient.

This is why our government is building a robust health care system that puts people at the centre of care, including the most ambitious plan for hospital expansion in the province's history.

Ontario's plan includes supporting more than 50 hospital projects that would add approximately 3,000 new beds over 10 years.

In fact, over the next 10 years, Ontario is investing nearly $50 billion in health infrastructure, including close to $36 billion in capital grants.

But we know Ontarians also depend on health care supports outside of hospitals. This is why our government is continuing to make health care more connected and convenient, to help patients receive the right care in the right place.

Through an additional investment of $546 million over three years, we are creating new and expanded primary care teams to provide team-based primary care to approximately 600,000 people.

We are also strengthening our health care workforce by providing $128 million over the next three years to support enrolment increases of 2,000 registered nurses and 1,000 registered practical nurses at publicly assisted colleges and universities.

The government is helping to address the increasing demand for health human resources across the province, particularly in underserved communities, through the expanded Ontario Learn and Stay Grant.

We're supporting a new medical school at York University, which will be the first medical school in Canada focused primarily on training family doctors.

We're building new schools and renovating existing schools to help ensure Ontario's students learn and grow, with $1.4 billion in the current school year alone to help build schools in places like North Bay, Kitchener, Lincoln, Barrhaven and Brockville.

We are helping students get back to basics through skills in math, reading and writing, and better preparing them for the in-demand jobs and opportunities of the future.

Our government knows Ontario families deserve to feel safe in their homes and communities.

This is why we are providing $46 million over three years to support patrol and response times in the GTA, including the purchase of four helicopters.

We are also investing in correctional and courthouse facilities to improve safety and security in aging institutions and to help to provide access to justice in growing communities, such as the recently completed expansion of the Brampton courthouse in Peel Region.

We're also hitting back against auto theft with $49 million over three years to help police put those responsible behind bars, and we are supporting increased crime-fighting measures to support prevention and detection of auto theft.

We're investing in these services because we know they are critical to helping Ontario workers and families reach their full potential and fully participate in society and the workforce.

We're doing so while retaining a path to balance the budget.

A Plan to Build Ontario

Our Plan to Build Ontario is working.

After years of neglect and mismanagement under previous governments, we are rebuilding Ontario's economy.

But we know there is more work to be done and at a time of high interest rates and global economic uncertainty, it is more important than ever to keep costs down.

This is why our government refuses to slow down our work to rebuild this province and it is why we refuse to put additional costs and taxes on families, businesses and municipalities.

We will continue our prudent, responsible approach. We will get it done.

Original signed by

The Honourable Peter Bethlenfalvy
Ontario's Minister of Finance

Contents

Minister's Foreword

Delivering on Our Plan to Build Ontario iii
Rebuilding Ontario's Economy iv
Building Infrastructure, Highways and Transit in Your Community v
Working for Workers vii
Keeping Your Costs Down viii
Better Services for You ix
A Plan to Build Ontario x

Ontario's Economic and Fiscal Outlook in Brief

Ontario's Economic and Fiscal Outlook in Brief 3
Ontario's Economic Outlook 5
Revisions to the Economic Outlook Since the *2023 Budget* 5
Managing Ontario's Finances Responsibly 7
Ontario's Fiscal Plan 8
Revenue Outlook Over the Medium Term 9
Program Expense Outlook Over the Medium Term 9
Interest on Debt Outlook Over the Medium Term 9
Other Fiscal Plan Assumptions 9
Economic and Fiscal Outlook Scenarios 10
Borrowing and Debt Management 12
A Capital Plan to Build a Better Ontario 14

Chapter 1: Building a Better Ontario

Section A: Building Ontario

Rebuilding Ontario's Economy 21
Strengthening Manufacturing and Attracting Investment 22
Leveraging Northern Ontario's Natural Resources 28
Powering Ontario's Growth 33
Supporting Innovation and Economic Growth Through Research and Technology 37
Keeping Costs Down for Ontario Businesses 39
Building Infrastructure, Highways and Transit in Your Communities 45
Funding Infrastructure to Build More Homes 45
Building Stronger Communities for Future Generations 47
Building Highways 52
Building Transit 59

Section B: Working for You

Working for Workers 67
Supporting Skills Development and Training 67
Helping Workers Plan for Retirement 70
Keeping Costs Down 71
Putting Money Back in Your Pocket 71
Helping Ontario's Most Vulnerable 77
Helping to Increase Housing Supply and Affordability 79
Better Services for You 83
Making Health Care More Connected and Convenient 83
Building and Expanding Hospitals to Improve Care 91
Building Long-Term Care Homes 93
Getting Back to Basics in Education 94
Supporting Students with Special Education Needs 95
Building Schools and Child Care Spaces 96
Supporting Efficiency, Transparency and Accountability in the Postsecondary Education Sector 100
Reducing Red Tape 102
Strengthening Provincial Agencies 103
Expanding Protected Areas and Provincial Green Spaces 103
Protecting You and Your Family 106
Modernizing Financial Services and Capital Markets to Protect Consumers 111

Chapter 2: Economic Performance and Outlook

Introduction 115
Revisions to the Outlook Since the *2023 Budget* 116
Recent Economic Performance 118
Real GDP Growth 120
Consumer Price Inflation 121
Economic Outlook 122
Global Economic Environment 125
Financial Markets and Other External Factors 127
Details of Ontario's Economic Outlook 129
Employment and Household Spending 130
Consumer Price Inflation 132
Housing Supply Progress 133
Housing Market 134
Risks to the Outlook 136
Economic Outlook Scenarios 137
Transparent Reporting on the Economy 139

Chapter 3: Continuing to Invest in the Plan to Build: Ontario's Fiscal Plan and Outlook

Introduction 143
2023–24 Interim Fiscal Performance 145
Revenue Update 146
Expense Update 148
Prudence in 2023–24 150
Medium-Term Fiscal Plan 150
Key Changes Since the *2023 Budget* 150
Medium-Term Revenue Outlook 152
Economic and Fiscal Outlook Scenarios 155
Medium-Term Expense Outlook 157
Prudence Built into the Medium-Term Outlook 161
Transparency and Risks 163
Details of Ontario's Finances 164

Chapter 4: Borrowing and Debt Management

Introduction 177
Borrowing Program 178
Sustainable Bond Program 182
Cost of Debt 184
Term of Debt 187
Ensuring Adequate Liquidity Levels 188
Debt Burden Reduction Strategy 189
Consolidated Financial Tables 193

Annex: Details of Tax Measures and Other Legislative Initiatives

Overview 197
Simplifying the Ontario Computer Animation and Special Effects Tax Credit 197
Extending the Temporary Gas Tax and Fuel Tax Rate Cuts 198
Reviewing Ontario's Tax System 198
Property Assessment and Taxation Review 199
Reviewing Alcohol Taxation and Fees 199
Summary of Measures 199
Technical Amendments 200

List of Tables

Ontario's Economic and Fiscal Outlook in Brief

Summary of Ontario's Economic Outlook 5

Changes in the Ontario Ministry of Finance Key Economic Forecast Assumptions: *2023 Budget* Compared to the *2024 Budget* 6

Details of Ontario's Fiscal Plan 8

Ontario Real GDP Growth Scenarios 10

Ontario Nominal GDP Growth Scenarios 10

2023–24 Borrowing Program and Medium-Term Outlook 12

Progress on Relevant Debt Sustainability Measures 13

Infrastructure Expenditures 18

Chapter 1: Building a Better Ontario

Table 1.1 Examples of Recently Approved and Completed Projects Under the Ontario Community Infrastructure Fund 49

Table 1.2 Recently Completed Highway Projects 58

Table 1.3 School Projects Opening in the 2023–24 School Year 97

Table 1.4 Continuing to Get Shovels in the Ground to Build More Schools 98

Chapter 2: Economic Performance and Outlook

Table 2.1 Summary of Ontario's Economic Outlook 115

Table 2.2 Changes in the Ontario Ministry of Finance Key Economic Forecast Assumptions: *2023 Budget* Compared to the *2024 Budget* 117

Table 2.3 Private-Sector Forecasts for Ontario Real GDP Growth 122

Table 2.4 Private-Sector Forecasts for Ontario Nominal GDP Growth 123

Table 2.5 External Factors 128

Table 2.6 Ontario's Economic Outlook 129

Table 2.7 Impact of Sustained Changes in Key External Factors on Real GDP Growth 136

Table 2.8 Ontario Real GDP Growth Scenarios 137

Table 2.9 Ontario Nominal GDP Growth Scenarios 137

Table 2.10 Ontario Economic Accounts Release Dates 139

Chapter 3: Continuing to Invest in the Plan to Build: Ontario's Fiscal Plan and Outlook

Table 3.1 Fiscal Summary 144
Table 3.2 2023–24 In-Year Fiscal Performance 145
Table 3.3 Summary of 2023–24 Revenue Changes Since the *2023 Budget* 146
Table 3.4 Summary of 2023–24 Expense Changes Since the *2023 Budget* 148
Table 3.5 Summary of Medium-Term Revenue Outlook 152
Table 3.6 Selected Economic and Revenue Sensitivities 154
Table 3.7 Ontario's Taxation Revenue Scenarios 155
Table 3.8 Summary of Medium-Term Expense Outlook 157
Table 3.9 Selected Expense Sensitivities 162
Table 3.10 Total Revenue 164
Table 3.11 Total Expense 166
Table 3.12 Infrastructure Expenditures 171
Table 3.13 10-Year Review of Selected Financial and Economic Statistics 172

Chapter 4: Borrowing and Debt Management

Table 4.1 2023–24 Borrowing Program and Medium-Term Outlook 178
Table 4.2 Progress on Relevant Debt Sustainability Measures 189
Table 4.3 Net Debt and Accumulated Deficit 193
Table 4.4 Medium-Term Outlook: Net Debt and Accumulated Deficit 194

Annex: Details of Tax Measures and Other Legislative Initiatives

Table A.1 Summary of Measures 199

List of Charts

Ontario's Economic and Fiscal Outlook in Brief

Current Fiscal Outlook Compared to the *2023 Budget* and *2023 Ontario Economic Outlook and Fiscal Review* 4

Ontario Fiscal Outlook Scenarios 11

Chapter 1: Building a Better Ontario

Chart 1.1 Supporting Ontario Businesses 40

Chart 1.2 Highway 413 Project Route 54

Chart 1.3 Bradford Bypass Project Route 55

Chart 1.4 Building Transit in the Greater Golden Horseshoe 62

Chart 1.5 Select Measures That Provide Relief to Families and Individuals 76

Chart 1.6 Ontario's Non-Resident Speculation Tax Timeline 80

Chart 1.7 Ontario Parks Electrifying and Creating New Campsites 104

Chapter 2: Economic Performance and Outlook

Chart 2.1 Ontario's Strong Employment Growth 118

Chart 2.2 Performance of Other Key Economic Indicators in 2023 119

Chart 2.3 Ontario's Real GDP Growth Moderated in 2023 120

Chart 2.4 Ontario's Consumer Price Inflation Moderating 121

Chart 2.5 Ontario Nominal GDP Growth Projected to Moderate 124

Chart 2.6 Global Real GDP Growth Projections 125

Chart 2.7 Global Supply Chain Pressures Have Eased 126

Chart 2.8 Bank of Canada Raised Policy Interest Rate Significantly 127

Chart 2.9 Ontario Unemployment Rate to Remain Below Historical Average 130

Chart 2.10 Canadian Households Paying More Interest 131

Chart 2.11 Inflation Projected to Ease 132

Chart 2.12 Making Progress on Housing Supply 133

Chart 2.13 Housing Affordability Impacted by Higher Mortgage Costs 134

Chart 2.14 Housing Market Projected to Rebound 135

Chart 2.15 Range of Ontario GDP Scenario Forecasts 138

Chapter 3: Continuing to Invest in the Plan to Build: Ontario's Fiscal Plan and Outlook

Chart 3.1 Current Fiscal Outlook Compared to the *2023 Budget* and *2023 Ontario Economic Outlook and Fiscal Review* 143

Chart 3.2 Sources of Revenue Changes Since the *2023 Budget* 151

Chart 3.3 Ontario Fiscal Outlook Scenarios 156

Chart 3.4 Composition of Total Revenue, 2024–25 170

Chart 3.5 Composition of Total Expense, 2024–25 170

Chapter 4: Borrowing and Debt Management

Chart 4.1 Borrowing Outlook Scenarios for Long-Term Borrowing 179

Chart 4.2 2023–24 Borrowing 180

Chart 4.3 Domestic and International Borrowing 181

Chart 4.4 Green Bond Allocation by Framework Category 182

Chart 4.5 Ontario's Green Bond Issues 183

Chart 4.6 Effective Interest Rate (Weighted Average) on Total Debt 184

Chart 4.7 Comparison of Average Annual Ontario Borrowing Rate Forecast 185

Chart 4.8 Comparison of Interest on Debt Expense Forecast 186

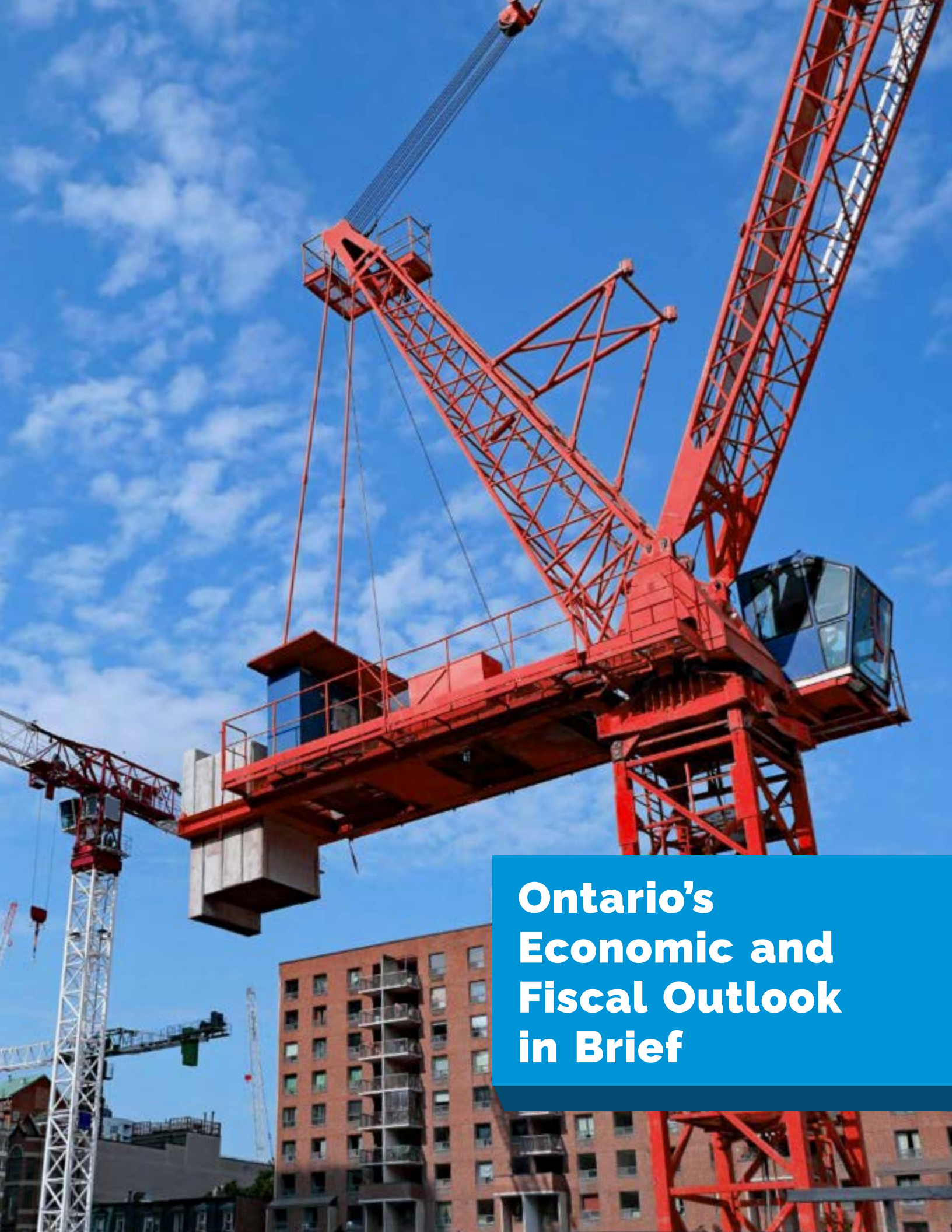
Chart 4.9 Weighted-Average Term of Borrowings 187

Chart 4.10 Average Unrestricted Liquid Reserve Levels 188

Chart 4.11 Net Debt-to-GDP 190

Chart 4.12 Net Debt-to-Revenue 191

Chart 4.13 Interest on Debt-to-Revenue 192



Ontario's Economic and Fiscal Outlook in Brief

Ontario's Economic and Fiscal Outlook in Brief

Ontario, like the rest of the world, continues to face economic challenges and elevated uncertainty. The outcomes of persistently high interest rates and inflation continue to be unclear. However, Ontario's economy has demonstrated continued resiliency in light of ongoing economic pressures. By taking a responsible approach to fiscal management while creating stronger communities for future generations, the government is continuing to make progress on its plan to build Ontario together.

Ontario's economy performed stronger than expected in 2023, despite continued economic headwinds prompted by elevated consumer price inflation and high interest rates. Nearly all private-sector forecasters expect continued but slower growth in 2024, compared to the projection in the *2023 Budget.*

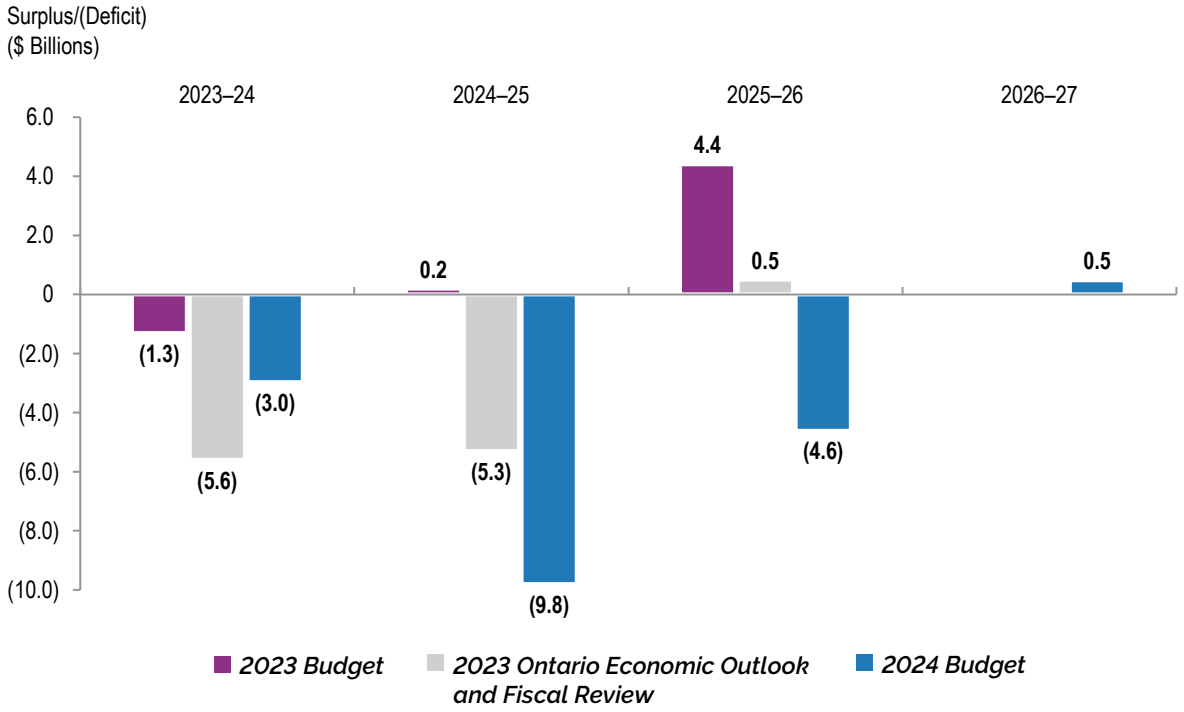
Ontario also experienced above average employment growth in 2023, adding 183,200 net new jobs, a 2.4 per cent increase. Ontario's unemployment rate rose modestly to 5.7 per cent in 2023 but remained low compared to its historic average.

The government's plan retains a path to balance the budget despite a fiscal deterioration relative to Ontario's *2023 Budget* and the outlook in the fall *2023 Ontario Economic Outlook and Fiscal Review*. While slower projected growth in 2024 and other factors beyond the province's control are key drivers of the deterioration, the government is continuing to invest in key public services and not raising taxes or fees to increase revenues at a time when it is important to keep costs down for people and businesses.

In 2023–24, Ontario is projecting a deficit of $3.0 billion. Over the medium term, the government is projecting deficits of $9.8 billion in 2024–25 and $4.6 billion in 2025–26 before planning for a surplus of $0.5 billion in 2026–27. The future pace of economic growth remains uncertain, which may impact these projections.

The government will continue to support people and businesses in Ontario and make prudent and targeted investments to build a strong future together.

Current Fiscal Outlook Compared to the *2023 Budget* and *2023 Ontario Economic Outlook and Fiscal Review*



Source: Ontario Ministry of Finance.

Ontario's Economic Outlook

High interest rates are expected to continue negatively impacting Ontario's economy in 2024, with real gross domestic product (GDP) growth projected to slow from an estimated 1.2 per cent in 2023 to 0.3 per cent in 2024. Real GDP growth is projected to accelerate to 1.9 per cent in 2025, and 2.2 per cent in 2026 and 2027. For the purposes of prudent fiscal planning, these projections are slightly below the average of private-sector forecasts.

Summary of Ontario's Economic Outlook

(Per Cent)

	2022	2023	2024p	2025p	2026p	2027p
Real GDP Growth	3.9	1.2e	0.3	1.9	2.2	2.2
Nominal GDP Growth	9.2	4.1e	2.7	3.9	4.3	4.1
Employment Growth	4.6	2.4	0.8	1.7	1.4	1.4
CPI Inflation	6.8	3.8	2.6	2.0	2.0	2.0

e = estimate.
p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024.
Sources: Statistics Canada and Ontario Ministry of Finance.

Revisions to the Economic Outlook Since the *2023 Budget*

Ontario's real GDP grew by an estimated 1.2 per cent in 2023, stronger than the projection in the *2023 Budget*, and nominal GDP growth is estimated at 4.1 per cent, higher than the 2.8 per cent *2023 Budget* projection.

The outlook has been revised compared to the projections in the *2023 Budget*. Key changes since the *2023 Budget* include the following:

- Stronger estimated real and nominal GDP growth in 2023, accompanied by significantly stronger job creation and a lower unemployment rate;
- Slower real and nominal GDP growth between 2024 and 2026, with the most pronounced deterioration in 2024;
- Weaker net operating surplus of corporations growth over the forecast period; and
- Stronger housing starts throughout the forecast period.

Changes in the Ontario Ministry of Finance Key Economic Forecast Assumptions: *2023 Budget* Compared to the *2024 Budget*

(Per Cent Change)

	2023		2024p		2025p		2026p	
	2023 Budget	***2024 Budget***	***2023 Budget***	***2024 Budget***	***2023 Budget***	***2024 Budget***	***2023 Budget***	***2024 Budget***
Real Gross Domestic Product	**0.2**	**1.2e**	**1.3**	**0.3**	**2.5**	**1.9**	**2.4**	**2.2**
Nominal Gross Domestic Product	**2.8**	**4.1e**	**3.6**	**2.7**	**4.6**	**3.9**	**4.5**	**4.3**
Compensation of Employees	5.1	6.7e	4.2	4.3	4.5	4.4	4.2	4.1
Net Operating Surplus — Corporations	(8.2)	(12.6)e	(0.5)	(4.7)	9.2	3.5	9.1	7.9
Nominal Household Consumption	5.1	6.0e	4.1	3.5	4.3	4.1	4.2	4.3
Other Economic Indicators								
Employment	0.5	2.4	1.0	0.8	1.7	1.7	1.7	1.4
Job Creation (000s)	39	183	78	63	133	136	136	114
Unemployment Rate (Per Cent)	6.4	5.7	6.6	6.7	6.3	6.6	6.3	6.4
Consumer Price Index	3.6	3.8	2.1	2.6	2.0	2.0	2.0	2.0
Housing Starts (000s)[1]	80.3	89.3	79.3	87.9	82.7	92.3	83.2	94.4
Home Resales	(8.9)	(12.3)	21.0	4.0	1.2	16.0	1.2	1.2
Home Resale Prices	(9.7)	(6.3)	2.2	(0.2)	4.0	3.1	4.0	4.0
Key External Variables								
U.S. Real Gross Domestic Product	0.5	2.5	1.2	2.1	2.1	1.7	2.1	2.1
WTI Crude Oil ($US per Barrel)	83	78	80	79	79	78	79	77
Canadian Dollar (Cents US)	74.4	74.1	76.5	74.6	77.6	77.6	78.5	78.2
Three-Month Treasury Bill Rate (Per Cent)[2]	4.3	4.8	3.3	4.4	2.5	3.0	2.4	2.6
10-Year Government Bond Rate (Per Cent)[2]	3.1	3.3	3.1	3.2	3.1	3.1	3.2	3.3

e = estimate.

p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024.

[1] Housing starts projection based on private-sector average as of January 25, 2024.

[2] Government of Canada interest rates.

Sources: Statistics Canada; Canada Mortgage and Housing Corporation; Canadian Real Estate Association; Bank of Canada; United States Bureau of Economic Analysis; *Blue Chip Economic Indicators* (October 2023 and February 2024); U.S. Energy Information Administration; and Ontario Ministry of Finance.

Managing Ontario's Finances Responsibly

The government is providing a transparent update on Ontario's finances and its plan to invest in communities.

The government's multi-year fiscal plan is consistent with the requirements of the *Fiscal Sustainability, Transparency and Accountability Act, 2019* and its governing principles guide Ontario's fiscal policy.

- Transparent: The government continues to demonstrate its commitment to transparency through the release of regular financial updates. In addition, for the sixth year in a row, the Auditor General of Ontario has provided a clean audit opinion on Ontario's consolidated financial statements.
- Responsible: The government has developed a measured and responsible approach to managing Ontario's finances, while investing in key public services and capital projects that will help to improve economic productivity, invest in communities and create jobs.
- Flexible: The government's plan has built in appropriate levels of prudence in the form of contingency funds and a reserve to ensure that the necessary fiscal flexibility is available to respond to changing circumstances.
- Equitable: The government's plan strengthens critical public services, such as health care, for people today and to ensure that they are available for future generations.
- Sustainable: The government is committed to employing a flexible approach to respond to ongoing economic uncertainty, while balancing these needs with the long-term sustainability of Ontario's finances, including the debt burden.

Defining Extraordinary Circumstances

The *Fiscal Sustainability, Transparency and Accountability Act, 2019* requires that the government define the extraordinary circumstances if it plans to run a deficit. The government is defining the extraordinary circumstance for the planned deficits in the current year and the medium-term outlook as the result of ongoing economic uncertainty related to inflation, high interest rates, and rapid population growth creating the need for investments in public services and infrastructure. Ontario is not alone, as these challenges have resulted in difficult economic and fiscal circumstances for governments around the world.

Ontario's Fiscal Plan

In 2024–25, the government is projecting a deficit of $9.8 billion, improving to a deficit of $4.6 billion in 2025–26 and a surplus of $0.5 billion in 2026–27. This is driven by slower growth impacting revenues, increased compensation costs and increased investments in infrastructure, municipalities and key public services, as well as gas tax relief.

Details of Ontario's Fiscal Plan

($ Billions)

	Actual	Interim[1]	Medium-Term Outlook		
	2022–23	2023–24	2024–25	2025–26	2026–27
Revenue					
Personal Income Tax	44.2	50.6	51.9	55.1	58.3
Sales Tax	36.1	39.8	38.8	40.6	42.7
Corporations Tax	27.8	24.2	24.9	26.3	28.0
Ontario Health Premium	4.4	4.9	5.0	5.2	5.4
Education Property Tax	6.0	5.8	5.8	5.9	5.9
All Other Taxes	18.0	17.2	18.2	20.4	21.0
Total Taxation Revenue	**136.5**	**142.5**	**144.7**	**153.5**	**161.3**
Government of Canada	31.3	34.8	36.3	37.5	38.7
Income from Government Business Enterprises	6.1	7.3	6.8	8.0	7.8
Other Non-Tax Revenue	19.0	19.8	18.0	18.5	18.8
Total Revenue	**192.9**	**204.3**	**205.7**	**217.4**	**226.6**
Base Programs[2]					
Health Sector	75.1	84.5	85.0	88.0	89.9
Education Sector[3]	33.6	36.6	37.6	38.8	39.4
Postsecondary Education Sector	11.7	12.6	12.2	12.5	13.0
Children, Community and Social Services Sector	18.0	19.4	19.9	20.1	20.1
Justice Sector	5.3	6.1	5.9	5.6	5.6
Other Programs	30.1	35.3	40.0	40.9	40.9
Total Base Programs	**173.8**	**194.5**	**200.6**	**205.8**	**208.9**
COVID-19 Time-Limited Funding	6.3	–	–	–	–
Other One-Time Expenses	6.3	–	–	–	–
Total Programs	**186.4**	**194.5**	**200.6**	**205.8**	**208.9**
Interest on Debt	12.4	12.8	13.9	14.7	15.2
Total Expense	**198.8**	**207.3**	**214.5**	**220.6**	**224.1**
Surplus/(Deficit) Before Reserve	**(5.9)**	**(3.0)**	**(8.8)**	**(3.1)**	**2.5**
Reserve	–	–	1.0	1.5	2.0
Surplus/(Deficit)	**(5.9)**	**(3.0)**	**(9.8)**	**(4.6)**	**0.5**
Net Debt as a Per Cent of GDP	38.2%	38.0%	39.2%	39.5%	39.1%
Net Debt as a Per Cent of Revenue	207.6%	203.0%	213.5%	211.4%	209.4%
Interest on Debt as a Per Cent of Revenue	6.4%	6.3%	6.8%	6.8%	6.7%

[1] Interim represents the *2024 Budget* projection for the 2023–24 fiscal year.

[2] For presentation purposes in the *2024 Budget*, one-time COVID-19-related spending in 2022–23 has been included within COVID-19 Time-Limited Funding. This funding is no longer reported separately, starting in 2023–24.

[3] Excludes Teachers' Pension Plan. Teachers' Pension Plan expense is included in Other Programs.

Note: Numbers may not add due to rounding.

Sources: Ontario Treasury Board Secretariat and Ontario Ministry of Finance.

Revenue Outlook Over the Medium Term

Ontario's revenue outlook is forecast to increase from $204.3 billion in 2023–24 to $226.6 billion in 2026–27.

Ontario's revenue outlook is anchored by an economic projection based on private-sector forecasts and the best available information at the time of finalizing the planning projection. Details of the medium-term revenue outlook are outlined later in this Budget. See Chapter 3: *Continuing to Invest in the Plan to Build: Ontario's Fiscal Plan and Outlook* for more details.

Key inputs included in the revenue forecast are a prudent economic outlook; existing federal–provincial agreements and funding formulas; and the business plans of government ministries, business enterprises and service organizations.

Program Expense Outlook Over the Medium Term

Ontario's program expense outlook is expected to grow from $194.5 billion in 2023–24 to $208.9 billion in 2026–27. The additional funding will primarily be used to strengthen communities through investments in health, education and infrastructure.

Interest on Debt Outlook Over the Medium Term

Interest on debt is forecast to be $12.8 billion in 2023–24, down from the *2023 Budget* forecast of $14.1 billion and remains lower than the forecast for each of the medium-term outlook years in the *2023 Budget*.

Other Fiscal Plan Assumptions

The reserve is set at $1.0 billion in 2024–25, $1.5 billion in 2025–26, and $2.0 billion in 2026–27, reflecting Ontario's commitment to maintaining a prudent and flexible fiscal plan.

The net debt-to-GDP ratio is projected to be 39.2 per cent in 2024–25, 39.5 per cent in 2025–26, and declining to 39.1 per cent in 2026–27.

Economic and Fiscal Outlook Scenarios

In recognition of the elevated degree of economic uncertainty, the Ontario Ministry of Finance has once again developed Faster Growth and Slower Growth scenarios that the economy could take over the next several years. These alternative scenarios should not be considered the best case or the worst case. Rather, they illustrate a broader range of possible alternative outcomes.

Ontario Real GDP Growth Scenarios

(Per Cent)

	2024p	2025p	2026p	2027p
Faster Growth Scenario	1.4	2.6	2.5	2.5
Planning Projection	**0.3**	**1.9**	**2.2**	**2.2**
Slower Growth Scenario	(0.6)	1.4	2.1	2.1

p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024, and alternative scenarios.
Source: Ontario Ministry of Finance.

Ontario Nominal GDP Growth Scenarios

(Per Cent)

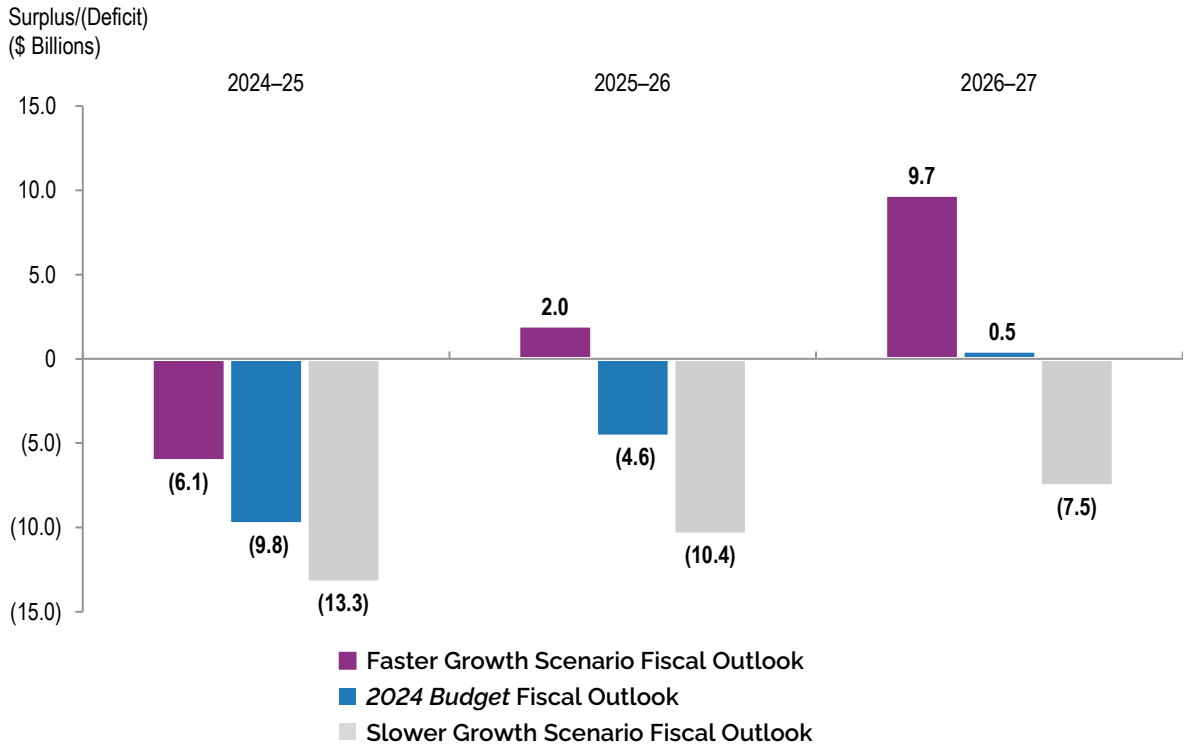
	2024p	2025p	2026p	2027p
Faster Growth Scenario	4.5	4.7	4.8	4.6
Planning Projection	**2.7**	**3.9**	**4.3**	**4.1**
Slower Growth Scenario	1.1	3.3	4.0	3.8

p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024, and alternative scenarios.
Source: Ontario Ministry of Finance.

In the event that the alternative economic scenarios materialize as opposed to the Planning Projection, Ontario's fiscal plan would also change as a result. See Chapter 3: *Continuing to Invest in the Plan to Build: Ontario's Fiscal Plan and Outlook,* Revenue Outlook Scenarios section for more information.

Under the Faster Growth scenario, the deficit outlook may improve to $6.1 billion in 2024–25, followed by surpluses of $2.0 billion in 2025–26 and $9.7 billion in 2026–27. However, if the Slower Growth scenario takes place instead, the deficit outlook may deteriorate to $13.3 billion in 2024–25, $10.4 billion in 2025–26 and $7.5 billion in 2026–27.

Ontario Fiscal Outlook Scenarios



Source: Ontario Ministry of Finance.

Borrowing and Debt Management

Ontario's borrowing program is primarily used to fund deficits, refinance maturing debt and make investments in capital assets. Ontario will continue to finance most of its borrowing program in the long-term public markets in Canada as well as internationally. Ontario has completed long-term public borrowing of $41.8 billion for 2023–24. The total long-term borrowing requirements for 2024–25, 2025–26 and 2026–27 are forecast to be $38.2 billion, $37.7 billion and $32.8 billion, respectively.

$18.0 Billion Ontario Green Bonds Issued Since 2014–15

Ontario remains the largest issuer of Canadian dollar Green Bonds and plans to continue its leadership in the Canadian dollar Green Bond market. The government released its new *Ontario Sustainable Bond Framework*, replacing the province's *Green Bond Framework* from 2014. The new framework will allow for a broader range of potential bond offerings in the future, including emissions-free nuclear power. On February 29, 2024, Ontario issued a $1.5 billion Green Bond, which was Ontario's first Green Bond issued under the new *Ontario Sustainable Bond Framework*, the second this fiscal year, and fifteenth overall.

2023–24 Borrowing Program and Medium-Term Outlook

($ Billions)

	2023–24			Medium-Term Outlook		
	2023 Budget	**Change from *2023 Budget***	**Interim[1] 2023–24**	**2024–25**	**2025–26**	**2026–27**
Deficit/(Surplus)	1.3	1.7	3.0	9.8	4.6	(0.5)
Investment in Capital Assets	13.6	1.2	14.7	17.7	20.2	20.4
Non-Cash and Cash Timing Adjustments	(9.2)	7.6	(1.6)	(11.0)	(12.0)	(13.9)
Net Loans and Investments	0.1	(0.4)	(0.2)	(0.3)	0.1	–
Debt Maturities and Redemptions	31.2	–	31.2	28.0	33.1	26.9
Total Funding Requirement	**37.0**	**10.1**	**47.1**	**44.2**	**46.0**	**32.8**
Decrease/(Increase) in Short-Term Borrowing	–	–	–	(5.0)	–	–
Increase/(Decrease) in Year-End Cash and Cash Equivalents[2]	5.0	4.3	9.3	(1.0)	(8.3)	–
Pre-borrowing in 2022–23 for 2023–24	(14.5)	–	(14.5)	–	–	–
Total Long-Term Public Borrowing	**27.5**	**14.3**	**41.8**	**38.2**	**37.7**	**32.8**

[1] Interim represents the *2024 Budget* projection for the 2023–24 fiscal year.

[2] Starting in 2024–25, pre-borrowing will be reflected as part of the increase in year-end cash and cash equivalents.

Note: Numbers may not add due to rounding.

Source: Ontario Financing Authority.

Ontario is forecast to pay $12.8 billion in interest costs in 2023–24, $13.9 billion in 2024–25 and $14.7 billion in 2025–26, down from the *2023 Budget* forecasts of $14.1 billion, $14.4 billion and $15.1 billion, respectively. These lower interest costs total a cumulative savings of more than $2 billion over three years and are a result of lower actual and projected cost of borrowing. Interest on debt in 2026–27 is forecast to be $15.2 billion.

The government remains committed to reducing the debt burden and putting Ontario's finances back on a more sustainable path. The province's debt sustainability targets are reviewed annually, based on the latest economic and fiscal conditions, to ensure Ontario is making progress towards reducing the debt burden. Meeting these targets on a sustained basis would help improve Ontario's credit rating profile and lower Ontario's cost of borrowing. This would result in less money being required to pay for interest on debt, which frees up resources for other priorities. The targets, which remain unchanged from the *2023 Budget*, are listed in the table below.

Progress on Relevant Debt Sustainability Measures

(Per Cent)

	Targets	*2023 Budget* 2023–24 Forecast	*2023 FES* 2023–24 Forecast	*2024 Budget* 2023–24 Forecast	*2024 Budget* 2024–25 Forecast
Net Debt-to-GDP	<40.0	37.8	38.4	38.0	39.2
Net Debt-to-Revenue	<200	199	206	203	214
Interest on Debt-to-Revenue	<7.5	6.9	6.7	6.3	6.8

Note: *2023 FES* is defined as the *2023 Ontario Economic Outlook and Fiscal Review*.
Source: Ontario Financing Authority.

See Chapter 4: *Borrowing and Debt Management* for more details on Ontario's borrowing program, including borrowing outlook scenarios and the debt burden reduction strategy.

A Capital Plan to Build a Better Ontario

Ontario's Plan to Build includes the most ambitious capital plan in Ontario's history, with planned investments over the next 10 years totalling $190.2 billion, including $26.2 billion in 2024–25. To address the historic infrastructure deficit, this plan is getting shovels in the ground to build highways, hospitals and other critical assets, laying the foundation for a better Ontario.

Key highlights in the capital plan include:

Building Highways

$27.4 billion over 10 years to support the planning and construction of highway expansion and rehabilitation projects across the province, including:

- Highway 413, a new 400-series highway and transportation corridor across Halton, Peel and York Regions that will bring relief to one of the busiest corridors in North America and save drivers up to 30 minutes each way on their commute;
- Bradford Bypass, a new four-lane freeway connecting Highway 400 in Simcoe County and Highway 404 in York Region, which will save drivers an estimated 35 minutes in travel time;
- Enabling the expansion of Highway 401 east from Brock Road in Pickering to help relieve gridlock for tens of thousands of drivers per day and get goods moving faster;
- The Queen Elizabeth Way (QEW) Garden City Skyway Bridge Twinning project, which includes construction of a new bridge on the QEW over the Welland Canal connecting the City of St. Catharines to the Town of Niagara-on-the-Lake;
- Widening existing corridors across the province, such as Highway 404 from Highway 407 to Major Mackenzie Drive in Markham, Highway 11/17 between Thunder Bay and Nipigon and Highway 17 between Kenora and the Manitoba border;
- Advancing work to support the new Highway 7 from Kitchener to Guelph, including replacement of the Frederick Street Bridge in Kitchener. Once fully constructed, the new highway will provide relief to the busy Highway 401 and connect the fast-growing urban centres of Kitchener, Waterloo and Guelph.
- Supporting the construction of a new interchange at Banwell Road and E.C. Row Expressway in the City of Windsor to keep people and goods moving and support development in the area;
- Supporting the planning and design for a new interchange connecting Highway 401 to Lauzon Parkway in Windsor, which will support increased opportunities for trade and better access to the Windsor-Detroit border;

- Widening Highway 3 from two to four lanes between Essex and Leamington to improve road safety and keep people and goods moving in Southwestern Ontario; and
- Supporting the planning and design for a new interchange at Highway 416 and Barnsdale Road in Ottawa to support population growth and development planned by the City for the Barrhaven South area.

Building Transit

$67.5 billion over 10 years for public transit, with a variety of projects underway, including:

- Transforming the GO Transit rail network to improve access and convenience across the Greater Golden Horseshoe by increasing service with two-way, all-day GO trains across the core network with faster trains, more stations and better connections;
- Making investments to extend GO Transit rail service to Bowmanville;
- Extending the Hazel McCallion Light Rail Transit (LRT) by beginning the planning and design activities for the Mississauga loop and extension of the line into downtown Brampton;
- Expanding service on the Milton GO Line by adding train trips and advancing the planning and design work for future two-way, all-day service;
- Continuing to increase frequency of GO train service between Union Station and the Niagara Region, with more express service between Hamilton, Burlington and Toronto. The government continues to see increased ridership with the recently introduced year-round weekend GO rail service between Union Station in Toronto and Niagara Falls;
- Advancing work on the Ontario Line, which will provide rapid transit from Exhibition/Ontario Place to Eglinton Avenue and Don Mills Road as well as connect more than 40 other transit routes, including GO train lines, subway and streetcar lines and the Eglinton Crosstown;
- Continuing tunnelling for the three-stop Scarborough Subway Extension from Kennedy Station to Sheppard Avenue and McCowan Road and awarding the contract for design and construction of new underground stations with bus terminals; and continuing tunnelling on the Eglinton Crosstown West Extension. As of February 2024, tunnelling is over 80 per cent complete. Contracts were awarded for the elevated guideway portion in December 2023 and the Advance Tunnel 2 project in February 2024;
- Advancing work on the Yonge North Subway Extension by issuing a Request for Proposal (RFP) for the Advance Tunnel Contract that includes work to design, build and finance the construction of the tunnels;
- Funding for construction of station and track improvements to restore the Northlander passenger rail service between Toronto and Northern Ontario. As part of its commitment, the government has purchased three new trainsets for the rail fleet for the reinstated service; and
- Making improvements to stations and the railway corridor to enable two-way, all-day service on the Kitchener Line.

Building Health Infrastructure

Nearly $50 billion over the next 10 years in hospital infrastructure, including close to $36 billion in hospital capital grants, to support more than 50 hospital projects that would add approximately 3,000 new beds over 10 years to increase access to reliable, quality care. Investments are being made to support hospital projects, including:

- Funding to support the Weeneebayko Area Health Authority (WAHA) Redevelopment Project to build a new hospital and Elder Care Lodge in Moosonee, as well as a new ambulatory care centre on Moose Factory Island contingent upon necessary federal investment;
- Support for the construction of a new 17-storey tower at the corner of Queen and Victoria in Toronto at the Unity Health Toronto – St. Michael's Hospital to accommodate an expanded emergency department, ambulatory services, administrative spaces and off-site dialysis services;
- Funding for the redevelopment of the Ottawa Hospital – Civic Campus to become one of the most advanced trauma centres in Eastern Ontario providing highly specialized emergency and trauma services for treatment of complex injuries and illnesses;
- Support for the new Windsor-Essex Regional Hospital — a new state-of-the-art acute care hospital in Windsor and Essex County;
- Support the redevelopment of the emergency department and fracture clinic at Centenary Hospital, as well as the construction of a new chronic kidney disease facility that will be located in the new Bridletowne Neighbourhood Centre community hub for the Scarborough Health Network to build more capacity for Scarborough and its surrounding communities; and
- Support the renovation of existing space at the Thunder Bay Regional Health Sciences Centre, in partnership with the University Health Network, to deliver high-quality cardiovascular surgery services.

Building Long-Term Care

Planned investments that total a historic $6.4 billion since 2019 to build 58,000 new and upgraded long-term care beds across the province by 2028 to modern design standards, including:

- Through the Accelerated Build Pilot Program, four new long-term care homes have been built on hospital-owned lands. These homes have created 1,272 new long-term care beds and are helping to meet urgent needs for more long-term care homes in Ajax, Toronto and Mississauga; and
- The government is helping to increase long-term care capacity in communities across the province by providing loan guarantees to select non-municipal not-for-profit homes.

Building Schools

- Investing over $23 billion, including approximately $16 billion in capital grants over the next 10 years, to build more schools and child care spaces, including a new joint French and English public school in Blind River, a new English public secondary school in Ottawa, an addition to St. Anne's Catholic Elementary School in St. Thomas and a new French Catholic secondary school in Vaughan.

Building Postsecondary Education Infrastructure

- Investing $6.1 billion in the Postsecondary Education sector over the next 10 years, including over $2.2 billion in capital grants, to help colleges, universities and Indigenous Institutes modernize facilities by upgrading technology, supporting critical repairs and improving energy efficiency.

Building High-Speed Internet

- Investing nearly $4 billion, beginning in 2019–20, to ensure every community across Ontario has access to high-speed internet by the end of 2025. Multiple programs are well underway to provide access to internet service and better cellular connectivity, including launching a Request for Proposal to find a qualified satellite internet service provider, as well as advancing the Southwestern Integrated Fibre Technology and Eastern Ontario Regional Network initiatives.

Building Housing-Enabling Municipal Infrastructure

- Investing $1.8 billion over three years, beginning in 2024–25, to help build municipal housing-enabling infrastructure projects through the $1.0 billion new Municipal Housing Infrastructure Program and the enhanced $825 million Housing-Enabling Water Systems Fund.

Infrastructure Expenditures[1]

($ Millions)

	Interim[2,3]	Medium-Term Outlook			10-Year
	2023–24	2024–25	2025–26	2026–27	Total[4]
Sector					
Transportation					
Transit	8,638	10,695	11,982	8,509	67,466
Provincial Highways	3,285	3,872	3,922	3,411	27,418
Other Transportation, Property and Planning	188	218	229	127	1,245
Health					
Hospitals	3,348	3,582	4,658	5,861	48,568
Other Health	640	303	578	1,390	8,684
Education	3,316	3,350	3,173	3,025	23,095
Postsecondary Education					
Colleges and Other	765	879	820	662	4,763
Universities	113	130	127	136	1,297
Social	435	975	787	527	3,376
Justice	514	908	707	587	4,135
Other Sectors[5]	2,874	4,307	4,550	4,368	22,704
Total Infrastructure Expenditures	**24,117**	**29,220**	**31,534**	**28,603**	**212,752**
Less: Other Partner Funding[6]	3,176	2,972	1,996	1,900	22,543
Total[7]	**20,941**	**26,248**	**29,538**	**26,703**	**190,209**

1 Includes interest capitalized during construction; third-party investments in hospitals, colleges and schools; federal and municipal contributions to provincially owned infrastructure investments; and transfers to municipalities, universities and non-consolidated agencies.
2 Interim represents the *2024 Budget* projection for the 2023–24 fiscal year.
3 Includes provincial investment in capital assets of $14.7 billion.
4 Total reflects the planned infrastructure expenditures for years 2024–25 through to 2033–34.
5 Includes high-speed internet infrastructure, government administration, natural resources, and culture and tourism industries.
6 Other Partner Funding refers to third-party investments primarily in hospitals, colleges and schools.
7 Includes Federal/Municipal contributions to provincial infrastructure investments.

Note: Numbers may not add due to rounding.
Source: Ontario Treasury Board Secretariat.



Chapter 1

Building a Better Ontario

Section A: Building Ontario

Ontario is on a mission to rebuild its economy. For too long, Ontario has had an infrastructure deficit and the time to rebuild is now. The government is leading the way to get new roads and highways built, while supporting the largest transit expansion in North America. Ontario was left behind with over 300,000 manufacturing jobs lost between the sector's peak in 2004 and 2018. Over the last three years, Ontario has created more jobs than ever before.

Rebuilding Ontario's Economy

Despite a challenging economic situation that is having an impact on the province's finances, the government has a plan to rebuild the economy. Companies are investing to start and grow their businesses, creating better jobs and bigger paycheques for workers across the province. Historic new investments are being made here across the electric vehicle supply chain, with Ontario soon to be host to the first electric vehicle battery plants in Canada. The future for these companies and other businesses across Ontario will be powered by the province's clean electricity grid, including nuclear energy, and critical minerals from the North. The government is helping to bring back manufacturing jobs to Ontario.

The government is continuing to rebuild Ontario's economy by attracting domestic and international manufacturing investments, expanding the province's electricity capacity, supporting innovation, and helping small businesses thrive. This plan will support economic growth here in Ontario, creating stronger communities for the future, and improving Ontario's productivity growth and creating prosperity for generations to come. The government will continue working to rebuild the economy and support good-paying jobs.



Strengthening Manufacturing and Attracting Investment

Ontario's manufacturing sector is a significant driver of the provincial economy, representing 11.5 per cent of Ontario's total GDP in 2022. Over the first three quarters of 2023, Ontario's manufacturing sector added $1.9 billion in real GDP compared to the same period in 2022. In 2023, manufacturing employed 808,000 workers in the province, an increase of 20,900 from the previous year.

This recent progress comes after two decades where the sector was negatively impacted by the rising cost of doing business in Ontario, and market share was lost to countries with more productive firms and more competitive labour markets.[1] By 2018, Ontario had lost over 300,000 manufacturing jobs from the sector's peak in 2004.

This is why *Ontario's Plan to Build* is continuing to help build a world-class manufacturing sector by attracting and supporting important investments in the province.

Helping Manufacturers Invest More in Their Businesses

As part of the *2023 Budget*, the government announced the Ontario Made Manufacturing Investment Tax Credit — a 10 per cent refundable corporate income tax credit for eligible investments in buildings, machinery and equipment for use in manufacturing or processing in the province. The credit is available to claim for qualifying corporations and provides up to $2 million per year for eligible investments.

Over the first four years of the incentive, from 2023–24 to 2026–27, the credit will provide Ontario businesses with estimated income tax relief of approximately $1.1 billion. By lowering costs for Ontario manufacturers, the government is helping local manufacturing companies invest and expand, so the products of the future get made right here in Ontario by Ontario workers.

[1] Bank of Canada, "Decomposing Canada's Market Shares: An Update," (August 2018), https://www.bankofcanada.ca/2018/08/staff-analytical-note-2018-26/

Supporting Small and Medium-Sized Businesses Through the Regional Development Program's Advanced Manufacturing and Innovation Competitiveness Stream

As manufacturers faced challenges from growing international competition and supply chain disruptions, the government acted by launching the $40 million Advanced Manufacturing and Innovation Competitiveness (AMIC) Stream in January 2022, under the Regional Development Program. This stream provides funding support to advanced manufacturers provincewide, including those in the automotive, aerospace, chemical, life sciences and steel sectors, with a focus on small and medium-sized enterprises. It also provides access to a range of complementary services and supports, including advisory services that help these businesses navigate other government programs.

To continue to create an environment that attracts investments to help grow the manufacturing sector, the government is providing additional funds to enhance the AMIC Stream. This will support current program demand by providing more firms with the financial support and tools needed to improve competitiveness and productivity while reinforcing essential supply chains.

Boosting Advanced Manufacturing Through the Regional Development Program

In July 2023, the government welcomed a $100 million investment by Siltech Corporation to build a new 210,000 square-foot manufacturing facility in Fort Erie — the company's third facility in the province. Siltech manufactures specialty silicone used in the personal care, automotive, agriculture, pulp and paper, and oil and gas industries. Ontario is providing $5 million in funding through the Regional Development Program to support this investment, which will create 51 good-paying jobs.

To date, the Ontario government has provided more than $130 million to support over 110 projects through the Regional Development Program, leveraging more than $1.4 billion in new investments and helping to create more than 2,600 jobs provincewide.

Building a World-Leading Electric Vehicle and Battery Supply Chain

The existing vehicle assembly and automotive parts production industries in Ontario directly support nearly 100,000 workers, as well as hundreds of thousands of indirect jobs throughout the auto supply chain, including over 700 parts firms as well as over 500 tool, die and mould makers.

The government has taken meaningful action to help rebuild Ontario's automotive sector, revitalize manufacturing in the province and position the sector for success. Right here in Ontario, manufacturers are making new investments across the emerging electric vehicle (EV) supply chain to help the province become a North American hub for building the cars of the future and create more good-paying jobs. In 2023, Ontario was responsible for shipping 90.8 per cent of Canada's international exports of automobiles and parts, with 96.4 per cent of these going to the United States. It is essential that the federal and Ontario governments work together to protect access to the market in the United States.

Over the last three years, Ontario has attracted more than $28 billion in transformative automotive and EV battery-related investments from global automakers, parts suppliers, and EV battery and materials manufacturers, which are expected to create more than 12,000 new jobs. By supporting these investments, the government is helping to build Ontario's end-to-end EV supply chain to position the province as a global player in this emerging industry. Recent significant EV supply chain investments have been made in EV production, batteries and battery components, as well as EV parts.

Electric Vehicle Production

- General Motors of Canada is investing more than $2 billion on multiple projects, including transforming the company's Ingersoll CAMI Assembly manufacturing plant to deliver its all-electric commercial vehicle brand BrightDrop. The new facility at its CAMI Assembly in Ingersoll will begin building battery modules in the second quarter of 2024, after converting the plant from traditional vehicle manufacturing to all-electric commercial delivery vehicle production.
- Ford Motor Company is investing $1.8 billion in its Oakville Assembly Complex to transform it into a high-volume hub of EV manufacturing, with the first EVs expected to be produced in 2025. The plant directly employs over 3,000 people and will be modernized with a flexible manufacturing system able to accommodate multiple battery electric vehicle models, including the installation of a battery pack assembly line.

Batteries and Battery Components

- Volkswagen is creating 3,000 jobs and investing $7 billion to establish its first overseas EV battery cell manufacturing plant in St. Thomas, Ontario. The plant will be completed in 2027 and produce battery cells for up to one million EVs per year.
- Stellantis N.V. and LG Energy Solution are partnering to support an estimated 2,500 jobs and invest more than $5 billion towards the NextStar Energy EV battery manufacturing plant in Windsor. The plant is expected to be fully operational in 2025 and would be the first large-scale, domestic, EV battery manufacturing facility in Canada.
- Umicore plans to create 600 new direct jobs and invest more than $2.7 billion to build North America's first industrial-scale cathode and precursor materials plant in Loyalist Township. In the project's first stage, the company will create these new direct jobs, in addition to 700 co-op positions for students that will be created throughout the project, making Umicore one of the largest private employers in Eastern Ontario.

Electric Vehicle Parts

- Magna International is adding more than 1,000 jobs and investing $471 million, supporting the opening of a new EV battery enclosure facility in Brampton, while also expanding its existing automotive manufacturing facilities in five other cities in the province: Guelph, Windsor, Belleville, Newmarket and Penetanguishene.
- Mitsui High-tec (Canada) Inc. is supporting 104 highly skilled jobs and investing $102.3 million to open a new manufacturing facility in Brantford to increase production of motor cores, the basic structure of the motor used in EVs.
- Dana Canada Corporation, a leading manufacturer in drivetrain and electric propulsion motor systems, is creating 105 jobs in its two facilities in Oakville and Cambridge, and investing approximately $60 million to expand its manufacturing capacity of thermal management systems, a key component for EV batteries and electronics.
- Bobaek America Inc. is creating 144 new jobs and investing $35 million to build a new manufacturing facility in Windsor, specializing in battery insulation panels and cell sheets for EVs. The new manufacturing facility is expected to open in June 2024.

Creating a World-Leading Automotive and Electric Vehicle Supply Chain

In February 2024, BloombergNEF (BNEF) released its latest *Global Lithium-Ion Battery Supply Chain Ranking*, which reported that Canada had overtaken China for the top spot. Third place in the ranking was the United States. The *Global Lithium-Ion Battery Supply Chain Ranking* rates 30 countries on their potential to build a secure, reliable and sustainable lithium-ion battery supply chain.

According to the report, Canada's raw material resources, strong integration with the United States' automotive sector, and clear policy commitments have given it an edge over competitors.

The province is the only sub-national jurisdiction in North America to have five major global automotive assemblers — Ford, General Motors, Honda, Stellantis and Toyota — and is the third largest sub-national vehicle-producing jurisdiction in North America. In addition, Volkswagen is establishing its first overseas electric vehicle battery cell manufacturing plant in Ontario.



Attracting Investments Through Invest Ontario

Invest Ontario was established in July 2020 to help attract investments from around the world and support businesses to expand their operations here in the province. The agency serves as a one-stop source to investors for business information and tailored investment solutions. It provides facilitated access to all levels of government and local service providers, as well as financial assistance through the Invest Ontario Fund. To date, Invest Ontario has helped secure $2.4 billion in investments, which are expected to create 2,600 new jobs, with many more opportunities in the pipeline.

To continue attracting major investments to Ontario, the government is allocating an additional $100 million to the Invest Ontario Fund. This builds on the $100 million announced in the *2023 Ontario Economic Outlook and Fiscal Review*, and brings the fund total to $600 million. The enhanced fund will allow the agency to attract more strategic investments that create good-paying jobs, encourage innovation and support stronger supply chains in strategic sectors where the province has a global competitive advantage, including advanced manufacturing, life sciences and technology.

Supporting Advanced Manufacturing Through Invest Ontario

In November 2023, Invest Ontario supported an investment of approximately $60 million by Dana Canada Corporation, a leading manufacturer in drivetrain and electric propulsion motor systems. This investment will expand the company's manufacturing capacity of thermal management systems, a key component for EV batteries and electronics.
A $2.5 million grant from the Invest Ontario Fund will support Dana Canada's expansion across its two facilities in Oakville and Cambridge, which is expected to create 105 new, good-paying jobs in these communities and the surrounding area.

Boosting Ontario's Shipbuilding Industry

Ontario's shipbuilding and repair industry supports the movement of people and goods across the province, while promoting safety and security. In 2022, Ontario's shipbuilding and boatbuilding industry contributed over $50 million to the economy. As part of the government's plan to support the marine sector, Ontario is moving forward with the development of a grant program that will help boost the economic competitiveness of the province's shipbuilding industry. This will help elevate Ontario's shipbuilding industry to compete with other parts of the country for key procurements. The government is engaging with the industry on the development of this new program to ensure it remains competitive, creates jobs and helps grow Ontario's economy.

Leveraging Northern Ontario's Natural Resources

Through *Ontario's Critical Minerals Strategy*, the government is working with Indigenous communities to unlock the economic potential of the province's critical minerals in the North, including in the Ring of Fire. The government is also supporting Northern Ontario through the *Sustainable Growth: Ontario's Forest Sector Strategy*, which sets out to encourage economic growth in the forestry industry, supporting Indigenous, Northern and rural communities that depend on the sector while ensuring forests are managed sustainably.

Mining Value From Critical Minerals in Ontario

Developing Critical Infrastructure for the Ring of Fire

Developing Ontario's Ring of Fire region is crucial to improving quality of life for those communities. The government is working together with its First Nations partners to increase prosperity and improve access to health care, high-speed internet and other services. The Ring of Fire region is a world-class source of several critical minerals, including chromite, cobalt, nickel, copper and platinum. These all play a significant role in supporting innovative technologies for high-growth sectors such as batteries, electronics, electric vehicles and cleantech. Building the necessary infrastructure in and around the region will be a prerequisite to unlocking and lowering the cost of mining projects in the Ring of Fire and creating better supply chain connections between resources, industries, workers and communities in Northern Ontario and the manufacturing sector in Southern Ontario.

Ontario has dedicated $1 billion to support critical legacy infrastructure such as all-season roads, broadband connectivity and community supports for the Ring of Fire region. Currently, there are no all-season roads connecting the Ring of Fire to the provincial highway network. These roads would improve First Nations' community access to goods and services, including education, health care and housing.

The government will continue to support the Environmental Assessments (EAs) for the Marten Falls Community Access Road Project, the Webequie Supply Road Project and the Northern Road Link Project, led by the Marten Falls First Nation and Webequie First Nation.

In March 2024, the Marten Falls First Nation and Webequie First Nation signed a Community Development Agreement with Ontario to develop community infrastructure projects that could support future economic development opportunities in the Ring of Fire area. The agreement commits Ontario to supporting shovel-ready infrastructure projects that could include the construction of health and training facilities, recreation centres, commercial buildings and labour force development programs. These projects would help improve the livelihood and well-being of the First Nation communities in the area. The agreement also commits Ontario and the two lead First Nations, Marten Falls and Webequie First Nations, to work together to make decisions about the construction, ownership and operation of the all-season road network, should the EAs be approved. This collaboration will accelerate project timelines and help ensure the communities are ready to participate in future economic development opportunities in the region.



In addition to supporting these EAs, Ontario is also supporting the development of additional critical infrastructure to benefit Northern communities. This includes initiatives such as the Matawa First Nations Rapid Lynx broadband project to provide modern and scalable telecommunication services to five Matawa First Nations member communities: Nibinamik, Neskantaga, Eabametoong, Marten Falls and Webequie First Nations.

As Ontario invests in and makes progress on developing critical infrastructure in the Ring of Fire region, the provincial government continues to call on the Government of Canada to step up, match Ontario's funding commitments, and expedite approval processes for all infrastructure that would enable the development of the Ring of Fire and bring considerable economic benefit to Indigenous and Northern communities.

Enhancing the Critical Minerals Innovation Fund

The mining industry has rapidly evolved into a high-tech industry, with innovative ideas such as adopting electric mobile mining equipment to replace the use of diesel equipment, or remote mining to help companies access resources in isolated areas. Research projects are needed to tackle problems such as mining at depth in existing mines, the successful extraction of minerals from mine wastes, and technology that supports the recycling of electric vehicle batteries.

In November 2022, Ontario launched the $5 million Critical Minerals Innovation Fund (CMIF) to support innovation and research projects in the critical minerals sector to help increase exploration, mining, development, production and processing of critical minerals in Ontario. These projects are expected to tackle strategic challenges faced by the critical minerals sector in several areas of focus, such as the battery supply chain, deep exploration and mining, mineral processing, as well as the recovery of minerals.

To further support critical minerals development in the province and the creation of Ontario-made intellectual property, the government is investing $15 million to enhance the CMIF. The additional funding of $5 million per year in 2024–25, 2025–26 and 2026–27 will continue to help Ontario's mining sector undertake research, development and commercialization of innovative technologies, including techniques, processes and solutions related to critical minerals. Through this investment, the CMIF will encourage further private–public collaboration and help create jobs supporting municipalities, Indigenous communities and regional economies.

Investing in Innovative Critical Minerals Projects

Last year, the Critical Minerals Innovation Fund supported 13 innovative projects by providing up to $500,000 in funding for a maximum of 50 per cent of eligible project costs. For example:

- Carbonix Inc., an Indigenous-owned company, received $475,000 to help refine the process for converting mining waste, petroleum coke and other by-products into high-energy density graphite for use in the battery supply chain.
- Canada Nickel Company received $500,000 to fund research to commercialize carbon capture processing techniques for nickel to produce battery grade nickel and nickel for clean steel.
- Vale Canada received $500,000 to develop bioleaching techniques for reprocessing tailings to extract nickel and cobalt from mine waste to help increase the supply of battery metals.
- Wyloo Metals received $500,000 to test the feasibility of repurposing and storing all tailings materials underground in the form of backfill in mine workings.

Improving Sustainability Through Ontario's Forestry Sector

Ontario's forest industry can derive significant economic benefits from the complete use of wood products including forest biomass — which includes bark, shavings and sawdust — along with low-grade trees.

To support the *Forest Biomass Action Plan* and the *Sustainable Growth: Ontario's Forest Sector Strategy*, the government created the Forest Biomass Program in May 2023. This $19.6 million program helps develop the economic potential and environmental benefits offered by new and emerging uses of underutilized wood and mill by-products. Potential biomass products include medicine, bioplastics, 3D printing, mass timber products, biodiesel and biofuels.

Ontario is providing additional investments to extend the program over the next three years at an annual funding level of $20 million. The Forest Biomass Program helps support projects to harvest more wood from Crown forests for use in traditional and innovative products, to increase forest-sector job creation and promote regional economic growth. The program will also contribute to the second pillar of the *Sustainable Growth: Ontario's Forest Sector Strategy*, Putting More Wood to Work, with the goal to harvest Ontario's sustainable wood supply of 30 million cubic metres by 2030.

The Forest Biomass Program includes four streams:

- Indigenous Bioeconomy Partnerships Stream — Supporting Indigenous businesses and communities to become more active participants in the forest sector through the use of forest biomass.
- Exploring Biomass Pathways Stream — Improving and supporting for-profit, and not-for-profit feasibility, engineering and design studies.
- Innovative Bioproduct Manufacturing Stream — Focusing on projects that support commercialization of new and/or innovative uses of forest biomass.
- Modernization Stream — Supporting major modernization investments in foundational forestry facilities and/or establishment of new complementary businesses to consume large quantities of underutilized wood and biomass.

Investing in the Economic Potential of Forest Biomass

Since its launch in May 2023, Ontario has committed over $17 million to 41 research, innovation and modernization projects through its Forest Biomass Program. Each project will advance the use of forest biomass, including:

- Thunder Bay Pulp and Paper Mill, which received $5 million to upgrade and improve equipment to modernize the mill's electrical system, enabling future measures to expand green energy production.
- Biopower Sustainable Energy Corporation (Atikokan), which received $997,500 to increase production, improve efficiency and increase usage of forest biomass by acquiring new equipment and supporting modernization of the wood handling facility.
- Whitesand First Nation, which received $1,289,573 to support the use of forest biomass for heat and power generation by fulfilling site preparatory work to construct a wood pellet plant in the Whitesand First Nation's Bio-Economy Centre in the Armstrong Region.

Powering Ontario's Growth

To meet growing electricity demand, and as the government rebuilds Ontario's economy, the province may need to double electricity capacity by 2050. Ontario's clean electricity grid is a competitive advantage in attracting investments and jobs to the province. The government is continuing to invest in a clean energy future across the province. This is essential to compete and support the transition to a cleaner economy, as Ontario attracts investments in sectors such as manufacturing, mining, electric vehicles and batteries.

In July 2023, the government released *Powering Ontario's Growth: Ontario's Plan for a Clean Energy Future*. It is a pragmatic plan outlining the actions Ontario is taking to meet increasing electricity demand, which invests in the future of nuclear, while keeping costs down for people and businesses. The plan includes new zero-emissions electricity generation, storage and transmission lines that will provide families and industries with the reliable, low-cost and clean power they need, as well as power the province's future. In the transition, natural gas-fired generation will continue to provide the province with the capacity to meet electricity demand and maintain system reliability.

Building on Ontario's Nuclear Advantage

The government is leveraging the Ontario nuclear sector, a world leader in experience and expertise in this safe, reliable and clean energy source as a way to develop the next generation of nuclear power, including grid-scale small modular reactors (SMRs). Ontario's nuclear advantage better positions the province to compete for international investments, which are increasingly prioritizing access to clean energy, as well as export development opportunities for Ontario's nuclear sector. The government has also introduced the *Ontario Sustainable Bond Framework*, which includes financing for nuclear energy. The new framework allows Ontario to issue Green Bonds for umbrella projects that provide environmental benefits to the province. Projects under this framework include clean transportation, green buildings, clean energy such as emissions-free nuclear, climate change, energy efficiency, and forestry and agriculture initiatives, all of which support sustainability across Ontario.

Supporting Nuclear Refurbishments

Refurbishing the Pickering Nuclear Generating Station

The Ontario government is supporting the Ontario Power Generation (OPG) plan to proceed with the next steps towards refurbishing the Pickering Nuclear Generating Station B Units. OPG is proceeding with the project initiation phase, which includes engineering and design work, as well as securing long lead time components that can require years for manufacturing.

Ontario is following a multi-phase approvals process to ensure the Pickering Nuclear Generating Station refurbishment project only proceeds if it is in the best interests of Ontario and its ratepayers. The Pickering refurbishment is also subject to regulatory approval by the federal regulator, the Canadian Nuclear Safety Commission.

Once refurbished, the Pickering Nuclear Generating Station would produce a total of more than 2,000 emissions-free megawatts (MW) of electricity, equivalent to powering two million homes, helping to meet increasing demand from electrification and fuelling the province's economic growth.

The Conference Board of Canada's preliminary analysis estimates this refurbishment would increase Ontario's GDP by $19.4 billion and create about 11,000 jobs over the 11-year project period. Post-refurbishment operation of the facility would also create and sustain about 6,410 Ontario jobs per year for decades to come.



Refurbishing Darlington and Bruce Nuclear Generating Stations

Ontario continues to support the refurbishments at the Darlington and Bruce Nuclear Generating Stations, securing clean, reliable and affordable electricity for generations to come. The generating capacity of the stations, with refurbished units, will provide approximately 3,500 MW and 6,550 MW, respectively, which is approximately equivalent to the combined 2022 peak demand of Alectra Utilities (serving 17 communities, including Mississauga, Hamilton, Brampton, Vaughan, St. Catharines and Barrie), Toronto Hydro, and Oshawa Power and Utilities Corporation (Oshawa PUC Networks) — in total, serving about 1.7 million residential customer accounts and 188,000 commercial, industrial and other customers, equivalent to about 36 per cent of the province's electricity customers.

OPG has already completed refurbishment of two of the four Darlington units. Approximately 96 per cent of the Darlington Refurbishment Project costs are being spent in the province, involving more than 260 companies. According to a report by The Conference Board of Canada, the $12.8 billion Darlington Refurbishment Project, together with the nuclear station's extended operation, will generate approximately $90 billion in economic benefits for Ontario, and increase employment by an average of 14,200 jobs per year across the province over an estimated 39-year operating period.

Building the Future of New Nuclear

As part of *Powering Ontario's Growth* plan, the government is working with OPG to commence planning and licensing for three additional Small Modular Reactors (SMRs) at the Darlington Nuclear Generating Station site. This would bring Ontario's total to four SMRs, which would produce enough clean electricity to power 1.2 million homes. OPG has commenced site preparation activities for the SMR project at Darlington.

The government is also working with Bruce Power on pre-development work for the first large-scale nuclear generation build in over three decades in Canada.

Growing Ontario's Nuclear Supply Chain

Ontario's expansion of nuclear energy is enhancing the province's position as a global leader in new nuclear technologies, creating new export opportunities that will drive economic growth.

- Ontario is leveraging the expertise of OPG and its subsidiary Laurentis Energy Partners to support a new collaboration agreement with SaskPower to support SaskPower's nuclear program management, project licensing and operational readiness.
- OPG and other Ontario nuclear supply chain providers have already signed major agreements valued at approximately $1 billion to export nuclear products and services to other countries, including Poland, Estonia and the Czech Republic.

Supporting Clean Energy Storage Projects

New energy storage projects will support the operation of Ontario's clean electricity grid by drawing and storing electricity off-peak when power demand is low, and returning the power to the system at times of higher electricity demand. The procurement of a targeted 2,500 MW of clean energy storage represents the largest battery procurement in Canada's history and will increase the efficiency of Ontario's clean electricity grid, complementing Ontario's 2023 agreement for the 250 MW Oneida Energy Storage Project.

Boosting the Electricity Grid with Clean Hydrogen

The Ontario government is investing in 15 new projects that will help integrate hydrogen into the province's electricity grid. This funding is through the $15 million Hydrogen Innovation Fund, which supports projects that pave the way for reliable, affordable and clean electricity generation from hydrogen to help power the province's growth.

Continuing to Support the Northern Economy

The Northern Energy Advantage Program (NEAP) provides a rebate for eligible mining, forestry and steel operations in Northern Ontario. NEAP helps eligible large industrial operators better manage electricity costs as well as create and sustain good jobs in Northern Ontario to maintain global competitiveness, with 28 facilities currently receiving benefits from NEAP. To provide for continuing support to eligible large facilities in the North, the government is increasing NEAP funding by an additional $86 million over three years, resulting in a total annual program amount of $167 million in 2024–25 and $206 million for 2025–26 and 2026–27.

Expanding Electricity Transmission Infrastructure in the North

Expanding electricity transmission infrastructure supports economic development opportunities and improves reliability in the North. For example, the East-West Tie transmission project, from Wawa to Thunder Bay, went into service in March 2022, improving transmission capacity and flexibility. The Wataynikaneyap Power Transmission Project is nearing completion and will connect 16 remote First Nation communities to Ontario's clean electricity grid as they transition away from diesel electricity generation.

The Waasigan Transmission Line project is also under development between Shuniah (near Thunder Bay), to Atikokan and then to Dryden. It will support community, industrial and mining growth in the Northwest.

Additional new projects proposed in the coming years include three new transmission lines in Northeastern Ontario to support forecast electricity demand growth, such as in the Sault Ste. Marie and Timmins areas, including from the conversion from coal to electric arc furnaces at Algoma Steel as well as from growth in the mining sector.

Keeping Electricity Costs Down in Indigenous Communities

The Ontario government is supporting building more clean energy projects to reduce electricity costs in Indigenous communities. In November 2023, the government announced an increase of $5 million for the Independent Electricity System Operator (IESO) Indigenous Energy Support Programs, bringing the total annual investment up to $15 million. The IESO awarded funding for 93 projects from across 58 Indigenous communities in 2023, which will help promote Indigenous leadership in the electricity sector. These Indigenous Energy Support Programs help ensure that Indigenous communities can fully leverage opportunities in the electricity sector that can create significant, long-term economic benefits.

Reviewing Time-Limited Relief for the Electricity Distribution Sector

Under the *Electricity Act, 1998*, municipal electricity utilities (MEUs) are subject to a transfer tax of 33 per cent on the fair market value of electricity assets sold to the private sector. The government supports sector consolidation in an effort to improve services and convenience, improve reliability and security, cyber security and the adoption of new technology and consumer demands.

In the *2022 Budget*, Ontario extended temporary tax relief measures related to the sale of assets until December 31, 2024. During this period, the transfer tax rate is reduced from 33 per cent to 22 per cent for larger MEUs, and the rate is reduced from 33 per cent to zero per cent for MEUs with fewer than 30,000 customers. In addition, any capital gains arising under the electricity payments in lieu of taxes (PILs) deemed disposition rules are exempt from any PILs.

In 2024, Ontario will review supports for consolidation of interested MEUs, and will provide a status update expected as part of the *2024 Ontario Economic Outlook and Fiscal Review*, prior to the expiry of the existing relief measures.

Consolidation in the electricity distribution sector can help local distribution companies be better positioned to support Ontario's electrification needs and improve services for customers well into the future.

Supporting Innovation and Economic Growth Through Research and Technology

Innovation is essential to Ontario's long-term economic growth. Technological advancements and new approaches across all industries help drive innovation and progress, propelling Ontario towards a stronger, more resilient and productive economy for today and the future.

Strengthening Research and Development With Advanced Research Computing

Ontario's advanced research computing (ARC) facilities help ensure researchers have the resources they need to make new discoveries and commercialize the innovations that benefit businesses, workers and families across the province. The Ontario government is investing an additional $18 million over the next three years to support the ongoing operation and maintenance of Ontario's ARC systems located across the province and ensure the systems meet the storage and computational demands for research into technologies such as artificial intelligence (AI). In addition, the government is investing $47.4 million for the infrastructure refresh of aging ARC systems at the University of Toronto (the Niagara Supercomputer) and University of Waterloo (the Graham Supercomputer).

In 2022–23, ARC systems helped support over 6,000 Ontario researchers and 4,000 trainees. Over the last five years, investments have also supported the development of 338 patent applications, the launch of more than 250 technology startups, and 800 global collaborations. This investment will support advancements in critical fields such as life sciences, engineering, clean technologies, nuclear research, electric vehicles and quantum computing.

Expanding Regional Innovation Centres to Barrie

Ontario is continuing to promote entrepreneurship and innovation by investing an additional $1 million per year starting in 2024–25 in Ontario's Regional Innovation Centres (RICs). With this funding, the government will launch a new RIC in Barrie to further expand the regional benefits of innovation and economic growth.

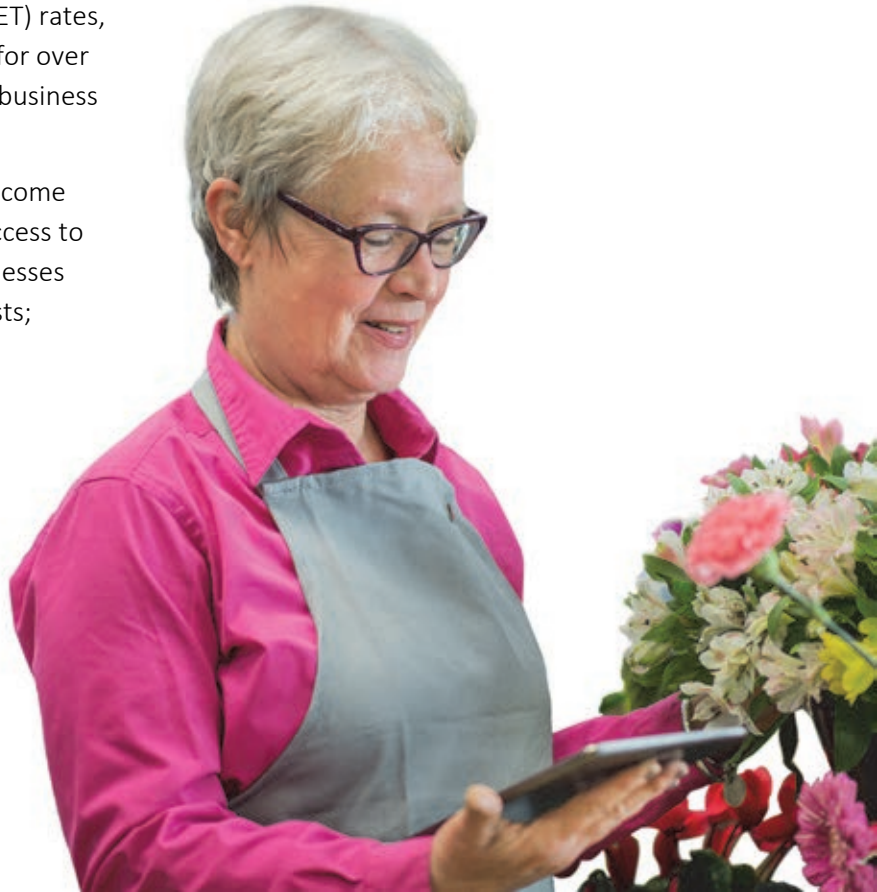
Regional Innovation Centres are non-profit organizations, with 17 centres currently located across the province. They play a vital role in the innovation ecosystem by ensuring entrepreneurs have the resources and networks they need to start and grow their businesses. These centres provide a number of programs and services, including expert advice and mentorship, training and workshops, market intelligence, as well as connections to resources, funding and partners. In 2022–23 alone, RICs supported 5,500 unique Ontario technology clients that contributed to the creation of over 10,000 new full-time jobs, playing a key role in supporting technology job creation in their respective regions. The new RIC in Barrie will further extend the reach of the Regional Innovation Centres across the province to support the growth and success of early-stage and growing innovation and technology companies.

Keeping Costs Down for Ontario Businesses

The government has taken significant action to lower costs for businesses to help them compete, grow and weather today's economic uncertainty. Ontario's small businesses account for more than 97 per cent of all businesses in the province, helping to drive the economy and create good-paying jobs for workers in growing communities across Ontario.

In 2024, the government would enable an estimated $8.0 billion in cost savings and support for Ontario businesses, of which $3.7 billion would go to small businesses. Some of the actions taken include:

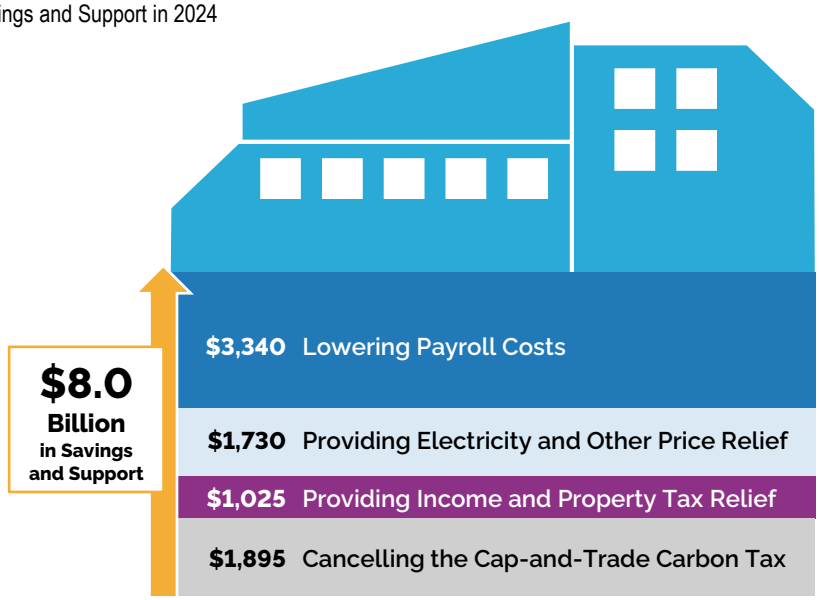
- Implementing the Ontario Made Manufacturing Investment Tax Credit to help local manufacturers invest and expand, by lowering costs for eligible investments in buildings, machinery or equipment used in manufacturing or processing in the province;
- Temporarily cutting the gas tax by 5.7 cents per litre and the fuel tax by 5.3 cents per litre beginning July 1, 2022, which are proposed to be extended to December 31, 2024, to help reduce the cost of gas and fuel for Ontario businesses;
- Supporting cuts to Workplace Safety and Insurance Board (WSIB) premium rates without reducing benefits, leading to a reduction in payroll costs for businesses;
- 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 on their total Ontario payroll;
- Cancelling the cap-and-trade carbon tax to remove its cost impact from items such as gasoline, diesel fuel and natural gas;
- Lowering high Business Education Tax (BET) rates, providing $450 million in annual savings for over 200,000 employers, or 95 per cent of all business properties in Ontario;
- Reducing the small business corporate income tax rate to 3.2 per cent and expanding access to this preferential rate, helping small businesses compete and thrive by lowering their costs;



- Implementing the Regional Opportunities Investment Tax Credit to support businesses that make investments and expand in regions of Ontario that have lagged in employment growth;
- Allowing businesses to accelerate writeoffs of capital investments for income tax purposes, to support businesses that make eligible investments across Ontario; and
- Implementing the Comprehensive Electricity Plan in January 2021, which is lowering electricity costs by an estimated average of 13 to 16 per cent in 2024 for medium-size and larger industrial and commercial customers, respectively.

Chart 1.1
Supporting Ontario Businesses

Aggregate Savings and Support in 2024
(in $ Millions)



Notes: Lowering payroll costs includes supporting Workplace Safety and Insurance Board (WSIB) premium reductions, increasing the Employer Health Tax (EHT) exemption to $1 million starting 2020 and changing the minimum wage. Providing electricity and other price relief represents lowering electricity prices through the Comprehensive Electricity Plan; reducing Liquor Control Board of Ontario (LCBO) wholesale prices for bars, restaurants and other eligible licence holders; and the direct savings to businesses from extending the 5.7 cent per litre cut to the gas tax and the 5.3 cent per litre cut to the fuel tax until December 31, 2024. Providing income and property tax relief includes reducing Ontario's small business corporate income tax rate to 3.2 per cent and expanding access to this preferential rate; allowing businesses to accelerate writeoffs of capital investments for income tax purposes; implementing the Regional Opportunities Investment Tax Credit; implementing the Ontario Made Manufacturing Investment Tax Credit; lowering high Business Education Tax (BET) rates; and not paralleling the federal tax increase on some small businesses earning passive investment income. Figures are rounded to the nearest five million.
Source: Ontario Ministry of Finance.

Helping Small Businesses Grow and Thrive

Small businesses and entrepreneurs are a critical part of Ontario's plan to grow the economy. The government understands that small businesses face unique challenges and that a one-size-fits-all approach to business support may not be effective.

Ontario's Small Business Enterprise Centres (SBECs) provide entrepreneurs with a full range of support services needed to start and successfully grow their small business. These centres are located across the province and provide one-stop access to advisors, programs and services, as well as learning opportunities for small business owners specific to their region, including:

- Financial support through microgrants for eligible entrepreneurs and students;
- Free consultations with a qualified business consultant;
- Internet and computer access for business research and planning;
- Review of business plans;
- Workshops and seminars; and
- Guidance on licences, permits, registration, regulations, and other documents required to start a business.

Ontario is investing an additional $6.8 million over the next two years to enhance the Starter Company Plus program and it is also providing additional support for Ontario entrepreneurs. The enhancement will allow more eligible entrepreneurs to receive a Starter Company Plus Grant of $5,000, and will provide grants to an additional 500 entrepreneurs over two years. Through the program, these entrepreneurs will receive training, mentoring and business advice.

In addition, this new funding will support the Summer Company program, which is delivered through the SBEC network. The program provides at least 12 hours of business training, one-on-one mentoring and grants up to $3,000 to Ontario students between the ages of 15 and 29 to start a full-time business over the summer. This additional funding will provide grants to an additional 250 students (15 to 29 years old) over two years. The Summer Company program has launched over 1,700 youth businesses over the last five years across Ontario.

The new funding will also help the Fédération des gens d'affaires francophones de l'Ontario (FGA) provide additional support to help Ontario's Francophone entrepreneurs start and grow their business through dedicated advisory supports, workshops and events. Through this funding, Francophone entrepreneurs will be able to receive services in their preferred language.

Modernizing Capital Markets

The government continues to collaborate closely with key partners, including the Ontario Securities Commission (OSC) and the Canadian Investment Regulatory Organization (CIRO), to modernize Ontario's capital markets and foster competition, innovation and economic growth while ensuring investor protection.

To support equitable access to capital markets, the government is actively supporting the OSC in engaging Indigenous partners to identify opportunities for increased participation of Indigenous businesses and communities in capital markets.

The Ontario government remains committed to promoting capital formation. This is why it continues to work with the OSC to establish a Long-Term Asset Fund (LTAF) framework to enhance both institutional and retail investor access to investment opportunities in capital-intensive assets such as infrastructure, natural resource projects, and other relatively less liquid assets.

In addition, to promote capital markets and facilitate investment in Ontario companies, the OSC has undertaken several priority initiatives. To encourage early-stage financing, the OSC is working to develop rules to support angel investor groups and broadening sources of capital by adopting a self-certified prospectus exemption. To support capital-raising for smaller issuers, the OSC is broadening investment dealer participation in prospectus offerings.

The government and the OSC continue to evaluate and implement, as appropriate, recommendations from the Capital Markets Modernization Taskforce as part of modernizing Ontario's capital markets regulatory framework. To date, 21 recommendations from the Capital Markets Modernization Taskforce have been fully implemented, with an additional five recommendations anticipated to be implemented by 2025.

Supporting Ontario's Film and Television Industry

Ontario's vibrant and growing film and television industry continues to create high-value jobs and attract investment across the province. Productions that received support from provincial programs spent approximately $3.2 billion in Ontario in 2022, which contributed to over 45,000 full-time direct and spinoff jobs.[2]

As first announced in the *2022 Budget*, the government is modernizing Ontario's film and television tax credits to reflect the latest industry practices. Since 2022, the government has expanded tax credit eligibility to productions made available exclusively online, introduced a screen credit requirement, and expanded eligible expenditures for the Ontario Production Services Tax Credit to include location fees.

The government also committed to exploring opportunities to simplify tax credit support for computer animation and special effects activities. Based on feedback from industry consultations, the government is proposing new requirements for the Ontario Computer Animation and Special Effects Tax Credit to simplify eligibility and help companies get their tax credits faster, while also ensuring support remains targeted to professional productions.

> *"Our members unanimously support the government's proposed changes to simplify the Ontario Computer Animation and Special Effects Tax Credit. These changes will help grow Ontario's visual effects and animation companies and improve our industry's competitiveness domestically and internationally."*
>
> Matt Bishop and Pete Denomme
> Co-Chairs
> Computer Animation Studios of Ontario (CASO)

Going forward, the government will review the Ontario Film and Television Tax Credit regional bonus to ensure it effectively supports film and television production across the province.

See the *Annex: Details of Tax Measures and Other Legislative Initiatives* for more information.

[2] Ontario Creates, "2022 Film and Television Production Statistics," https://www.ontariocreates.ca/assets/images/research/Statistics/Eng/2022-Film-and-Television-Production-Statistics-Backgrounder-final.pdf

Supporting Ontario's Agriculture and Food Sector

The government recognizes the importance of the agriculture and food sector to the people of Ontario and to the provincial economy, as well as the challenging economic environment. Ontario will continue to work with the sector to manage the risks that it faces and to help grow the industry. In addition, in January 2024, the government announced the beginning of consultations to help inform the development of a new rural economic development strategy.

Building Infrastructure, Highways and Transit in Your Communities

Ontario is investing more than $190.2 billion over the next 10 years in highways, transit, broadband, housing-enabling and other infrastructure. This is the most ambitious capital plan in Ontario's history, and is part of the government's plan to build the infrastructure that communities and municipalities need to grow and prosper.

Funding Infrastructure to Build More Homes

To address Ontario's housing crisis, the provincial government is working with other levels of government and industry partners to help build at least 1.5 million homes by 2031.

Introducing the New Municipal Housing Infrastructure Program

Building more homes is critical to rebuilding Ontario's economy. Building homes requires housing-enabling infrastructure. This is why the government is investing $1 billion for the new Municipal Housing Infrastructure Program to largely support core infrastructure projects, such as roads and water infrastructure to enable housing for growing and developing communities.



Enhancing the Housing-Enabling Water Systems Fund

In January 2024, Ontario launched the three-year $200 million Housing-Enabling Water Systems Fund to help municipalities repair, rehabilitate and expand drinking water, wastewater and stormwater infrastructure. The government is quadrupling the Housing-Enabling Water Systems Fund to total $825 million so more funding can be available, through an application-based program, for municipal water infrastructure projects that would enable new housing.

Rewarding Municipalities with the Building Faster Fund

In August 2023, the government announced the Building Faster Fund, a three-year $1.2 billion fund to support municipalities that meet or exceed the housing targets they have pledged to achieve by 2031. The fund rewards municipalities that make significant progress against their targets by providing funding for housing-enabling and community-enabling infrastructure. Funding is provided to municipalities that have reached at least 80 per cent of their provincially assigned housing target for the year with increased funding for municipalities that exceed their target.

The Building Faster Fund also includes $120 million for small, rural and Northern communities that have not been assigned a housing target to support their unique needs and circumstances, following municipal consultations.

The government is giving municipalities the tools they need to build more homes faster, to tackle the affordability crisis that is pricing too many people, especially young families and newcomers, out of the dream of homeownership.

Ontario continues to call on the federal government to pay its fair share and help fund housing-enabling infrastructure investments. The provincial government will continue to work with municipalities as part of Ontario's continuing commitment to help unlock housing opportunities and support growing communities.

Improving Flexibility on Loans for Water Infrastructure Projects

The government will also be providing municipalities increased access to financing for housing-enabling municipal water and wastewater infrastructure projects under Infrastructure Ontario's loan program, with options that will provide flexibility on construction period interest payments, including deferred interest payments until projects are substantially complete, longer loan terms, more flexible repayment terms, and lower administration costs. Deferring interest and principal payments until after the construction period will better align municipal revenues from new housing with payments on the loans from Infrastructure Ontario.

Building Stronger Communities for Future Generations

Advancing the Plan to Build With the Building Ontario Fund

Ontario's new infrastructure bank, the Building Ontario Fund, will support the financing and building of critical infrastructure projects across the province. As the government moves forward with *Ontario's Plan to Build*, the fund will act as a tool to attract capital in order to help meet the infrastructure needs of a growing Ontario. The government has allocated an initial $3 billion to the fund.

Following its introduction in the *2023 Ontario Economic Outlook and Fiscal Review*, the fund announced the appointment of its inaugural board of directors. The fund continues to make progress in laying the foundation for future success as it establishes a governance framework and builds out the organization, including recruitment of the chief executive officer.

The Building Ontario Fund is developing a detailed process to ensure there is appropriate criteria for selecting projects and partners in priority areas, including long-term care homes, energy infrastructure, affordable housing, municipal and community infrastructure and transportation. This includes support for infrastructure projects for Indigenous communities that advance community and economic well-being. The fund is also creating opportunities for pension funds to put their members' investments to work right here in Ontario.

The fund is also exploring opportunities to support large-scale projects in the postsecondary student housing, long-term care, energy generation and municipal infrastructure sectors. For example, the Building Ontario Fund is currently engaging with Canadian entities with long-term investment horizons and an Ontario-based postsecondary institution to help finance new student housing projects. The fund is also exploring opportunities with partners to finance additional long-term care homes and major energy generation, including attracting investments to build new nuclear projects.

The Ontario government is proposing legislation to further support the Building Ontario Fund's mandate and investment objectives as an independent, arm's-length agency. The legislation, along with the government's allocation of initial funding, would support the fund in making infrastructure investments and help deliver more infrastructure faster.

Introducing the Community Sport and Recreation Infrastructure Fund

Ontario is investing $200 million over three years in a new application-based local Community Sport and Recreation Infrastructure Fund, demonstrating the government's commitment to provide children, families and seniors across Ontario with new and improved opportunities to participate in sport and recreational activities. The fund will support a growing population by investing in new and revitalized sport, recreation and community facilities for youth and families. Addressing the critical need for infrastructure support in the sport and recreation sectors will ensure that the people of Ontario can live, work and play in their local communities.

Doubling the Ontario Community Infrastructure Fund

The Ontario Community Infrastructure Fund continues to build community infrastructure and provides investments in asset management for 425 small, rural and Northern communities across the province. The government doubled its annual investment to nearly $2 billion over five years beginning in 2021–22 to help build and repair community infrastructure such as roads, bridges, water and wastewater infrastructure.



Table 1.1

Examples of Recently Approved and Completed Projects Under the Ontario Community Infrastructure Fund

Northern

- Replacement of road crossing culverts on Poplar Road and construction of guardrails and surface treatment in the **Municipality of Gordon-Barrie**.
- Replacement of Richer Bridge with a new road crossing in the **Municipality of St. Charles**.
- Repairs and improvements to the water tower, including new interior lining and safety upgrades in the **Town of Smooth Rock Falls.**

Eastern

- Reconstruction of Princess Street watermain, sewers, sidewalks and asphalt in the **Town of Almonte**.
- Replacement and enhancement of existing watermain on Heber Street in the **Town of Trenton**.
- Reconstruction of Battersea Road, including road surface and ditching improvements in the **Township of South Frontenac**.

Southwestern

- Establishment of a multi-year project to complete inspections of municipal storm sewers in the **Town of Grimsby**.
- Replacement of Vanneck Road Bridge in the **Municipality of Middlesex Centre**.
- Renewal and upgrades of sanitary sewers, storm sewers, sidewalks and road rehabilitations along Dufferin Street in the **City of Welland**.

Central

- Reconstruction of Margaret Street, including asphalt replacement, a new sidewalk, new storm sewer and drainage improvements, in the **Township of Angus**.
- Rehabilitation of Mountainview Road Bridge, including repairing sidewalks, retaining walls and concrete curbs, in the **Town of Halton Hills**.
- Commencement of a multi-year road rehabilitation project in the **Township of Brock** to repair roads and pave high traffic gravel roads with asphalt.

Source: Ontario Ministry of Infrastructure.

Expanding High-Speed Internet Access

The government is investing nearly $4 billion to provide access to high-speed internet to every community across the province by the end of 2025. As of March 2024, more than 88,000 previously underserved premises now have access to high-speed internet. High-speed internet allows people to access vital services like health care, learn from home, enhance their business, participate in the agricultural sector and connect with loved ones.

Multiple programs and initiatives are being used to meet this goal, many of which are well underway already, providing access to internet service and better cellular connectivity, including:

- Awarding contracts to eight internet service providers, through the provincial Accelerated High-Speed Internet Program, which represents a diverse selection of local, regional and national carriers, to bring access to high-speed internet to unserved and underserved areas;
- Advancing the Improving Connectivity for Ontario program through co-funded projects with the Government of Canada;
- Improving cellular access to numerous rural communities in Eastern Ontario with a provincial investment of $71 million in the Eastern Ontario Regional Network;
- Investing more than $63 million in the Southwestern Integrated Fibre Technology (SWIFT) project to bring high-speed internet access to over 64,000 more homes, businesses and farms across Southwestern Ontario. To date, 91 of 97 SWIFT projects have been completed;
- Investing $10.9 million to bring improved internet access to rural and First Nation communities across Northern Ontario; and
- Launching a Request for Proposals (RFP) in January 2024 for a qualified satellite internet service provider to deliver high-speed internet access for approximately 43,000 unserved and underserved homes and businesses where fibre optic or fixed wireless services are not available.

Providing High-Speed Internet Access Across Ontario

The provincial government has an interactive map[3] that provides information on the status of high-speed internet projects in Ontario. This map allows the people of Ontario to search by address, community or municipality, making it easier to learn what is happening in select locations. The map also shows where there is high-speed internet access and locations of planned, active and completed provincially funded high-speed internet projects. Users can learn additional information on specific projects, such as the internet service provider, project status, provincial contributions and the technology to be used.

[3] "Ontario High-Speed Internet Projects and Availability — Provincial Projects Download," https://www.ontario.ca/page/ontario-connects-making-high-speed-internet-accessible-in-every-community

Protecting Toronto's Waterfront: Port Lands Flood Protection

In January 2024, Ontario — along with the Government of Canada, City of Toronto and Waterfront Toronto — announced two new roads and bridges that will link the future Villiers Island to downtown Toronto, as well as to the surrounding Port Lands.

These bridges along Cherry Street North and Commissioners Street are the latest connections to open in the Port Lands, marking a key advancement in the Port Lands Flood Protection Project. The Cherry South Bridge, which crosses the future renaturalization of the mouth of the Don River, opened in October 2022.

The Port Lands Flood Protection Project will provide critical flood protection to southeastern portions of downtown Toronto, transform the area into usable public and green space, and upgrade roads and bridges to connect people cycling, walking and driving along the waterfront. Completion of the Port Lands Flood Protection Project will allow for thousands of housing units to be built on Villiers Island in the coming years. To date, Ontario has contributed over $400 million to the project.

This work is an important step towards building future communities and housing in the Port Lands. As part of the new deal with the City of Toronto, the municipality will work with the provincial government to advance housing development projects on available Waterfront Toronto property.

Modernizing Ontario's Public Infrastructure

Ontario is investing $250 million over three years in critical repairs for key public infrastructure across the province such as courts, detention centres, laboratories and offices. These investments will improve safety and support modern delivery of government services.

In addition, Ontario is returning surplus properties into productive use in support of government priorities such as attainable housing and other social infrastructure. This includes investing $99.1 million over three years through the Site Preparation Pilot Program to repurpose surplus sites at the former Thistletown Regional Centre in Toronto and the St. Thomas Psychiatric Hospital.

The public should not be responsible for the costs of government buildings that are no longer needed or being used. This pilot program will help generate revenue from surplus government properties and reduce liabilities, while supporting priorities such as attainable housing and other social infrastructure.

Building Highways

Supporting the Construction of the Banwell Road and E.C. Row Expressway Interchange in Windsor

Ontario is supporting the construction of a new interchange at Banwell Road and E.C. Row Expressway in the City of Windsor to keep people and goods moving. This interchange will support the needs of this growing community and the development of the NextStar Energy electric vehicle battery plant, a joint venture between LG Energy Solution and Stellantis N.V., as well as associated supply chain facilities, and the new regional acute care hospital.

Advancing a New Interchange at Highway 416 and Barnsdale Road in Ottawa

The government is working with the City of Ottawa to plan and design a new interchange at Highway 416 and Barnsdale Road to support population growth and development planned by the City for the Barrhaven South area, including housing, commercial areas and employment lands. This interchange will improve safety and help keep people and the economy moving.



Expanding Highway 7 in York-Durham Region

The government is planning to expand Highway 7 from two to four lanes from west of Reesor Road in Markham, east to Brock Road in Pickering, to support the development of the City of Pickering's Innovation Corridor. This will ensure Highway 7 is a continuous four-lane highway, supporting the movement of goods and people in the region.

Building the New Highway 7 from Kitchener to Guelph

The government is advancing the project with activities that include replacement of the Frederick Street Bridge in Kitchener, environmental fieldwork, and other engineering work to support construction on the remainder of the corridor. Contractors were invited to submit proposals for the replacement of the Frederick Street Bridge in February 2024.

The final phase of construction for the new Highway 7 between Kitchener and Guelph will provide relief to the busy Highway 401 and connect the fast-growing urban centres of Kitchener, Waterloo and Guelph.

Connecting Highway 401 to Lauzon Parkway in Windsor

The government is supporting the City of Windsor by initiating a procurement for an environmental assessment and design of a new interchange connecting Highway 401 to Lauzon Parkway. The interchange will support increased opportunities for trade and better access to the Windsor-Detroit border.

Building Highway 413

By 2051, the population in the Greater Golden Horseshoe is expected to reach nearly 15 million, growing by approximately one million new residents every five years. There is a pressing need for new highways to prepare for this growth and to help alleviate gridlock in what is already one of the busiest corridors in North America.

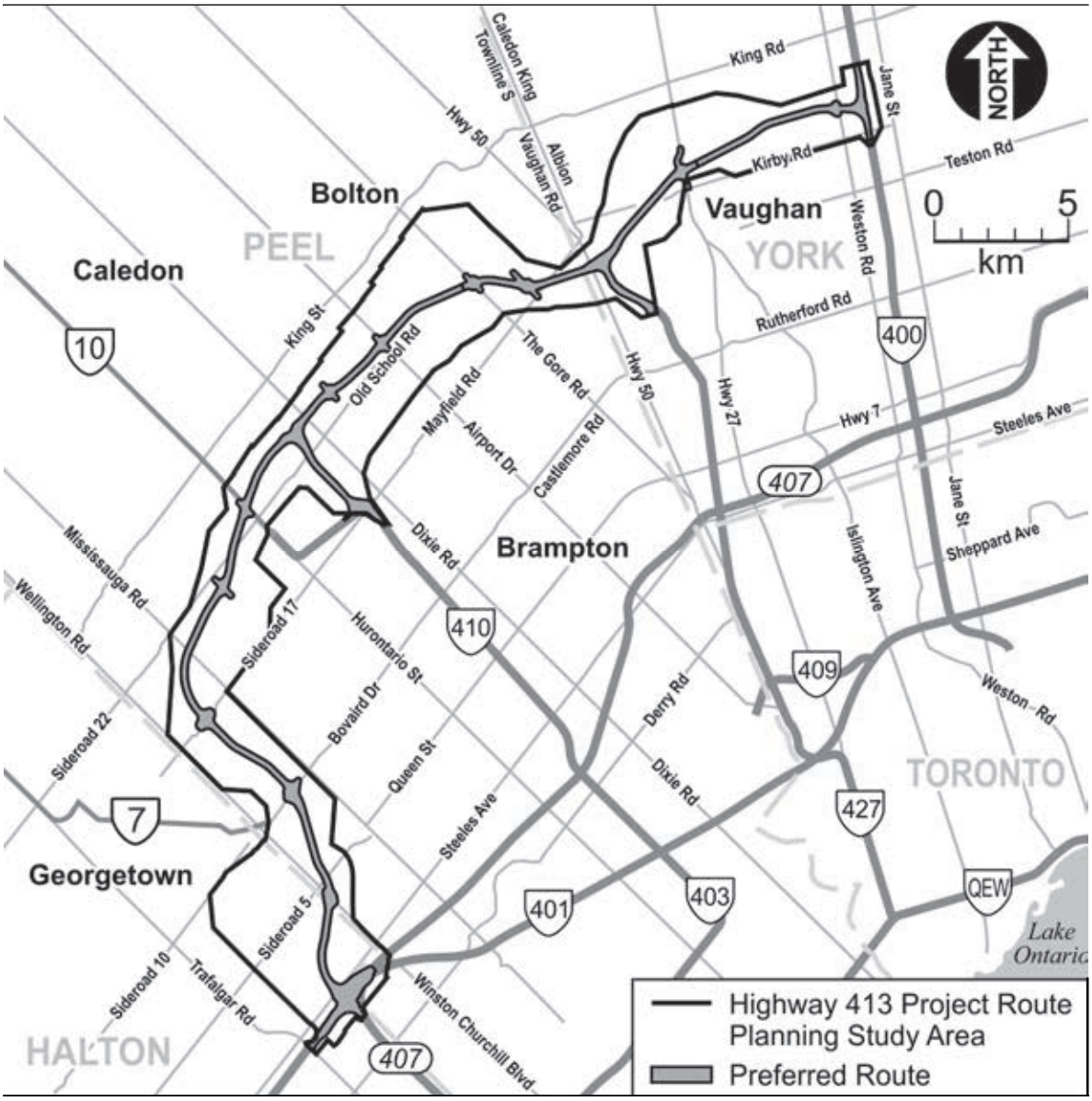
Ontario continues to move ahead with Highway 413, a new 52-kilometre (km) 400-series highway to better connect the corridor across Halton, Peel and York Regions. The highway will extend from Highway 400 in the east to the Highway 401/407 Express Toll Route (ETR) Interchange in the west and include extensions to Highway 410 and Highway 427.

During construction, Highway 413 is expected to support up to 3,500 jobs each year and generate up to $350 million in annual real GDP. Once completed, Highway 413 will save drivers up to 30 minutes each way on their commute and keep goods and the economy moving. Upon completion, more than 300,000 trips will be taken on the highway every day.

The Highway 413 project is currently in Stage 2 of the Environmental Assessment, which includes refining the route, determining interchange and crossing road locations, and completing preliminary design for the proposed new transportation corridor. Significant data collection, fieldwork and analysis is continuing. In addition, several community and advisory group meetings have been held, as well as engagements and consultations with Indigenous communities.

Chart 1.2

Highway 413 Project Route



Source: Ontario Ministry of Transportation.

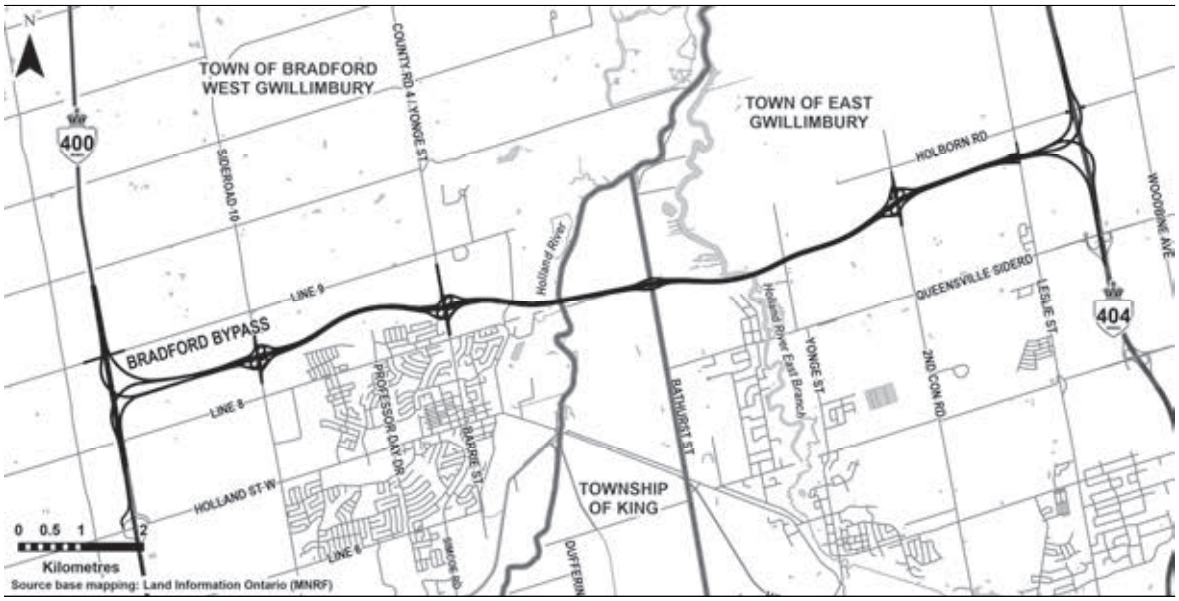
Getting the Bradford Bypass Built

Ontario is helping prepare York Region and Simcoe County for rapid population growth over the next 10 years by building the Bradford Bypass, a new four-lane highway that would relieve congestion on existing east-west local roads and provide a northern freeway connection between Highway 400 and Highway 404.

In November 2022, construction began with an Early Works contract to build a new bridge at Simcoe County Road 4. In December 2023, the government initiated procurement activities to advance the development of the West Contract of the Bradford Bypass for the section from Highway 400 to County Road 4. This includes procuring services to design the route. This procurement is expected to be completed by late spring 2024.

Once complete, the Bradford Bypass will save drivers an estimated 35 minutes in travel time. During construction, the project is expected to create up to 2,200 jobs per year and contribute up to $286 million to GDP between 2024 and 2030.

Chart 1.3
Bradford Bypass Project Route



Source: Ontario Ministry of Transportation.

Expanding Highway 401

The Highway 401 corridor in Eastern Ontario is an important economic link between Ontario, Eastern Canada and the United States. It carries about 10,000 trucks with commodities valued at up to $380 million per day. The government is continuing work to widen Highway 401 easterly from Brock Road in Pickering, as well as replacing bridges in Port Hope, helping tens of thousands of drivers per day get to work and home faster, as well as get goods to market sooner.

This builds on the previous work to improve the Highway 401 corridor, including the recent completion of additional lanes in Mississauga and Milton.

Widening Highway 401 from Mississauga to Milton

The government expanded Highway 401, the busiest and most congested highway in North America, with 18 kilometres of new lanes from Mississauga to Milton. Approximately 180,000 vehicles and $930 million worth of goods per average weekday travel this section of Highway 401 from the Credit River in Mississauga to Regional Road 25 in Milton. The expansion was completed prior to the 2023 winter season to help keep goods and people moving across the Greater Golden Horseshoe.

Building Highways for Northern Ontario

The government is investing in highways in the North to improve road safety and unlock economic opportunities. Projects include:

- Supporting the construction and repair of municipal roads and bridges that connect to provincial highways through communities, including the reconstruction of Highway 101 through Timmins;
- Widening Highway 17 from Kenora to the Manitoba border;
- Resurfacing Highway 144 from north of Highway 560 northerly to Highway 661, near Gogama;
- Continuing to widen Highway 69 from two to four lanes, from Parry Sound to Sudbury;
- Expanding Highway 11/17 between Coughlin Road and Highway 582 (east junction) west of Red Rock;
- Widening Highway 11/17 between Thunder Bay and Nipigon; and
- Proceeding with the design and environmental assessment work for a 2+1 highway pilot in Northern Ontario, for two locations on Highway 11 north of North Bay. A 2+1 highway is a three-lane highway with a centre passing lane that changes direction approximately every two to five kilometres.

Expanding and Improving Roads, Highways and Bridges Across Ontario

The government is investing $27.4 billion over the next 10 years to connect communities, fight gridlock and keep goods and people moving across the province. The Ontario highways program includes more than 650 expansion and rehabilitation projects that are either underway or planned over the next four years.

In 2024–25 alone, Ontario is investing $3.9 billion towards projects that will expand and rehabilitate provincial highways and bridges.

The government is building capacity and enhancing road safety for travellers by:

- Moving forward with the Queen Elizabeth Way (QEW) Garden City Skyway Bridge Twinning project, which includes construction of a new twin bridge on the QEW over the Welland Canal;
- Widening Highway 404 from Highway 407 to Major Mackenzie Drive, Markham, for high-occupancy vehicle (HOV) lanes;
- Widening Highway 3 from two to four lanes between Essex and Leamington;
- Replacing the Little Current Swing Bridge on Highway 6 in the Town of Northeastern Manitoulin and the Islands;
- Rehabilitating Highway 403 between Highway 401 and West Quarter Townline Road in Brant and Oxford Counties;
- Repairing bridges and culverts on Highway 28 in Renfrew County;
- Constructing a new interchange on Highway 6 in Wellington County as part of advance work for the Morriston Bypass;
- Rehabilitating the Bay of Quinte Skyway Bridge;
- Replacing bridges on Highway 417 in Ottawa; and
- Widening Highway 3 and Highway 4 to support growth and economic development in St. Thomas.

Table 1.2

Recently Completed Highway Projects

Northern

- **Highway 11/17**: Expansion from two to four lanes from west of CPR Overhead at Ouimet, westerly to Dorion East Loop Road.
- **Highway 11/17**: Highway expansion, including construction of a new Commercial Vehicle Inspection Facility from 7.3 km east of Highway 527, easterly for 3.3 km.
- **Highway 17**: Resurfacing, paved shoulders and other improvements from Sudbury easterly to Kukagami Road, west of Markstay.
- **Highway 101**: Resurfacing for 21 km from west of Little Star Lake Road to Nat River Bridge, east of Foleyet.

Eastern

- **Highway 17**: New interchange at Calabogie Road, Renfrew County.
- **Highway 401**: Replacement of Halleck's Road Bridge, United Counties of Leeds and Grenville, west of Brockville (allowing for future expansion of Highway 401).
- **Highway 7**: Paving and drainage improvements, from Omemee westerly to Slanted Road, Kawartha Lakes.

Southwestern

- **Highway 21**: Rehabilitation from Bruce Road 10 to Springmount.
- **Highway 402**: Rehabilitation from Longwoods Road to Colonel Talbot Road, Middlesex County.
- **Highway 402**: Resurfacing and culvert replacement from Colonel Talbot Road to Highway 401, London.
- **Highway 24**: Resurfacing and reconstruction from Powerline Road to Glen Morris Road, County of Brant.
- **Highway 401**: Widening from Highway 8 to Townline Road, Cambridge.

Central

- **Highway 400**: Bridge and pavement rehabilitation from Steeles Avenue to Langstaff Road, Vaughan.
- **Highway 35**: Bridge and pavement rehabilitations from Main Street north junction (Durham Road 17) to Highway 115, Clarington.
- **Highway 11**: Bridge replacement, West Street, Orillia.
- **Highway 89**: Pavement rehabilitation, culvert replacement, and other improvements from Industrial Parkway to west of Simcoe Road 50, Adjala-Tosorontio, Simcoe.

Source: Ontario Ministry of Transportation.

Building Transit

Delivering on *Ontario's Plan to Build* with public transit projects is vital to supporting the province's economy, alleviating gridlock, and connecting more people to jobs and housing.

Building More Frequent and Connected GO Transit Services

To better connect growing communities across the Greater Golden Horseshoe and Southwestern Ontario, the government is continuing to expand and build better GO train and GO bus services to make it easier and faster for people to get where they need to.

Expanding GO Service in Milton

The government is working to deliver fast, frequent GO rail service on the Milton GO Line, the fourth busiest line in the GO network, by adding two train trips every weekday and advancing the planning and design work for future two-way, all-day service. This expansion will support the growing communities of Mississauga and Milton by connecting more people to transit, jobs and housing across the Greater Golden Horseshoe.

Ontario is also calling on the federal government to agree to a cost-sharing partnership that will deliver all-day, two-way GO rail service along the Milton GO rail corridor by building a fully separated passenger rail line.

Ontario continues to invest in service and capacity improvements across the core network to bring two-way, all-day GO Transit service with faster trains, more stations and better connections.

- Kitchener GO Line: To enable two-way, all-day service on the Kitchener Line, improvements are being made to stations and the railway corridor. In Guelph, installation of the steel structure for the new south platform canopy was completed in August 2023, and work on the new train platform will be completed in 2024.
- Bowmanville GO Rail Extension: In June 2023, the government awarded a contract to advance the planning to extend GO rail service east of Oshawa into Bowmanville, which includes new tracks and signals, seven new bridges and at-grade crossing upgrades.
- Niagara GO Rail: In May 2023, the government increased GO train service between Union Station and the Niagara Region, with more express service between Hamilton, Burlington and Toronto. Year-round daily trips will not only reduce travel times for commuters but help to promote tourism in the Niagara Region.

- Bloor GO Station: In August 2023, the government awarded a contract for the construction of a pedestrian tunnel connecting the Bloor GO/Union Pearson (UP) Express Station and the TTC's Dundas West Station. The Bloor GO/UP Express Station/TTC Connection will encourage travellers to choose to combine GO Transit or UP Express trips with TTC subway, streetcar or bus services, and support the growth of a more interconnected regional rapid transit network.
- Bramalea GO Station: The brand new accessible station, parking garage and bus loop will provide better access to GO Transit and Brampton Transit services. These improvements at the Bramalea GO Station will support future two-way, all-day GO train service along the Kitchener Line and connect more people to transit, jobs and housing across the Greater Golden Horseshoe.
- Aurora GO Station: The government is making critical infrastructure upgrades to the Aurora GO Station, which will provide commuters with better service, more transit connections and future two-way, all-day service between the Aurora GO Station and Union Station in Toronto. In August 2023, construction began on improvements that will include a new second platform and track, a new pedestrian tunnel with elevators, additional parking spaces, as well as rail signal upgrades.
- Stouffville GO Line: In October 2023, the government completed major infrastructure improvements at the new Old Elm GO Station and added two additional GO train trips along the Stouffville Line, which will increase safety and accessibility for customers, while supporting future two-way, all-day train service.



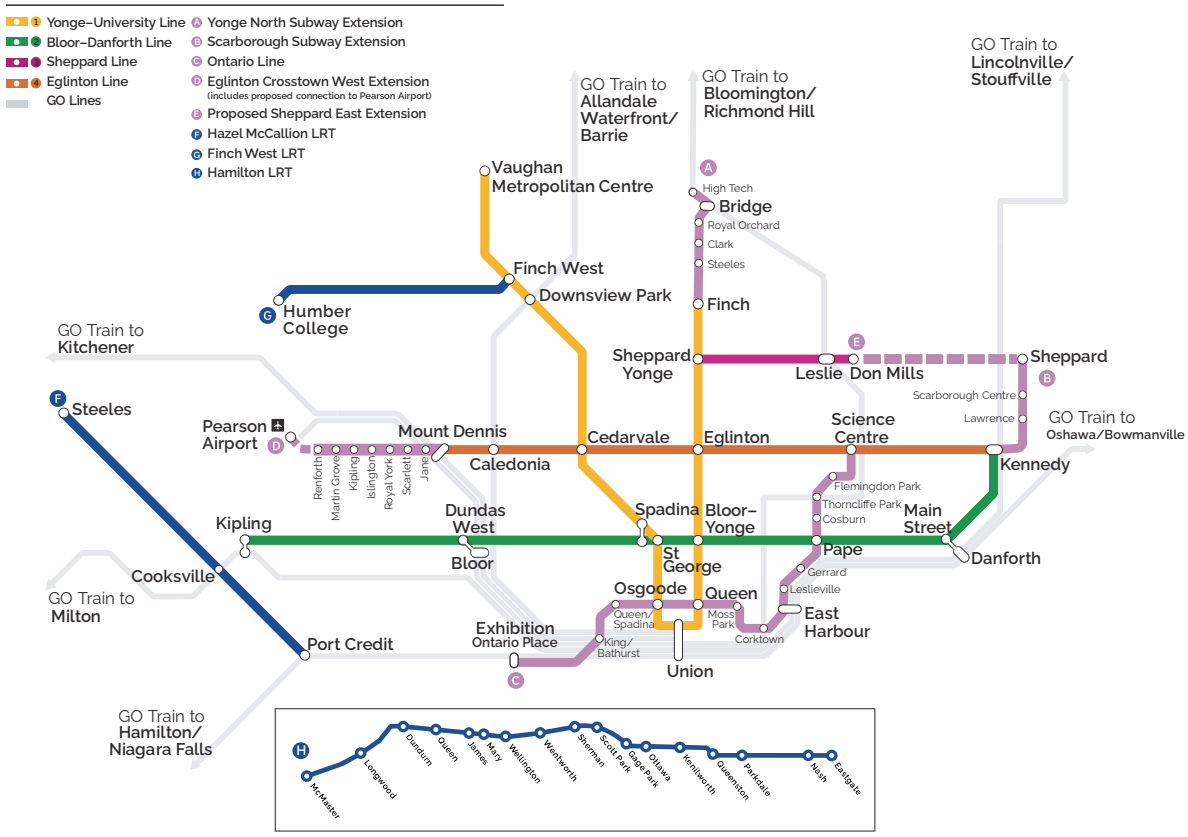
Building Subways

Work is underway on all four of Ontario's priority subway projects. The government is closer to providing better travel options, alleviating gridlock on the roads and creating thousands of good, local jobs.

The combined subway projects will support more than 16,000 jobs annually during construction over the next decade. Shovels are in the ground and recent milestones include:

- Ontario Line: The government received responses to its RFPs for the Pape Tunnel and Underground Stations and the Elevated Guideway and Stations contracts. Metrolinx and Infrastructure Ontario (IO) will enter into a development phase with the preferred proponent for each contract in 2024. Work is also underway in the Lakeshore East rail corridor, bringing transit upgrades including new rail bridges, retaining walls and noise walls to neighbourhoods surrounding the future sites of East Harbour, Riverside-Leslieville and Gerrard Stations. The project will provide significant relief from crowding throughout the existing transit network with 388,000 daily boardings expected and will reduce traffic congestion with 28,000 fewer cars on the road expected daily.
- Three-Stop Scarborough Subway Extension: In November 2022, the government selected a development partner for the Stations, Rail and Systems Contract. This contract includes design and construction of three new underground stations and bus terminals at each station. Work to build the extraction shaft for the tunnel boring machine began in October 2023. The project is expected to have 105,000 daily boardings and provide transit access within walking distance to 38,000 more people.
- Yonge North Subway Extension: In December 2023, the government issued an RFP for the Advance Tunnel Contract that includes work to design, build and finance the construction of tunnels. Early upgrade work at Finch Station, where the Yonge North Subway Extension will connect with existing Line 1 subway service, is now substantially complete. The upgrades set the stage for major construction of the subway extension to Richmond Hill and Markham.
- Eglinton Crosstown West Extension: As of February 2024, tunnelling is over 80 per cent complete. Contracts were awarded for the elevated guideway portion in December 2023 and the Advance Tunnel 2 project in February 2024.

Chart 1.4
Building Transit in the Greater Golden Horseshoe



Source: Ontario Ministry of Transportation.

Building and Expanding Light Rail Transit

The government is bringing fast, reliable transit projects to help reduce travel times and create more transit options, including:

- Finch West Light Rail Transit (LRT): This LRT from Humber College to Finch West Station will give those in Northwest Toronto a transit system that offers more choices to travel, cuts down on travel time and increases transit reliability. The project has reached a number of important milestones, including completing the construction of the guideway and maintenance and storage facility and receipt of all 18 light rail vehicles. The project is now undergoing testing and commissioning in preparation for service.
- Eglinton Crosstown LRT: The last remaining lane restrictions for construction of the Eglinton Crosstown LRT have been lifted. Platform work is also largely complete. Rigorous testing is currently underway across various systems.
- Proposed Sheppard East Extension: The government is currently studying options and seeking community input to extend rapid transit east along Sheppard Avenue, which would improve transit connections in Toronto's north end and make it easier and faster for people to get around Toronto and the GTA.
- Hamilton LRT: Due diligence work is currently underway related to matters such as subsurface investigations. In addition, engagement with Indigenous communities is also ongoing.

Extending the Hazel McCallion Light Rail Transit Line

Ontario is providing more transit options to connect people to good-paying jobs and housing in the rapidly growing cities of Mississauga and Brampton. The government has accepted an initial business case and will begin planning and design activities for the extension of the Hazel McCallion LRT Line. A downtown loop would connect the City of Mississauga's Square One District, and a Main Street extension would bring the LRT into downtown Brampton along the Hurontario-Main Street transit corridor. The planning and design activities will ensure the proposed extensions can progress as the construction of the Hazel McCallion LRT Line continues. Ontario will also use measures introduced in the *Building Transit Faster Act, 2020* to declare the Hazel McCallion Line extensions as priority transit projects.

Building Transit-Oriented Communities

The Transit-Oriented Communities Program is part of the government's plan to build vibrant, complete, mixed-use communities at or around transit stations. Transit-Oriented Communities will help increase transit ridership, create sustainable communities and build more homes, including more affordable housing, around GO Transit, LRT and subways. While Ontario works to help build 1.5 million homes by 2031, work is already underway to deliver on the Transit-Oriented Communities at 12 future stations along the new Ontario Line, Scarborough Subway Extension, and the Yonge North Subway Extension, creating over 79,000 new jobs and approximately 54,000 new residential units.

The government also passed the *GO Transit Station Funding Act, 2023*, to provide a new, voluntary funding tool for municipalities. This tool, called the Station Contribution Fee, could be used by municipalities to fund the design and construction of new GO Transit stations and recover costs over time as new development occurs around these future stations, encouraging new housing and mixed-used communities.

As part of the new deal with the City of Toronto, the municipality agreed to advance Transit-Oriented Communities by prioritizing approvals and finalizing agreements for the development of East Harbour, along with cooperation and collaboration from the City of Toronto on a proposal for a mixed-use Transit-Oriented Community at the future Woodbine GO Station.

Bringing Back the Northlander

Ontario is delivering on its promise to restore passenger rail service to Northern Ontario as the original Northlander service was cancelled in 2012. The Northlander train service will provide a safe and reliable transportation option for Northern communities and will run from Toronto to Timmins with a rail connection to Cochrane.



As part of this commitment, Ontario has purchased three new trainsets for the reinstated service. Moving forward, implementation activities include detailed design and engineering, environmental assessment, Indigenous and municipal engagement and consultation, and procurement, with construction of station and track improvements expected to begin in 2024.

The Northlander train will provide improved access to essential services such as health care and education, while supporting economic prosperity and tourism in the region, as well as strengthening the connection between the North and the South.

Supporting Ontario's Shortline Rail System

A well-functioning supply chain is critical for Ontario's economy. Ontario has an extensive network of railways including both larger national railways and several shortline railway systems. Shortline railways typically run shorter distances than the larger national railways and are often used to move goods between shippers and the main railway lines, providing critical "first and last mile" service to rail customers.

Ontario is committed to exploring ways to support shortline rail, which plays an integral role in providing safe and efficient transport of goods and people throughout the province.

In January 2023, the provincial government partnered with the federal government to announce an investment to support the rehabilitation of key rail infrastructure for the Huron Central Railway, which operates freight service between Sault Ste. Marie and Sudbury.

Launching the Ontario Transit Investment Fund

The government is launching the Ontario Transit Investment Fund to provide annual funding of $5 million to deliver local and intercommunity transportation projects in unserved and underserved areas in Ontario, particularly in rural areas. The Ontario Transit Investment Fund builds on the Community Transportation Grant Program and will include an ongoing application-based intake with expanded eligibility that includes municipalities, Indigenous communities and non-profit organizations.

Exploring the Use of Digital Twins

As Ontario executes its most ambitious capital plan, the government is investing $5 million to explore the use of digital twins to deliver its public infrastructure projects.

Digital twins are virtual models of a physical object or system, which are continuously updated with data to reflect the most current physical state of the asset more accurately. Digital twin technology could be used to assess potential issues with water treatment systems and other underground infrastructure. By using digital infrastructure to run simulations, proposed improvements and performance issues can be assessed before solutions are implemented. Utilizing digital twin technology could improve capital project delivery by leveraging existing infrastructure and data more effectively to help keep costs down, manage risks, and mitigate against potential schedule delays.

Through this initiative, Infrastructure Ontario is partnering with local and global organizations such as Toronto Metropolitan University to leverage their experience with digital twins and explore solutions to help modernize the delivery of public infrastructure.

Section B: Working for You

As Ontario continues its plan to rebuild the economy, the government remains committed to investing in workers and key public services, without raising taxes or fees.

Working for Workers

Ontario is continuing to make it easier for workers to get the skills they need for better jobs and bigger paycheques, while also helping them to plan for a secure retirement. The provincial government is making investments in training to help fill in-demand jobs in key areas like the skilled trades and health care, strengthening Ontario's economy and helping prepare the skilled workers needed to build roads, transit, hospitals and homes.

Supporting Skills Development and Training

Investing in Skills Training Through the Skills Development Fund Training Stream

The Skills Development Fund Training Stream is helping to address challenges in hiring, training and retaining workers through an additional $100 million in 2024–25 to help workers and job seekers, including apprentices, get the skills they need to advance in their careers. This is in addition to the over $860 million that has been invested since its launch in 2021. To date, the government has delivered close to 600 training projects to help more than 500,000 workers, including those in the skilled trades and health care, take the next step in their careers.

Helping Indigenous Workers in Northern Ontario Train for Rewarding Careers in Their Communities

The government is investing $7.3 million through the Skills Development Fund to support Indigenous workers across Northern Ontario. The investment will fund eight innovative training projects that will help prepare 1,700 workers for in-demand jobs in critical sectors such as forestry, construction and health care. One of the projects, led by Ironworkers Local 759, will support 100 workers and job seekers to upgrade their skills for well-paying jobs in the construction sector. The other seven projects are led by various organizations across Northern Ontario and will help prepare job seekers for in-demand jobs across a number of industries.

Building New Skilled Trades Training Centres

Ontario is investing $224 million to expand access to bricks-and-mortar training centres through the Skills Development Fund Capital Stream. The funding will help unions, Indigenous centres, and industry associations build new training centres, or upgrade and convert existing facilities into new training centres with state-of-the-art equipment and technology. The investments made through the Skills Development Fund Capital Stream will help ensure that Ontario has the world-class training facilities it needs to train more workers for the skilled trades and build Ontario's economy. These training centres will prepare people for emerging and in-demand jobs in critical sectors, including construction and health care, among others.

Training Apprentices Through Ontario's Skilled Trades Strategy

Ontario is helping people explore and prepare for life-long careers in the skilled trades to support the province's growing economy, deliver on the government's ambitious capital plan, and support better jobs and bigger paycheques. The government has invested more than $1 billion in the skilled trades through its Skilled Trades Strategy and is providing an additional $16.5 million annually over the next three years to support a variety of programs that focus on breaking the stigma and attracting more young people into the skilled trades, simplifying the system and encouraging employer participation in apprenticeships.

Helping Young People Kick-Start Careers in the Skilled Trades

Ontario is investing over $62.9 million in two of the province's foundational programs to help more than 18,000 young people explore careers in the skilled trades, including:

- $21.1 million to expand the Ontario Youth Apprenticeship Program (OYAP), a specialized high school program that gives students who have completed Grade 10 the chance to explore the trades through cooperative education courses, while completing their Ontario Secondary School Diploma; and
- $41.8 million to launch approximately 100 pre-apprenticeship training projects around the province to help young people get firsthand experience working in trades, including a paid work placement with a local employer.

This funding for skills development and training programs will help train the skilled workers needed to build transit, hospitals and at least 1.5 million homes by 2031.



Helping Workers Train for In-Demand Jobs Through Better Jobs Ontario

The Better Jobs Ontario program helps eligible job seekers access short-term training programs by providing up to $28,000 to cover expenses such as tuition, transportation and child care. In the *2023 Budget*, Ontario invested an additional $15 million over three years to support the recent expansion of the program to more job seekers including youth, gig workers, newcomers and those on social assistance who may face barriers to finding stable employment. Since January 2021, this program has supported over 7,700 people looking to find better jobs and bigger paycheques.

Calling for Secure, Modern and Flexible Federal Labour Market Transfers From the Federal Government

Labour Market Transfer Agreements (LMTAs) provide critical support to Ontario for the design and delivery of employment, training and skills development programs. This funding supports skills training for the people of Ontario, including workers, job seekers, people with disabilities, youth and adult learners. These agreements support the continued investments Ontario is making to help job seekers and workers get and keep good jobs, and employers get the talent they need so that the province's labour market can thrive.

In March 2023, the federal government provided a one-year extension to the previous federal commitments under these agreements, which have been in place since 2017. Ontario joins other provinces and territories in urgently calling on the federal government to maintain this funding at current levels. Without action, 2024–25 would be the first year since 2017 that the federal government has not provided this funding to provinces and territories at its current level. In addition, immediate federal engagement is needed to modernize the LMTAs. This includes a clear commitment to adequate, flexible and predictable levels of LMTA funding, and to respect Ontario's expertise and experience in addressing the employment and training needs of the people of Ontario, including people with disabilities, newcomers and youth.

Helping Workers Plan for Retirement

Implementing a Target Benefit Framework

Target benefit pension plans provide a monthly stream of income in retirement at a predictable cost for employers. Multi-employer pension plans that provide target benefits are often created by a union or association within a specific industry, especially industries involving the skilled trades. This means members of these plans can move from employer to employer while continuing to participate in the same pension plan, which encourages job mobility and will help to attract more people into the skilled trades.

The government has been engaging with the sector over the past year on a permanent target benefit framework that builds on best practices for plan funding and governance and enhances communication with plan members. Taking into consideration feedback received during these consultations, the government is now drafting proposed regulations that would support the framework. These proposed regulations will be made available for technical review by the sector in summer 2024.

The government is also proposing legislative amendments that would support implementation of the framework. The government intends for the permanent target benefit framework to come into effect on January 1, 2025.

The permanent framework would help support the sustainability of these workplace pension plans and pave the way for more employers to offer them, helping workers to save for their retirement.

Keeping Costs Down

At a time when inflation and the Bank of Canada interest rates are high and everyday costs are up, the government is keeping costs down for families. While the economic situation remains challenging, Ontario continues to invest in key public services and lay out a path to a balanced budget without raising taxes or fees. Through investments and relief measures, the government aims to help with keeping costs down and making life more affordable for people. From housing to postsecondary education to transportation, the government is helping keep costs down for essentials for Ontario families while making the province a more affordable and competitive place to live and work.

Putting Money Back in Your Pocket

Recognizing that it is a challenging time for many across the province, the government is making it more affordable to take public transit, drive a car and attend postsecondary school, among other measures to help keep costs down.

Extending the Temporary Gas Tax and Fuel Tax Rate Cuts

In spring 2022, the Ontario government temporarily cut the gasoline tax rate by 5.7 cents per litre and the fuel tax rate by 5.3 cents per litre.

To provide additional relief to people and businesses, the government is proposing to extend these rate cuts so that the rate of tax on gasoline and fuel (diesel) would remain at nine cents per litre until December 31, 2024. This would save Ontario households $320 on average over two and a half years since 2022. The resulting relief is especially important as the federal carbon tax is set to increase on April 1, 2024.

See the *Annex: Details of Tax Measures and Other Legislative Initiatives* for more information.

Protecting Against Carbon Taxes

The government is committed to protecting people and businesses from the high costs of a new and unexpected provincial carbon pricing program. This is why the government has taken a meaningful step to protect taxpayers' hard-earned dollars by introducing legislation that would require the provincial government to first ask the people of Ontario, via a referendum, before implementing a new provincial carbon pricing program.

As the government works to protect taxpayers, Ontario continues to call on the federal government to eliminate the federal carbon tax, which has increased inflation and made life less affordable for the people of Ontario.

Expanding Access to the Ontario Electricity Support Program

The government is keeping electricity costs down for about 100,000 additional families by expanding the eligibility for the Ontario Electricity Support Program (OESP). Beginning March 1, 2024, the income eligibility thresholds for the OESP were increased by up to 35 per cent to provide thousands of additional low-income families access to the program and make electricity more affordable. Families can apply for the OESP at any time. The OESP provides an on-bill credit of $35 to $75 per month, depending on household size, to provide support for low-income households when paying their electricity bills. Higher monthly credits of between $52 to $113 are available to customers who are Indigenous, living with Indigenous family members, using electric heating, or using certain electricity-intensive medical devices.

Continuing to Make Postsecondary Education Affordable Through an Extended Tuition Freeze

The government is continuing to provide financial relief for students and families seeking access to affordable postsecondary education. The provincial government is extending the tuition fee freeze for Ontario students in publicly assisted colleges and universities for at least three more years. Institutions will have the flexibility to increase tuition by up to five per cent for out-of-province domestic students. Since the freeze was first introduced after a 10 per cent reduction in tuition fees, students and parents have saved an estimated $1,600 per year, on average, to attend university and an estimated $350 per year, on average, to attend a public college, compared to what they would have paid under the previous policy.

Keeping Transit Costs Down

Ontario is keeping costs down for public transit riders through One Fare, which will save daily riders on participating systems an average of $1,600 each year. Transit riders will only pay once to transfer between transit systems in the Greater Toronto Area (GTA). This is expected to lead to over eight million new rides every year.

One Fare builds on improvements the government made in 2022 and will make cross-boundary travel more affordable and convenient for students, seniors and other commuters.

Banning Road Tolls

Ontario is keeping costs down for drivers by proposing to ban any new tolls on new and existing provincial highways. This ban would also apply to the Don Valley Parkway and the Gardiner Expressway once uploaded to the province. The government already removed tolls on Highways 412 and 418 in April 2022.

Freezing Driver's Licence Fees

Ontario is also keeping costs down by freezing fees on driver's licences and Ontario Photo Cards, ensuring that any future increases can only be made through legislation. This would save drivers an estimated $66 million over the next five years compared to a situation where fees would have increased at a historical rate. The people of Ontario have already saved $22 million since the current freeze was put in place by the government in 2019.

Eliminating Licence Plate Renewal Fees and Stickers

The government put money back in people's pockets in 2022 by refunding eligible licence plate renewal fees paid since March 2020 for nearly eight million vehicle owners in Ontario. The government also eliminated licence plate renewal fees and plate stickers on a go-forward basis for passenger vehicles, light-duty commercial vehicles, motorcycles and mopeds that are owned by individuals, a company or business, resulting in savings of $1.1 billion per year for vehicle owners.

Effective April 2019, the government also eliminated the Drive Clean program for passenger vehicles, saving money for Ontario drivers and reducing the regulatory burden on Ontario families.

Making Auto Insurance Work for You

In alignment with previous Budget commitments, the government will move forward with auto insurance reforms that would empower Ontario drivers with more affordable options, improved access to benefits and create a more modern system. Implementation of the proposed changes will be done in a way to help ensure that drivers are able to make informed decisions when choosing insurance coverage options available to them.

Enabling More Consumer Choice

Mandatory auto insurance accident benefit coverage will continue to apply to medical, rehabilitation and attendant care benefits, while all other benefits would become optional. This would provide drivers with an opportunity to lower their premiums by taking advantage of a wider range of coverage options to meet their needs.

For example, drivers may already have access to certain benefits through their workplace benefit plans, so they should have the choice to not have to pay for them twice through their auto insurance policies.



The government will be proposing to make auto insurance pay for medical and rehabilitation benefits following an auto accident before extended health care plans do. This would apply to all automobile accidents, regardless of the injury sustained. The proposed change would ensure that auto insurance companies pay for health care costs before extended health care plans and it would also help reduce paperwork and red tape for patients and their health care providers.

Reviewing Health Service Provider Guidelines and Frameworks

The government is committed to ensuring that those injured in auto accidents continue to receive the care they need and that health service providers are compensated appropriately for their services. The government is requesting that the Financial Services Regulatory Authority of Ontario (FSRA) review the Professional Services Guideline and the Attendant Care Hourly Rate Guideline, and consider updating these guidelines based on their findings. The government will consider FSRA's findings in future reviews of the Statutory Accident Benefits Schedule.

The government is also requesting that FSRA conduct a review of the Health Service Provider Framework and the Health Claims for Auto Insurance (HCAI) system to find administrative and cost efficiencies to contribute to having a more modern and efficient system.

Moving Forward With Product and Services Innovation

In January 2022, the government enabled a Test and Learn Environment allowing FSRA to support the creation of more innovative auto insurance products and services with the goal to improve customer experience and affordability. The government will continue to work with FSRA to identify further opportunities for innovation, competition and cost reductions by proposing to expand the number of items that could be piloted in FSRA's Test and Learn Environment.

Ensuring Fair Use of Territorial Ratings

The government, in collaboration with FSRA, is working to ensure there is no unfair use of territorial ratings. In January 2024, FSRA launched a pilot in their Test and Learn Environment to modernize Ontario's territory rating approach to support fairer pricing for auto insurance.

The Territories Test and Learn Environment allows participating auto insurers to propose and evaluate territory rate changes for private passenger vehicles within the GTA over a minimum two-year period. The findings of this pilot may be applied to other regions over time.

Keeping Taxes Low on Beer and Wine

The Ontario government is keeping costs down by stopping the estimated 4.6 per cent increase to the beer basic tax and Liquor Control Board of Ontario (LCBO) mark-up rates that were scheduled for March 1, 2024. This increase would have resulted from rates being indexed to inflation, which the government has consistently waived over the last six years. This latest freeze will be in place for two years, until March 1, 2026.

The government is proposing to eliminate the 6.1 per cent basic tax at on-site winery retail stores and preparing Ontario-based producers to help with the transition to a more open alcohol marketplace.

The government will conduct a targeted review of taxes and fees on beer, wine and alcoholic beverages with the aim of promoting a more competitive marketplace for Ontario-based producers and consumers.



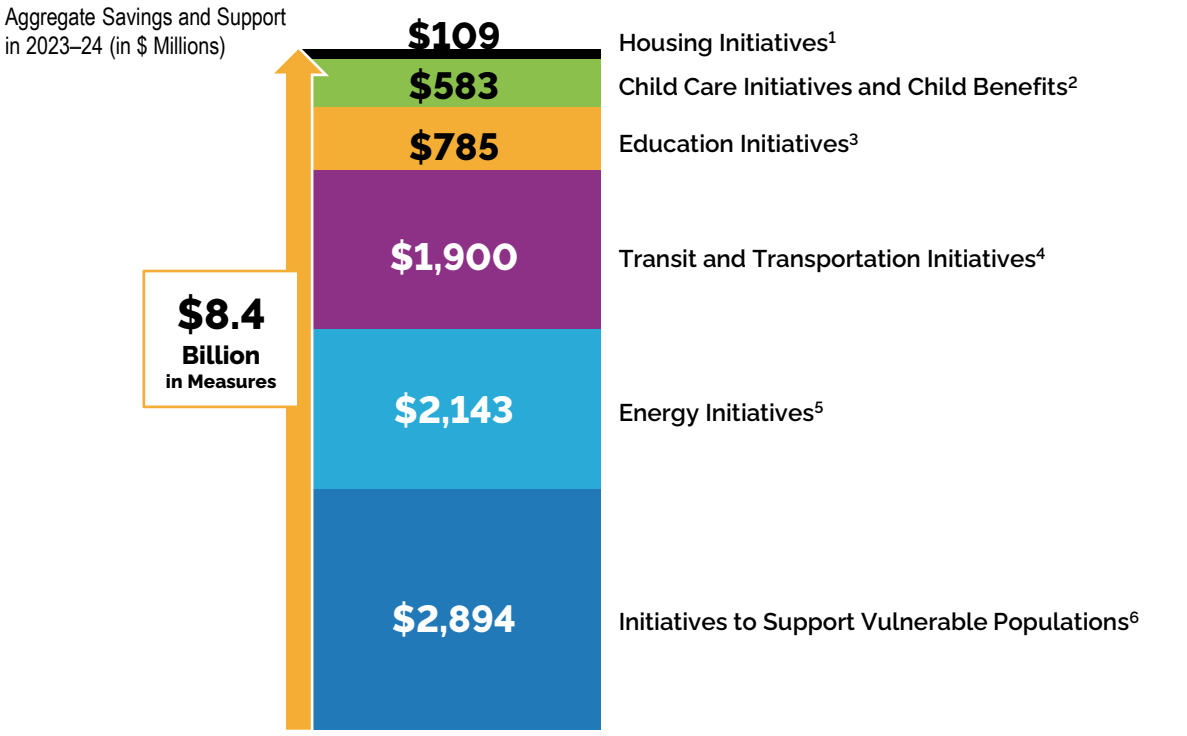
Supporting Individuals and Families

Financial pressures have left many in Ontario, especially those who are more vulnerable, feeling the burden of rising costs on their household budgets. The government understands that it is a challenging time for many across the province, particularly with recent high inflation. This is why the government has acted early to provide relief, taking steps to provide support and deliver on its commitment to make life more affordable.

Actions taken to date, summarized in Chart 1.5, will total $8.4 billion in relief for families and individuals in the 2023–24 fiscal year.

Chart 1.5

Select Measures That Provide Relief to Families and Individuals



1 Includes the provincial contributions to the Housing Supply Action Plan.
2 Includes the Ontario Child Benefit (OCB) indexed to inflation and program growth; Ontario's contribution to the Canada-wide Early Learning and Child Care Agreement; and the Childcare Access and Relief from Expenses (CARE) Tax Credit.
3 Includes a 10 per cent tuition fee reduction and subsequent freeze for postsecondary students and its extension.
4 Includes eliminating and refunding fees from licence plate renewal and vehicle validation tags; fee freeze on driver's licence, tests, and vehicle validation and subsequent annual fee increase cancellation; removing double fares for GO Transit and increasing the PRESTO discount for postsecondary students (Fare and Service Integration); removing tolls on Highways 412 and 418; and cutting gas tax and fuel tax rates.
5 Includes cancelling the cap-and-trade carbon tax and also includes ongoing funding for the Ontario Electricity Support Program (OESP).
6 Includes increases to the Ontario Disability Support Program (ODSP) core allowances and Assistance for Children with Severe Disabilities (ACSD); the temporary doubling of the Ontario Guaranteed Annual Income System (GAINS) payments; the Low-income Individuals and Families Tax (LIFT) Credit and its enhancement; the Ontario Seniors Care at Home Tax Credit; OHIP+ and the Ontario Drug Benefit (ODB) Program reform for children and youth without a private plan; expanding the Home and Vehicle Modification Program; expanding the Assistive Devices Program for Continuous Glucose Monitors and Supplies; the Ontario Seniors Dental Care Program; the Ontario Community Support Program; the Shelters and Homelessness Operating Support component of the Toronto new deal; and the Homelessness Prevention Program and Indigenous Supportive Housing Program.

Notes: Numbers may not add due to rounding. Impacts on families and individuals will vary significantly since programs have different eligibility criteria.
Source: Ontario Ministry of Finance.

Helping Ontario's Most Vulnerable

Rising costs have impacted household budgets. The government continues to help Ontario's most vulnerable, including low-income seniors and individuals living with mental health and addictions challenges who are experiencing unstable housing conditions.

Providing Financial Support to More Seniors

To ensure that more seniors who need financial help get it, the government is expanding the Ontario Guaranteed Annual Income System (GAINS) program and indexing the GAINS benefit to inflation.

Starting in July 2024, the maximum benefit will increase to $87 per month for eligible single seniors and to $174 per month for couples. Going forward, the benefit will be adjusted to inflation annually.

Also in July, the annual private income eligibility threshold will increase from $1,992 to $4,176 for single seniors, and from $3,984 to $8,352 for couples.

These changes will allow about 100,000 more low-income seniors to receive payments, which is a 50 per cent increase in recipients.



Supporting the Seniors Community Grant Program

Through the Seniors Community Grant Program, the government is continuing to support local, not-for-profit community groups and organizations to deliver programs and services for seniors aged 55+. In 2023–24, approximately $6 million in funding was provided to over 280 groups and organizations for activities for seniors that encourage greater social inclusion, volunteerism and community engagement. This helps seniors live independently and avoid isolation by staying connected to their communities.

Expanding Access to Supportive Housing

Ontario is investing an additional $152 million over the next three years to support individuals facing unstable housing conditions and dealing with mental health and addictions challenges. This investment aligns with *Your Health: A Plan for Connected and Convenient Care* and advances the government's ongoing commitment to expand mental health and addictions support across individuals' lifespans through Ontario's Roadmap to Wellness. This funding will go towards a suite of supportive housing initiatives designed to bolster support for vulnerable populations, such as:

- Providing rent supplements for up to 10,679 supportive housing units to mitigate the impact of increasing rent costs due to housing market conditions.
- Maintaining 1,137 dedicated supportive housing units with expiring operating agreements, ensuring continued supportive housing for individuals with mental health and addictions challenges that are at risk of homelessness.
- Providing Indwell Community Homes funding for rent supplements and mental health and addictions support services to maintain supportive housing for over 640 individuals.
- Maintaining supportive housing for Salus in Ottawa and the Canadian Mental Health Association in North Bay and District, through investments to repair and renovate buildings, as well as to relocate up to 79 displaced low-income tenants with mental health and/or addictions needs.

The government will be considering new projects, starting next fiscal year, to build more supportive housing units across the province.

Adding More Supportive Housing Units to the Guelph-Wellington Area

The government is investing $9 million over three years for Stonehenge Therapeutic Community and Guelph Community Health Centre to support individuals with complex, high acuity mental health and substance use issues. This investment will provide supportive housing and comprehensive mental health and addictions wraparound health care services to 32 new clients and also increase service levels for 76 high-needs supportive housing residents in the Guelph-Wellington area.

These measures complement the $202 million in additional funding each year for the Homelessness Prevention Program and Indigenous Supportive Housing Program that was announced in the *2023 Budget.*

Helping to Increase Housing Supply and Affordability

One way to improve access to the housing market and affordability is to increase housing supply. This is why the government is taking action to make more homes available to the people of Ontario and supporting lower taxes on new purpose-built rental housing.

Empowering Municipalities to Make More Vacant Homes Available for Housing

Ontario will empower municipalities to increase housing supply and address housing affordability through municipal Vacant Home Taxes.

An unoccupied home is unacceptable in a housing crisis, which is why Ontario is extending authority broadly to all single- and upper-tier municipalities to impose a tax on vacant homes. This measure will increase housing supply, address housing affordability, and ensure more Ontario families can afford a home. Currently, Toronto, Ottawa and Hamilton have the authority to impose vacant home taxes.

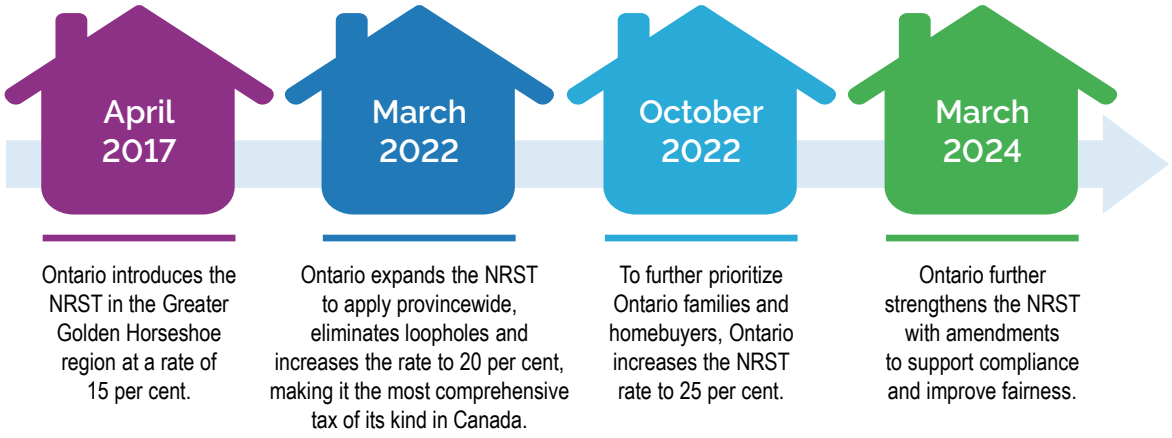
Municipalities will be supported with a new provincial policy framework that sets out best practices for implementing a Vacant Home Tax. The framework will also encourage municipalities to set a higher Vacant Home Tax rate for foreign-owned vacant homes.

Prioritizing Ontario Homebuyers

Ontario's Non-Resident Speculation Tax (NRST) is a tax applied at the time of a home purchase by a foreign entity.

The government has taken steps to enhance the NRST — the most comprehensive tax of its kind in Canada — to tackle the issue of foreign investors speculating on the province's housing market, in order to help make more homes available for the people of Ontario. In 2022, the government expanded the tax provincewide and increased the rate from 15 per cent to 25 per cent. Moving forward, the government is taking further action to strengthen the NRST with amendments to support compliance and improve fairness.

Chart 1.6
Ontario's Non-Resident Speculation Tax Timeline



Source: Ontario Ministry of Finance.

In addition, the government is taking steps to increase information sharing between provincial, federal and municipal governments. Ontario's leadership on this initiative would support greater understanding of home vacancy, foreign purchasing and ownership patterns. All three levels of government need to work together to solve the housing supply crisis, to ensure Ontario families and homebuyers take priority in the housing market. Data is a powerful tool to better understand vacancy and foreign-purchasing patterns, while simultaneously supporting tax compliance and incentives to discourage speculation.

Removing Harmonized Sales Tax on Purpose-Built Rentals

As announced in fall 2023, Ontario has taken steps to enhance the Ontario Harmonized Sales Tax (HST) New Residential Rental Property Rebate to remove the full eight per cent provincial portion of the HST on qualifying new purpose-built rental housing. This will help encourage the construction of more purpose-built rental housing. Canada Mortgage and Housing Corporation (CMHC) data show that 2023 had a record high number of rental housing starts in Ontario.[1]

The enhanced relief would apply to new purpose-built rental housing, such as apartment buildings, student housing and senior residences built specifically for long-term rental accommodation. This would mirror the enhancements to the federal Goods and Services Tax/Harmonized Sales Tax (GST/HST) New Residential Rental Property Rebate and together would remove the full 13 per cent HST on qualifying new purpose-built rental housing in Ontario.

The enhanced rebate would apply to qualifying projects that begin construction on or after September 14, 2023, and on or before December 31, 2030, and complete construction by December 31, 2035.

Changes to Ontario's rebate require federal regulatory changes. Ontario will continue to work closely with the federal government to ensure the coordinated and timely implementation of the enhanced rebate, and to maximize its impact.

Enabling Municipalities to Lower Taxes on New Purpose-Built Rentals

Ontario is committed to addressing the current housing crisis and increasing housing affordability for the people of Ontario. To further encourage the development of purpose-built rental properties, effective immediately, Ontario is providing municipalities with the flexibility to offer a reduced municipal property tax rate on new multi-residential rental properties.

[1] CMHC Starts and Completions Survey (by intended market, for population centres of over 10,000).

Investing in Innovative Modular Construction

The government recognizes that fresh approaches to tackle Ontario's housing crisis will give people more options to access housing that is affordable and attainable. As part of this strategy, the government is developing an attainable housing program that will help make homeownership a reality for more Ontario families.

This includes embracing modular construction and other innovative options to accelerate development, improve affordability and nurture home-grown industries that support quality jobs in Ontario. Modular construction involves building a home using one or more prefabricated components or modules. The home is constructed partially or completely off-site, then transported to a property for assembly.

The government is engaging with the construction sector, municipalities and Indigenous communities on the use of modular construction and other innovative technologies so that more people can live in a home that they can afford. Embracing innovative solutions like modular housing will help improve the supply of affordable and attainable housing for the people of Ontario.

Better Services for You

From health care to child care, transit and justice services, the public services that the people of Ontario need should be convenient and easy to access. The government is challenging the status quo to provide better services for people and businesses across the province.

Making Health Care More Connected and Convenient

The government is continuing to make health care more connected and convenient across the province to ensure patients are provided with the right care in the right place, and have faster access through an expanded health care workforce and enhanced services. This is why, in February 2023, the government introduced *Your Health: A Plan for Connected and Convenient Care*, which puts people at its heart, by adding and expanding health care services closer to home. The plan is built on three pillars: The Right Care in the Right Place, Faster Access to Care, and Hiring More Health Care Workers.

The government also continues to invest in improved access to digital services for the people of Ontario. This includes enhancing Health811 services to enable increased access to virtual care, online appointment booking, and integration with Ontario Health Teams. This also includes continuing to invest in remote care management, which is integral to supporting patients in the comfort of their homes rather than in hospital for a wide range of conditions, including post-surgical discharge and chronic disease management.

Supporting Home and Community Care

In the *2023 Budget*, the government accelerated the commitment of $1 billion over three years to stabilize the home and community care workforce and to support the expansion of home care services. In this Budget, the government is investing an additional $2 billion over three years to boost this acceleration, support earlier investments to increase compensation for personal support workers, nurses and other frontline care providers, and to stabilize expanded services.

The government continues to invest in transforming the home care system, including new models of care and modernizing the Client Health and Related Information System (CHRIS), the digital infrastructure system supporting home care.

For community care, the government is providing supports for the workforce to strengthen adult day programs, meal services, transportation and assisted living services. Having strong home and community care is a key part of the government's plan for connected and convenient care, to keep people healthy and in the comfort of their homes.

Investing in Hospitals

Ontario recognizes the indispensable role hospitals play in delivering critical health services to communities across the province. This is why the government is investing an additional $965 million in 2024–25, including a four per cent increase in total base hospital funding for an unprecedented second year in a row, to ensure public hospitals are able to meet patients' needs and to increase access to high-quality care. This investment also includes funding for stabilization and management of the surgical system, with a focus on maximizing capacity to increase the number of surgeries performed to provide the people of Ontario the care they need with shorter wait times.

As part of ongoing efforts to build a strong and resilient health system, the government is also providing funding to ease pressures faced by small and Northern hospitals. This will help address health human resources shortages, increased agency staffing costs, emergency department closures and other areas requiring stabilization.

These investments demonstrate Ontario's ongoing commitment to build a more connected and convenient health care system, prepared to face the challenges of today and tomorrow.

Expanding Hospice Services

The government is expanding palliative care services in local communities by adding up to 84 new adult beds and 12 pediatric beds, bringing the total to over 750. This will provide people with comfort and dignity closer to their communities and loved ones when they are nearing the end of life.

Connecting More People to Primary Care

While hospitals are core to Ontario's health care system, it can be more cost effective and convenient for people to receive care through their family doctors or primary care teams. This is why the government is making historic investments to enhance access to primary care with a goal that everyone who wants to have a primary care provider can connect to one. On February 1, 2024, Ontario announced an investment of $110 million in 2024–25. Building on this, the government will provide a total investment of $546 million over three years, starting in 2024–25. This funding will support connecting approximately 600,000 people to team-based primary care through new and expanded interprofessional care teams. This builds on the *2023 Budget* commitment of an additional $60 million in funding, bringing the total investment to $606 million since 2023–24.

Interprofessional primary care teams connect people to a range of health professionals who work together, including doctors, nurse practitioners, registered and practical nurses, physiotherapists, social workers and dietitians, among others. Interprofessional primary care teams enhance the quality of patient care, improve health outcomes, and increase the efficiency of health service delivery by relieving pressures on emergency departments and walk-in clinics.

This investment will also provide support to all existing interprofessional primary care teams through ongoing operational funding for their facilities and supplies so that they continue to provide high-quality care to the people of Ontario. This will further ensure that interprofessional primary care teams can maintain effective direct service delivery to patients.

Funding for new and expanded teams will focus on high-need areas, bringing the government one step closer to connecting everyone in Ontario to primary care. Examples include:

- Peterborough: More than $3 million in funding will allow the newly established Peterborough Community Health Centre to connect up to 11,375 people to team-based primary care.
- Kingston: More than $4 million in funding will help up to 10,000 people connect to team-based primary care at the Periwinkle site.
- North Dumfries: More than $1.9 million in funding to help up to 5,400 people connect to team-based primary care in a rural setting.
- Simcoe Muskoka, Barrie and Orillia: More than $1.4 million to increase access to team-based primary care and mobile services for up to 1,200 people with a focus on Indigenous populations.
- Niagara Region: More than $2.1 million to increase access to team-based primary care across the communities of Fort Erie, Port Colborne, Welland, Niagara Falls and St. Catharines.
- Sault Ste. Marie and Area: More than $1.1 million to two organizations, Maamwesying North Shore Community Health Services Inc. and the Sault Community Health Centre, to help connect people to team-based primary care in Sault Ste. Marie and surrounding First Nation communities.



Investing in the Creation of a New Medical School With York University

The government is addressing the need for family physicians and improving the province's primary care capacity by expanding medical training and supporting York University in establishing a new medical school in Vaughan. This will be the first medical school in Canada primarily focused on training family doctors.

This investment builds on other existing medical education and training expansions within Ontario, including the establishment of a medical school at Toronto Metropolitan University. It will also help to alleviate pressures facing the health care system, attract and retain future doctors, enhance long-term community health outcomes and support research, training and technological innovation.

The York University School of Medicine will prepare the next generation of talented frontline primary care doctors, who represent the diversity of the communities in which they live and serve. It is part of this government's efforts to enhance access to primary care across the province for communities currently facing family doctor shortages, including the communities in York, Simcoe and Muskoka.

Strengthening the Health Care Workforce

Ontario is investing $743 million over three years to continue to address immediate health care staffing needs, as well as to grow the workforce for years to come. This includes:

- Making the Extern Program Permanent: This program will offer up to 5,590 health care students training opportunities to work in hospitals and gain practical experience as they continue their education. Since 2021, over 7,300 health care students have participated in the program — creating much needed capacity in the system and a pool of new graduates who are more experienced and prepared to work as they begin their health care careers.
- Making the Supervised Practice Experience Partnership Program Permanent: This program will support up to 1,500 internationally educated nurses annually to become accredited nurses in Ontario. More than 3,600 nurses have participated in this program since its inception and over 2,700 internationally trained nurses are already fully registered and practising in Ontario.
- Increasing Nursing Enrolment: Ontario continues to expand nursing enrolment in colleges and universities to help address the need for nurses now and in the years to come. This is why Ontario is investing an additional $128 million over the next three years to support the sustained enrolment increases of nursing spaces at publicly assisted colleges and universities by 2,000 registered nurse and 1,000 registered practical nurse seats. This expansion is part of the government's plan to address health human resource needs and support the growing demand for health care professionals in Ontario.

- Merging the Clinical Scholar Program: This program amalgamates the Late Career Nurse Initiative and the Clinical Preceptor Program that support experienced nurses to mentor and coach new graduates and internationally educated nurses, as well as nurses seeking to upskill.
- Upskilling Nurses: This program supports the upskilling of nursing students to be able to work in priority areas within a hospital, such as critical care.
- Stabilizing Emergency Department Staffing: This strategy provides critical investments to bolster and stabilize the emergency department nursing workforce.

Expanding Access to Allied Health Professions

Ontario is continuing to make significant investments to expand access to allied health care providers across the province, including by adding an additional 700 education seats for medical radiation and imaging technologists, medical laboratory technologists, medical lab technicians and medical radiation extenders. Ontario is also working with colleges to explore and pilot compressed programs for pharmacy technicians and medical radiation technologists so more qualified professionals can enter the workforce sooner.

Supporting Adoption of Innovative Health Care Technologies

Ontario is providing $12 million to establish a new Health Technology Accelerator Fund to help health care service providers buy and use promising new technologies to improve patient care. This fund will provide innovators, including Ontario-based companies, more opportunities to partner with the health care system to promote early adoption and create the conditions for companies to grow in Ontario.

In collaboration with Supply Ontario, this fund would accelerate the review and adoption of promising new health innovations and bring them into the system faster for patients to benefit. Adopting Ontario technologies to solve some of the province's greatest health care challenges is a key pillar of Ontario's Life Sciences Strategy, *Taking Life Sciences to the Next Level*. As part of the forthcoming second phase of the government's Life Sciences Strategy, Ontario will leverage the fund to improve the adoption and uptake of Ontario-made technologies in clinical settings. This is another step forward as Ontario focuses on removing barriers to early adoption of new and innovative technologies.

Supporting Northern and Rural Health Care

The government is investing $50 million over three years to enhance and stabilize health care capacity within Northern and rural communities. This investment will introduce long-term solutions encompassing education, recruitment, retention, scope of practice and care models to provide residents of Northern Ontario and those in remote areas with improved access to health care services. This funding will also support the expansion of existing rural generalist pathways for physicians and fund additional supports and upskilling for other health care workers.

The Northern and rural hospitals have exhibited remarkable resilience in the face of health system challenges, with these challenges disproportionately impacting patients who must travel extensive distances for medical care. In recognition of the critical role these hospitals play and to support the communities they serve, the government is expanding services to help prevent emergency department shutdowns.

Enhancing the Northern Health Travel Grant Program

The government is investing $45 million over three years to enhance the Northern Health Travel Grant Program. This investment will help foster more equitable access to specialized care and diagnostic services for the residents of Northern Ontario. The program plays a vital role in mitigating the financial burden of medical-related travel for the people of Ontario in Northern communities. Residents of these communities who travel more than 100 kilometres to consult with medical professionals and receive care will be eligible for enhanced supports, including an additional $75 per night accommodation allowance. This investment reaffirms the government's dedication to supporting equitable health care access for the people of Ontario.

Adding More Health Care Workers in Underserved Communities

The government remains committed to building a stronger, more resilient health care workforce in underserved communities in Northern, Eastern and Southwestern Ontario through the expanded Ontario Learn and Stay Grant. The grant provides full, upfront funding for tuition, books and other direct educational costs for students who enrol in an eligible nursing, paramedic or medical laboratory technologist program in return for working in the communities where they studied for a term of service after graduation.

Supported by over $30 million in funding to date, there are currently about 3,800 students participating in the program across Ontario. In fact, thanks to the Ontario Learn and Stay Grant, there has been notable uptake in paramedic programs, with almost 40 per cent more students enrolling through the grant in 2023–24 than the previous year's enrolment in these programs.

Through this initiative, the government aims to deliver more connected health care across Ontario by addressing the increasing demand for nurses, paramedics and medical laboratory technologists while also responding to labour market needs in underserved communities.

Investing in Indigenous and Northern Community Supports

The government is committed to enhancing the health and well-being of Indigenous and Northern communities through several investments totalling approximately $94 million over three years. These investments focus on culturally responsive and safe care tailored to the needs of these communities, such as public health, chronic disease prevention and maternal care, including:

- $60 million over three years to maintain mental health and addictions services, including clinical supports, community mental health and well-being initiatives, and opioid programming.
- $15 million over three years to support the ongoing delivery of Indigenous public health programs, including vaccination initiatives to improve health outcomes.
- $11 million over three years to enhance early detection and management of foot complications arising from diabetes for Indigenous communities. Through prevention and earlier detection, this program aims to improve health outcomes for those living with diabetes and cardiovascular disease.
- $8 million over three years to strengthen prevention initiatives in Indigenous communities, targeting diabetes, smoking and chronic diseases.

Supporting Women's and Children's Health

The government is taking action to ensure women and children are better able to access culturally responsive and safe care to strengthen the health of their families with investments of $50 million over three years, including:

- $24 million over three years to enhance access to the Indigenous Healthy Babies Healthy Children Program across 160 Indigenous delivery sites. The Indigenous Healthy Babies Healthy Children Program is a community-based initiative aimed at helping Indigenous families and children have a healthy start to life and laying a solid foundation for their future health, well-being and success.
- $15 million over three years for Mobile Maternal Care. This innovative mobile clinic will offer a range of services, from prenatal to postnatal care, improving accessibility of maternal and newborn health care in remote communities.
- $11 million over three years to support safer births in Northern Ontario. This funding is aimed at improving maternal and newborn health outcomes by providing mothers in Northern Indigenous communities with vital birthing supports, including more doulas, second attendants or birth helpers.

Connecting People to Mental Health Services

Building on the historic investment of $3.8 billion over 10 years for mental health and addictions services as part of the *Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System* strategy, the government is investing an additional $396 million over three years. These investments support the stabilization, improved access and expansion of existing mental health and addictions services and programs.

As part of this investment, the government is providing $124 million over three years to support the continuation of the Addictions Recovery Fund to ensure the people of Ontario continue to have access to enhanced specialized services for mental health and addictions treatment, including:

- Maintaining 383 addictions treatment beds for adults who need intensive supports, helping to stabilize and provide care for approximately 7,000 clients each year;
- Three Mobile Mental Health Clinics to provide a suite of mental health and addictions services to individuals living in remote, rural and underserved communities; and
- Three police-partnered Mobile Crisis Response Teams to support individuals in a mental health or addictions crisis.

The government is also providing ongoing support for the innovative Ontario Structured Psychotherapy Program to support those with anxiety and depression through cognitive behavioural therapy, providing the people of Ontario with high-quality mental health care no matter where they live in the province.

With these investments, the government is continuing to deliver on the *Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System*, connecting those in need of mental health and addictions services to care.

Helping Young People Access Mental Health Services

In January 2024, the government unveiled the West Toronto Youth Wellness Hub, marking the opening of the eighth hub within the past year. Since 2020, Ontario has established 22 Youth Wellness Hubs, helping connect over 43,000 youth and their families to mental health and wellness services and accounting for over 168,000 visits. Reflecting the success of these Youth Wellness Hubs, Ontario plans to expand this network by adding five more hubs in Port Hope, Thunder Bay, Oxford County, Vaughan and Brampton, bringing the total number to 27.

In addition, the government is investing $8.3 million over three years to add another five hubs. This expansion aims to connect more communities to youth mental health services, close to home, increasing the total number of hubs to 32.

Building and Expanding Hospitals to Improve Care

The government is building a convenient and connected health care system that puts people first. This is why Ontario is delivering on the most ambitious plan for hospital expansion in the province's history. Ontario's plan will lead to investments of nearly $50 billion over the next 10 years in health infrastructure, including close to $36 billion in capital grants. This includes supporting more than 50 hospital projects that would add approximately 3,000 new beds over 10 years to improve access to reliable quality care. Recent milestones include:

- Grand River Hospital — MRI Expansion and Upgrade Project: In October 2023, completed renovations and expansion of the MRI, nuclear medicine and imaging spaces to improve patient flow, safety and operational efficiency.
- Health Access Thorncliffe Park — Thorncliffe Park Community Hub Project: In October 2023, awarded the construction contract for the Thorncliffe Park Community Hub. This project will convert approximately 68,000 square feet at the East York Town Centre to an integrated and sustainable multi-service hub that offers primary health care, mental health services, maternal reproductive health care, and newborn, child and youth services. The project is targeted to be completed by August 2024.
- Queensway Carleton Hospital — Phase 3B Mental Health Redevelopment: In November 2023, completed renovations to increase acute mental health beds (to a total of 26 beds) and expand and improve space for inpatient and outpatient mental health programs.
- Quinte Health — Prince Edward County Memorial Hospital Redevelopment Project: In October 2023, moved forward to tender the redevelopment of the Prince Edward County Memorial Hospital with the addition of eight new beds, a 24/7 emergency department, diagnostic imaging and surgical suites, and ambulatory care.
- Sault Area Hospital — Percutaneous Coronary Intervention (PCI) Project: Opened in January 2024, the new program supports cardiac procedures in Sault Ste. Marie and Northern Ontario.
- The Ottawa Hospital — Civic Campus Redevelopment Project: In February 2024, signed a Development Agreement with The Ottawa Hospital Build Partners. Upon completion, the 641-bed hospital will have one of the most advanced trauma centres in Eastern Ontario to provide highly specialized emergency and trauma services to treat complex injuries and illness for patients.

- University Health Network — Toronto Western Hospital New Patient Care Tower: In January 2024, awarded the construction contract to build a new 15-storey tower at the Toronto Western Hospital site in downtown Toronto. The project would add 82 new acute care patient beds, 20 state-of-the-art operating rooms, new pre-operative and post-anaesthetic care units and a new pharmacy. The project is targeted to be completed by December 2027.
- West Park Healthcare Centre Redevelopment Project: In November 2023, substantially completed the construction of the new six-storey facility, which will provide increased capacity for inpatient care with up to 314 beds upon opening, as well as outpatient care and diagnostic and therapeutic services.
- Waypoint Centre for Mental Health Care — Additional Acute Mental Health Inpatient Beds Project: In December 2023, announced the project to renovate over 10,000 square feet of existing space to add 20 additional acute mental health beds to the facility. Once complete, the new acute mental health inpatient unit will connect more people and their families to a range of services, including psychiatry, psychology, occupational and recreation therapy, and addictions counselling.
- New Windsor-Essex Regional Hospital: The project will support a new state-of-the-art acute care hospital in Windsor and Essex County to add more hospital beds and expand services in the region with procurement expected to begin in 2025.

Investing in Small Hospitals and Community Infrastructure

In addition to building hospitals, the government is committing an additional $620 million over 10 years for the Health Infrastructure Renewal Fund and the Community Infrastructure Renewal Fund. This funding will allow health care system partners to address urgent infrastructure renewal needs such as upgrades or replacements of roofs, windows, security systems, fire alarms and back-up generators. These investments will ensure funds are available for much-needed equipment upgrades, building repairs, and to extend the life of hospital and community infrastructure.

The government is also committing an additional $500 million over 10 years for small hospital projects and community health programs. These smaller hospital and community projects can create much needed capacity in the short term. Community health programs also help to prevent hospital visits that put pressure on emergency departments as well as hospital admissions.

Building Long-Term Care Homes

Ontario continues to make progress on its plan to build modern, safe and comfortable long-term care homes for seniors and residents. Through planned investments that total a historic $6.4 billion since 2019, Ontario is making progress to build 58,000 new and upgraded beds across the province by 2028.

Increasing the Construction Funding Subsidy

The government is investing $155 million in 2024–25 to increase the construction funding subsidy, to support the cost of developing or redeveloping a long-term care home. This additional investment will fast-track construction for the next tranche of beds so that work can begin by November 30, 2024. Eligible projects will receive an additional construction funding subsidy of up to $35 per bed, per day, for 25 years. In addition, eligible not-for-profit applicants will be able to convert up to $15 per bed, per day, of the supplemental funding into a construction grant payable at the start of construction, to increase projects' upfront equity and enable applicants to secure financing.

The government first provided a supplemental increase to the construction funding subsidy in November 2022 to stimulate the start of construction for long-term care homes across Ontario. Since introducing the supplemental increase, Ontario advanced construction for over 60 long-term care homes and over 10,000 beds between April 1, 2022, and August 31, 2023.

Making Progress to Build Long-Term Care Homes

Through the Accelerated Build Pilot Program, four new long-term care homes have been built on hospital-owned lands. These homes have created 1,272 new long-term care beds and are helping to meet urgent needs for more long-term care homes in Mississauga, Ajax and Toronto.

The government continues to make progress towards its commitment of building 58,000 new and upgraded beds to modern design standards across the province by 2028 with over 18,000 beds that are either open, under construction, or have approval to start construction. This includes:

- Over 4,500 beds open with new capacity of 2,246 beds and 2,336 upgraded beds;
- Over 12,500 beds under construction with 6,745 new beds and 5,789 upgraded beds; and
- Approximately 1,200 beds that have governmental approvals to start construction.

In response to higher costs in the sector, the government is increasing operating funding to help support the financial stability of new and existing long-term care homes.

The Loan Guarantee Program also continues to be available to support financing of the development of long-term care beds in non-municipal, not-for-profit projects.

Since the *2023 Ontario Economic Outlook and Fiscal Review*, the following long-term care homes have been completed and opened to new residents:

- Wellbrook East and Wellbrook West, two new state-of-the-art long-term care homes, opened in November 2023, with 632 new long-term care beds in Mississauga, developed under the Ontario Accelerated Build Pilot Program; and
- Woodland Villa opened in December 2023 with 17 new long-term care beds and 111 upgraded long-term care beds in Long Sault.

Adding More Specialized Long-Term Care Beds

The government is investing an additional $46 million over three years, starting in 2024–25, to support the continued operation of 59 Behavioural Specialized Unit (BSU) beds added in 2023–24, and to add more than 200 net new BSU beds to expand care for individuals with complex needs. Behavioural Specialized Units provide timely and appropriate support for individuals with responsive behaviours requiring increased levels of care. The government continues to provide connected and convenient health care for the people of Ontario by providing the right care in the right place.

Getting Back to Basics in Education

Ontario is supporting a back to basics learning strategy by building foundational skills in reading, writing and math. Students have benefited from a new math curriculum focused on financial literacy and coding, as well as the overhauled language curriculum that brings back phonics and cursive writing. Recent Education Quality and Accountability Office (EQAO) assessment results show encouraging progress, which demonstrates the importance of students learning in the classroom without disruption and with targeted supports focused on literacy and math.

The government will continue existing supports through the back to basics learning strategy, including:

- An investment of $15 million for the 2024–25 school year for digital math tools that will continue to provide anytime access to learning opportunities at home and in the classroom, as part of total funding of about $72 million in math supports. As part of these math supports, the government also continues to support one-on-one French-language online tutoring through Eurêka!;

- An investment of $65 million for the 2024–25 school year for dedicated educators working in small groups or individually with students in kindergarten to Grade 3. This brings total funding to about $100 million for reading supports for the 2024–25 school year; and
- An updated kindergarten curriculum, starting in September 2025, which will introduce learning through clear and direct instruction in reading, writing and math for kindergarten students. Combined with hands-on and play-based learning, the changes will help ensure students entering Grade 1 have the foundational skills needed for long-term success.

Enhancing School Safety

Ontario is investing $30 million over three years to help equip schools with security cameras, lighting and other security upgrades, including vape detectors. Ontario is also enhancing student safety by including learning on privacy and online safety in elementary and secondary curriculum. Together, these measures are part of this government's ongoing commitment to promote student well-being and to help keep students, staff and schools safe.

Supporting Students with Special Education Needs

Ontario is committed to providing all students with the opportunity to succeed in school and life, including students with disabilities and special education needs. This is why the government is investing $18 million in the 2024–25 school year to help the most vulnerable students.

This includes $8 million to introduce dedicated resources to help students with special education needs navigate the school system and beyond, as well as $10 million for increased in-class supports for students with the highest level of need.



Supporting the Ontario Autism Program

The government is increasing its investment in the Ontario Autism Program by $120 million in 2024–25, which is double the increase provided in 2023–24. This increased funding will support the government's commitment to enrol 20,000 children and youth in core clinical services. 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.

Building Schools and Child Care Spaces

The government is committed to building modern schools by investing $23 billion, including approximately $16 billion in capital grants over 10 years, to build, expand and renew schools and child care spaces across Ontario. Since 2018, the government has supported nearly 300 school or child care-related projects, of which more than 100 are actively under construction. This includes $1.4 billion for the current school year to support the repair and renewal needs of schools.

Table 1.3

School Projects Opening in the 2023–24 School Year

Northern

- Maple View Public School in **North Bay**, which serves 308 students and includes 73 licensed child care spaces.
- Lasalle Elementary School in **Sudbury**, which serves 387 students and includes 49 licensed child care spaces.
- École élémentaire publique de Thunder Bay in **Thunder Bay**, which serves 257 French-language students.

Southwestern

- An addition to Peace Bridge Public School in **Fort Erie** with 230 more student spaces.
- An addition to St. Anthony's Catholic School in **Kincardine** with 190 more student spaces and 78 more licensed child care spaces.
- St. Josephine Bakhita Catholic Elementary School in **Kitchener**, which serves 650 students and includes 88 licensed child care spaces.
- West Niagara Secondary School in **Lincoln**, which serves 1,533 students.
- An addition to Hyland Heights Elementary School in **Shelburne** with 92 more student spaces.
- An addition to Sacred Heart Catholic School in **Port Lambton** with 46 more student spaces and 49 more licensed child care spaces.
- Eastview Horizon Public School in **Windsor**, which serves 501 students and includes 73 licensed child care spaces.

Eastern

- École élémentaire catholique des Deux-Rivières in **Arnprior**, which serves 248 French-language students and includes 49 licensed child care spaces.
- An addition to Westminster Public School in **Brockville** with 25 more licensed child care spaces.
- An addition to St. Joseph Catholic Elementary School in **Douro-Dummer** with 92 more student spaces.
- École secondaire publique Mille-Îles and École secondaire catholique Sainte-Marie-Rivier joint school in **Kingston**, which serves 600 French-language students and includes 49 licensed child care spaces.
- St. Bernadette Catholic Elementary School in **Stittsville**, which serves 507 students and includes 39 licensed child care spaces.
- An addition to Williamstown Public School in **Williamstown** with 121 more student spaces.

Central

- An addition to École secondaire Jeunes sans frontières in **Brampton** with 207 more French-language student spaces.
- E.J. Sand Public School in **Markham**, which serves 409 students and includes 39 licensed child care spaces.
- An addition to St. Anne Catholic School in **Oshawa**, with 184 more elementary student spaces.
- Glen Orchard Public School retrofit in **Port Carling**, which includes 54 licensed child care spaces.
- École secondaire Michelle-O'Bonsawin retrofit in **Toronto**, which serves 501 French-language students.
- An addition to Terry Fox Public School in **Toronto**, with 276 more student spaces and 88 more licensed child care spaces.
- Regina Mundi Catholic School retrofit in **Toronto**, which serves 450 students and includes 88 child care spaces.

Source: Ontario Ministry of Education.

Table 1.4

Continuing to Get Shovels in the Ground to Build More Schools

Northern

- A new joint French and English public elementary and secondary school in **Blind River**, which will serve 72 French-language students, 381 English language students and include 64 licensed child care spaces.
- A new English public elementary and secondary school in **Rainy River**, which will serve 311 students and include 39 licensed child care spaces.
- An addition to Tarentorus Public School in **Sault Ste. Marie**, which will add 92 student spaces and 49 licensed child care spaces.

Eastern

- A new French public elementary school in **Barrhaven**, which will serve 475 students and include 49 licensed child care spaces.
- An addition to St. Joseph Catholic School in **Belleville**, which will add 334 student spaces and 49 licensed child care spaces.
- A new English public elementary school in **Brockville**, which will serve 500 students and include 64 licensed child care spaces.
- A new English Catholic School in **Kingston**, which will serve 481 students and include 73 licensed child care spaces.
- An addition to Collège catholique Mer Bleue in **Orleans**, which will add 343 student spaces.
- A new English public secondary school in **Ottawa**, which will serve 1,516 students and include 39 licensed child care spaces.
- A new English public secondary school in **Ottawa**, which will serve 1,353 students.
- A new French public school in **Ottawa**, which will serve 475 students and include 49 licensed child care spaces.
- An addition to École secondaire catholique Paul-Desmarais in **Stittsville**, which will add 389 student spaces.

Source: Ontario Ministry of Education.

continued…

Table 1.4

Continuing to Get Shovels in the Ground to Build More Schools (continued)

Southwestern

- A new English public elementary and secondary school in **Kingsville**, which will serve 1,798 students and include 98 licensed child care spaces.
- A new English Catholic elementary school in **Kitchener**, which will serve 527 students and include 88 licensed child care spaces.
- An addition to St. Louis Catholic Elementary School in **Leamington**, which will add 147 student spaces and 63 licensed child care spaces.
- An addition to Listowel Eastdale Public School in **Listowel**, which will add 98 student spaces and 49 licensed child care spaces.
- A new English public elementary school in **London**, which will serve 804 students and include 88 licensed child care spaces.
- A new English Catholic elementary school in **Sarnia**, which will serve 659 students and include 88 licensed child care spaces.
- A new English Catholic elementary school in **Stoney Creek**, which will serve 590 students and include 49 licensed child care spaces.
- An addition to St. Anne's Catholic School in **St. Thomas**, which will add 210 student spaces.
- A new English public elementary school in **Windsor**, which will serve 651 students and include 73 licensed child care spaces.

Central

- A new English public elementary school in **Brampton**, which will serve 850 students and include 73 licensed child care spaces.
- A new English public elementary school in **East Gwillimbury**, which will serve 638 students and include 39 licensed child care spaces.
- A new English public elementary school in **Bowmanville**, which will serve 786 students and include 73 licensed child care spaces.
- A new English public elementary school in **Beaverton**, which will serve 418 students and include 49 licensed child care spaces.
- A new Catholic elementary school in **Milton**, which will serve 671 students and include 88 licensed child care spaces.
- A new English public elementary school in **Oro-Medonte**, which will serve 570 students.
- An addition to École élémentaire catholique Saint-Michel in **Scarborough**, which will add 92 student spaces.
- A new Catholic secondary school in **Toronto**, which will serve 1,300 students.
- A new English public secondary school in **Toronto**, which will serve 922 students.
- A new French Catholic secondary school in **Vaughan**, which will serve 407 students and include 49 licensed child care spaces.

Source: Ontario Ministry of Education.

Supporting Efficiency, Transparency and Accountability in the Postsecondary Education Sector

The provincial government is helping to stabilize Ontario's colleges and universities, with nearly $1.3 billion in new funding, while maintaining the tuition fee freeze to keep costs down for Ontario students and parents. Ontario is focused on supporting the postsecondary education sector in delivering high-quality educational experiences in an efficient, accountable and transparent manner. To help achieve this, Ontario will provide $15 million over the next three years to implement an Efficiency and Accountability Fund.

This fund will support third-party reviews to identify actions that institutions can take to drive long-term cost savings and positive outcomes for students and communities. These reviews will target structural issues as well as operational policies in order to improve sustainability and student experiences. This Efficiency and Accountability Fund is part of Ontario's plan to help build a financially viable postsecondary sector that supports student success.

Ontario is also committed to supporting access to affordable postsecondary education. This is why the government is also extending the tuition fee freeze at publicly assisted colleges and universities for at least three more years, helping to keep costs down for Ontario students and parents.

Supporting the Financial Sustainability of Ontario's Postsecondary Sector

Ontario understands the importance of stabilizing the postsecondary education sector to ensure the continued delivery of high-quality educational experiences for students. This is why the government is investing $903 million over three years, starting in 2024–25, to create a Postsecondary Education Sustainability Fund. This investment will include a sector-wide increase to operating grants that will help provide financial stability and predictability for Ontario's postsecondary institutions, while not raising tuition for Ontario students. This includes $203 million in targeted supports for the financial sustainability of publicly assisted colleges and universities with the greatest financial need.

Through the Postsecondary Education Sustainability Fund, the government will support the continued stability of the postsecondary education system in a responsible way, while building an even stronger foundation for future generations.

Strengthening Accountability and Student Supports

To increase transparency on ancillary fees and other student costs, while also supporting student mental health and keeping campuses safe and inclusive, the government introduced the Strengthening Accountability and Student Supports Act, 2024 on February 26, 2024. If passed, it would authorize the Minister of Colleges and Universities to issue directives requiring colleges and universities to provide information about ancillary fees and other student costs, including for textbooks. This would help students and their families understand the full cost of the courses they are selecting.

If passed, the Strengthening Accountability and Student Supports Act, 2024 would also require colleges and universities to have mental health policies in place that should include clear and transparent information about programs and supports available to students, along with policies to address racism and hate, including but not limited to antisemitism and Islamophobia.

Supporting Science, Technology, Engineering and Mathematics in Postsecondary Education

To be responsive to increasing labour market demands for workers in sectors related to Science, Technology, Engineering and Mathematics (STEM), the government has provided one-time funding of $100 million in 2023–24 to support STEM program costs at publicly assisted colleges and universities with enrolments above their funded levels.

Supporting Small, Northern and Rural Postsecondary Institutions

To ensure that small, Northern and rural colleges and Northern universities can provide students with competitive choices for local postsecondary education, the government is providing an additional $10 million in funding through the Small, Northern and Rural Grant for colleges and the Northern Ontario Grant for universities in 2024–25. The funding is intended to provide targeted support to eligible institutions that are financially vulnerable, while the government works with them on efficiency initiatives.

Supporting Ontario's Francophone Community

The government is committed to improving access to services in French across Ontario and enhancing the vitality of Franco-Ontarian communities. The provincial government is working with the federal government to renew the Canada–Ontario Agreement on Minority-Language Services and would further invest close to $10 million over three years to expand the delivery of quality French-language services. This would support the development of bilingual training programs, improve the economic opportunity of Francophone businesses and enhance French-language supports in communities across Ontario.

Reducing Red Tape

Since 2018, Ontario has taken over 500 actions to reduce regulatory burdens — all without compromising health and safety in the population, or the environment.

These changes have helped to open doors to new economic opportunities and reduce unnecessary burdens for individuals and businesses, saving $939 million in gross annual compliance costs that would have otherwise been incurred by businesses, not-for-profit organizations and the broader public sector. Ontario's Fall 2023 Red Tape Reduction package alone is estimated to save people and businesses over 100,000 hours of time each year.

The government reports on the progress to reduce red tape in the annual Burden Reduction Report. The *2023 Burden Reduction Report: Delivering Better Services and a Stronger Economy* highlights how the government is reducing burdens and costs for people and businesses in Ontario, including:

- Creating new ways for individuals to receive medical care in their community;
- Making the online process easier for the application, replacement and renewal of accessible parking permits;
- Upgrading the ServiceOntario appointment booking system to book multiple services in a single appointment or a single appointment for the whole family;
- Streamlining housing development approvals; and
- Helping municipalities better manage restrictions on roads (load periods), including shortening their duration when conditions permit, to support lower costs and better delivery times for the trucking and agri-businesses industry.

These accomplishments are part of Ontario's efforts to save time and costs for people and businesses.

Strengthening Provincial Agencies

Ontario's 156 provincial agencies deliver important public services to individuals, families and businesses across Ontario — services such as managing home care, protecting drinking water and Ontario's food supply, and ensuring the province's energy infrastructure is reliable and sustainable. Provincial agencies such as Supply Ontario and the Building Ontario Fund are transforming how the government buys goods and services, as well as funds vital infrastructure projects.

This is why the government is strengthening oversight of provincial agencies to ensure that public services are modernized and accountable. The government is introducing new measures and reporting requirements to ensure provincial agencies are efficient, sustainable and accountable while also being nimble to meet the demands of the public they serve. This includes supporting improved service delivery, protecting data and privacy, and aligning agency business strategies with government priorities such as the Community Jobs Initiative announced in the *2022 Budget*.

In this way, the government is ensuring the public services that the people of Ontario rely upon are delivered in an effective way for years to come.

Expanding Protected Areas and Provincial Green Spaces

The people of Ontario are passionate about the great outdoors and the natural spaces that communities offer.

Providing More Opportunities to Enjoy Ontario Parks

Ontario is building stronger and healthier communities by expanding recreational opportunities for families to enjoy. This is why the government is actively taking steps to open the first new, all-season, operating provincial park in 40 years. The Bigwind Lake Provincial Park, located near the Town of Bracebridge, will offer facilities and recreational activities including swimming, hiking, cross-country skiing, and add around 250 new campsites to the Ontario Parks system.

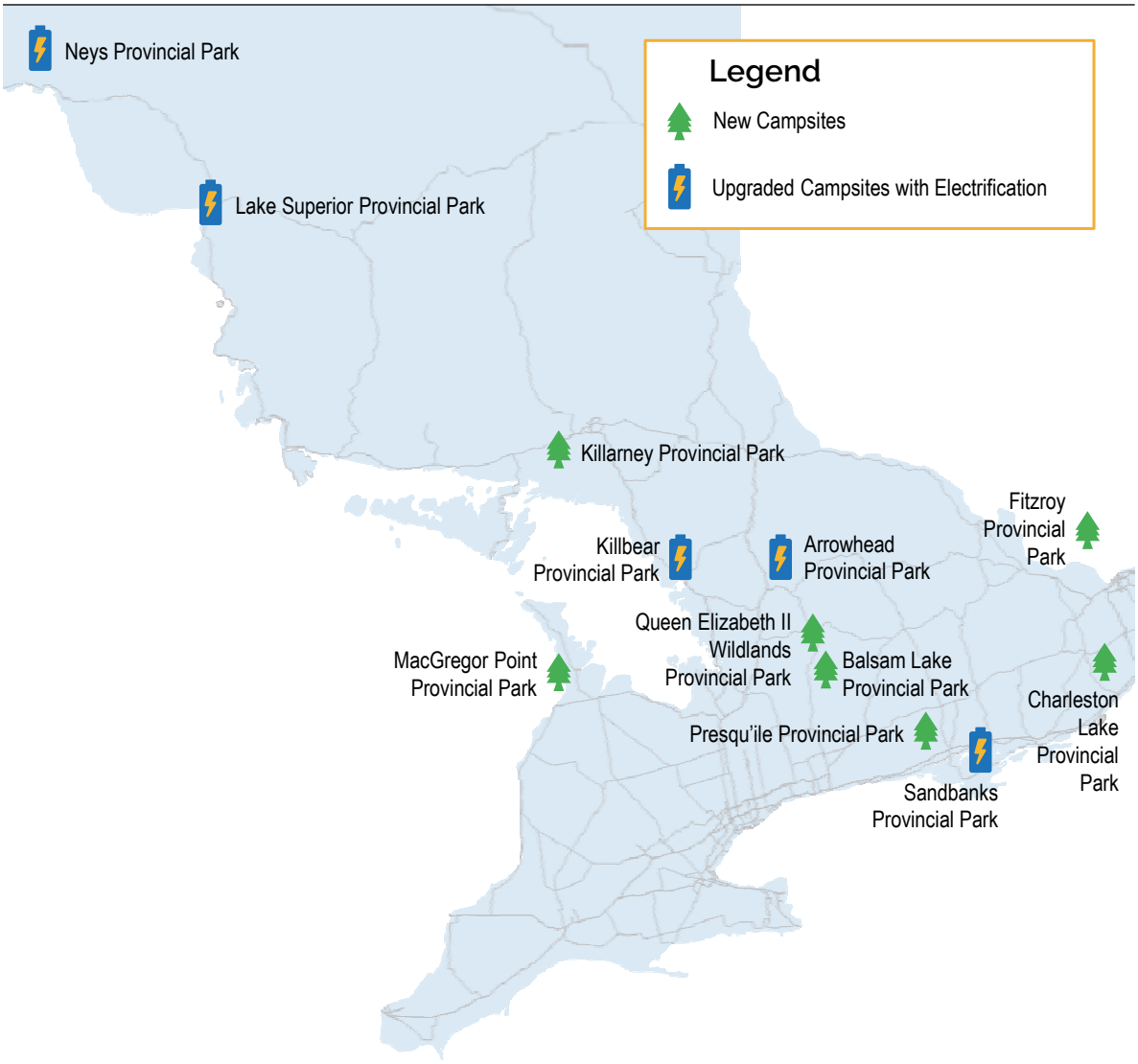
The government is also creating the province's first urban provincial park in the Township of Uxbridge, which will serve as a year-round day-use provincial park and support Ontario's progress on its commitment to provide families with more outdoor recreational opportunities while conserving and protecting areas of natural and scientific interest. A survey was conducted in summer 2023 to seek public input on the programming and activities that could be enjoyed in the proposed park. The government will also explore further opportunities for partnerships for additional urban parks for the people of Ontario.

Improving and Expanding Ontario Parks

Furthermore, the government is enhancing recreational opportunities for the people of Ontario by also implementing a number of other initiatives, including bringing electrical services to over 800 campsites and creating approximately 300 new campsites across several provincial parks.

Chart 1.7

Ontario Parks Electrifying and Creating New Campsites



Source: Ontario Ministry of the Environment, Conservation and Parks.

Strengthening Conservation Partnerships

Spending time in nature and green spaces has a positive impact on a person's health and well-being. The government is committed to continuing to work with partners and conservation leaders to preserve more areas of significant ecological importance, protect natural areas and promote the importance of healthy, natural spaces. The government is continuing the Greenlands Conservation Partnership program by investing an additional $20 million over four years. The investment will allow conservation partners to raise matching private-sector contributions to secure new, privately owned natural areas, such as wetlands, grasslands and forests, as well as ensure they are protected and managed for the future.

Protecting Ontario Lakes

Protecting Ontario's lakes is a key commitment in the government's plan to help ensure a safe, healthy and clean environment now and for future generations. The Holland Marsh area produces more carrots, celery, onions, lettuce and greens than any other single region across Canada. The government is supporting farmers to implement technologies and food washing processes that reduce the amount of phosphorus in the water that flows into Lake Simcoe.

The government is continuing to protect and restore the Great Lakes through annual investments of $6.4 million to support innovative projects. These projects are led by community-based organizations, small businesses, municipalities, conservation authorities and Indigenous communities, which focus on protecting and restoring coastal, shoreline and nearshore areas of the Great Lakes and connecting rivers and streams.

Ontario is also investing over $24 million towards the innovative Lake Simcoe Phosphorus Reduction Strategy for a new phosphorus recycling project to help reduce phosphorus discharges from the Holland River into Lake Simcoe.



Protecting You and Your Family

Fighting Criminals With New Air Support

Violent crime within the Greater Toronto Area (GTA) has been increasing in volume, scope and complexity in recent years. To address this challenge, the government is investing $46 million over three years to support patrol and improve response times to major incidents and serious crimes, including the purchase of four helicopters.

These additional resources will help protect communities by:

- Keeping highways and roadways safe from street racing, impaired driving, violent carjacking and automobile theft;
- Locating missing persons, including children, the elderly and vulnerable people;
- Apprehending high-risk suspects, including perpetrators of violent crime; and
- Supporting marine units and enhancing search and rescue capacity.

Public safety is a top priority for this government. This initiative builds on the government's ongoing commitment to enhance public safety in Ontario by continuing to help ensure that police services have the resources they need to respond to major incidents and urgent situations.

Fighting Auto Theft

Auto theft is a serious and growing problem impacting jurisdictions across Canada, especially Ontario. To combat auto theft, the government is collaborating with municipalities and the federal government, providing funding to police services and raising public awareness of auto theft prevention measures.

The government's plan includes $49 million over three years to help police put those responsible for auto thefts behind bars. These investments support the Ontario Provincial Police (OPP) Organized Crime Towing and Auto Theft Team, which is working with municipal police services to identify, disrupt and dismantle organized crime networks participating in vehicle theft. In addition, Ontario's Major Auto Theft Prosecution Response Team provides dedicated support to the OPP to prepare and prosecute complex cases, ensuring that offenders are held accountable.

This funding also continues support for the Greater Toronto Area-Greater Golden Horseshoe Investigative Fund, which was created to help stop the illegal export of stolen vehicles and target violent crime linked to criminal organizations.

Ontario is also continuing prevention and public awareness initiatives to combat auto theft. The Preventing Auto Thefts Grant provides funding to police services for projects that feature new and enhanced crime-fighting measures focused on prevention, detection, analysis and enforcement. In addition, the Financial Services Regulatory Authority of Ontario (FSRA) will be launching an anti-auto-theft campaign that focuses on consumer awareness and auto theft prevention.

The government is combatting auto theft by helping to prevent thefts before they happen, targeting organized crime networks, and ensuring that those responsible are brought to justice to keep people and communities safe.

Increasing Public Safety in Communities

Ontario continues to advocate for the federal government to amend the Criminal Code and implement tougher penalties for individuals who commit violent crime and car thefts. The federal government has signaled its willingness to work with all provinces and territories to identify and implement concrete, collaborative and innovative solutions. Ontario will continue to be a partner in this work and looks forward to effective changes being made.

The government is also investing in correctional and courthouse facilities to improve safety and security in aging institutions, make efficient use of space and modernize technology. Investments in new courthouses help to provide access to justice in growing communities, such as the recently completed expansion of the Brampton courthouse in Peel Region. This is another way that the government is showing its commitment to justice and public safety for the people of Ontario.

Protecting the Health and Safety of Firefighters

The government is committed to keeping communities safe and supporting the province's firefighters. Firefighters are more likely to experience health problems because of exposure to hazardous chemicals. To keep first responders and Ontario's communities safe, fire departments need resources to ensure they have the right infrastructure and protective equipment.

This is why the government is investing $30 million over the next three years to launch the Fire Protection Grant. This application-based grant will provide municipal fire departments, including those in small and rural communities, with funding for personal protective equipment and specialized decontamination tools to clean and sanitize firefighter gear and mitigate the long-term effects of exposure to chemicals and other fire-related contaminants.

The Fire Protection Grant will support departments by ensuring they have the right infrastructure and protective equipment to respond to local needs and that they may do so safely and more effectively.

Improving Response Times for First Responders

The government will continue working to enable seamless communication between fire and paramedic dispatch systems across the province. This technology will enable municipalities with tiered response agreements to implement simultaneous notification between their fire and paramedic services. This will facilitate faster response times, drive better patient outcomes and enhance Ontario's public safety response model for the people of this province.

The government is working to ensure that simultaneous notification between fire and paramedic services is operational in the near future in Halton Region, while working on provincial implementation.

Strengthening Emergency Preparedness to Keep People Safe

The government has invested $5 million to ensure communities across the province have the resources and equipment they need to prepare for natural disasters and emergencies. The funding will help communities and organizations purchase critical supplies and equipment and deliver training and services to improve local emergency preparation and response. This commitment highlights the government's proactive approach to enhancing community resilience and safety across Ontario.

Preventing Gender-Based Violence

The government is taking action to help end gender-based violence. Building on existing investments of $1.4 billion over four years, the government is providing an additional $13.5 million over three years to enhance initiatives that support women, children, youth and others who are at increased risk of violence or exploitation — such as Indigenous and racialized communities, and children and youth in the child welfare system. These initiatives include:

- $6 million over three years to support the Children at Risk of Exploitation (CARE) Unit in Kenora District with increased access to trauma-informed specialized supports for children and youth who have been sex trafficked;
- $4.5 million over three years in additional funding for the Victim Quick Response Program+ to increase access to basic necessities for victims of human trafficking and gender-based violence and their families, especially those in Northern, rural and remote communities;
- $2.5 million over three years in additional funding to increase outreach to children and youth with involvement in the child welfare system and link them with resource and educational supports; and
- $0.5 million in 2024–25 to increase training for workers in the child welfare sector to help them respond to human trafficking and identify at-risk children and youth.

This funding will support the government's commitments under the Anti-Human Trafficking Strategy to protect children and youth, build safer and healthier communities, and support women's well-being.

Supporting Victims and Survivors of Sexual Assault and Domestic Violence

The government is also investing $27 million over three years to enhance sexual assault and domestic violence services across the province to help victims and survivors receive compassionate and professional support directly within hospital settings.

Ontario is home to a network of 37 Sexual Assault/Domestic Violence Treatment Centres that are dedicated to delivering comprehensive, trauma-informed care and treatment to individuals impacted by sexual and domestic violence. This investment will provide the treatment centres with additional clinical resources and extend the reach of sexual and domestic violence services to hospitals currently not in the network. It will also support the expansion of the Provincial Sexual Assault/Domestic Violence Navigation Line to provide 24/7 care for victims and survivors.

In addition, Ontario is investing $6.4 million over three years to support the Independent Legal Advice for Survivors of Sexual Assault program, and sustain and expand the Child Victim Witness Support Program. These programs provide legal support for survivors of sexual assault and for children who are victims or witnesses of crime. Participation in these programs allows recipients to better understand the criminal court process and make informed decisions about their legal options, including reporting the incident and holding the offenders to account after experiencing sexual assault.

Through these measures, the government is dedicated to building a stronger, more accessible network of support for survivors of sexual and domestic violence across Ontario, ensuring that every individual has access to care and support when they need it.

Combatting the Illegal Cannabis Market

Since the legalization of cannabis in 2018, Ontario has moved forward with rules to keep cannabis out of the hands of children and youth and keep roads safe. The government is committed to combatting the illegal cannabis market to ensure the integrity of the regulated private retail model and address the significant health risks associated with illegal cannabis products that do not meet government safety standards.

This is why the government is investing $31 million over the next three years to support the Provincial Joint Forces Cannabis Enforcement Teams (PJFCET). The PJFCET is an OPP-led centralized enforcement unit that has a proven track record in enforcement operations against illegal cannabis storefronts. This investment would enable the PJFCET to respond to the challenge of illegal online operators and crack down further on the production, sale and distribution of illegal cannabis in the online and offline space.

Modernizing and Enhancing Tobacco Tax Oversight

The *2023 Budget* committed to proceed with a review to modernize the *Tobacco Tax Act.* The government is now proposing changes that would strengthen oversight and reduce burden on registrants. The government remains committed to addressing contraband tobacco and recognizes that it is a persistent challenge in Ontario.

To better address this issue, the government is proposing to strengthen fines in the *Tobacco Tax Act* to help tackle contraband tobacco while also providing the Ontario Ministry of Finance with the tools to be a modern regulator. Continued support to the OPP Contraband Tobacco Enforcement Team will help disrupt the links between organized crime and contraband tobacco.

Better administration can occur when government uses its resources more effectively. In the case of tobacco, the Ontario Ministry of Finance and the Ministry of Health will begin partnering in 2024 on an initiative to cross designate inspectors to seize certain tobacco products in contravention of both the *Tobacco Tax Act* and the *Smoke-Free Ontario Act, 2017*. This will allow inspectors to take a coordinated approach, to help address unregulated tobacco while also meeting the requirements under the *Smoke-Free Ontario Act, 2017*.

The government is committed to making it easier to comply with administrative requirements. For instance, beginning in July 2024, it is proposing to move the monthly filing deadline for tobacco tax registrants from the tenth to the twenty-eighth of each month to allow registrants more time to file and to align with other tax filing deadlines that registrants must also comply with. The Ontario Ministry of Finance is also working towards improving the overall online experience for registrants, making the filing process easier and more efficient.

Moving forward, the review will continue to engage with stakeholders and First Nations partners to identify additional opportunities to modernize the Act, strengthen oversight and align the legislation to the changing tobacco marketplace.

Modernizing Financial Services and Capital Markets to Protect Consumers

Supporting Ontario Credit Unions' Access to Emergency Lending Assistance

Ontario's credit unions and caisses populaires play an important role in extending financial services to people and businesses in urban and rural communities across the province. Ontario credit unions manage assets of about $95 billion, employ about 9,000 staff and serve approximately 1.8 million members through almost 550 locations. To support their ability to compete and help ensure broader market stability, it is important to enable direct access to the Bank of Canada's emergency liquidity facilities for Ontario credit unions. The provincial government is encouraged by the proposal in the federal *2023 Fall Economic Statement* to amend the *Canadian Payments Act*, which would allow eligible provincially regulated credit unions direct access to the Bank of Canada's Standing Term Liquidity Facility and its Emergency Lending Assistance, and looks forward to ongoing collaboration as changes are being implemented.

Protecting Investors and Enhancing Enforcement in Capital Markets

The government supports the ongoing work of the Ontario Securities Commission (OSC) to modernize the dispute resolution framework available to Ontario investors and remains committed to a modernized capital markets framework that protects investors. This is why the OSC is working to develop rules governing the distribution of disgorged funds to harmed investors. Furthermore, the recently enhanced protections for whistleblowers are intended to encourage individuals to come forward to report misconduct. These measures support enforcement efforts and help increase investor confidence in Ontario's capital markets.



Chapter 2

Economic Performance and Outlook

Introduction

Ontario's economy performed better than expected in 2023, despite economic headwinds prompted by elevated consumer price inflation and high interest rates. Ontario's labour market performed strongly in 2023 and the unemployment rate remained low. This builds on record job growth since 2021.

However, the economic outlook has deteriorated compared to the *2023 Budget* with significantly lower growth projected in 2024, and slightly lower growth in 2025 and 2026. Job growth is also projected to be lower in 2024 as a result.

High interest rates are expected to continue impacting Ontario's economy in 2024, with real gross domestic product (GDP) growth projected to slow from an estimated 1.2 per cent in 2023 to 0.3 per cent in 2024. Real GDP growth is projected to accelerate to 1.9 per cent in 2025, and 2.2 per cent in 2026 and 2027. For the purposes of prudent fiscal planning, these projections are slightly below the average of private-sector forecasts.

Table 2.1

Summary of Ontario's Economic Outlook

(Per Cent)

	2022	2023	2024p	2025p	2026p	2027p
Real GDP Growth	3.9	1.2e	0.3	1.9	2.2	2.2
Nominal GDP Growth	9.2	4.1e	2.7	3.9	4.3	4.1
Employment Growth	4.6	2.4	0.8	1.7	1.4	1.4
CPI Inflation	6.8	3.8	2.6	2.0	2.0	2.0

e = estimate.
p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024.
Sources: Statistics Canada and Ontario Ministry of Finance.

Revisions to the Outlook Since the *2023 Budget*

Ontario's real GDP grew by an estimated 1.2 per cent in 2023, stronger than the projection in the *2023 Budget*, and nominal GDP growth is estimated at 4.1 per cent, higher than the 2.8 per cent *2023 Budget* projection.

The outlook has been revised compared to the projections in the *2023 Budget*. Key changes since the *2023 Budget* include the following:

- Stronger estimated real and nominal GDP growth in 2023, accompanied by significantly stronger job creation and a lower unemployment rate;
- Slower real and nominal GDP growth between 2024 and 2026, with the most pronounced deterioration in 2024;
- Weaker net operating surplus of corporations growth over the forecast period; and
- Stronger housing starts throughout the forecast period. See the Housing Supply Progress section later in this Chapter for further details on the latest information for 2023.

Table 2.2

Changes in the Ontario Ministry of Finance Key Economic Forecast Assumptions: *2023 Budget* Compared to the *2024 Budget*

(Per Cent Change)

	2023		2024p		2025p		2026p	
	2023 Budget	***2024 Budget***	***2023 Budget***	***2024 Budget***	***2023 Budget***	***2024 Budget***	***2023 Budget***	***2024 Budget***
Real Gross Domestic Product	**0.2**	**1.2e**	**1.3**	**0.3**	**2.5**	**1.9**	**2.4**	**2.2**
Nominal Gross Domestic Product	**2.8**	**4.1e**	**3.6**	**2.7**	**4.6**	**3.9**	**4.5**	**4.3**
Compensation of Employees	5.1	6.7e	4.2	4.3	4.5	4.4	4.2	4.1
Net Operating Surplus — Corporations	(8.2)	(12.6)e	(0.5)	(4.7)	9.2	3.5	9.1	7.9
Nominal Household Consumption	5.1	6.0e	4.1	3.5	4.3	4.1	4.2	4.3
Other Economic Indicators								
Employment	0.5	2.4	1.0	0.8	1.7	1.7	1.7	1.4
Job Creation (000s)	39	183	78	63	133	136	136	114
Unemployment Rate (Per Cent)	6.4	5.7	6.6	6.7	6.3	6.6	6.3	6.4
Consumer Price Index	3.6	3.8	2.1	2.6	2.0	2.0	2.0	2.0
Housing Starts (000s)[1]	80.3	89.3	79.3	87.9	82.7	92.3	83.2	94.4
Home Resales	(8.9)	(12.3)	21.0	4.0	1.2	16.0	1.2	1.2
Home Resale Prices	(9.7)	(6.3)	2.2	(0.2)	4.0	3.1	4.0	4.0
Key External Variables								
U.S. Real Gross Domestic Product	0.5	2.5	1.2	2.1	2.1	1.7	2.1	2.1
WTI Crude Oil ($US per Barrel)	83	78	80	79	79	78	79	77
Canadian Dollar (Cents US)	74.4	74.1	76.5	74.6	77.6	77.6	78.5	78.2
Three-Month Treasury Bill Rate (Per Cent)[2]	4.3	4.8	3.3	4.4	2.5	3.0	2.4	2.6
10-Year Government Bond Rate (Per Cent)[2]	3.1	3.3	3.1	3.2	3.1	3.1	3.2	3.3

e = estimate.

p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024.

[1] Housing starts projection based on private-sector average as of January 25, 2024.

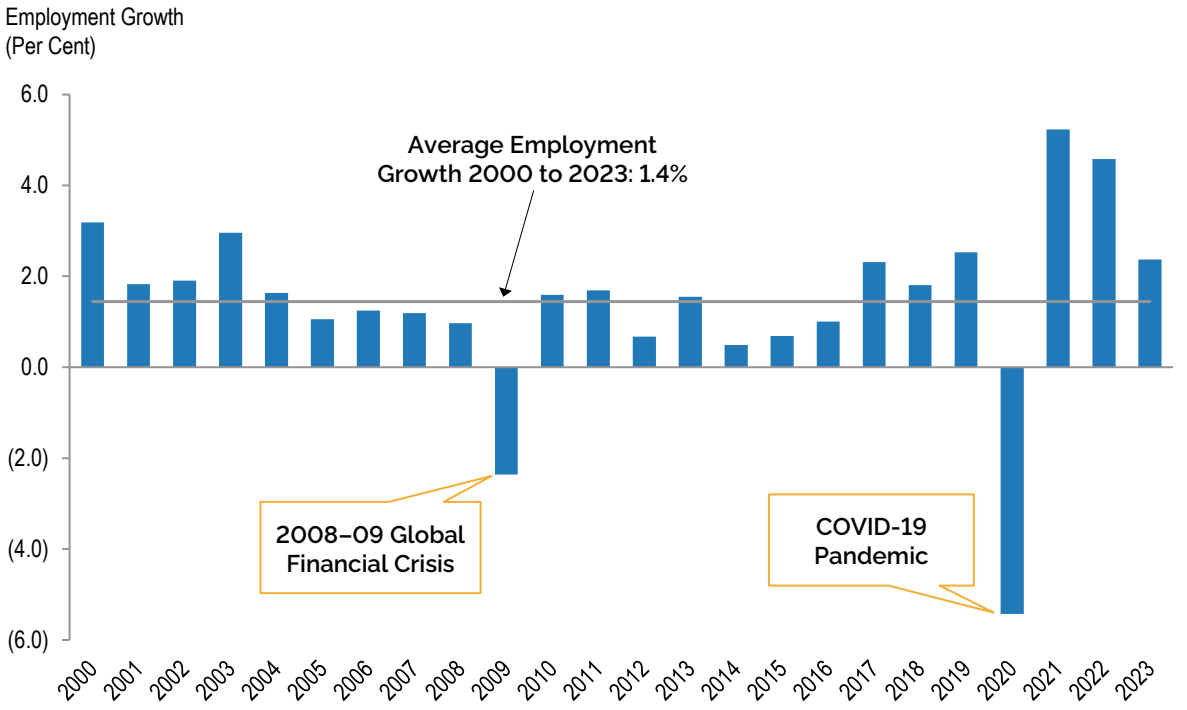
[2] Government of Canada interest rates.

Sources: Statistics Canada; Canada Mortgage and Housing Corporation; Canadian Real Estate Association; Bank of Canada; United States Bureau of Economic Analysis; *Blue Chip Economic Indicators* (October 2023 and February 2024); U.S. Energy Information Administration; and Ontario Ministry of Finance.

Recent Economic Performance

Despite ongoing economic headwinds, Ontario continued to experience above average employment growth in 2023, adding 183,200 net new jobs, a 2.4 per cent increase. This followed record gains of 5.2 per cent in 2021 and 4.6 per cent in 2022. Job creation over the 3-year period since 2021 is the highest on record. Ontario's unemployment rate rose modestly to 5.7 per cent in 2023 but remained low compared to its recent historic average.

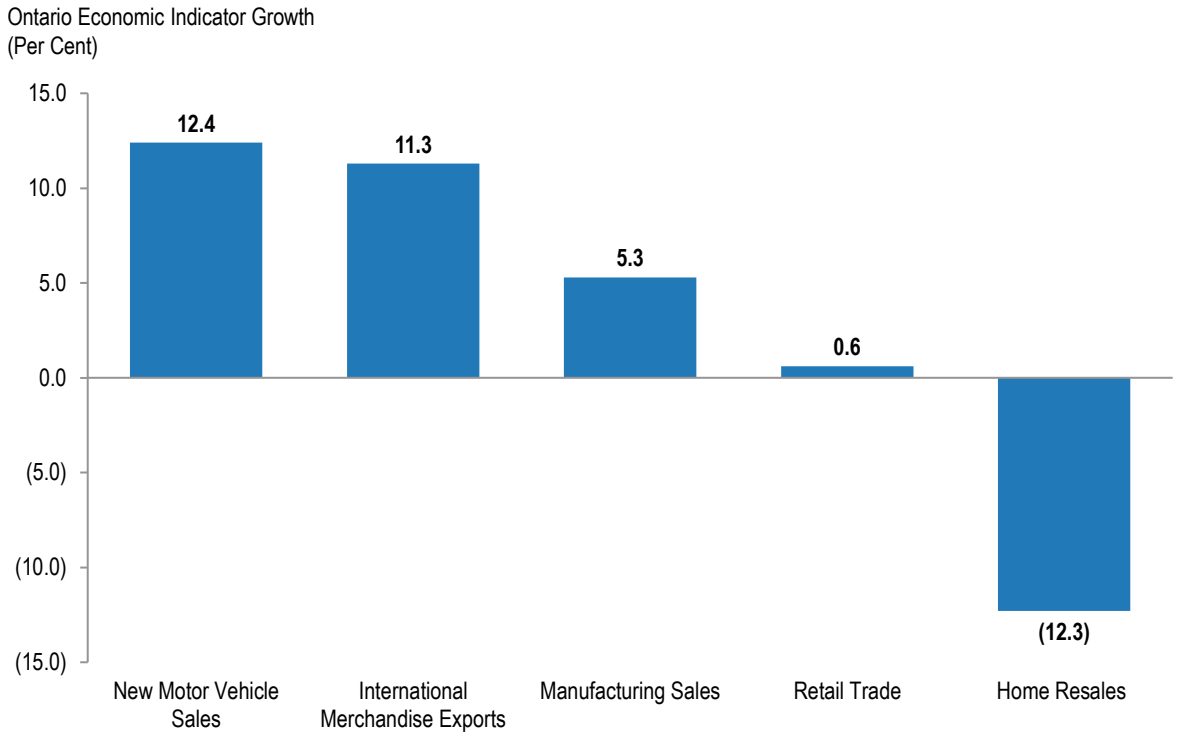
Chart 2.1
Ontario's Strong Employment Growth



Source: Statistics Canada.

Other economic indicators were largely positive for Ontario in 2023. New motor vehicle sales, exports, manufacturing sales and retail trade all posted growth in the year. The housing market moderated as higher mortgage rates contributed to home resales declining by 12.3 per cent in 2023.

Chart 2.2
Performance of Other Key Economic Indicators in 2023

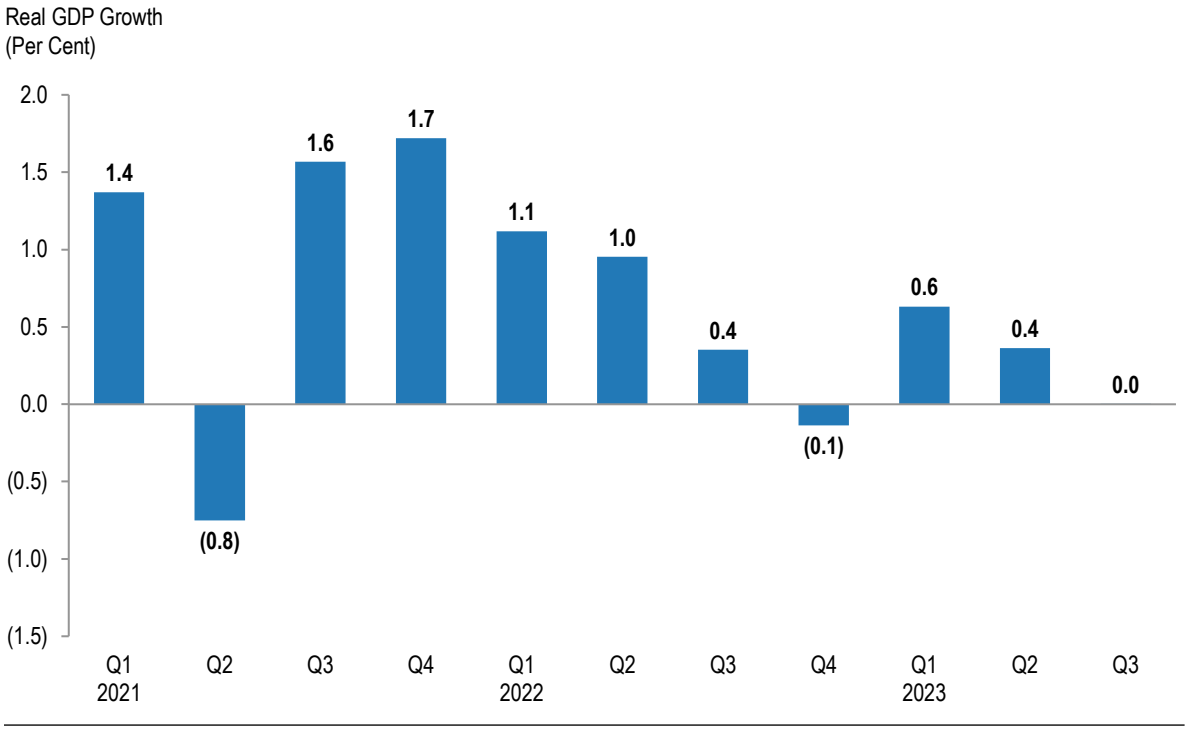


Sources: Statistics Canada and Canadian Real Estate Association.

Real GDP Growth

After a strong start to the year, Ontario's real GDP growth moderated through the course of 2023, as the Bank of Canada's high interest rates weighed on the economy. Real GDP was unchanged in the third quarter of 2023, slowing from gains of 0.6 per cent and 0.4 per cent in the first and second quarters, respectively. Interest-sensitive components such as household consumption and business investment have been particularly impacted by past interest rate increases. Despite this easing of growth in the second half of the year, Ontario real GDP is estimated to have grown 1.2 per cent in 2023.

Chart 2.3
Ontario's Real GDP Growth Moderated in 2023

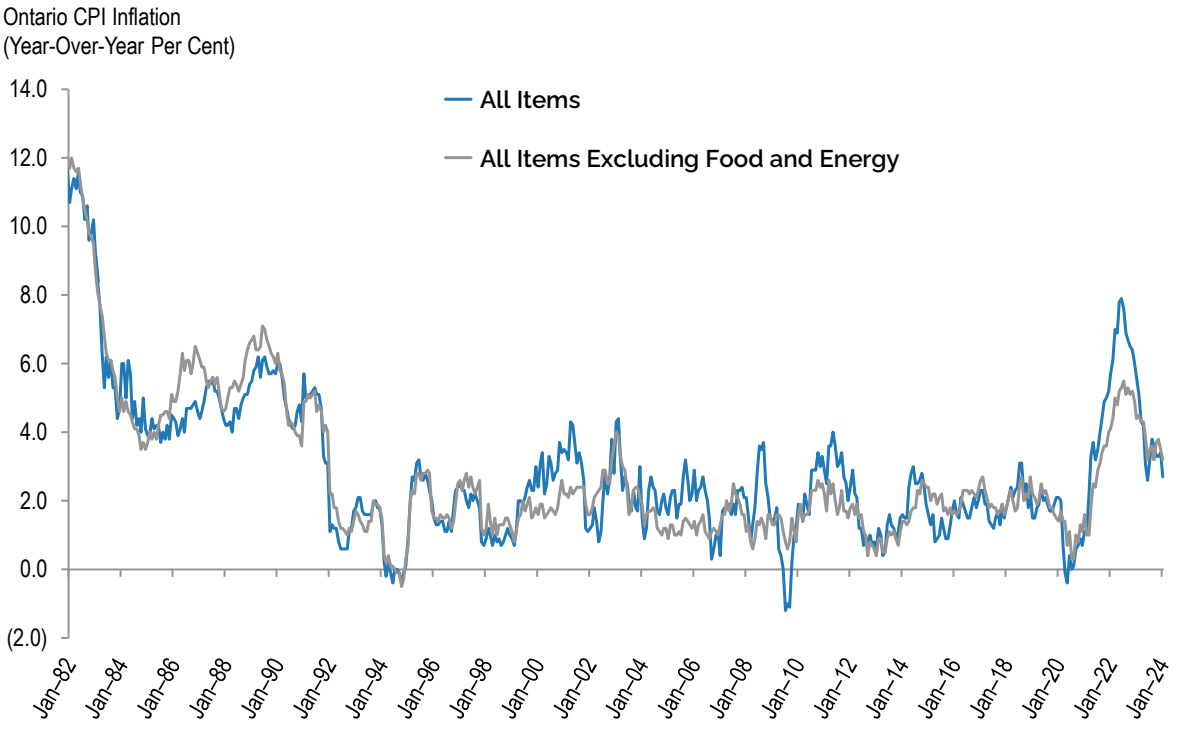


Source: Ontario Ministry of Finance.

Consumer Price Inflation

Ontario Consumer Price Index (CPI) inflation has eased significantly to 2.7 per cent (year-over-year) in January 2024 from 7.9 per cent in June 2022. The CPI moderation was largely due to lower energy prices, which declined 4.0 per cent on a year-over-year basis in January 2024, compared to a 37.0 per cent increase in June 2022. Inflation excluding food and energy also moderated to 3.2 per cent in January 2024 from 5.5 per cent in July 2022.

Chart 2.4
Ontario's Consumer Price Inflation Moderating



Note: Latest data point is January 2024.
Source: Statistics Canada.

Economic Outlook

The Ontario Ministry of Finance regularly consults with private-sector economists while tracking their forecasts to inform the government's planning assumptions.

Private-sector forecasters, on average, are projecting that Ontario's real GDP will grow by 0.4 per cent in 2024, 2.0 per cent in 2025, and 2.3 per cent in 2026 and 2027. This is a deterioration in the economic forecast since the *2023 Budget.* The Ontario Ministry of Finance's real GDP projections are set slightly below the average of private-sector forecasts in each year for prudent planning purposes. Three external economic experts reviewed the Ontario Ministry of Finance's economic planning assumptions and found them to be reasonable.[1]

Table 2.3

Private-Sector Forecasts for Ontario Real GDP Growth

(Per Cent)

	2024	2025	2026	2027
BMO Capital Markets (January)	0.4	2.3	–	–
Central 1 Credit Union (January)	0.8	2.1	–	–
CIBC Capital Markets (January)	0.3	1.8	–	–
The Conference Board of Canada (January)	0.6	2.3	2.6	2.5
Desjardins Group (January)	(0.1)	2.1	–	–
Laurentian Bank Securities (January)	0.4	2.0	–	–
National Bank of Canada (December)	(0.4)	1.5	–	–
Quantitative Economic Decisions, Inc. (January)	1.2	0.5	1.6	1.7
Royal Bank of Canada (December)	0.2	2.3	–	–
Scotiabank (December)	0.5	2.6	–	–
Stokes Economics (January)	0.5	2.2	2.6	2.8
TD Bank Group (January)	0.3	1.5	2.0	2.0
University of Toronto (January)	0.0	2.5	2.8	2.6
Private-Sector Survey Average	**0.4**	**2.0**	**2.3**	**2.3**
Ontario's Planning Assumption	**0.3**	**1.9**	**2.2**	**2.2**

Sources: Ontario Ministry of Finance Survey of Forecasters (January 25, 2024) and Ontario Ministry of Finance.

[1] The three experts are from the Policy and Economic Analysis Program at the University of Toronto; Quantitative Economic Decisions, Inc. (QEDinc.); and Stokes Economics Consulting, Inc.

Private-sector forecasters, on average, are projecting that Ontario's nominal GDP will grow by 2.8 per cent in 2024, 4.0 per cent in 2025, 4.4 per cent in 2026 and 4.2 per cent in 2027. The Ontario Ministry of Finance's nominal GDP projections are set slightly below the average of private-sector forecasts in each year for prudent planning purposes.

Table 2.4

Private-Sector Forecasts for Ontario Nominal GDP Growth

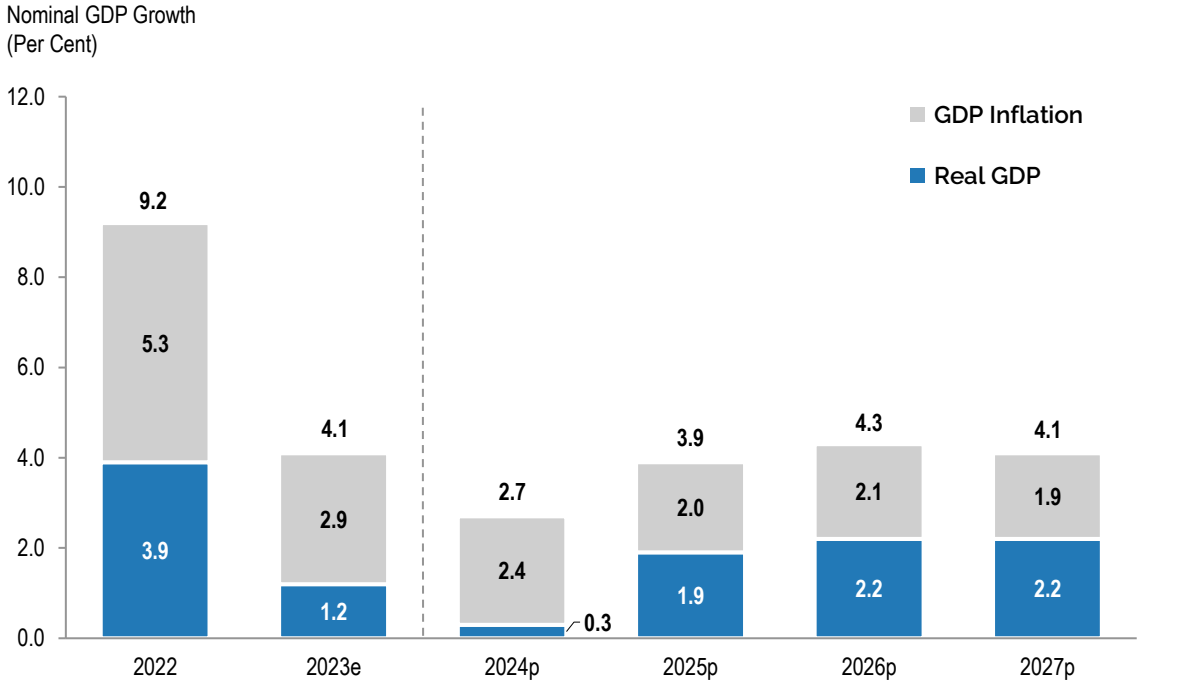
(Per Cent)

	2024	2025	2026	2027
BMO Capital Markets (January)	3.0	4.2	–	–
Central 1 Credit Union (January)	3.2	3.6	–	–
CIBC Capital Markets (January)	2.2	4.1	–	–
The Conference Board of Canada (January)	3.1	4.6	4.7	4.6
Desjardins Group (January)	1.4	3.6	–	–
Laurentian Bank Securities (January)	2.7	4.1	–	–
National Bank of Canada (December)	1.4	3.1	–	–
Quantitative Economic Decisions, Inc. (January)	5.5	3.7	3.5	2.6
Royal Bank of Canada (December)	2.1	3.7	–	–
Scotiabank (December)	3.0	4.4	–	–
Stokes Economics (January)	2.8	4.6	4.8	5.0
TD Bank Group (January)	3.2	3.5	4.0	4.0
University of Toronto (January)	2.7	4.5	4.9	4.7
Private-Sector Survey Average	**2.8**	**4.0**	**4.4**	**4.2**
Ontario's Planning Assumption	**2.7**	**3.9**	**4.3**	**4.1**

Sources: Ontario Ministry of Finance Survey of Forecasters (January 25, 2024) and Ontario Ministry of Finance.

The Ontario Ministry of Finance estimates that Ontario nominal GDP increased by 4.1 per cent in 2023, largely reflecting continued elevated GDP inflation coupled with moderate growth in real GDP. Nominal GDP growth is projected to slow in 2024 and then is projected to accelerate over the outlook period.

Chart 2.5
Ontario Nominal GDP Growth Projected to Moderate



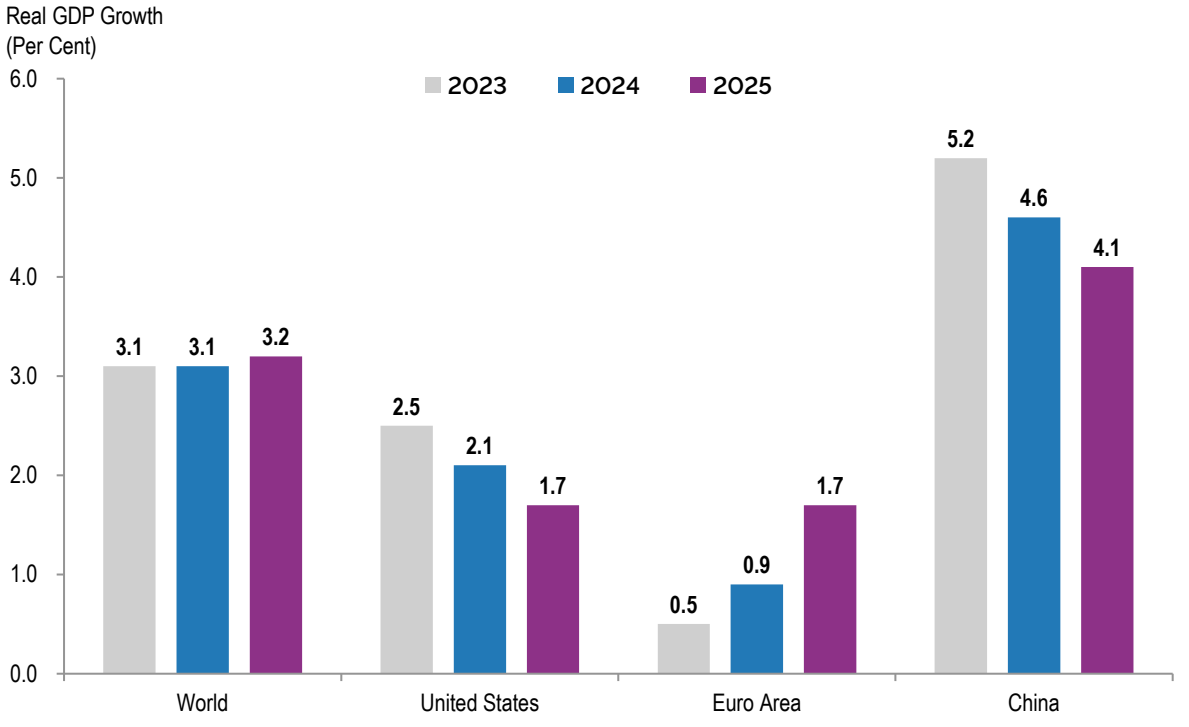
e = estimate.
p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024.
Sources: Statistics Canada and Ontario Ministry of Finance.

Global Economic Environment

The global economic growth outlook for 2024 has improved slightly as growth in several countries, notably the United States, has been resilient despite significant monetary policy tightening by key central banks over the past two years to address elevated price inflation. The International Monetary Fund projects global real GDP growth of 3.1 per cent in 2024, up from the 2.9 per cent forecast in October. For 2025, global real GDP growth is forecast to be 3.2 per cent, unchanged from the October forecast.

Real GDP growth in the United States is projected to ease from 2.5 per cent growth in 2023 to 2.1 per cent in 2024 and 1.7 per cent in 2025, as domestic demand moderates and labour markets adjust to the cumulative impacts of past monetary policy tightening. Euro area real GDP growth is projected to pick up from 0.5 per cent in 2023 to 0.9 per cent in 2024 and 1.7 per cent in 2025, as household spending strengthens, and the region continues to adjust to the energy and other commodity price shocks that followed the Russian invasion of Ukraine in 2022. China's real GDP growth is forecast to moderate from 5.2 per cent in 2023 to 4.6 per cent in 2024 and 4.1 per cent in 2025, with financial stresses originating from the property sector continuing to weigh on the economy.

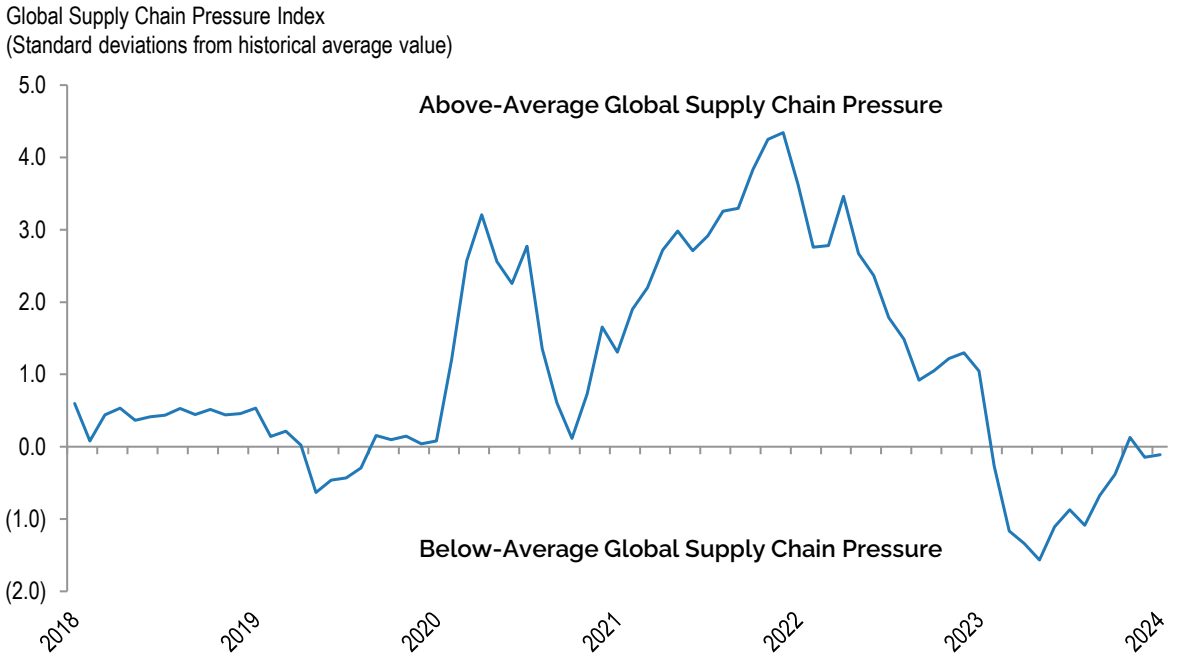
Chart 2.6
Global Real GDP Growth Projections



Note: World real GDP growth for 2023 is an estimate, while United States, Euro Area and China real GDP growth rates in 2023 are actuals.
Sources: International Monetary Fund (January 2024) and *Blue Chip Economic Indicators* (February 2024).

Global supply chains that came under significant pressure during the COVID-19 pandemic have improved significantly over the past two years. The Global Supply Chain Pressure Index (GSCPI) produced by the Federal Reserve Bank of New York shows that supply chain pressures peaked in December 2021. As demand patterns normalized and pressures on production and transportation systems eased, the index subsequently declined. By February 2023, the supply chain pressure index declined below its historical average, reaching a low in May 2023. Global supply chain pressures have since risen but are currently close to their historical average level.

Chart 2.7
Global Supply Chain Pressures Have Eased

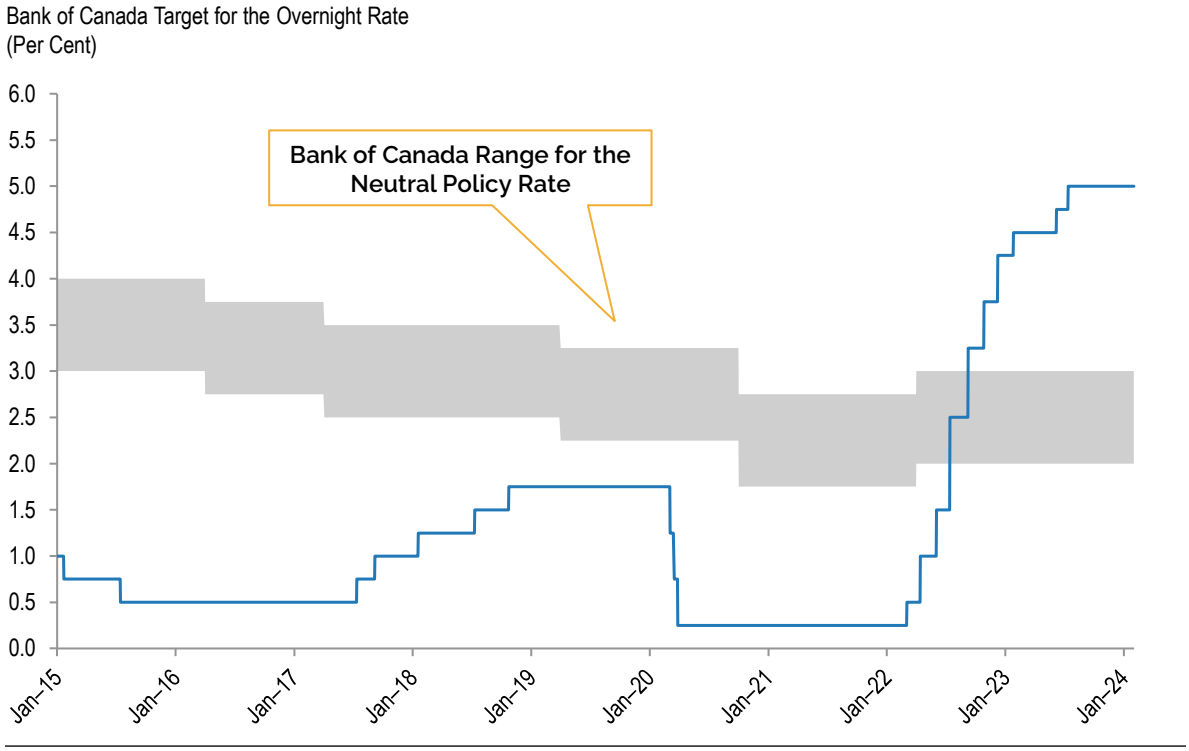


Notes: Standard deviation is a measure of variability in data. The more standard deviations an observation is from the average value, the less likely an observation is to occur.
Source: Federal Reserve Bank of New York, Global Supply Chain Pressure Index (January 2024).

Financial Markets and Other External Factors

Following the fastest pace of policy rate increases since 1981, the Bank of Canada has maintained its policy interest rate at 5.0 per cent since July 2023. The Bank's current policy rate stands well above the 2.0 to 3.0 per cent range that the Bank considers as its neutral policy interest rate, which is the interest rate consistent with the economy producing at its potential capacity when inflation is at two per cent. The Bank's current monetary policy stance is helping to moderate CPI inflation but has contributed to slowing economic growth. The Bank projects inflation to remain around three per cent during the first half of 2024 before easing, returning to the two per cent target in 2025.

Chart 2.8
Bank of Canada Raised Policy Interest Rate Significantly



Source: Bank of Canada data.

Most private-sector forecasters expect the Bank of Canada to begin easing policy interest rates in 2024 and continue easing into 2025. Accordingly, the Government of Canada three-month treasury bill rate is expected to moderate from 4.8 per cent in 2023 to 4.4 per cent in 2024 and reach 2.6 per cent by 2026 and 2027. The Government of Canada 10-year bond rate increased from 2.8 per cent in 2022 to 3.3 per cent in 2023 and is expected to moderate to an average of 3.2 per cent in 2024 and 2025. It is then expected to average 3.4 per cent in 2026 and 2027.

Energy prices are expected to remain relatively stable over the projection horizon. West Texas Intermediate (WTI) crude oil prices moderated to US$78 per barrel in 2023, down from US$95 per barrel in 2022. The WTI price is expected to average US$78 between 2024 and 2027. The Canadian dollar is projected to appreciate gradually over the projection period from 74.1 cents US in 2023 to 74.6 cents US in 2024, and average of 77.6 cents US from 2025 to 2027.

Table 2.5

External Factors

	2022	2023	2024p	2025p	2026p	2027p
World Real GDP Growth (Per Cent)	3.5	3.1e	3.1	3.2	3.2	3.1
U.S. Real GDP Growth (Per Cent)	1.9	2.5	2.1	1.7	2.1	1.9
West Texas Intermediate (WTI) Crude Oil ($US per Barrel)	95	78	79	78	77	78
Canadian Dollar (Cents US)	76.8	74.1	74.6	77.6	78.2	77.0
Three-Month Treasury Bill Rate[1] (Per Cent)	2.3	4.8	4.4	3.0	2.6	2.6
10-Year Government Bond Rate[1] (Per Cent)	2.8	3.3	3.2	3.1	3.3	3.5

e = International Monetary Fund estimate.

p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024.

[1] Government of Canada interest rates.

Sources: International Monetary Fund *World Economic Outlook* (October 2023 and January 2024); U.S. Bureau of Economic Analysis; U.S. Energy Information Administration; Bank of Canada; *Blue Chip Economic Indicators* (October 2023 and February 2024); and Ontario Ministry of Finance Survey of Forecasters (January 25, 2024).

Details of Ontario's Economic Outlook

The Ontario Ministry of Finance projects real GDP to rise by 0.3 per cent in 2024, 1.9 per cent in 2025, and 2.2 per cent in 2026 and in 2027. Nominal GDP is projected to grow by 2.7 per cent in 2024 and accelerate to 3.9 per cent in 2025, 4.3 per cent in 2026 and 4.1 per cent in 2027.

Table 2.6

Ontario's Economic Outlook

(Per Cent Change)

	2022	2023	2024p	2025p	2026p	2027p
Real Gross Domestic Product	3.9	1.2e	0.3	1.9	2.2	2.2
Nominal Gross Domestic Product	9.2	4.1e	2.7	3.9	4.3	4.1
Compensation of Employees	8.9	6.7e	4.3	4.4	4.1	4.1
Net Operating Surplus — Corporations	(5.9)	(12.6)e	(4.7)	3.5	7.9	6.0
Nominal Household Consumption	13.2	6.0e	3.5	4.1	4.3	4.2
Other Economic Indicators						
Employment	4.6	2.4	0.8	1.7	1.4	1.4
Job Creation (000s)	338	183	63	136	114	115
Unemployment Rate (Per Cent)	5.6	5.7	6.7	6.6	6.4	6.2
Consumer Price Index	6.8	3.8	2.6	2.0	2.0	2.0
Housing Starts (000s)[1]	96.1	89.3	87.9	92.3	94.4	95.8
Home Resales	(31.9)	(12.3)	4.0	16.0	1.2	1.2
Home Resale Prices	6.7	(6.3)	(0.2)	3.1	4.0	4.0
Key External Variables						
U.S. Real Gross Domestic Product	1.9	2.5	2.1	1.7	2.1	1.9
WTI Crude Oil ($US per Barrel)	95	78	79	78	77	78
Canadian Dollar (Cents US)	76.8	74.1	74.6	77.6	78.2	77.0
Three-Month Treasury Bill Rate (Per Cent)[2]	2.3	4.8	4.4	3.0	2.6	2.6
10-Year Government Bond Rate (Per Cent)[2]	2.8	3.3	3.2	3.1	3.3	3.5

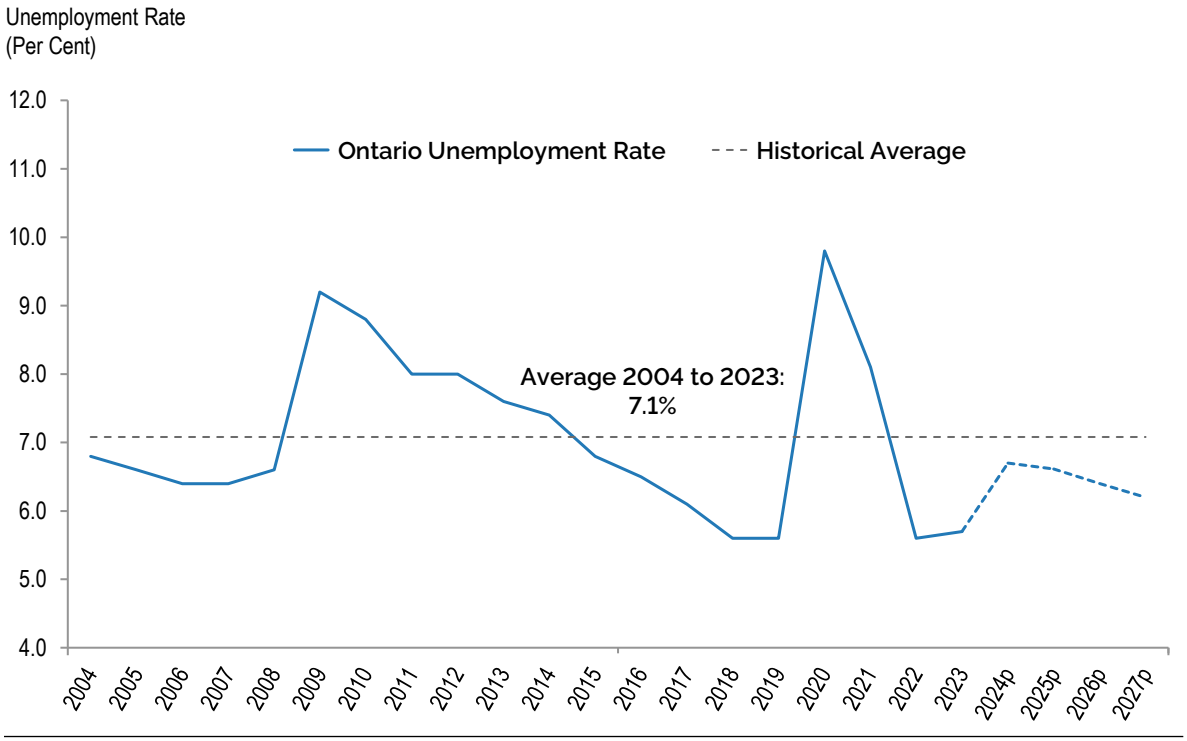
e = estimate.
p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024.
[1] Housing starts projection based on private-sector average as of January 25, 2024.
[2] Government of Canada interest rates.
Sources: Statistics Canada; Canada Mortgage and Housing Corporation; Canadian Real Estate Association; Bank of Canada; United States Bureau of Economic Analysis; *Blue Chip Economic Indicators* (October 2023 and February 2024); U.S. Energy Information Administration; and Ontario Ministry of Finance.

Employment and Household Spending

High interest rates are projected to contribute to an easing in the labour market in early 2024 before improving later in the year. Employment is projected to rise by 0.8 per cent in 2024, slowing from a 2.4 per cent increase in 2023. The slower employment growth, along with continued robust population and labour force growth, is projected to raise the unemployment rate to 6.7 per cent in 2024. The unemployment rate over the outlook period is projected to remain below the recent historical average.

A strengthening economy is projected to boost employment growth to 1.7 per cent in 2025 and 1.4 per cent in both 2026 and 2027. As employment gains increase, the unemployment rate is expected to gradually decline to 6.2 per cent by 2027.

Chart 2.9
Ontario Unemployment Rate to Remain Below Historical Average

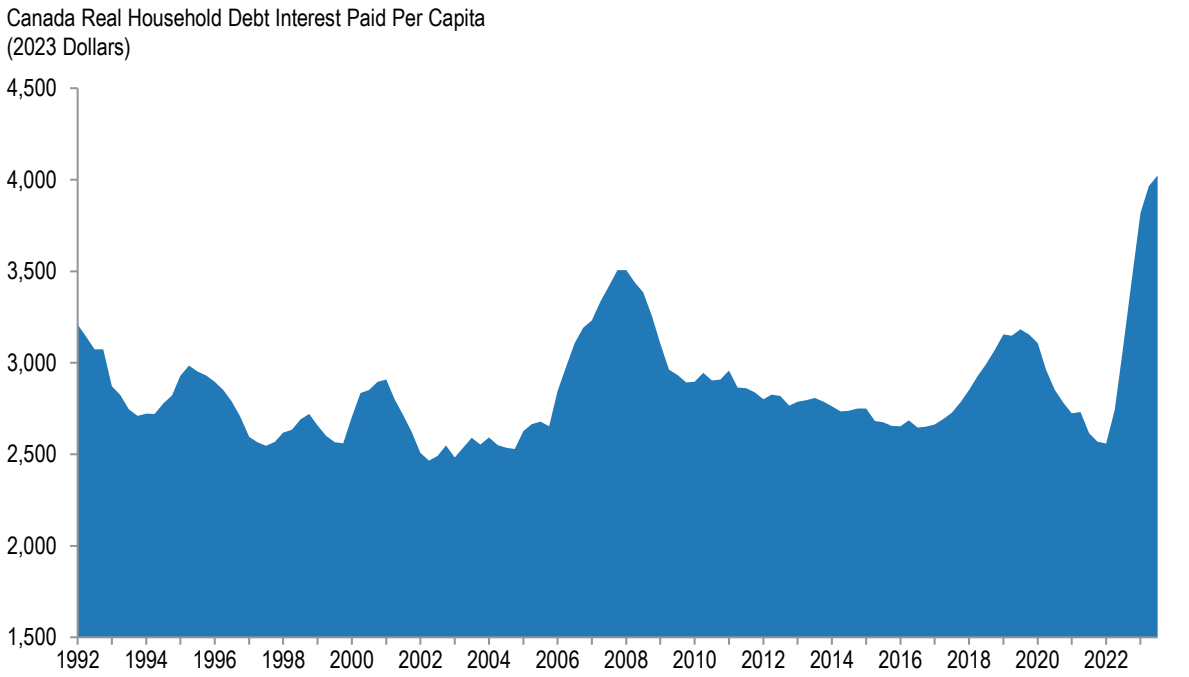


p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024.
Sources: Statistics Canada and Ontario Ministry of Finance.

Slowing demand has helped ease price pressures while population increases have contributed to rising nominal household spending in 2023, which was up 6.0 per cent, after a 13.2 per cent increase in 2022. Despite these strong gains, real spending softened on a per capita basis in 2023 as higher prices and interest costs weighed on household budgets. Canadian household interest payments on debt on a real per capita basis have risen significantly and are at the highest level in over 30 years.

Nominal household spending growth is projected to moderate to 3.5 per cent in 2024 but is expected to accelerate to 4.1 per cent in 2025 as interest rates decrease and the labour market strengthens.

Chart 2.10
Canadian Households Paying More Interest



Notes: Data is seasonally adjusted annual rate. Canada real household debt interest paid per capita is calculated using Canada Consumer Price Index. Last data point is 2023Q3.
Sources: Statistics Canada and Ontario Ministry of Finance calculations.

Consumer Price Inflation

Following a significant easing in inflationary pressures in 2023, price pressures are projected to continue to moderate in 2024 as high interest rates continue to dampen demand.

For planning purposes, the Ontario Ministry of Finance is projecting CPI inflation to slow from 3.8 per cent in 2023 to 2.6 per cent in 2024, before returning to the Bank of Canada's inflation rate target of 2.0 per cent in 2025.

However, the future path of CPI inflation is uncertain. Elevated inflation for certain goods and services remains persistent. As well, risks to global supply chains have risen in recent months, impacting shipping costs and delivery times. Private-sector economists have a wide range of views, with forecasts for 2024 inflation ranging from 1.8 per cent to 3.0 per cent.

Chart 2.11
Inflation Projected to Ease



p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024.
Sources: Statistics Canada, Ontario Ministry of Finance and Ontario Ministry of Finance Survey of Forecasters.

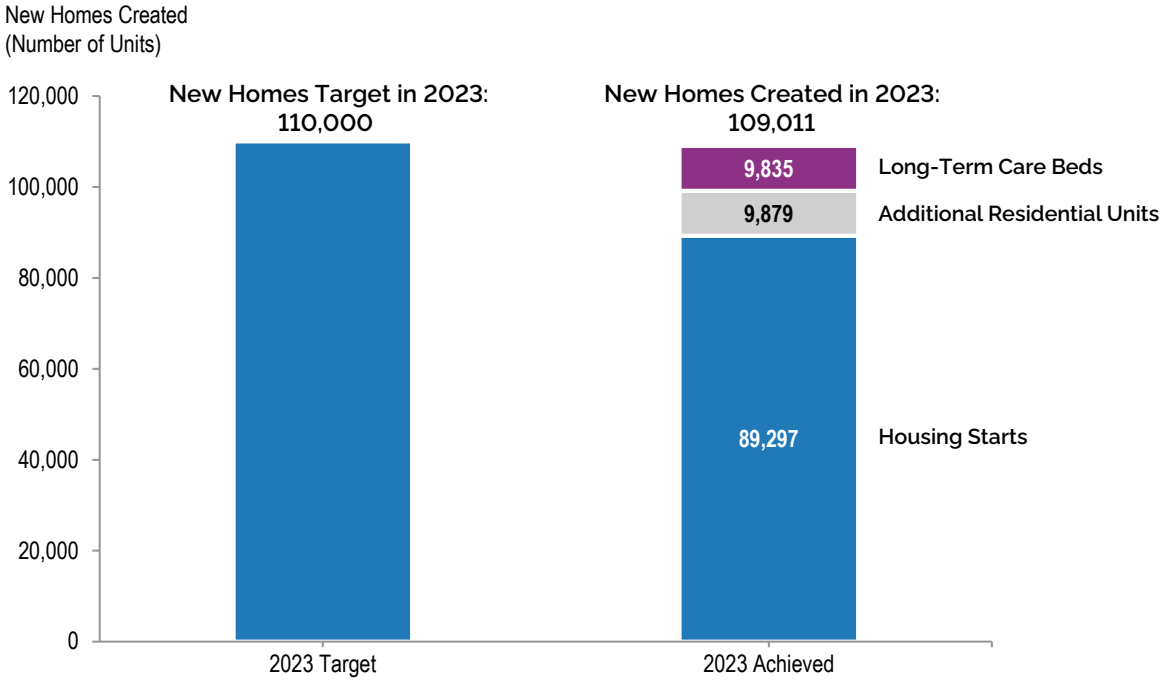
Federal carbon tax policy has contributed to inflation. The Bank of Canada has estimated that eliminating the carbon tax could create a one-time drop in inflation of 0.6 percentage points in Canada.[2] On April 1, the federal carbon tax is scheduled to increase. According to the Bank of Canada, the planned increase of the carbon tax would raise year-over-year inflation by roughly 0.1 percentage points.[3]

Housing Supply Progress

Ontario has set a goal of building at least 1.5 million homes by 2031 and has assigned the province's 50 largest municipalities with housing targets to help meet this goal.

In 2023, the goal was to create 110,000 new homes in Ontario. By year-end, 109,011 new homes were created, or 99 per cent of the target. This included a mix of market housing starts, additional residential units and long-term care beds.

Chart 2.12
Making Progress on Housing Supply



Note: Long-term care beds includes new and upgraded beds.
Sources: Canada Mortgage Housing Corporation, Ontario Ministry of Municipal Affairs and Housing, and Ontario Ministry of Long-Term Care.

[2] Canada, Parliament, House of Commons, Standing Committee on Finance, Minutes of Proceedings and Evidence, 44th Parliament, 1st Session, No 112 (October 30, 2023).

[3] Bank of Canada. *Monetary Policy Report*, (October 2023).

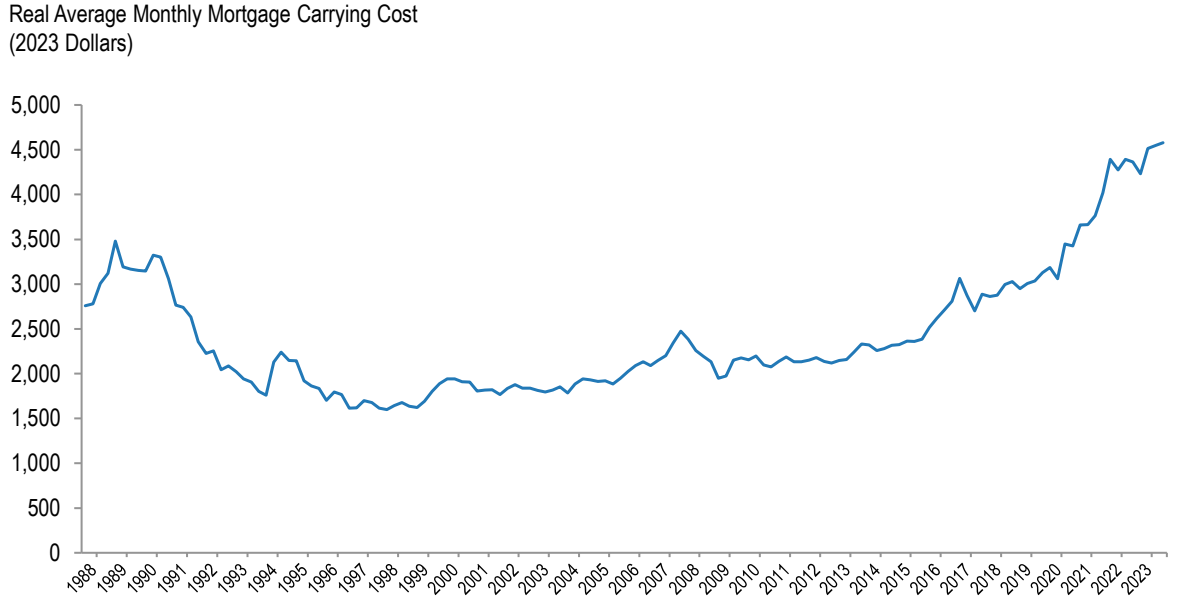
Housing Market

Ontario's housing market continues to face challenges from elevated interest rates and insufficient supply amid record population increases. See Chapter 1, Section A: *Building Ontario* for details on how the provincial government is working with other levels of government and industry partners to get more homes built in Ontario.

The Bank of Canada has held its policy interest rate at 5.0 per cent since July 2023. However, the cumulative impact of its rate increases since March 2022 has elevated mortgage costs, which have weighed on Ontario's housing market activity. The average home price declined 6.3 per cent in 2023 to $872,100, a level on par with that in 2021. Home resales were 12.3 per cent lower in 2023 following a sharp decline of 31.9 per cent in 2022, reaching the lowest volume of sales in more than two decades.

Despite the decline in average home prices, high interest rates have kept mortgage carrying costs at record levels. The average monthly mortgage carrying cost, based on the Ontario average home resale price with a 20 per cent down payment and a 25-year amortization period, was around $4,600 in the last quarter of 2023, well above the previous peak recorded in the late 1980s after adjusting for inflation. This has been a significant contributor to housing-related CPI inflation over the past year.

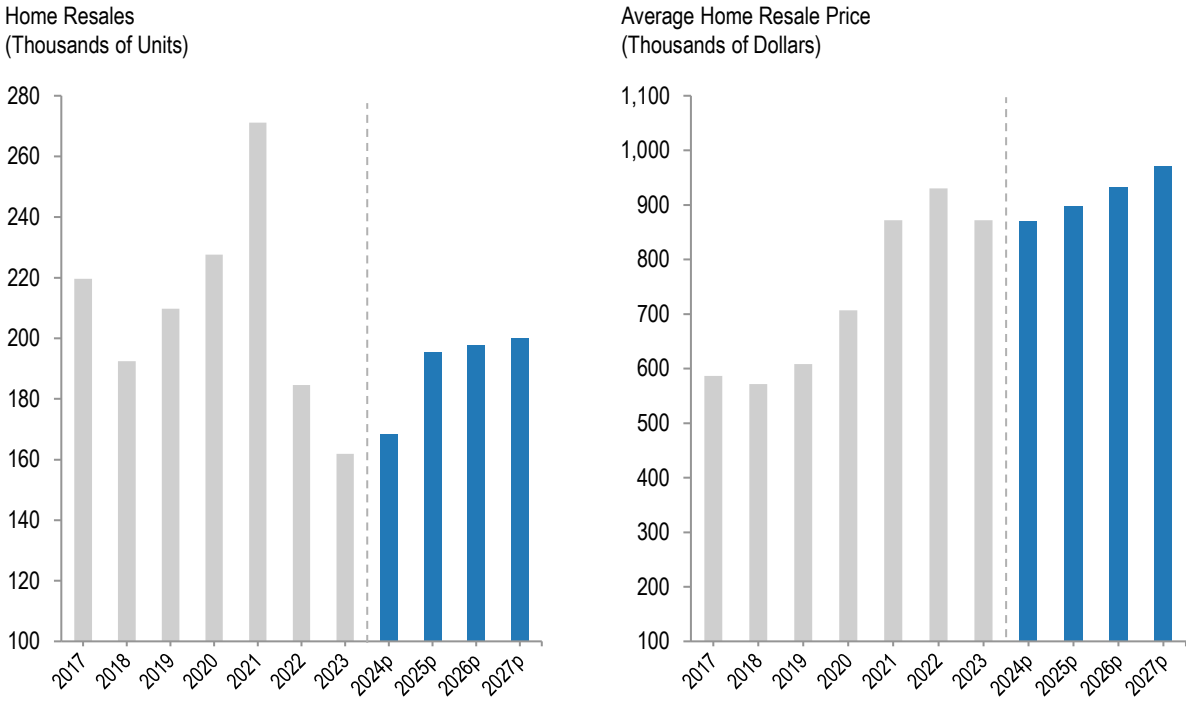
Chart 2.13
Housing Affordability Impacted by Higher Mortgage Costs



Notes: Real average monthly mortgage carrying cost calculated using Ontario average home resale price and CPI inflation with assumptions of a 20 per cent down payment, 25-year amortization period and 5-year conventional mortgage rates. Last data point is 2023Q4.
Sources: Statistics Canada, Canadian Real Estate Association and Ontario Ministry of Finance calculations.

Projected population growth and moderating mortgage interest rates are expected to boost housing market activity over the projection period. The average home resale price in Ontario is projected to decline 0.2 per cent in 2024 before growing 3.1 per cent in 2025 and 4.0 per cent in 2026. Home resales are projected to grow 4.0 per cent in 2024, 16.0 per cent in 2025 and 1.2 per cent in 2026.

Chart 2.14
Housing Market Projected to Rebound



Sources: Canadian Real Estate Association and Ontario Ministry of Finance.

Risks to the Outlook

Consumer price inflation has continued to ease in many jurisdictions, but measures of core inflation, which adjust for more volatile components, remain elevated. The outlook for inflation remains a key source of uncertainty for the global economy as well as for Canada and Ontario. Although several major central banks, including the Bank of Canada and the U.S. Federal Reserve, have signalled that they have likely concluded their recent cycles of interest rate increases, a significant downside risk is that they may maintain higher interest rates for longer if they judge it necessary to ensure the return of inflation to the target rate. Conversely, an upside risk for the economy is that inflation normalizes more rapidly than expected, allowing for a quicker easing of monetary policy.

Economic growth in the United States has proven surprisingly resilient in the face of significant monetary policy tightening, including strong consumer demand and buoyant labour markets. Continued economic resilience in the United States represents an upside risk to the Ontario economy, notably for growth in Ontario exports. However, the economy in the United States is exposed to significant risks as the cumulative impact of past interest rate rises are expected to weigh on aggregate demand. There is also a risk of fiscal consolidation, as ongoing sizable fiscal deficits have raised federal government debt in the United States to high levels.

Geopolitical developments continue to pose a significant risk to the economic outlook. Global conflicts continue to disrupt commodity markets and pose risks to supply chains. In addition, rising trade tensions are continuing to weigh on international trade in goods and services, which could impact Ontario's key trading relationships in North America.

Table 2.7 displays current estimates of the impact of sustained changes in key external factors on Ontario's real GDP planning assumptions, assuming other external factors remain unchanged. The relatively wide range of estimated impacts reflects the uncertainty regarding how the economy could respond to these changes in external conditions.

Table 2.7
Impact of Sustained Changes in Key External Factors on Real GDP Growth

(Percentage Point Change)

	Change in Real GDP Growth	
	First Year	**Second Year**
Canadian Dollar Appreciates by Five Cents US	(0.1) to (0.7)	(0.2) to (0.8)
Crude Oil Prices Increase by $10 US per Barrel	(0.1) to (0.3)	(0.1) to (0.3)
U.S. Real GDP Growth Increases by One Percentage Point	+0.2 to +0.6	+0.3 to +0.7
Canadian Interest Rates Decrease by One Percentage Point	+0.1 to +0.5	+0.2 to +0.6

Source: Ontario Ministry of Finance.

Economic Outlook Scenarios

To provide more transparency about the province's economic outlook amid the elevated degree of economic uncertainty, the Ontario Ministry of Finance has developed Faster Growth and Slower Growth scenarios that the economy could take over the next few years. These alternative scenarios should not be considered the best case or the worst case, but reasonable possible outcomes in this period of uncertainty.

Table 2.8

Ontario Real GDP Growth Scenarios

(Per Cent)

	2024p	2025p	2026p	2027p
Faster Growth Scenario	1.4	2.6	2.5	2.5
Planning Projection	**0.3**	**1.9**	**2.2**	**2.2**
Slower Growth Scenario	(0.6)	1.4	2.1	2.1

p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024, and alternative scenarios.
Source: Ontario Ministry of Finance.

Table 2.9

Ontario Nominal GDP Growth Scenarios

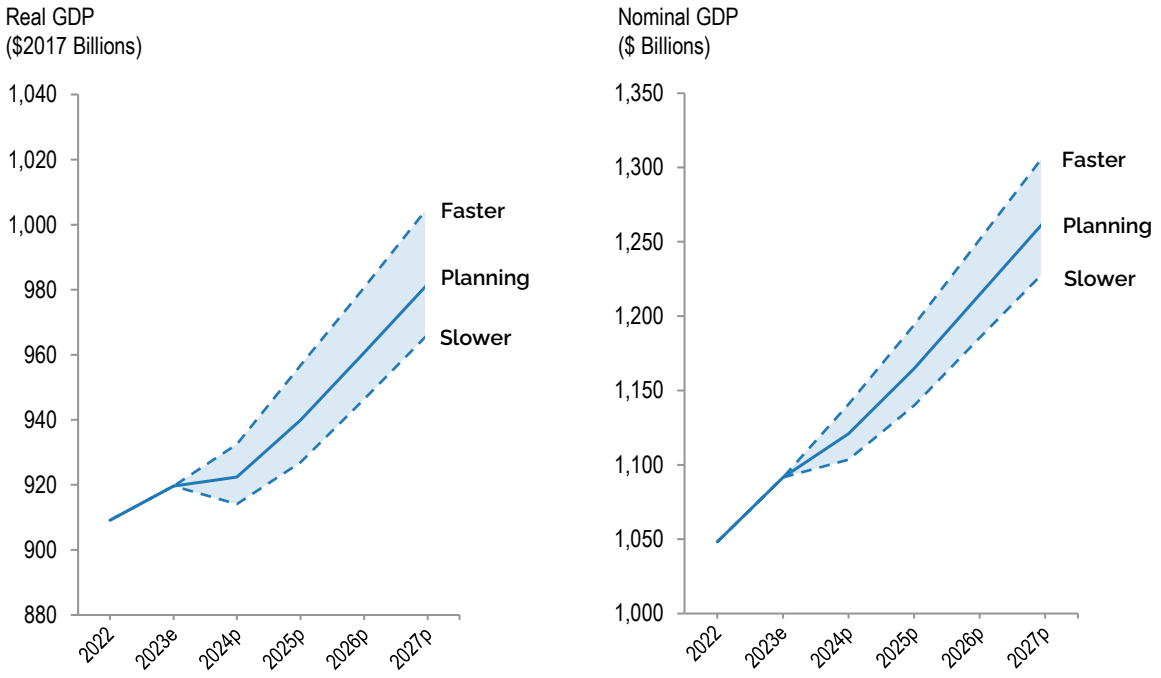
(Per Cent)

	2024p	2025p	2026p	2027p
Faster Growth Scenario	4.5	4.7	4.8	4.6
Planning Projection	**2.7**	**3.9**	**4.3**	**4.1**
Slower Growth Scenario	1.1	3.3	4.0	3.8

p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024, and alternative scenarios.
Source: Ontario Ministry of Finance.

By 2027, the level of real GDP in the Faster Growth scenario is 2.4 per cent higher than in the Planning Projection, while in the Slower Growth scenario, the level of real GDP is 1.6 per cent lower. The nominal GDP scenarios show a wider range of outcomes over the next several years compared to the real GDP scenarios, due largely to heightened near-term uncertainty around GDP inflation. By 2027, the level of nominal GDP in the Faster Growth scenario is 3.5 per cent higher than in the Planning Projection, while in the Slower Growth scenario, the level of nominal GDP is 2.7 per cent lower.

Chart 2.15
Range of Ontario GDP Scenario Forecasts



e = estimate.
p = Ontario Ministry of Finance planning projection based on external sources as of January 25, 2024 and alternative scenarios.
Sources: Statistics Canada and Ontario Ministry of Finance.

Transparent Reporting on the Economy

The Ontario Economic Accounts provide a comprehensive overall assessment of the performance of Ontario's economy. Private-sector economists use this to assess the current state of the province's economy and as a basis for updating their forecasts. The Ontario Economic Accounts help inform the government's economic and revenue forecasts, providing a key foundation for Ontario's fiscal plan.

The *Fiscal Sustainability, Transparency and Accountability Act, 2019* states that the quarterly Ontario Economic Accounts shall be released within 45 days after the Statistics Canada release of the National Income and Expenditure Accounts.

In compliance with the legislation, the quarterly Ontario Economic Accounts will be released according to the schedule outlined in Table 2.10.

Table 2.10

Ontario Economic Accounts Release Dates

Reference Period	Expected Statistics Canada Release of National Income and Expenditure Accounts	Corresponding Deadline for Release of Ontario Economic Accounts
Fourth quarter (October-December) 2023	February 29, 2024	By April 12, 2024
First quarter (January-March) 2024	May 31, 2024	By July 15, 2024
Second quarter (April-June) 2024	August 30, 2024	By October 15, 2024
Third quarter (July-September) 2024	November 29, 2024	By January 13, 2025
Fourth quarter (October-December) 2024	February 28, 2025	By April 14, 2025

Sources: Statistics Canada and Ontario Ministry of Finance.



Chapter 3

Continuing to Invest in the Plan to Build: Ontario's Fiscal Plan and Outlook

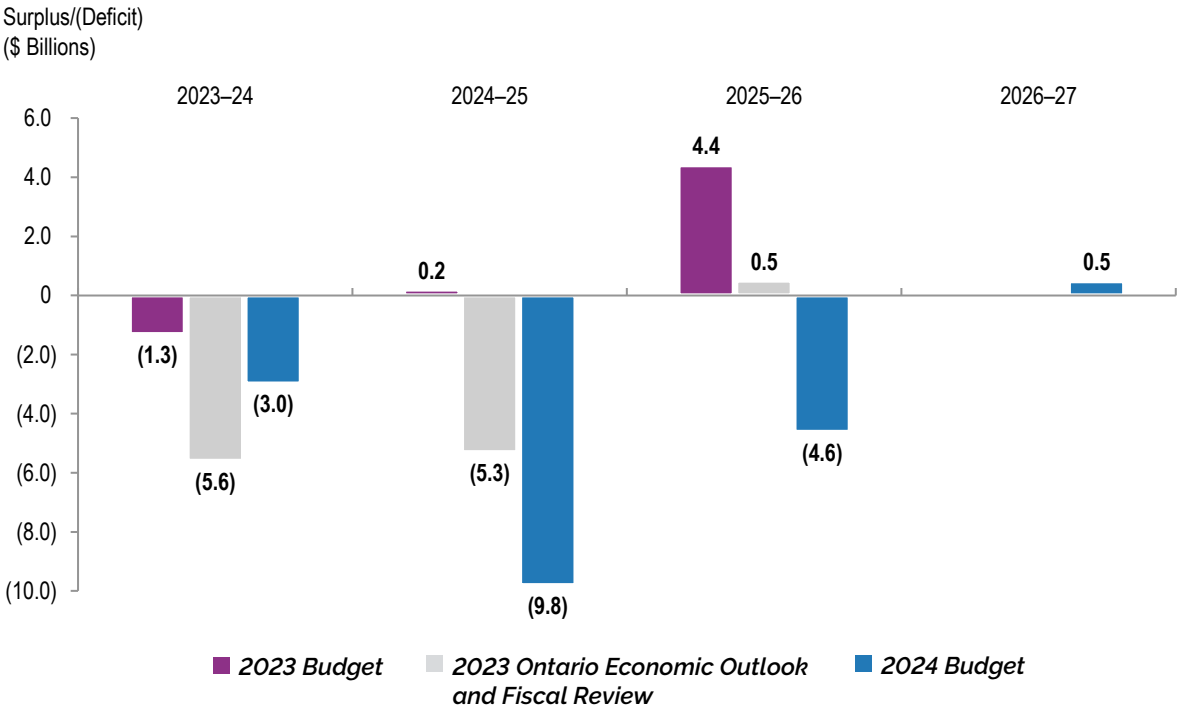
Introduction

With economic headwinds weighing on household and government finances, it is more important than ever to continue investing in *Ontario's Plan to Build* and to keep costs down and taxes low. While Ontario's economy has remained resilient, it is expected to reflect continued but slower growth in 2024, compared to the projection in the *2023 Budget*.

This slower projected growth and other factors beyond the provincial government's control — such as lower tax assessments and the federal government's cap on international student study permit applications — have put new pressures on government finances. But the government will not stop investing in growth, infrastructure, economic development and communities across Ontario, and will also not raise taxes or fees at a time when families and businesses are struggling.

For 2023–24, the government is projecting a deficit of $3.0 billion. Over the medium term, the government is projecting deficits of $9.8 billion in 2024–25 and $4.6 billion in 2025–26, before reaching a surplus of $0.5 billion in 2026–27. The government's plan retains a path to balance the budget despite a fiscal deterioration relative to the outlooks in Ontario's *2023 Budget* and the fall *2023 Ontario Economic Outlook and Fiscal Review*.

Chart 3.1
Current Fiscal Outlook Compared to the *2023 Budget* and *2023 Ontario Economic Outlook and Fiscal Review*



Source: Ontario Ministry of Finance.

A strong federal–provincial partnership is also key to Ontario's long-term fiscal sustainability. While Ontario and the federal government have recently achieved agreements on health funding, Ontario continues to make new investments in critical health services while also facing increased cost pressures. More is needed to be done to ensure the Canada Health Transfer provides adequate funding going forward. In addition, with significant new infrastructure investments announced in Ontario's *2024 Budget*, Ontario is calling on the Government of Canada to build on these actions to support municipalities and to get shovels in the ground on housing-enabling infrastructure.

Table 3.1

Fiscal Summary

($ Billions)

	Actual	Interim[1]	Medium-Term Outlook		
	2022–23	2023–24	2024–25	2025–26	2026–27
Revenue	**192.9**	**204.3**	**205.7**	**217.4**	**226.6**
Expense					
Programs	186.4	194.5	200.6	205.8	208.9
Interest on Debt	12.4	12.8	13.9	14.7	15.2
Total Expense	**198.8**	**207.3**	**214.5**	**220.6**	**224.1**
Surplus/(Deficit) Before Reserve	**(5.9)**	**(3.0)**	**(8.8)**	**(3.1)**	**2.5**
Reserve	–	–	1.0	1.5	2.0
Surplus/(Deficit)	**(5.9)**	**(3.0)**	**(9.8)**	**(4.6)**	**0.5**
Net Debt as a Per Cent of GDP	38.2%	38.0%	39.2%	39.5%	39.1%
Net Debt as a Per Cent of Revenue	207.6%	203.0%	213.5%	211.4%	209.4%
Interest on Debt as a Per Cent of Revenue	6.4%	6.3%	6.8%	6.8%	6.7%

[1] Interim represents the *2024 Budget* projection for the 2023–24 fiscal year.
Notes: Numbers may not add due to rounding. Interim and medium-term outlook primarily reflect information available as of February 28, 2024.
Sources: Ontario Treasury Board Secretariat and Ontario Ministry of Finance.

2023–24 Interim[1] Fiscal Performance

Ontario's 2023–24 deficit is projected to be $3.0 billion — $1.7 billion higher than the outlook published in the *2023 Budget* but $2.6 billion lower than the outlook published in the *2023 Ontario Economic Outlook and Fiscal Review*. It is also $1.6 billion lower than the outlook published in the *2023–24 Third Quarter Finances*.

The *2024 Budget* is projecting revenues in 2023–24 to be $204.3 billion — slightly lower than forecast in the *2023 Budget.* Declines in taxation revenue and Government of Canada transfers are mostly offset by gains in net income from Government Business Enterprises and Other Non-Tax Revenue.

Program expense is projected to be $194.5 billion, $3.8 billion higher than the *2023 Budget* forecast.

Ontario is forecast to pay $12.8 billion in interest costs in 2023–24 — lower than the forecast in the *2023 Budget*, mainly due to lower than projected borrowing costs. At 38.0 per cent, the net debt-to-GDP ratio in 2023–24 is forecast to be 0.2 percentage point higher than in the *2023 Budget*, primarily due to a modestly higher than forecast deficit and investments in infrastructure.

[1] Defining Interim

Interim represents the *2024 Budget* projection for the 2023–24 fiscal year and is subject to change as actual provincial revenue and expense are finalized in the *Public Accounts of Ontario 2023–2024*, to be released no later than September 27, 2024.

The *2023 Budget* also included a $1.0 billion reserve in 2023–24 to protect the fiscal plan against unforeseen adverse changes in Ontario's revenue and expense forecasts. The reserve was not required at fiscal year-end and has been drawn down to zero at interim, reducing the deficit further.

Table 3.2

2023–24 In-Year Fiscal Performance

($ Millions)

	2023 Budget	**Interim[1] 2023–24**	**In-Year Change**
Revenue	**204,367**	**204,336**	**(32)**
Expense			
Programs	190,622	194,470	3,848
Interest on Debt	14,058	12,843	(1,215)
Total Expense	**204,680**	**207,313**	**2,633**
Surplus/(Deficit) Before Reserve	**(313)**	**(2,977)**	**(2,665)**
Reserve	1,000	–	(1,000)
Surplus/(Deficit)	**(1,313)**	**(2,977)**	**(1,665)**

[1] Interim represents the *2024 Budget* projection for the 2023–24 fiscal year.
Notes: Numbers may not add due to rounding. Interim and medium-term outlook primarily reflect information available as of February 28, 2024.
Sources: Ontario Treasury Board Secretariat and Ontario Ministry of Finance.

Revenue Update

The 2023–24 total revenue outlook is $204.3 billion — slightly lower than projected in the *2023 Budget*. Since the release of the most recent update as part of the *2023–24 Third Quarter Finances*, total revenue is projected to increase by $1.6 billion due to higher Taxation Revenue, Other Non-Tax Revenue and Net Income from Government Business Enterprises, after factoring in a decline in Government of Canada Transfers.

Table 3.3
Summary of 2023–24 Revenue Changes Since the *2023 Budget*

($ Millions)

		Interim[1] 2023–24
***2023 Budget* Total Revenue**		**204,367**
Revenue Changes in the *2023–24 First Quarter Finances*		**0.2**
Revenue Changes in the *2023 Ontario Economic Outlook and Fiscal Review*		**(2,566)**
Revenue Changes in the *2023–24 Third Quarter Finances*		**942**
Revenue Changes Since the *2023–24 Third Quarter Finances*		
Corporations Tax	2,410	
Electricity Payments in Lieu of Taxes	(9)	
Personal Income Tax	(1,281)	
Total Taxation Revenue		1,119
Government of Canada Transfers		(394)
Government Business Enterprises		475
Other Non-Tax Revenue		392
Total Revenue Changes Since the *2023–24 Third Quarter Finances*		**1,592**
Total Revenue Changes Since the *2023 Budget*		**(32)**
***2024 Budget* Total Revenue Outlook**		**204,336**

[1] Interim represents the *2024 Budget* projection for the 2023–24 fiscal year.
Notes: Numbers may not add due to rounding. Interim and medium-term outlook primarily reflect information available as of February 28, 2024.
Source: Ontario Ministry of Finance.

The forecast for **Total Taxation Revenue** has increased by $1,119 million compared to the *2023–24 Third Quarter Finances*. Key changes in the taxation revenue outlook include:

- **Corporations Tax** revenue projections increased by $2,410 million, mainly due to a stronger than expected corporate profit outlook than anticipated mid-way through 2023–24;
- **Electricity Payments in Lieu of Taxes (PILs)** revenue projections decreased by $9 million, reflecting a lower Municipal Electricity Utilities PILs forecast; and
- **Personal Income Tax** revenue projections decreased by $1,281 million, reflecting anticipated weaker taxable income growth for 2023.

Government of Canada Transfers projections decreased by $394 million, mainly due to a reprofiling of funding under the Canada-wide Early Learning and Child Care Agreement and Investing in Canada Infrastructure Program.

Net income from Government Business Enterprises projections increased by $475 million, due to a higher forecast for income from Ontario Power Generation (OPG) reflecting a revised consolidation adjustment under International Financial Reporting Standards (IFRS).

Other Non-Tax Revenues projections increased by $392 million, largely due to higher revenue resulting from recoveries of prior-year expenditures and updates from consolidated government organizations.

Expense Update

Since the release of the *2023 Budget*, the government has made targeted investments throughout the fiscal year to continue to make progress on *Ontario's Plan to Build* while also investing in critical public services. The 2023–24 total expense outlook is $207.3 billion, $2.6 billion higher than the *2023 Budget*.

Since the release of the most recent update as part of the *2023–24 Third Quarter Finances*, the total program expense projection has increased by $1.1 billion, primarily due to compensation costs and higher than forecasted ministry spending.

Table 3.4
Summary of 2023–24 Expense Changes Since the *2023 Budget*

($ Millions)

		Interim[1] 2023–24
***2023 Budget* Total Expense**		**204,680**
Total Expense Changes in the *2023–24 First Quarter Finances*		**0.2**
Total Expense Changes in the *2023 Ontario Economic Outlook and Fiscal Review*		**1,734**
Total Expense Changes in the *2023–24 Third Quarter Finances*		**(136)**
Program Expense Changes Since the *2023–24 Third Quarter Finances*		
Health Sector	1,581	
Education Sector[2]	1,881	
Postsecondary Education Sector	(116)	
Children, Community and Social Services Sector	44	
Justice Sector	638	
Other Programs	(2,945)	
Total Program Expense Changes Since the *2023–24 Third Quarter Finances*		**1,081**
Interest on Debt Change Since the *2023–24 Third Quarter Finances*		(46)
Total Expense Changes Since the *2023–24 Third Quarter Finances*		**1,035**
Total Expense Changes Since the *2023 Budget*		**2,633**
***2024 Budget* Total Expense Outlook**		**207,313**

[1] Interim represents the *2024 Budget* projection for the 2023–24 fiscal year.
[2] Excludes Teachers' Pension Plan. Teachers' Pension Plan expense is included in Other Programs.
Notes: Numbers may not add due to rounding. Interim and medium-term outlook primarily reflect information available as of February 28, 2024.
Sources: Ontario Treasury Board Secretariat and Ontario Ministry of Finance.

The following program expense changes are projected since the release of the *2023–24 Third Quarter Finances*:

- Health sector expense is projected to be $1,581 million higher, primarily to address pressures related to compensation costs, including Bill 124 remedy settlements, and other health services, such as utilization-driven programs like OHIP and the Ontario Public Drug Programs.
- Education sector expense is projected to be $1,881 million higher, mainly due to compensation costs, including Bill 124 remedy settlements and arbitration outcomes, and higher than forecasted school board spending.
- Postsecondary Education sector expense is projected to be $116 million lower, mainly due to updates to forecasted expense in the college sector.
- Children, Community and Social Services sector expense is projected to be $44 million higher, primarily due to investments in the Ontario Autism Program and compensation costs including Bill 124 remedy settlements.
- Justice sector expense is projected to be $638 million higher, primarily due to compensation costs including Bill 124 remedy settlements and investments related to essential service delivery in corrections, courts, and coroner and forensic pathology services.
- Other Programs expense is projected to be a net $2,945 million lower, primarily due to the following key changes:
  - $2,772 million drawdown of the Contingency Fund to offset increases in other sectors;
  - $377 million in lower than forecasted spending for the Ministry of Infrastructure, primarily due to revised implementation timelines for infrastructure projects, including the Investing in Canada Infrastructure Program and the Transit-Oriented Communities Program;
  - $118 million in lower than forecasted spending for the Ministry of Labour, Immigration, Training and Skills Development, mainly due to revised implementation timelines for the Skills Development Fund Capital Stream; and
  - $95 million higher than forecasted spending for the Ministry of Agriculture, Food and Rural Affairs, primarily due to higher uptake from the agricultural sector for demand-driven Business Risk Management programming, driven by various factors such as growing conditions.

Interest on debt expense is projected to be $46 million lower due to a lower projected deficit.

Prudence in 2023–24

The Contingency Fund is maintained to help mitigate expense risks that may adversely affect Ontario's fiscal performance. For the remainder of 2023–24, the Contingency Fund has a current remaining balance of $0.5 billion, which is available to offset additional expenses that may materialize before the end of the fiscal year.

The *2023 Budget* included a reserve of $1.0 billion in 2023–24, which was not required and has been drawn down to zero at interim.

Medium-Term Fiscal Plan

The government is projecting deficits of $9.8 billion in 2024–25, $4.6 billion in 2025–26, and a surplus of $0.5 billion in 2026–27. This outlook reflects the government's continuing investments in infrastructure, housing, economic development and key public services, while not raising taxes or fees.

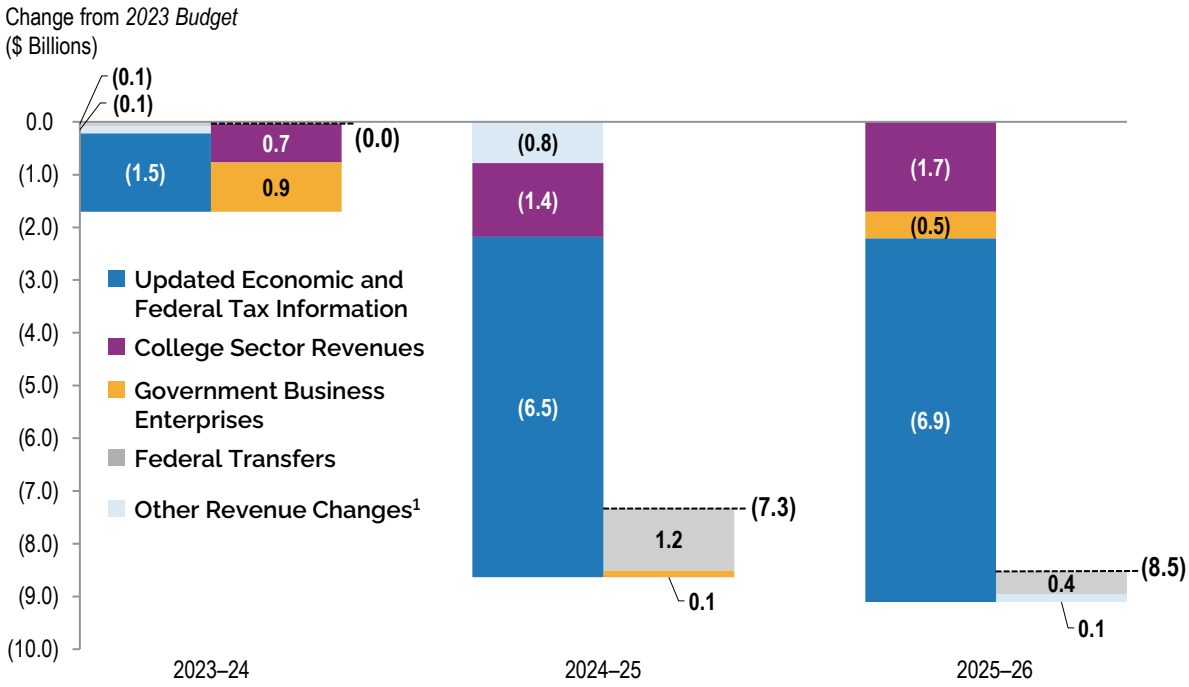
Defining the Medium-Term Outlook

Medium term represents the *2024 Budget* projection for the Plan year (2024–25), or current year, and the following two fiscal years (2025–26 and 2026–27).

Key Changes Since the *2023 Budget*

Since the *2023 Budget*, revenues have decreased by $7.3 billion in 2024–25 and $8.5 billion 2025–26. This is mainly reflecting lower actual tax assessment information from the federal government and slower economic growth over the outlook period. The financial results of colleges are consolidated into the province's financial statements. As a result of the federal government's cap on international student study permit applications for two years, a significant downward revision to Broader Public Sector Colleges revenue is also contributing to the decline in 2024–25 and beyond.

Chart 3.2
Sources of Revenue Changes Since the *2023 Budget*



[1] Other Revenue Changes mainly reflect the impact of extending the gasoline and fuel tax cut, changes in other Non-Tax Revenues excluding Broader Public Sector Colleges, Cannabis Tax, Education Property Tax, Electricity Payments-in-Lieu of Taxes and other miscellaneous taxes.
Source: Ontario Ministry of Finance.

The total expense outlook is projected to increase from $207.3 billion in 2023–24 to $220.6 billion in 2025–26. Total expense is projected to be higher than forecast at the time of the *2023 Budget* as a result of program expense increases, partially offset by interest on debt savings.

The program expense outlook is projected to be higher by $4.2 billion in 2024–25 and $3.4 billion in 2025–26, compared with the medium-term forecast in the *2023 Budget*. This increase reflects the government's commitment to strengthen communities through investments in health, education, infrastructure, and economic development as well as additional compensation-related costs.

Ontario's medium-term outlook for interest on debt is currently below the *2023 Budget* estimate by $0.5 billion in 2024–25 and $0.3 billion in 2025–26, primarily as a result of lower than projected borrowing costs.

The fiscal plan also includes a reserve of $1.0 billion in 2024–25, $1.5 billion in 2025–26 and $2.0 billion in 2026–27, which aligns with long-run historical reserve levels while maintaining a prudent and flexible fiscal plan.

Medium-Term Revenue Outlook

Total revenue is projected to increase from $204.3 billion in 2023–24 to $226.6 billion in 2026–27, for an average annual growth rate of 3.5 per cent. Revenue growth reflects the Ontario Ministry of Finance's outlook for economic growth and the key economic drivers that underpin the revenue forecast, which are based on private-sector forecasts.

Table 3.5

Summary of Medium-Term Revenue Outlook

($ Billions)

	Actual	Interim[1]	Medium-Term Outlook		
	2022–23	2023–24	2024–25	2025–26	2026–27
Revenue					
Personal Income Tax	44.2	50.6	51.9	55.1	58.3
Sales Tax	36.1	39.8	38.8	40.6	42.7
Corporations Tax	27.8	24.2	24.9	26.3	28.0
Ontario Health Premium	4.4	4.9	5.0	5.2	5.4
Education Property Tax	6.0	5.8	5.8	5.9	5.9
All Other Taxes	18.0	17.2	18.2	20.4	21.0
Total Taxation Revenue	**136.5**	**142.5**	**144.7**	**153.5**	**161.3**
Government of Canada	31.3	34.8	36.3	37.5	38.7
Income from Government Business Enterprises	6.1	7.3	6.8	8.0	7.8
Other Non-Tax Revenue	19.0	19.8	18.0	18.5	18.8
Total Revenue	**192.9**	**204.3**	**205.7**	**217.4**	**226.6**

[1] Interim represents the *2024 Budget* projection for the 2023–24 fiscal year.
Note: Numbers may not add due to rounding.
Source: Ontario Ministry of Finance.

The primary driver of the forecast for Personal Income Tax (PIT) revenues is the outlook for growth in compensation of employees. Personal Income Tax revenue is projected to grow at an average annual rate of 4.9 per cent between 2023–24 and 2026–27.

The forecast for Sales Tax (ST) revenue is driven by the projection for household consumption spending. Average growth in ST revenue is 2.4 per cent between 2023–24 and 2026–27.

The forecast for Corporations Tax (CT) revenue is driven by the projections of corporate profitability. Corporations Tax revenue is projected to grow at an average annual rate of 5.0 per cent between 2023–24 and 2026–27.

The primary driver of the forecast for Ontario Health Premium revenue is the outlook for growth in compensation of employees. Ontario Health Premium revenue is projected to grow at an average annual rate of 3.5 per cent between 2023–24 and 2026–27.

Education Property Tax revenue is based primarily on the outlook for growth in the property assessment base resulting from new construction activities.

Revenues from **All Other Taxes** are projected to increase at an average annual rate of 6.8 per cent between 2023–24 and 2026–27. This includes revenues from the Employer Health Tax; Land Transfer Tax; Beer, Wine and Spirits Taxes; and volume-based taxes such as the Gasoline Tax, Fuel Tax and Tobacco Tax.

The forecast for **Government of Canada Transfers** is largely based on existing federal–provincial funding agreements and formulas. Federal transfers are projected to increase at an average annual rate of 3.6 per cent between 2023–24 and 2026–27.

The outlook for **Income from Government Business Enterprises (GBEs)** is based on Ontario Ministry of Finance estimates of net income for Hydro One Ltd. (Hydro One) and projections provided by Ontario Power Generation (OPG), the Ontario Cannabis Store (OCS), the Liquor Control Board of Ontario (LCBO), the Ontario Lottery and Gaming Corporation (OLG) and iGaming Ontario (iGO). Net incomes of GBEs are projected to increase at an average annual rate of 2.2 per cent from 2023–24 to 2026–27.

The forecast for **Other Non-Tax Revenue** is based on projections provided by government ministries and agencies. The outlook for Other Non-Tax Revenue is projected to decline at an average annual rate of 1.7 per cent from 2023–24 to 2026–27, largely due to the decrease in third-party revenues from Broader Public Sector Colleges reflecting the federal government's cap on international student study permit applications for two years, beginning in 2024.

Risks to the Revenue Outlook

There are a variety of risks to the economic planning assumptions underlying the revenue forecast, as outlined in Chapter 2: *Economic Performance and Outlook*. Table 3.6 highlights some key risks and sensitivities to the 2024–25 revenue forecast that could arise from unexpected changes in economic conditions. These are only estimates; actual results can vary. The risks identified are based on factors that are considered to have the most material impact on the largest revenue sources.

Table 3.6

Selected Economic and Revenue Sensitivities

Economic Factors	Revenue Sources	2024–25 Sensitivities
Nominal GDP	Total Taxation Revenue	$1,080 million revenue change for each percentage point change in nominal GDP growth. This can vary significantly, depending on the composition and source of changes in GDP growth.
Compensation of Employees	Personal Income Tax; Ontario Health Premium; and Employer Health Tax	$723 million revenue change for each percentage point change in growth in compensation of employees.
Household Consumption Expenditures	Sales Tax	$282 million revenue change for each percentage point change in growth of household consumption expenditures.
Net Operating Surplus of Corporations	Corporations Tax	$228 million revenue change for each percentage point change in growth in net operating surplus of corporations.
Housing Resales and Resale Prices	Land Transfer Tax	$37 million revenue change for each percentage point change in growth of either housing resales or resale prices.
Ontario Population Share	Canada Health Transfer	$52 million revenue change for each one-tenth of a percentage point change in Ontario's population share.
Ontario Population Share	Canada Social Transfer	$17 million revenue change for each one-tenth of a percentage point change in Ontario's population share.

Source: Ontario Ministry of Finance.

Economic and Fiscal Outlook Scenarios

To illustrate the potential impacts of elevated economic uncertainty, the Ontario Ministry of Finance has developed two alternative scenarios that the economy could take over the next several years (see Chapter 2: *Economic Performance and Outlook* for more details). Based on the two alternative nominal GDP growth economic scenarios, two taxation revenue outlook scenarios were developed. The Faster Growth and Slower Growth scenarios each represent a potential path intended to illustrate a broader range of possible outcomes depending on the pace of economic growth, but neither should be considered as the best case or the worst case.

Table 3.7

Ontario's Taxation Revenue Scenarios

($ Billions)

	2024–25p	2025–26p	2026–27p
Faster Growth Scenario	148.4	159.7	170.0
Planning Projection	**144.7**	**153.5**	**161.3**
Slower Growth Scenario	141.3	147.9	153.9

p = Ontario Ministry of Finance Planning Projection and alternative scenarios based on external sources as of January 25, 2024.
Note: Numbers may not add due to rounding.
Source: Ontario Ministry of Finance.

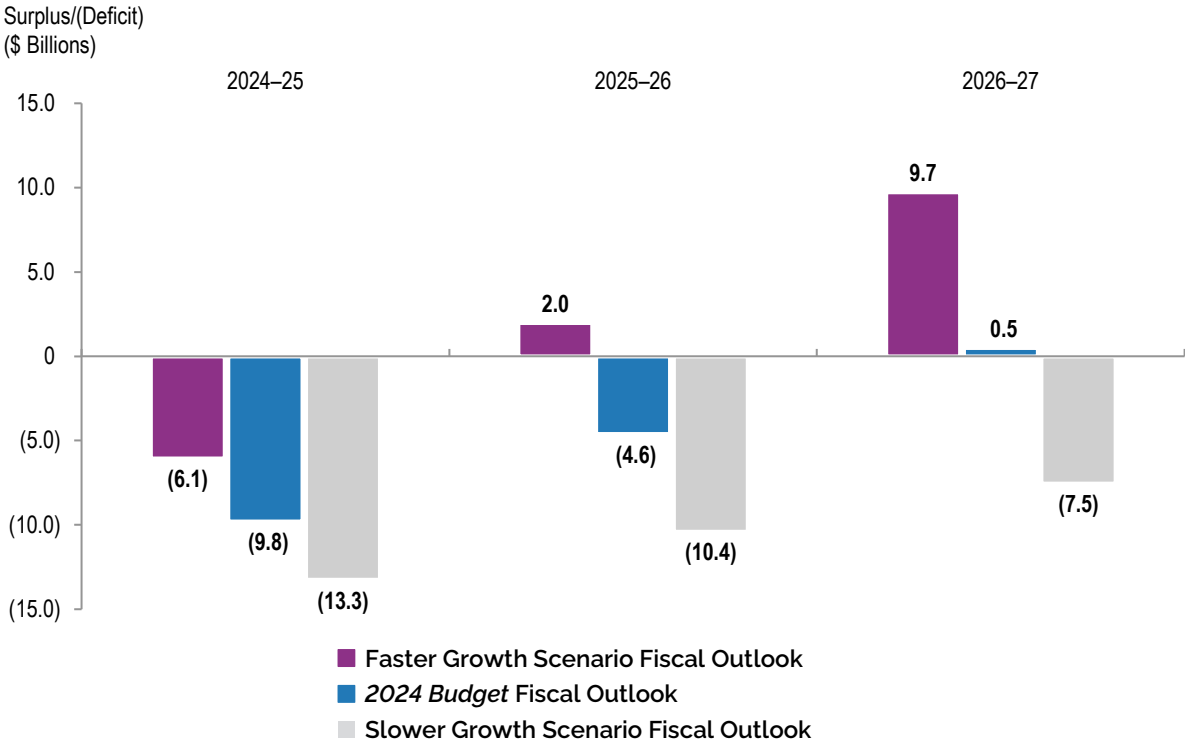
In the Faster Growth scenario, total taxation revenue over the medium term is $8.7 billion higher in 2026–27 than the Planning Projection, while in the Slower Growth scenario, total taxation revenue is $7.4 billion lower.

In the event that the alternative economic scenarios materialize, as opposed to the Planning Projection, Ontario's fiscal plan would also change as a result.

Under the Faster Growth scenario, the deficit outlook would improve to $6.1 billion in 2024–25, followed by surpluses of $2.0 billion in 2025–26 and $9.7 billion in 2026–27. However, if the Slower Growth scenario materializes, the deficit outlook would deteriorate to $13.3 billion in 2024–25, $10.4 billion in 2025–26 and $7.5 billion in 2026–27.

Chart 3.3

Ontario Fiscal Outlook Scenarios



Source: Ontario Ministry of Finance.

In these alternative outlook scenarios, program expenses are assumed to be unchanged compared to the medium-term expense outlook and only revenue and interest on debt are adjusted.

Medium-Term Expense Outlook

The government is committed to strengthening communities through investments in health care, education, infrastructure, and economic development. The total expense outlook is projected to grow from $207.3 billion in 2023–24 to $224.1 billion in 2026–27.

The government continues to invest in programs that serve the people of Ontario. Ontario's program expense outlook is projected to grow from $194.5 billion in 2023–24 to $208.9 billion in 2026–27 for an average annual growth rate of 2.4 per cent. This also reflects additional compensation-related costs.

Table 3.8
Summary of Medium-Term Expense Outlook

($ Billions)

	Actual	Interim[1]	Medium-Term Outlook		
	2022–23	2023–24	2024–25	2025–26	2026–27
Base Programs[2]					
Health Sector	75.1	84.5	85.0	88.0	89.9
Education Sector[3]	33.6	36.6	37.6	38.8	39.4
Postsecondary Education Sector	11.7	12.6	12.2	12.5	13.0
Children, Community and Social Services Sector	18.0	19.4	19.9	20.1	20.1
Justice Sector	5.3	6.1	5.9	5.6	5.6
Other Programs	30.1	35.3	40.0	40.9	40.9
Total Base Programs	**173.8**	**194.5**	**200.6**	**205.8**	**208.9**
COVID-19 Time-Limited Funding	6.3	–	–	–	–
Other One-Time Expenses	6.3	–	–	–	–
Total Programs	**186.4**	**194.5**	**200.6**	**205.8**	**208.9**
Interest on Debt	12.4	12.8	13.9	14.7	15.2
Total Expense	**198.8**	**207.3**	**214.5**	**220.6**	**224.1**

[1] Interim represents the *2024 Budget* projection for the 2023–24 fiscal year.
[2] For presentation purposes in the *2024 Budget*, one-time COVID-19-related spending in 2022–23 has been included within COVID-19 Time-Limited Funding. This funding is no longer reported separately, starting 2023–24.
[3] Excludes Teachers' Pension Plan. Teachers' Pension Plan expense is included in Other Programs.
Note: Numbers may not add due to rounding.
Sources: Ontario Treasury Board Secretariat and Ontario Ministry of Finance.

Highlights of the changes to the program expense outlook over the medium term include the following:

- Health sector expense is projected to increase from $84.5 billion in 2023–24 to $89.9 billion in 2026–27. The growth is primarily due to investments to:
  - Address the growing demands in the health sector, including funding for hospitals and cancer treatment services to respond to Ontario's aging and growing population;
  - Support health human resources initiatives to optimize the existing workforce and recruit and retain health care providers;
  - Improve and transform the home and community care sector;

  - Improve quality of care in the long-term care sector; and
  - Support mental health and addictions services through the *Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System*.

- Education sector expense is projected to increase from $36.6 billion in 2023–24 to $39.4 billion in 2026–27. Key investments include:
  - Funding to address enrolment growth and support student achievement, including through Ontario's back to basics learning strategy on reading and math;
  - Continued implementation of the Canada-wide Early Learning and Child Care Agreement to increase access to high-quality affordable child care while reducing average out-of-pocket child care fees; and
  - Supporting commitments consistent with labour agreements reached.

- Postsecondary Education sector expense is projected to increase from $12.6 billion in 2023–24 to $13.0 billion in 2026–27. This is mainly due to:
  - Increased supports to institutions of $903 million to strengthen postsecondary education in Ontario, including implementing a Postsecondary Education Sustainability Fund to help address immediate financial sustainability challenges;
  - Investments of over $485 million to support Health Human Resources initiatives, including the ongoing expansion of nursing and medical school seats and the Ontario Learn and Stay Grant where students in targeted nursing, paramedic and medical laboratory technologist programs study and work in underserviced communities; and
  - Lower forecasted college sector spending, primarily as a result of the federal government announcement to cap international student study permit applications for two years, beginning in 2024.

- Children, Community and Social Services sector expense is projected to increase from $19.4 billion in 2023–24 to $20.1 billion in 2026–27. This is mainly due to:
  - $310 million over three years to address increasing operational costs for community organizations that support vulnerable populations, including children in care and those with special needs, people with developmental disabilities, and people who have experienced gender-based violence and human trafficking; and
  - Annual inflation adjustments to core allowances for the Ontario Disability Support Program and the maximum monthly amount for the Assistance for Children with Severe Disabilities Program, which started in July 2023.

- **Justice sector expense** is projected to decrease from $6.1 billion in 2023–24 to $5.6 billion in 2026–27. Investments in the sector include:
  - One-time funding in 2023–24 for compensation costs, including Bill 124 remedy settlements in the Justice sector;
  - Funding provided in 2023–24 to support essential service delivery in corrections, coroner and forensic pathology services, as well as courts and animal welfare services; and
  - Continuing investments in the Justice sector to protect public safety such as the Guns, Gangs and Violence Reduction Strategy, air support equipment, initiatives to fight auto theft, and the expansion of the Basic Constable Training Program including the elimination of its tuition fees.
- **Other Programs expense** is projected to increase from $35.3 billion in 2023–24 to $40.9 billion in 2026–27. Key changes include:
  - $3.3 billion over three years, beginning in 2024–25, as part of the government's multi-year commitment to provide access to high-speed internet for every community across Ontario by the end of 2025;
  - $2.8 billion over three years, beginning in 2024–25, for strategic investments in industrial support and land development, including Ontario's auto manufacturing sector and electric vehicle battery production;
  - $1.8 billion over three years, beginning in 2024–25, to help build municipal housing-enabling infrastructure projects through the $1.0 billion new Municipal Housing Infrastructure Program and the enhanced $825 million Housing-Enabling Water Systems Fund; and
  - $200 million over three years, beginning in 2024–25, for the new Community Sport and Recreation Infrastructure Fund to support new facilities and revitalize existing venues for youth and families, while creating good local jobs and supporting economic growth.

The total expense outlook includes **Interest on Debt** expense, which is projected to increase from $12.8 billion in 2023–24 to $15.2 billion in 2026–27.

Building on the Federal–Provincial Partnership

Governments work best when they work together. In the past year, Ontario and the federal government have made important progress to build Ontario and Canada. Working together, Ontario and the federal government secured major investments across Ontario's electric vehicle (EV) supply chain and are helping to spur new purpose-built rental housing in Ontario by removing the harmonized sales tax (HST) to support construction. In addition, the federal government has built on the investments Ontario is making to support asylum seekers and provide connected and convenient health care for the people of Ontario.

Going forward, there are more opportunities for collaborative action in building a stronger Ontario. These include joining the Ontario government to support housing-enabling infrastructure, going further to support cities, and growing Ontario's end-to-end electric vehicle supply chain. As Ontario continues to secure its position as a global leader of responsibly sourced critical minerals, it is important that the federal government supports Ontario through funding and expedited approval processes for all infrastructure that will enable the development of the Ring of Fire.

Ontario is also committed to working with the federal government, provinces and territories on improving Canada's competitiveness. This includes working together to support skills training for the people of Ontario through the Labour Market Transfer Agreements, which must be modernized and, as a start, maintained at current levels of funding. Effective federal–provincial transfers are also a key component of ensuring sustainable public services and building a stronger Ontario. Building on the recent federal agreements and the initial down payment on health care funding, ensuring adequate, flexible and fair funding through the Canada Health Transfer will continue to be a critical priority. The review mechanisms built into recent agreements lay the groundwork to ensure that they truly reflect the costs and pressures facing Ontario, while helping deliver on shared objectives.

Canada shares a unique economic relationship with the United States, as our closest trading partner, and the largest economy in the world. Ontario remains vigilant in protecting the province's interests, workers, jobs and investments. Ontario will continue to work both with the federal government and on its own initiative to seek opportunities for increased trade and collaboration through Memoranda of Understanding with key U.S. states on trade and procurement, building supply chains for electric vehicles (EVs), and supporting the Canada–U.S. Joint Action Plan on Critical Minerals Collaboration. It is also imperative that the federal government continue to partner with Ontario to attract strategic EV investments.

Prudence Built into the Medium-Term Outlook

In keeping with sound fiscal planning practices, Ontario's revenue outlook is based on prudent economic planning projections, as discussed in Chapter 2: *Economic Performance and Outlook*. Three external economic experts reviewed the Ontario Ministry of Finance's economic assumptions and found them to be reasonable.[1]

The government maintains a responsible and flexible fiscal plan to respond to uncertainty and risks. Ontario incorporates prudence in the form of a reserve to protect the fiscal outlook against unforeseen adverse changes in Ontario's revenue and expense, including those resulting from changes in Ontario's economic performance.

In addition, the Contingency Fund is maintained to help mitigate expense risks that may adversely affect Ontario's fiscal performance. The Contingency Fund in 2024–25 is set at $1.5 billion and increases further through the remainder of the medium-term outlook, reflecting the government's prudent and responsible fiscal planning.

The reserve has been set at $1.0 billion in 2024–25, $1.5 billion in 2025–26 and $2.0 billion in 2026–27. This reflects Ontario's commitment to maintaining a prudent and flexible fiscal plan.

Risks to the Expense Outlook

Table 3.9 provides a summary of key expense risks and sensitivities that could result from unexpected changes in economic conditions and program demands. A change in these factors could affect total expense and the public sector, causing variances in the overall fiscal forecast. These sensitivities illustrate possible effects on the government's key programs and can vary, depending on the nature and composition of potential risks.

[1] The three experts are from the Policy and Economic Analysis Program at the University of Toronto; Quantitative Economic Decisions, Inc. (QEDinc.); and Stokes Economics Consulting, Inc.

Table 3.9

Selected Expense Sensitivities

Program/Sector	2024–25 Assumption	2024–25 Sensitivities
Hospital[1]	Annual growth of 4.0 per cent.	One per cent change in hospital costs: $249.3 million.
Home Care[2]	Approximately 39.8 million hours of personal support services.	One per cent change in hours of personal support services: approximately $19.5 million.
	Approximately 9.8 million nursing and therapy visits and 1.3 million nursing shifts.	One per cent change in all nursing and therapy visits: approximately $12.8 million.
Elementary and Secondary Schools	Approximately 2.066 million average daily pupil enrolment.	One per cent enrolment change: approximately $176 million.
Ontario Works	263,748 average annual caseload.	One per cent caseload change: approximately $30 million.
Ontario Disability Support Program	376,462 average annual caseload.	One per cent caseload change: approximately $63 million.
Interest on Debt	Average cost of borrowing in 2024–25 is forecast to be 4.0 per cent.	In the first full year, the impact of a 100 basis-point change in borrowing rates: approximately $700 million.

[1] Hospital costs are based on hospital operating transfer payments and exclude one-time funding, consolidations and arbitrated wage settlements.
[2] Home Care statistics are based on a combination of 2022–23 and 2023–24 data and estimates.
Sources: Ontario Treasury Board Secretariat and Ontario Ministry of Finance.

Transparency and Risks

The government continues to be transparent about the state of Ontario's finances. This principle is reflected in the *Fiscal Sustainability, Transparency and Accountability Act, 2019*, which stipulates that Ontario's fiscal policy should be clearly articulated and information about it should be readily available to the public without charge.

To ensure a reasonable and prudent economic forecast, the government's key economic planning projections are set below the average of private-sector forecasts in each year. While the planning assumptions for economic growth are reasonable and prudent, the Ontario Ministry of Finance has also developed Faster Growth and Slower Growth scenarios to provide greater transparency around a broader range of possible outcomes depending on the pace of Ontario's economic growth amid heightened economic uncertainty.

As a matter of transparent fiscal management, financial pressures are monitored throughout the fiscal year with the goal of ensuring value for taxpayer dollars through the use of robust and prudent methodologies to develop forecasts. Other important risk management tools include closely tracking the pace of implementation of initiatives and proactively identifying emerging program and policy risks. Comprehensive analysis of known pressures informs the fiscal planning processes, including the development of plans to mitigate and manage fiscal pressures, as well as maintaining adequate contingencies as part of the medium-term fiscal projections. The fiscal plan also incorporates the impact of the Bill 124 court decision on compensation-related costs.

In addition to the key demand sensitivities and economic risks to the fiscal plan, there are risks stemming from the government's contingent liabilities. Whether future events will result in actual liabilities for Ontario is beyond the direct control of the government. For example, losses could result from legal settlements, a call on a loan or funding guarantees. While a Contingency Fund is included in the fiscal plan to help mitigate expense risks, until there exists certainty around the likelihood and costs of these future events, these risks are not included in the government's fiscal plan. Provisions for losses that are likely to occur and can be reasonably estimated are expensed and reported as liabilities in Ontario's financial statements. Any significant contingent liabilities related to the 2023–24 fiscal year will be disclosed as part of the *Public Accounts of Ontario 2023–2024*, to be released no later than September 27, 2024.

Details of Ontario's Finances

Table 3.10

Total Revenue

($ Millions)

	Actual 2021–22	Actual 2022–23	Interim[1] 2023–24	Plan 2024–25
Taxation Revenue				
Personal Income Tax	46,750	44,209	50,593	51,936
Sales Taxes	30,357	36,092	39,762	38,832
Corporations Tax	25,227	27,791	24,179	24,915
Education Property Tax	5,713	5,991	5,755	5,831
Employer Health Tax	7,223	7,797	8,364	8,720
Ontario Health Premium	4,414	4,445	4,918	5,014
Gasoline Tax	2,202	2,103	1,664	1,953
Land Transfer Tax	5,827	4,443	3,739	3,881
Tobacco Tax	927	864	827	771
Fuel Tax	771	571	499	623
Beer, Wine and Spirits Taxes	624	600	599	576
Electricity Payments in Lieu of Taxes	666	674	535	536
Ontario Portion of the Federal Cannabis Excise Duty	215	310	344	379
Other Taxes	759	627	673	720
	131,675	**136,518**	**142,452**	**144,687**
Government of Canada				
Canada Health Transfer	16,731	17,525	19,277	20,256
Canada Social Transfer	6,003	6,178	6,404	6,576
Equalization	–	–	421	576
Infrastructure Programs	562	769	1,075	1,185
Labour Market Programs	1,476	1,181	1,148	904
Social Housing Agreement	305	263	218	174
Other Federal Payments	5,091	4,817	5,739	6,098
Direct Transfers to Broader Public Sector Organizations	439	530	481	482
	30,607	**31,264**	**34,764**	**36,252**
Income from Government Business Enterprises				
Liquor Control Board of Ontario	2,543	2,457	2,546	2,450
Ontario Power Generation Inc./Hydro One Ltd.	2,151	850	1,973	1,314
Ontario Lottery and Gaming Corporation	1,561	2,505	2,351	2,623
Ontario Cannabis Store	186	234	242	225
iGaming Ontario	–	87	162	174
	6,441	**6,133**	**7,274**	**6,786**

continued…

Table 3.10

Total Revenue (continued)

($ Millions)

	Actual 2021–22	Actual 2022–23	Interim[1] 2023–24	Plan 2024–25
Other Non-Tax Revenue				
Fees, Donations and Other Revenues from Hospitals, School Boards and Colleges	9,688	11,492	11,737	10,239
Vehicle and Driver Registration Fees[2]	33	1,251	1,190	1,181
Miscellaneous Other Non-Tax Revenue	2,628	2,149	2,392	2,000
Other Fees and Licences	1,237	1,438	1,698	1,657
Sales and Rentals	1,046	1,227	1,388	1,546
Reimbursements	1,233	1,031	1,112	1,002
Royalties	468	335	289	295
Power Supply Contract Recoveries	67	48	39	44
Net Reduction of Power Purchase Contracts	5	–	–	–
	16,405	**18,972**	**19,845**	**17,965**
Total Revenue	**185,128**	**192,887**	**204,336**	**205,690**

[1] Interim represents the *2024 Budget* projection for the 2023–24 fiscal year.

[2] Vehicle and Driver Registration Fees in 2021–22 reflect the elimination and rebate of eligible licence plate renewal fees paid since March 1, 2020.

Note: Numbers may not add due to rounding.

Source: Ontario Ministry of Finance.

Table 3.11

Total Expense[1,2]

($ Millions)

Ministry Expense	Actual 2021–22	Actual 2022–23	Interim[3] 2023–24	Plan 2024–25
Agriculture, Food and Rural Affairs (Base)	284	300	352	378.2
Demand-Driven Risk Management and Time-Limited Programs	358	502	577	477.5
COVID-19 Time-Limited Funding[4]	32	30	–	–
Agriculture, Food and Rural Affairs (Total)	**674**	**832**	**929**	**855.7**
Attorney General (Base)	1,615	1,783	1,950	1,960.5
Statutory Appropriations — *Crown Liability and Proceedings Act, 2019*	49	79	36	–
Bad Debt Expense	7	30	25	5.3
Compensation Settlements	–	–	81	–
COVID-19 Time-Limited Funding[4]	145	31	–	–
Attorney General (Total)	**1,816**	**1,923**	**2,092**	**1,965.8**
Board of Internal Economy (Base)	283	392	321	320.4
COVID-19 Time-Limited Funding[4]	2	0	–	–
Board of Internal Economy (Total)	**284**	**392**	**321**	**320.4**
Children, Community and Social Services (Base)	16,717	17,991	19,438	19,925.7
COVID-19 Time-Limited Funding[4]	293	48	–	–
Children, Community and Social Services (Total)	**17,010**	**18,039**	**19,438**	**19,925.7**
Citizenship and Multiculturalism (Base)	33	54	70	70.7
Time-Limited Investments	–	–	21	–
COVID-19 Time-Limited Funding[4]	3	2	–	–
Citizenship and Multiculturalism (Total)	**36**	**56**	**90**	**70.7**
Colleges and Universities (Base)[5]	9,542	10,714	11,244	10,818.8
Student Financial Assistance	954	1,019	1,332	1,370.3
COVID-19 Time-Limited Funding[4]	117	32	–	–
Colleges and Universities (Total)	**10,614**	**11,764**	**12,576**	**12,189.1**
Economic Development, Job Creation and Trade (Base)	164	167	189	193.0
Tax Credits for Business Investment and Research and Development[6]	258	299	537	550.9
Tax Credits for Business Investment and Research and Development — Amounts Related to Prior Years	46	22	18	–
Time-Limited Investments	157	540	609	1,935.6
COVID-19 Time-Limited Funding[4]	360	46	–	–
Economic Development, Job Creation and Trade (Total)	**985**	**1,074**	**1,352**	**2,679.5**
Education (Base)	28,893	32,357	35,063	37,605.6
Teachers' Pension Plan	1,610	1,661	1,653	1,700.0
Compensation Settlements	–	1,266	1,532	–
COVID-19 Time-Limited Funding[4]	1,060	918	–	–
Education (Total)	**31,563**	**36,202**	**38,248**	**39,305.6**
Energy (Base)	240	254	329	316.7
Electricity Cost-Relief Programs	6,313	5,844	6,120	7,336.1
COVID-19 Time-Limited Funding[4]	274	2	–	–
Energy (Total)	**6,827**	**6,100**	**6,448**	**7,652.9**
Environment, Conservation and Parks (Base)	687	727	835	860.4
One-Time Accounting Adjustment for Contaminated Sites	–	–	80	–
COVID-19 Time-Limited Funding[4]	16	17	–	–
Environment, Conservation and Parks (Total)	**703**	**743**	**915**	**860.4**

continued…

Table 3.11

Total Expense[1,2] (continued)

($ Millions)

Ministry Expense	Actual 2021–22	Actual 2022–23	Interim[3] 2023–24	Plan 2024–25
Executive Offices (Base)	49	55	68	66.8
COVID-19 Time-Limited Funding[4]	2	0	–	–
Executive Offices (Total)	**51**	**55**	**68**	**66.8**
Finance (Base)	759	799	906	969.3
Investment Management Corporation of Ontario[7]	210	245	296	312.7
Ontario Municipal Partnership Fund	502	501	502	501.9
Temporary and Other Local Assistance	21	21	68	41.0
Power Supply Contract Costs	67	48	39	43.7
Time-Limited Investments	–	174	119	–
COVID-19 Time-Limited Funding[4]	231	0	–	–
Finance (Total)	**1,789**	**1,789**	**1,930**	**1,868.6**
Francophone Affairs (Base)	7	7	8	8.6
Time-Limited Investments	–	1	–	4.7
COVID-19 Time-Limited Funding[4]	2	–	–	–
Francophone Affairs (Total)	**9**	**8**	**8**	**13.3**
Health (Base)	64,285	67,872	74,638	75,636.4
Compensation Settlements	–	970	2,080	–
Health (Total)[8]	**64,285**	**68,842**	**76,717**	**75,636.4**
COVID-19 Health Response[9]	**6,167**	**3,331**	**–**	**–**
Indigenous Affairs (Base)	85	111	134	137.0
One-Time Investments Including Settlements	152	6,273	17	–
COVID-19 Time-Limited Funding[4]	4	1	–	–
Indigenous Affairs (Total)	**241**	**6,384**	**151**	**137.0**
Infrastructure (Base)	192	170	454	856.0
Federal–Provincial Infrastructure Programs	267	303	366	414.5
High-Speed Internet	75	328	316	1,376.9
Waterfront Toronto Revitalization (Port Lands Flood Protection)	156	25	25	30.2
Municipal Infrastructure Program Investments	399	396	393	672.1
Realty	1,174	1,195	1,198	1,340.8
COVID-19 Time-Limited Funding[4]	10	–	–	–
Infrastructure (Total)	**2,272**	**2,416**	**2,753**	**4,690.5**
Labour, Immigration, Training and Skills Development (Base)	102	202	248	256.1
Training Tax Credits (Co-operative Education and Apprenticeship Training)[10]	105	86	116	113.9
Demand-Driven Employment and Training Programs	1,016	1,269	1,294	1,268.3
Time-Limited Investments	–	–	13	–
COVID-19 Time-Limited Funding[4]	794	310	–	–
Labour, Immigration, Training and Skills Development (Total)	**2,017**	**1,866**	**1,670**	**1,638.3**
Long-Term Care (Total)[11]	**5,301**	**6,305**	**7,750**	**9,324.6**
Mines (Base)	135	147	191	209.1
One-Time Accounting Adjustment for Contaminated Sites	183	86	334	–
Mines (Total)	**318**	**233**	**525**	**209.1**

continued…

Table 3.11

Total Expense[1,2] (continued)

($ Millions)

Ministry Expense	Actual 2021–22	Actual 2022–23	Interim[3] 2023–24	Plan 2024–25
Municipal Affairs and Housing (Base)	486	564	779	785.0
Time-Limited Investments	351	404	764	1,099.4
Social Housing Agreement — Payments to Service Managers[12]	281	206	194	168.8
COVID-19 Time-Limited Funding[4]	330	390	–	–
Municipal Affairs and Housing (Total)	**1,447**	**1,563**	**1,738**	**2,053.2**
Natural Resources and Forestry (Base)	605	613	666	680.2
Emergency Forest Firefighting	237	95	216	135.0
Compensation Settlements	–	–	26	–
COVID-19 Time-Limited Funding[4]	12	2	–	–
Natural Resources and Forestry (Total)	**855**	**710**	**907**	**815.1**
Northern Development (Base)	605	661	719	762.3
COVID-19 Time-Limited Funding[4]	41	–	–	–
Northern Development (Total)	**646**	**661**	**719**	**762.3**
Public and Business Service Delivery (Base)[13]	613	963	1,131	743.0
COVID-19 Time-Limited Funding[4]	141	201	–	–
Public and Business Service Delivery (Total)	**754**	**1,165**	**1,131**	**743.0**
Seniors and Accessibility (Base)	53	63	65	66.3
Seniors Tax Credits (Home Safety and Care at Home)	30	164	108	119.4
COVID-19 Time-Limited Funding[4]	43	11	–	–
Seniors and Accessibility (Total)	**127**	**237**	**173**	**185.6**
Solicitor General (Base)	2,981	3,375	3,765	3,912.6
Compensation Settlements	–	–	233	–
COVID-19 Time-Limited Funding[4]	150	96	–	–
Solicitor General (Total)	**3,131**	**3,472**	**3,998**	**3,912.6**
Tourism, Culture and Sport (Base)	833	829	840	870.2
Time-Limited Investments	–	–	–	50.0
Ontario Cultural Media Tax Credits	693	833	841	1,034.4
Ontario Cultural Media Tax Credits — Amounts Related to Prior Years	84	51	89	–
COVID-19 Time-Limited Funding[4]	257	200	–	–
Tourism, Culture and Sport (Total)	**1,868**	**1,913**	**1,770**	**1,954.7**
Transportation (Base)	4,854	5,547	6,388	6,390.4
Federal–Provincial Infrastructure Programs	557	477	743	708.4
Time-Limited Investments	–	–	729	–
Compensation Settlements	–	–	25	–
COVID-19 Time-Limited Funding[4]	369	609	–	–
Transportation (Total)	**5,780**	**6,633**	**7,885**	**7,098.7**

continued…

Table 3.11

Total Expense[1,2] (continued)

($ Millions)

Ministry Expense	Actual 2021–22	Actual 2022–23	Interim[3] 2023–24	Plan 2024–25
Treasury Board Secretariat (Base)[13]	315	476	633	918.1
Employee and Pensioner Benefits	2,633	1,178	1,035	1,223.5
Operating Contingency Fund	–	–	500	1,405.4
Capital Contingency Fund	–	–	–	100.0
COVID-19 Time-Limited Funding[4]	2	0	–	–
Treasury Board Secretariat (Total)	**2,950**	**1,654**	**2,168**	**3,647.0**
Interest on Debt[14]	**12,583**	**12,389**	**12,843**	**13,913.0**
Total Expense	**183,103**	**198,750**	**207,313**	**214,495.9**

1 Numbers reflect current ministry structure.

2 Ministry expenses have been restated for reclassification and program transfer changes. These changes are fiscally neutral. The actual results are presented on a similar basis for consistency.

3 Interim represents the *2024 Budget* projection for the 2023–24 fiscal year.

4 COVID-19 Time-Limited Funding is no longer reported separately, starting in 2023–24.

5 Projected to decline from 2023–24 to 2024–25 primarily due to lower college spending as a result of the federal government announcement to cap international student study permit applications for two years, beginning in 2024.

6 Includes the estimated cost of tax credit claims for the Regional Opportunities Investment Tax Credit, the Ontario Made Manufacturing Investment Tax Credit (OMMITC), the Ontario Innovation Tax Credit and the Ontario Business-Research Institute Tax Credit. The OMMITC was introduced in the *2023 Budget* with costs commencing in 2023–24.

7 Based on the requirements of Public Sector Accounting Standards, the Ontario government consolidates the financial results of the Investment Management Corporation of Ontario.

8 Includes accounting adjustments tied primarily to grants provided for infrastructure projects and other related investments.

9 For presentation purposes in the *2024 Budget*, Time-Limited COVID-19-related health response spending has been included separately for 2021–22 to 2022–23 instead of within the Ontario Ministry of Health and Ontario Ministry of Long-Term Care.

10 The Co-operative Education Tax Credit remains in effect. The Apprenticeship Training Tax Credit is eliminated for eligible apprenticeship programs that commenced on or after November 15, 2017. Amounts from 2021–22 to 2023–24 include tax credit amounts related to prior years; however, a decrease in costs of $18 million for the Apprenticeship Training Tax Credit in 2022–23 was reported separately as revenue.

11 The Ontario Ministry of Long-Term Care total includes expenses incurred by Ontario Health and hospitals for funding for long-term care. These amounts will be consolidated in the total expense of the Ontario Ministry of Health, including $4.4 billion for interim 2023–24 and $5.2 billion in 2024–25.

12 The annual decline from 2021–22 to 2023–24 is mainly due to declining federal obligations, such as maturing mortgages, under the Social Housing Agreement.

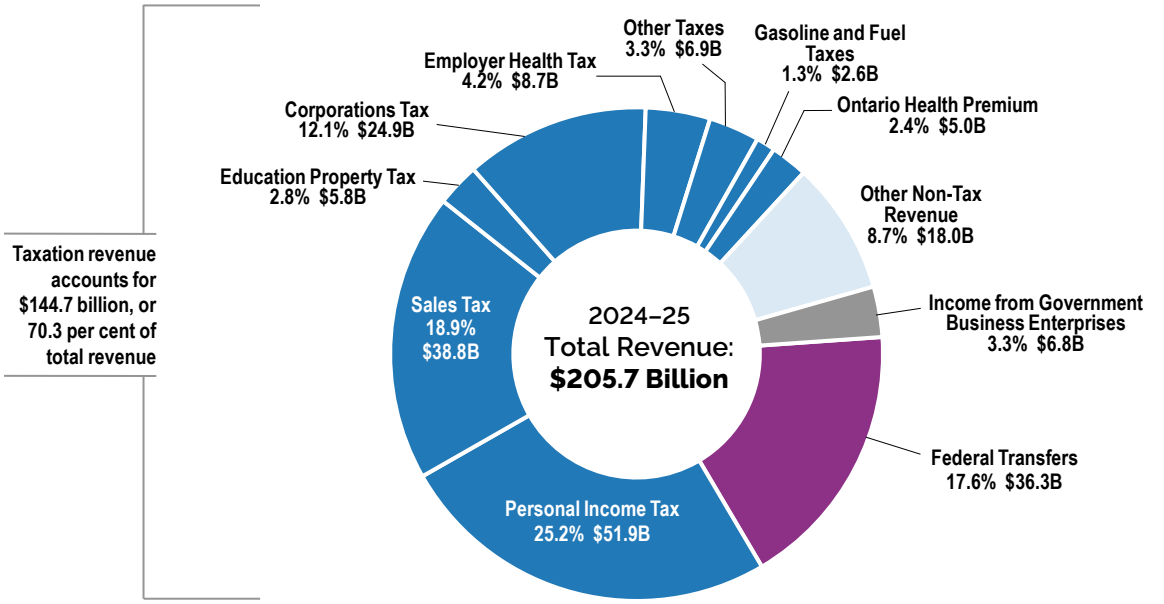
13 Funding for Supply Ontario will transfer from the Ministry of Public and Business Service Delivery to Treasury Board Secretariat as of April 1, 2024, to reflect ministerial responsibility for oversight of the provincial agency.

14 Interest on debt is net of interest capitalized during construction of tangible capital assets of $321 million in 2021–22, $694 million in 2022–23, $573 million in 2023–24 and $865 million in 2024–25.

Note: Numbers may not add due to rounding.

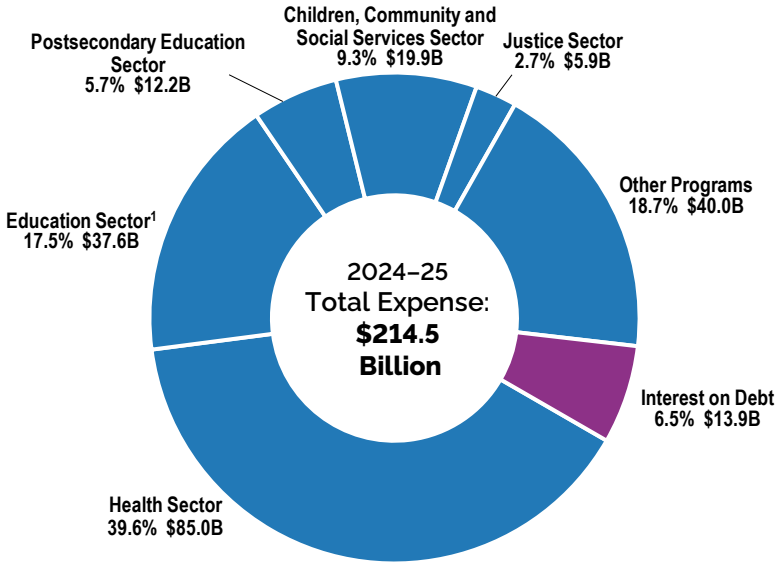
Sources: Ontario Treasury Board Secretariat and Ontario Ministry of Finance.

Chart 3.4
Composition of Total Revenue, 2024–25



Note: Numbers may not add due to rounding.
Source: Ontario Ministry of Finance.

Chart 3.5
Composition of Total Expense, 2024–25



[1] Excludes Teachers' Pension Plan. Teachers' Pension Plan expense is included in Other Programs.
Note: Numbers may not add due to rounding.
Sources: Ontario Treasury Board Secretariat and Ontario Ministry of Finance.

Table 3.12

Infrastructure Expenditures

($ Millions)

Sector	Total Infrastructure Expenditures Interim[1,2] 2023–24	2024–25 Plan		
		Investment in Capital Assets[3]	Transfers and Other Infrastructure Expenditures[4]	Total Infrastructure Expenditures
Transportation				
Transit	8,638	9,535	1,160	10,695
Provincial Highways	3,285	3,649	222	3,872
Other Transportation, Property and Planning	188	137	81	218
Health				
Hospitals	3,348	3,545	37	3,582
Other Health	640	47	255	303
Education	3,316	3,127	223	3,350
Postsecondary Education				
Colleges and Other	765	792	87	879
Universities	113	–	130	130
Social	435	26	949	975
Justice	514	860	48	908
Other Sectors[5]	2,874	1,089	3,219	4,307
Total Infrastructure Expenditures	**24,117**	**22,808**	**6,412**	**29,220**
Less: Other Partner Funding[6]	3,176	2,972	–	2,972
Total[7]	**20,941**	**19,836**	**6,412**	**26,248**

1 Interim represents the *2024 Budget* projection for the 2023–24 fiscal year.
2 Includes provincial investment in capital assets of $14.7 billion.
3 Includes $865 million in interest capitalized during construction.
4 Includes transfers to municipalities, universities and non-consolidated agencies.
5 Includes high-speed internet infrastructure, government administration, natural resources, and culture and tourism industries.
6 Other Partner Funding refers to third-party investments primarily in hospitals, colleges and schools.
7 Includes Federal–Municipal contributions to provincial infrastructure investments.

Note: Numbers may not add due to rounding.
Source: Ontario Treasury Board Secretariat.

Table 3.13

10-Year Review of Selected Financial and Economic Statistics[1]

($ Millions)

	2015–16	2016–17	2017–18
Revenue	**136,148**	**140,734**	**150,696**
Expense			
Programs	129,905	131,442	142,464
Interest on Debt[2]	11,589	11,727	11,912
Total Expense	**141,494**	**143,169**	**154,375**
Reserve	–	–	–
Surplus/(Deficit)	**(5,346)**	**(2,435)**	**(3,679)**
Net Debt	306,357	314,077	323,068
Accumulated Deficit	203,014	205,939	208,257
Gross Domestic Product (GDP) at Market Prices	760,435	790,749	824,979
Primary Household Income	512,570	520,486	541,501
Population (000s) — July[3]	13,709	13,877	14,078
Net Debt per Capita (Dollars)	22,347	22,634	22,948
Household Income per Capita (Dollars)	37,389	37,508	38,463
Net Debt as a Per Cent of Revenue	225.0%	223.2%	214.4%
Interest on Debt as a Per Cent of Revenue	8.5%	8.3%	7.9%
Net Debt as a Per Cent of GDP	40.3%	39.7%	39.2%
Accumulated Deficit as a Per Cent of GDP	26.7%	26.0%	25.2%

[1] Amounts reflect a change in pension expense that was calculated based on recommendations of the Independent Financial Commission of Inquiry, as described in Note 19 to the Consolidated Financial Statements, in *Public Accounts of Ontario 2017–2018*. Amounts for net debt and accumulated deficit also reflect this change.

[2] Interest on debt is net of interest capitalized during construction of tangible capital assets of $321 million in 2021–22, $694 million in 2022–23, $573 million in 2023–24 and $865 million in 2024–25.

[3] Population figures are for July 1 of the fiscal year indicated (i.e., for 2023–24, the population on July 1, 2023, is shown).

[4] Interim represents the *2024 Budget* projection for the 2023–24 fiscal year.

Note: Numbers may not add due to rounding.

Sources: Statistics Canada, Ontario Treasury Board Secretariat and Ontario Ministry of Finance.

2018–19	2019–20	2020–21	2021–22	Actual 2022–23	Interim[4] 2023–24	Plan 2024–25
153,804	**156,167**	**164,970**	**185,128**	**192,887**	**204,336**	**205,690**
148,747	152,265	168,964	170,520	186,361	194,470	200,583
12,385	12,497	12,296	12,583	12,389	12,843	13,913
161,132	**164,762**	**181,260**	**183,103**	**198,750**	**207,313**	**214,496**
–	–	–	–	–	–	1,000
(7,328)	**(8,595)**	**(16,290)**	**2,025**	**(5,863)**	**(2,977)**	**(9,806)**
337,623	352,382	372,501	382,842	400,484	414,814	439,056
215,770	224,814	238,231	238,160	246,804	249,781	259,587
860,103	893,224	874,354	960,226	1,048,258	1,091,497	1,120,967
567,484	593,065	592,514	642,859	695,228	739,268	768,844
14,327	14,574	14,762	14,842	15,145	15,608	16,021
23,566	24,180	25,234	25,794	26,443	26,576	27,405
39,610	40,695	40,138	43,312	45,905	47,364	47,990
219.5%	225.6%	225.8%	206.8%	207.6%	203.0%	213.5%
8.1%	8.0%	7.5%	6.8%	6.4%	6.3%	6.8%
39.3%	39.5%	42.6%	39.9%	38.2%	38.0%	39.2%
25.1%	25.2%	27.2%	24.8%	23.5%	22.9%	23.2%



Chapter 4

Borrowing and Debt Management

Introduction

As Ontario continues on its path to balance the budget, the borrowing program remains responsibly and prudently managed to minimize interest on debt (IOD).

Ontario has completed $41.8 billion in long-term borrowing in 2023–24. This is $14.3 billion higher than anticipated in the *2023 Budget*, primarily as a result of non-cash and cash timing adjustments, a modestly higher deficit for 2023–24 and higher year-end cash levels to pre-borrow for future years' funding needs. The 2024–25 and 2025–26 long-term public borrowing forecasts are $38.2 billion and $37.7 billion, an increase of $9.5 billion and $4.3 billion from the *2023 Budget* forecast, respectively, but only $0.8 billion and $0.7 billion higher than the forecast in the *2023 Ontario Economic Outlook and Fiscal Review*. Long-term public borrowing for 2026–27 is forecast to be $32.8 billion.

Ontario is forecast to pay $12.8 billion in interest costs in 2023–24, $13.9 billion in 2024–25 and $14.7 billion in 2025–26, down from the *2023 Budget* forecast of $14.1 billion, $14.4 billion and $15.1 billion, respectively. These lower interest costs total a cumulative savings of more than $2 billion over the three years, due to lower than projected borrowing costs. Interest costs in 2026–27 are forecast to be $15.2 billion.

Ontario continues to make progress on its debt burden reduction strategy. The net debt-to-GDP ratio is now forecast to be 38.0 per cent in 2023–24, 39.2 per cent in 2024–25, 39.5 per cent in 2025–26 and 39.1 per cent in 2026–27.

Ontario's net debt-to-revenue is forecast to be 203 per cent in 2023–24, 214 per cent in 2024–25, 211 per cent in 2025–26 and 209 per cent in 2026–27.

Ontario's interest on debt-to-revenue is forecast to be 6.3 per cent in 2023–24, 6.8 per cent in 2024–25 and 2025–26, and 6.7 per cent in 2026–27.

Borrowing Program

Ontario's borrowing program is primarily used to fund deficits, refinance maturing debt, and make investments in capital assets. Ontario will continue to finance most of its borrowing program in the long-term public markets in Canada and internationally.

Table 4.1

2023–24 Borrowing Program and Medium-Term Outlook

($ Billions)

	2023–24			Medium-Term Outlook		
	2023 Budget	**Change from *2023 Budget***	**Interim[1] 2023–24**	**2024–25**	**2025–26**	**2026–27**
Deficit/(Surplus)	1.3	1.7	3.0	9.8	4.6	(0.5)
Investment in Capital Assets	13.6	1.2	14.7	17.7	20.2	20.4
Non-Cash and Cash Timing Adjustments	(9.2)	7.6	(1.6)	(11.0)	(12.0)	(13.9)
Net Loans and Investments	0.1	(0.4)	(0.2)	(0.3)	0.1	–
Debt Maturities and Redemptions	31.2	–	31.2	28.0	33.1	26.9
Total Funding Requirement	**37.0**	**10.1**	**47.1**	**44.2**	**46.0**	**32.8**
Decrease/(Increase) in Short-Term Borrowing	–	–	–	(5.0)	–	–
Increase/(Decrease) in Year-End Cash and Cash Equivalents[2]	5.0	4.3	9.3	(1.0)	(8.3)	–
Pre-borrowing in 2022–23 for 2023–24	(14.5)	–	(14.5)	–	–	–
Total Long-Term Borrowing	**27.5**	**14.3**	**41.8**	**38.2**	**37.7**	**32.8**

[1] Interim represents the *2024 Budget* projection for the 2023–24 fiscal year.
[2] Starting in 2024–25, pre-borrowing will be reflected as part of the increase in year-end cash and cash equivalents.
Note: Numbers may not add due to rounding.
Source: Ontario Financing Authority.

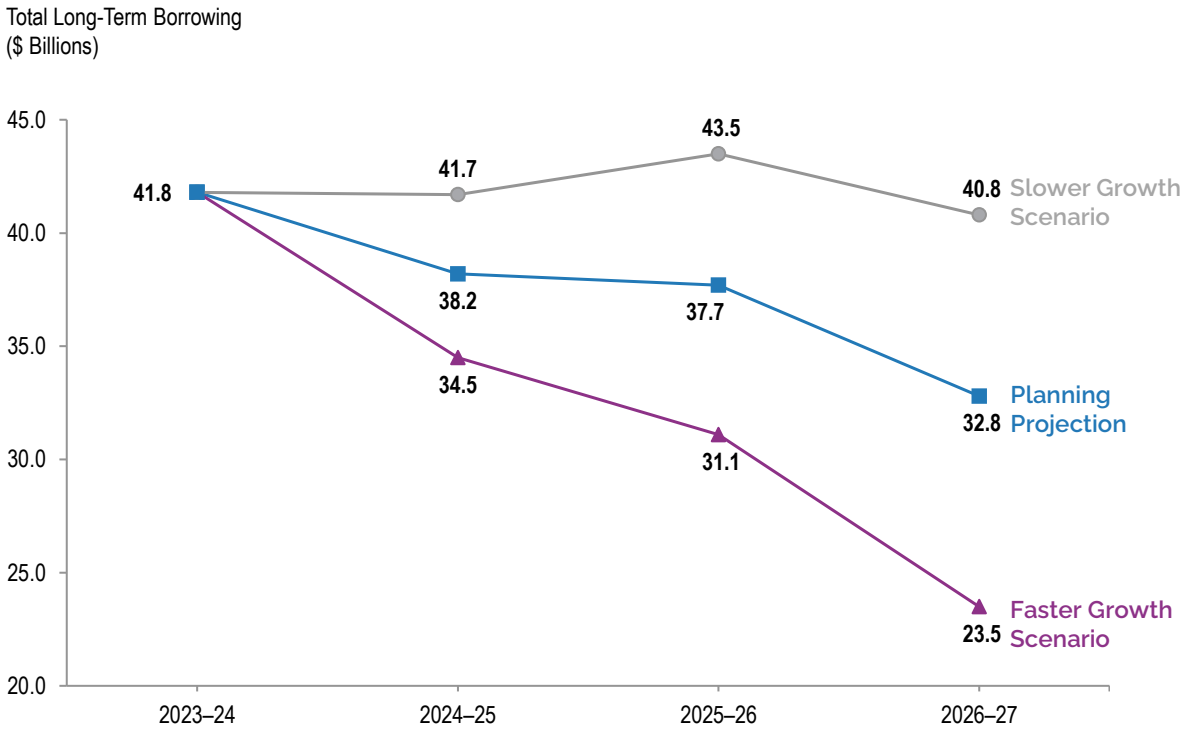
Ontario has completed $41.8 billion in long-term borrowing in 2023–24. This is $14.3 billion higher than anticipated in the *2023 Budget*, primarily as a result of non-cash and cash timing adjustments, a modestly higher deficit for 2023–24 and higher year-end cash levels to pre-borrow for future years' funding needs. The 2024–25 and 2025–26 long-term public borrowing forecasts are $38.2 billion and $37.7 billion, an increase of $9.5 billion and $4.3 billion from the *2023 Budget* forecast, respectively, but only $0.8 billion and $0.7 billion higher than the forecast in the *2023 Ontario Economic Outlook and Fiscal Review*. Long-term public borrowing for 2026–27 is forecast to be $32.8 billion.

Year-end cash and cash equivalents are forecast to decrease by $1.0 billion in 2024–25 and $8.3 billion in 2025–26. Starting in 2024–25, pre-borrowing will be reflected as part of the increase in year-end cash and cash equivalents, rather than having a separate line for pre-borrowing.

Ontario plans to increase short-term borrowing by $5.0 billion in 2024–25. This positions Ontario to respond to recent changes in market demand for short-term Ontario debt. It will also maintain the proportion of short-term debt as a percentage of total debt outstanding within the target range of five to seven per cent, as it has been over the past 10 years.

In the event that alternative economic scenarios materialize, Ontario's borrowing requirements in the next three years would also change (see Chapter 3: *Continuing to Invest in the Plan to Build: Ontario's Fiscal Plan and Outlook* for more details, and a description of the resulting alternative medium-term outlook scenarios). Under the Faster Growth scenario, long-term borrowing would decrease by a total of $19.6 billion over the three-year outlook period, while under the Slower Growth scenario, long-term borrowing would increase by $17.3 billion over the same period.

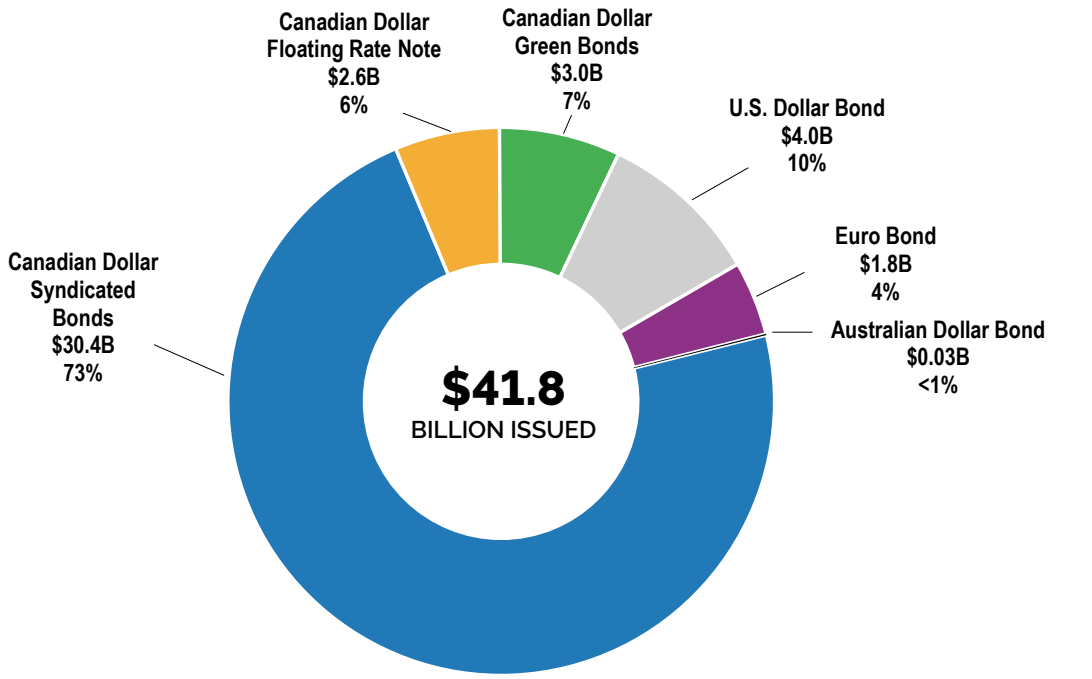
Chart 4.1
Borrowing Outlook Scenarios for Long-Term Borrowing



Sources: Ontario Financing Authority and Ontario Ministry of Finance.

Approximately 86 per cent of 2023–24 long-term borrowing was completed in Canadian dollars, through 36 syndicated issues, one floating rate note and two Green Bonds. This percentage was within Ontario's target range for domestic borrowing of 75 to 90 per cent for the 2023–24 fiscal year. Based on the combined experience of the last five fiscal years, Ontario's target range for domestic borrowing will remain unchanged for 2024–25. This range will be adjusted, if necessary, in response to evolving investor demand in the Canadian dollar and foreign currency debt markets.

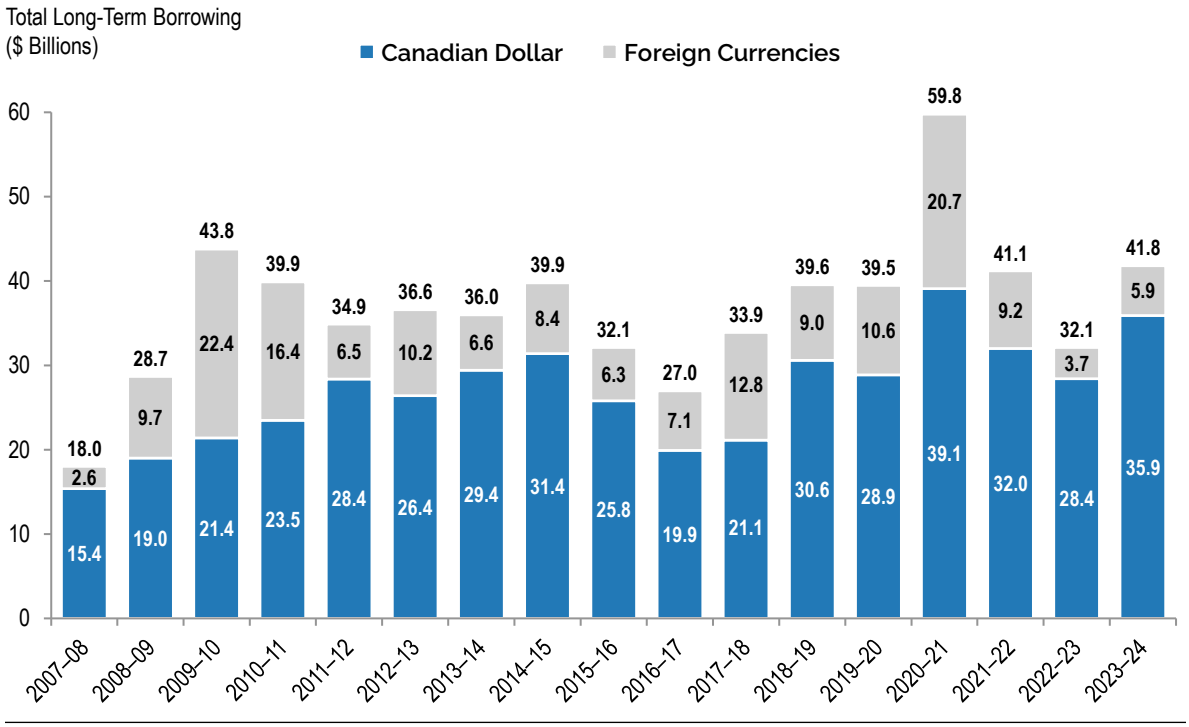
Chart 4.2
2023–24 Borrowing



Note: Numbers may not add due to rounding.
Source: Ontario Financing Authority.

Foreign currency borrowing helps reduce Ontario's overall borrowing costs by continuing to diversify Ontario's investor base. This diversification ensures the province will continue to have access to capital even if domestic market conditions become challenging. Approximately $5.9 billion, or 14 per cent of this year's long-term borrowing, was completed in foreign currencies, primarily in U.S. dollars and euros.

Chart 4.3
Domestic and International Borrowing



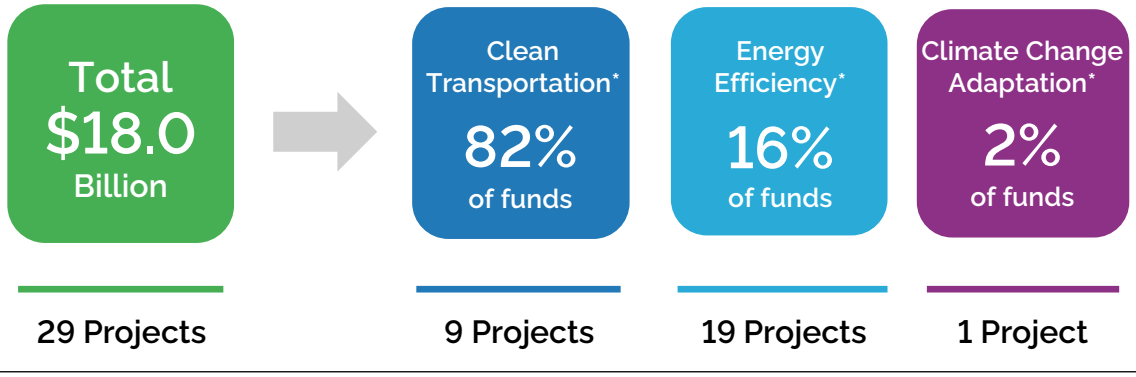
Note: Numbers may not add due to rounding.
Source: Ontario Financing Authority.

Sustainable Bond Program

Green Bonds have been a core component of Ontario's borrowing program since 2014. They are an important tool to help finance public transit initiatives, extreme weather-resistant infrastructure, as well as energy efficiency and conservation projects. Ontario remains the largest and most frequent issuer of Canadian dollar Green Bonds, with 15 issues totalling $18.0 billion since 2014–15 and $15.95 billion outstanding.

In January 2024, the government released the new *Ontario Sustainable Bond Framework*, replacing its *Green Bond Framework* from 2014. The new framework will allow for a broader range of potential bond offerings in the future, including emissions-free nuclear power.

Chart 4.4
Green Bond Allocation by Framework Category



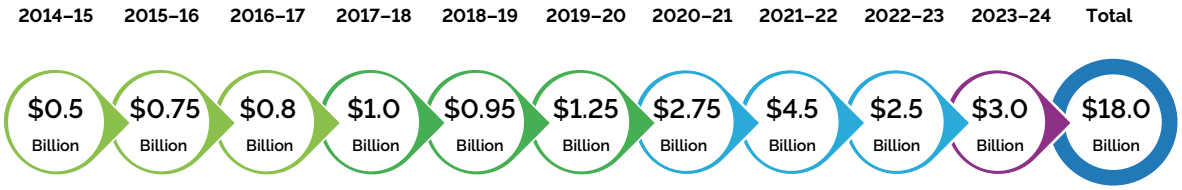
*Data include bonds issued under the 2014 *Green Bond Framework*, categories have been updated to align with those in the new 2024 *Ontario Sustainable Bond Framework*.
Note: Numbers may not add due to rounding.
Source: Ontario Financing Authority.

On February 29, 2024, Ontario issued a $1.5 billion Green Bond. This was the second Green Bond issued in 2023–24, fifteenth Green Bond overall, and Ontario's first Green Bond issued under the new *Ontario Sustainable Bond Framework*. Five projects were selected to receive funding from the most recent Green Bond:

- GO Transit Expansion;
- Hazel McCallion Light Rail Transit;
- Ontario Line Subway;
- Scarborough Subway Extension; and
- Electric Vehicle (EV) ChargeON.

Ontario plans to continue its leadership in the Canadian dollar Green Bond market and, subject to market conditions, will issue multiple Green Bonds each fiscal year, including in 2024–25.

Chart 4.5
Ontario's Green Bond Issues

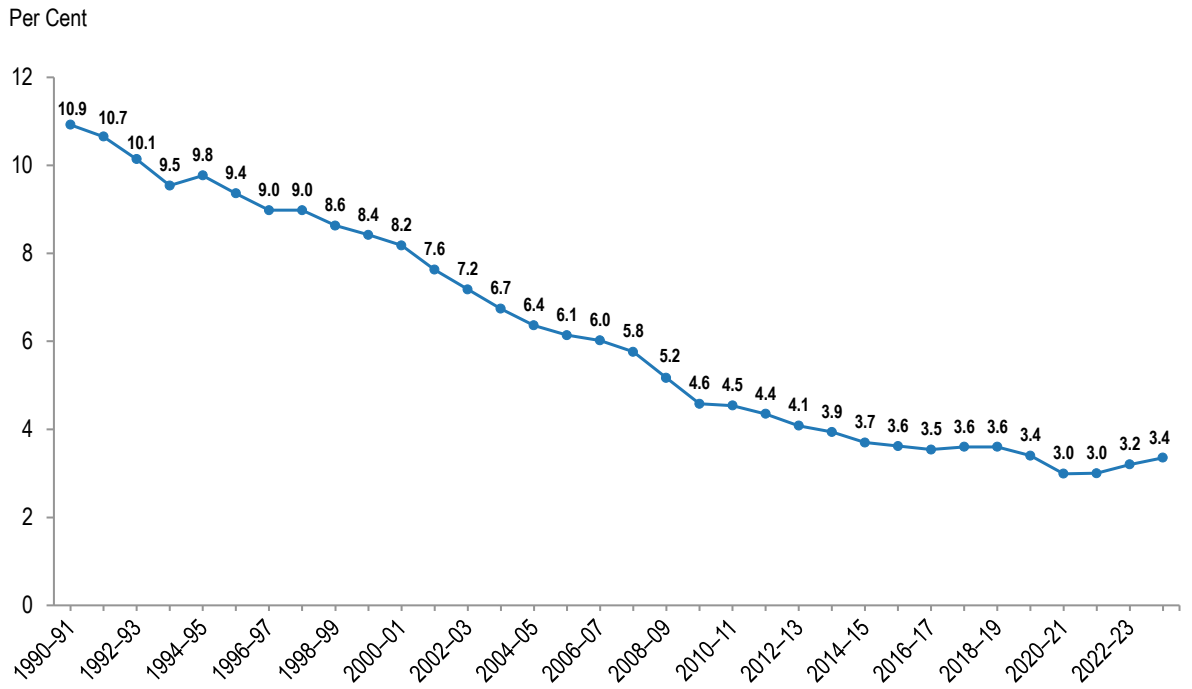


Source: Ontario Financing Authority.

Cost of Debt

After a three-decade decline, interest rates have risen as central banks, including the Bank of Canada and the U.S. Federal Reserve, have raised overnight interest rates since early 2022. Interest rates have remained elevated throughout 2023 and into 2024. Chart 4.6 shows that while the effective interest rate on Ontario's debt has risen modestly, it remains low in historical terms due to the decision to lock in long-term rates to extend the term of debt.

Chart 4.6
Effective Interest Rate (Weighted Average) on Total Debt

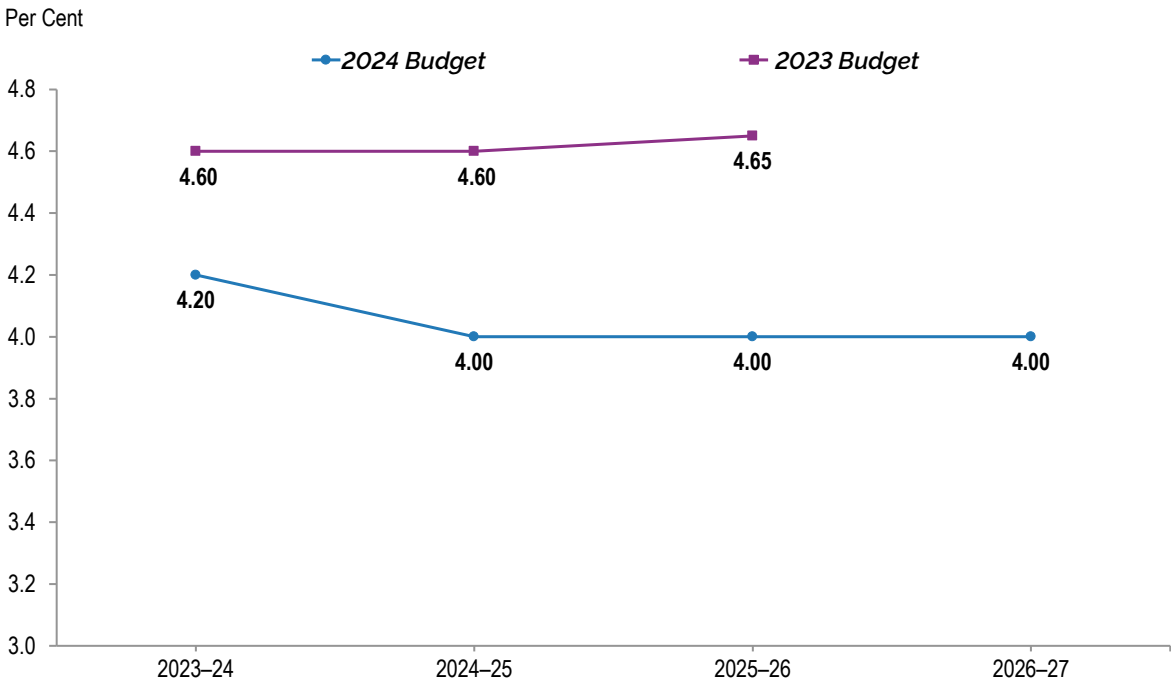


Sources: *Public Accounts of Ontario* (1990–1991 to 2022–2023) and Ontario Financing Authority.

Ontario's borrowing costs for 2023–24 are now estimated to be 4.2 per cent, 40 basis points lower than forecasted in the *2023 Budget,* as shown in Chart 4.7. Borrowing costs in 2024–25 and 2025–26 are also projected to be lower than forecasted in the *2023 Budget* by an even greater margin. A one percentage point change in interest rates, either up or down from the current interest rate forecast, is estimated to have a corresponding change in Ontario's borrowing costs of approximately $0.7 billion in the first full year.

Chart 4.7

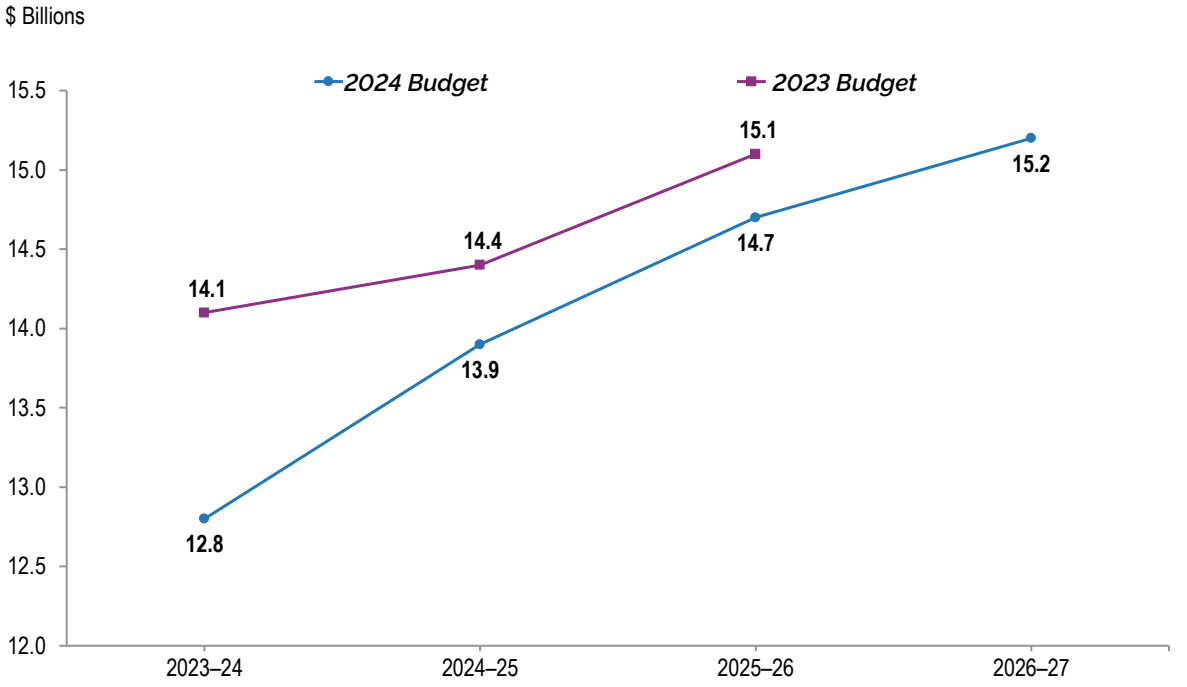
Comparison of Average Annual Ontario Borrowing Rate Forecast



Source: Ontario Financing Authority.

Ontario is forecast to pay $12.8 billion in interest costs in 2023–24, $13.9 billion in 2024–25 and $14.7 billion in 2025–26, down from the *2023 Budget* forecasts of $14.1 billion, $14.4 billion and $15.1 billion, respectively. These lower interest costs total a cumulative savings of more than $2 billion over three years, due to lower than projected borrowing costs.

Chart 4.8
Comparison of Interest on Debt Expense Forecast



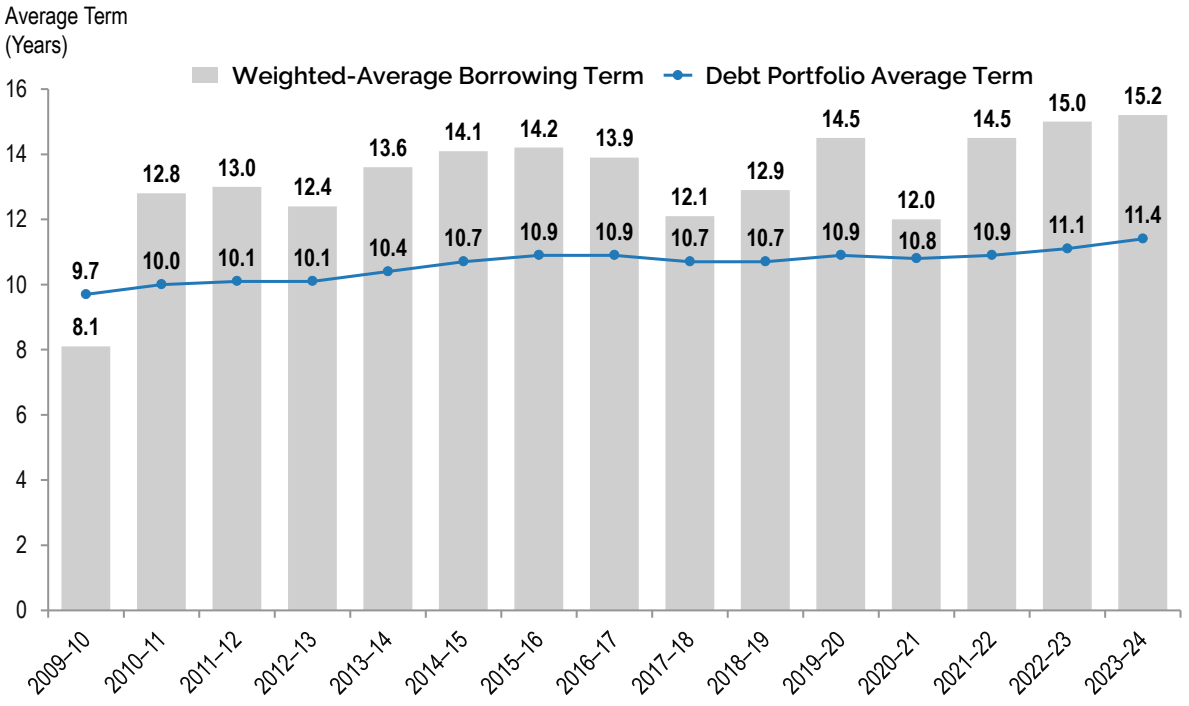
Source: Ontario Financing Authority.

Term of Debt

Ontario has continued to extend the term of its debt, to reduce refinancing risk on maturing debt. This also protects the IOD forecast against further increases in interest rates in the long term. Ontario has issued $137.0 billion of bonds, or almost one-third of total debt outstanding, with maturities of 30 years or longer since 2010–11. This includes $12.8 billion in 2023–24.

The success Ontario has had in extending the term of its debt from the time of the Global Financial Crisis has created flexibility for managing its large borrowing program and debt portfolio. Due to the extension of the term of debt in recent years, the impact on IOD in the short term and medium term has been lessened. Given interest rates have risen to near historical averages, Ontario will monitor the market and adjust the debt term strategy in the future, if necessary, in response to further changes to interest rates and the yield curve.

Chart 4.9
Weighted-Average Term of Borrowings



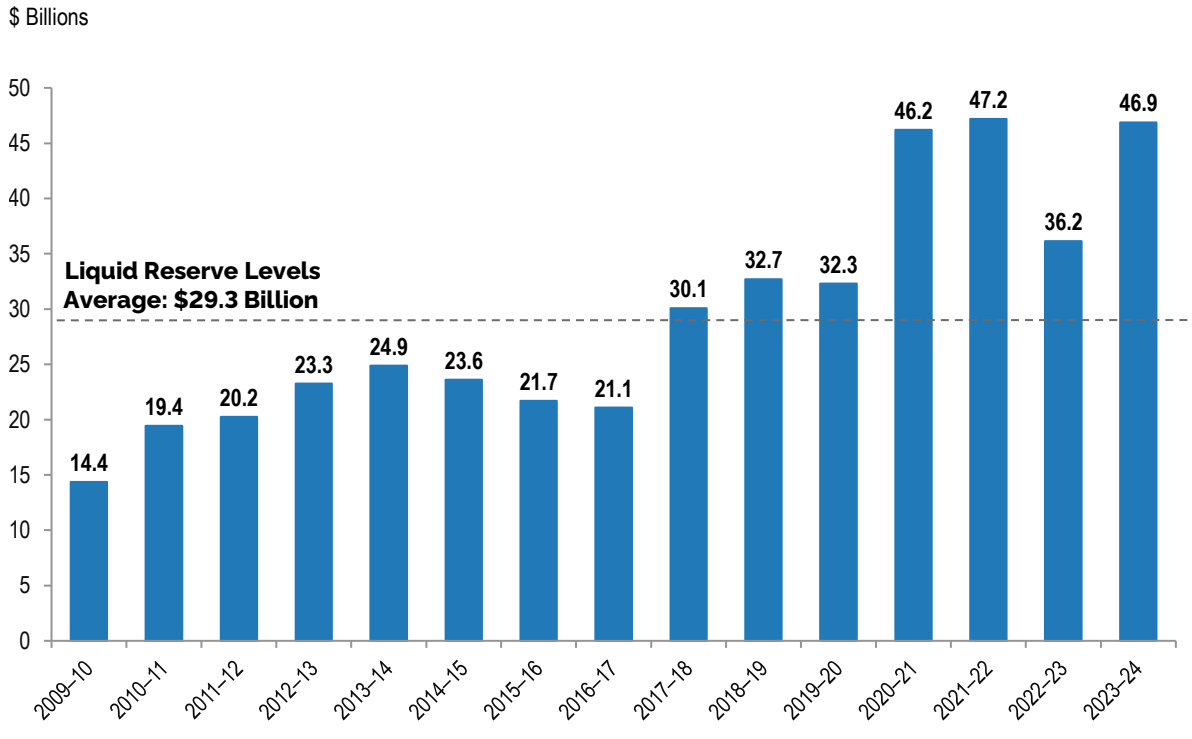
Source: Ontario Financing Authority.

Ensuring Adequate Liquidity Levels

Ontario aims to maintain an optimal level of cash reserves that balances potential holding costs with the need to have adequate funds to meet its financial obligations in a timely manner, as well as to be able to respond promptly to unforeseen market events or economic shocks. With short-term interest rates higher than long-term rates through 2023–24, holding liquid reserves reduced IOD as short-term investments earned more income than Ontario's cost of borrowing long-term debt.

Ontario's cash reserves averaged $46.9 billion in 2023–24. As shown in Chart 4.10, this is higher than the average in the previous fiscal year, reflecting higher operating requirements, investments in infrastructure and debt maturities.

Chart 4.10
Average Unrestricted Liquid Reserve Levels



Source: Ontario Financing Authority.

Debt Burden Reduction Strategy

The government remains committed to reducing the debt burden and putting Ontario's finances back on a more sustainable path. As a result, Ontario has maintained the targets set in the *2023 Budget* and continues to make progress towards achieving them over the medium-term outlook. In addition, Ontario's path to balance by 2026–27 will further support progress towards its debt burden reduction strategy.

Making Progress on the Debt Burden Reduction Strategy

The *2024 Budget* includes an updated debt burden reduction strategy that continues to focus on meeting the established targets over the medium-term outlook for the relevant measures of debt sustainability. These targets are reviewed annually, based on the latest economic and fiscal conditions, to ensure Ontario is making progress towards reducing the debt burden. Meeting these targets on a sustained basis would help improve Ontario's credit rating profile and lower Ontario's cost of borrowing. This would result in less money being required to pay for interest on debt, while freeing up resources for other priorities. The targets, which remain unchanged from the *2023 Budget,* are:

Net debt-to-GDP to stay below **40.0 per cent**

Net debt-to-revenue to be below **200 per cent**

IOD-to-revenue to stay below **7.5 per cent**

Table 4.2

Progress on Relevant Debt Sustainability Measures

(Per Cent)

	Targets	*2023 Budget* 2023–24 Forecast	*2023 FES* 2023–24 Forecast	*2024 Budget* 2023–24 Forecast	*2024 Budget* 2024–25 Forecast
Net Debt-to-GDP	<40.0	37.8	38.4	38.0	39.2
Net Debt-to-Revenue	<200	199	206	203	214
Interest on Debt-to-Revenue	<7.5	6.9	6.7	6.3	6.8

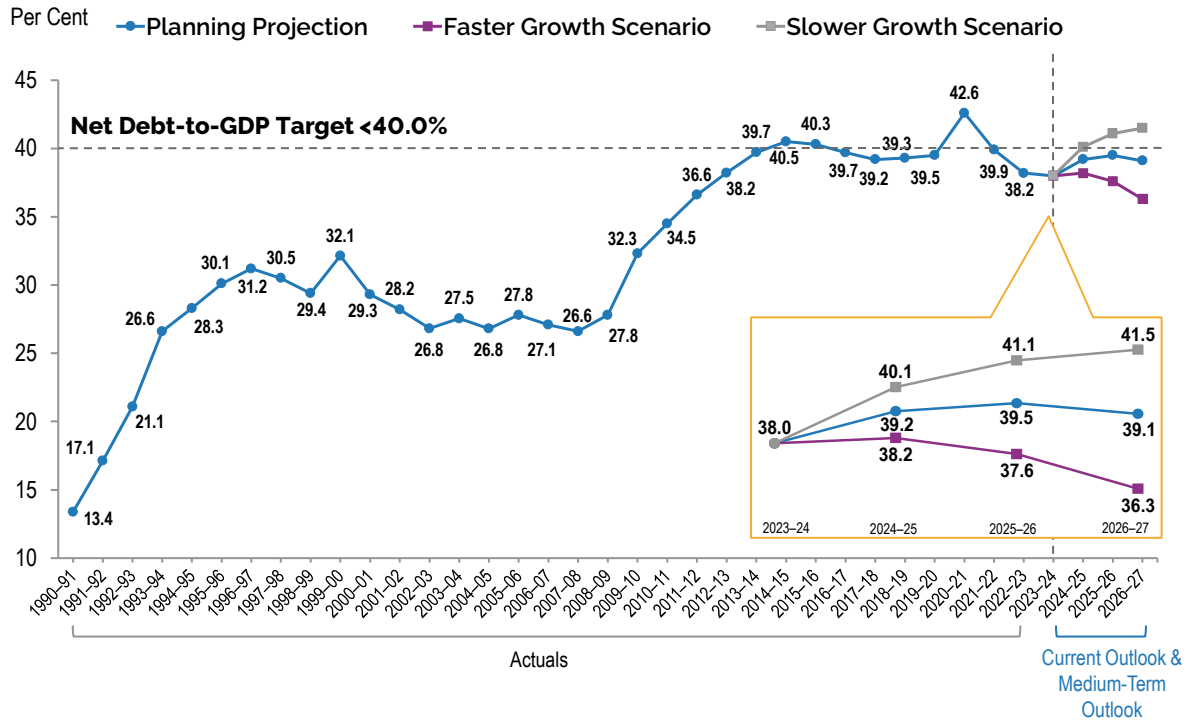
Note: 2023 FES is defined as the *2023 Ontario Economic Outlook and Fiscal Review.*
Source: Ontario Financing Authority.

Ontario's net debt-to-GDP is projected to be 38.0 per cent in 2023–24, 39.2 per cent in 2024–25 and 39.5 per cent in 2025–26. In comparison to the *2023 Budget*, the ratio increased by 0.2 percentage points, 1.5 percentage points and 2.6 percentage points, respectively. The increase in this ratio over the medium-term outlook is primarily due to higher than projected deficits and investments in infrastructure. The ratio is forecast to be 39.1 per cent in 2026–27. This ratio measures the relationship between a government's obligations and its ability to meet them, indicating the burden of government debt as a share of the economy.

When compared to the *2023 Ontario Economic Outlook and Fiscal Review*, the ratio decreased by 0.4 percentage points in 2023–24, followed by increases of 0.1 percentage points in 2024–25 and 0.8 percentage points in 2025–26. However, when further compared to the *2022 Budget*, the ratio decreased by 3.4 percentage points in 2023–24, 2.1 percentage points in 2024–25 and 1.5 percentage points in 2025–26. These trends indicate that although the net debt-to-GDP ratio increased in comparison to the *2023 Budget*, it remains relatively consistent or lower than in other recently published forecasts.

Over the medium-term outlook, the net debt-to-GDP ratio is forecast to stay below the target of 40.0 per cent, demonstrating that Ontario continues to make positive progress towards reducing the debt burden, while remaining committed to the target originally set in the *2023 Budget*.

Chart 4.11
Net Debt-to-GDP



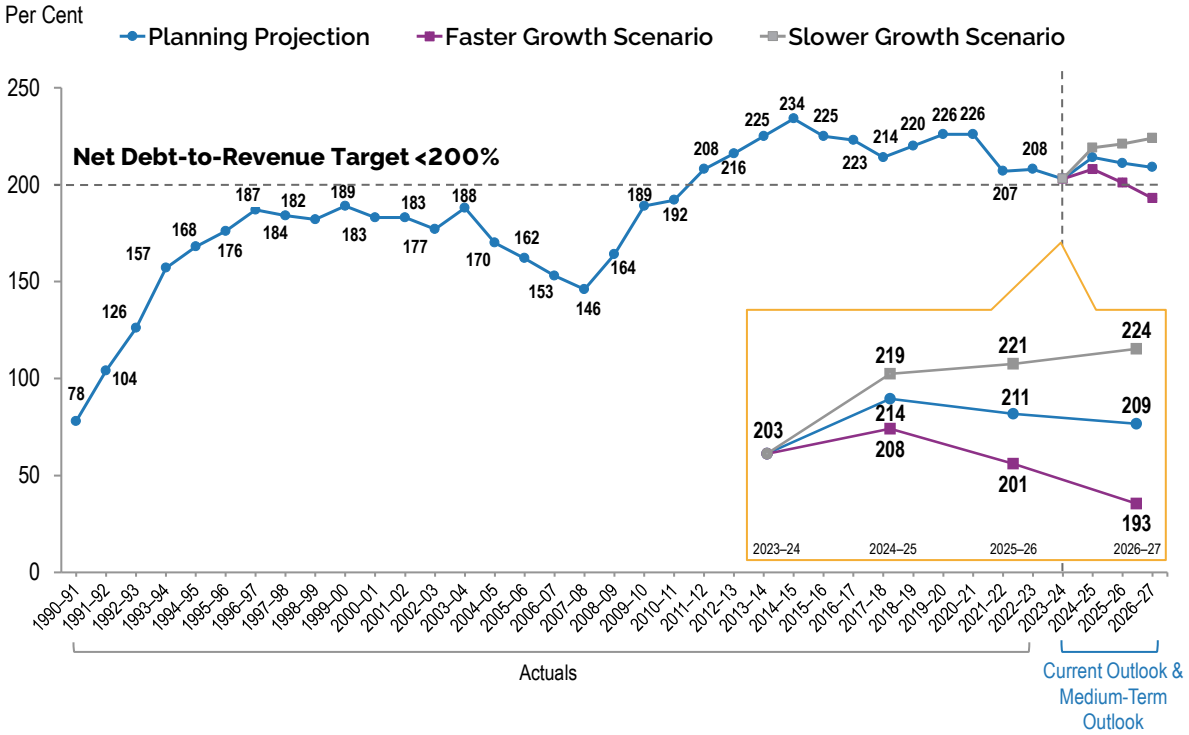
Note: See Chapter 3: *Continuing to Invest in the Plan to Build: Ontario's Fiscal Plan and Outlook* for details on the Faster Growth and Slower Growth scenarios.
Sources: Statistics Canada and Ontario Ministry of Finance.

Ontario's net debt-to-revenue is projected to be 203 per cent in 2023–24, 214 per cent in 2024–25 and 211 per cent in 2025–26. In comparison to the *2023 Budget*, the ratio increased by 4 percentage points, 16 percentage points and 21 percentage points, respectively. The increase in this ratio over the medium-term outlook is primarily due to reduced revenues as a result of lower projected economic growth, updated tax receipts information and investments in infrastructure. The ratio is forecast to be 209 per cent in 2026–27. This ratio is an indicator of how many years it would take to eliminate the debt if the Ontario government were to spend all its annual revenue on debt repayment.

When compared to the *2023 Ontario Economic Outlook and Fiscal Review*, the ratio decreased by 3 percentage points in 2023–24, followed by increases of 3 percentage points in 2024–25 and 7 percentage points in 2025–26. However, when further compared to the *2022 Budget*, the ratio decreased by 36 percentage points in 2023–24 and 25 percentage points in 2024–25 and 2025–26. These trends indicate that although the net debt-to-revenue ratio increased in comparison to the *2023 Budget*, it remains relatively consistent or lower than in other recently published forecasts.

Ontario's target for the net debt-to-revenue ratio remains to be below 200 per cent. Based on the growth trend in net debt and revenue beyond the medium-term outlook, this ratio is expected to meet the target of 200 per cent by 2029–30, or as early as 2026–27 should the Faster Growth scenario materialize.

Chart 4.12
Net Debt-to-Revenue

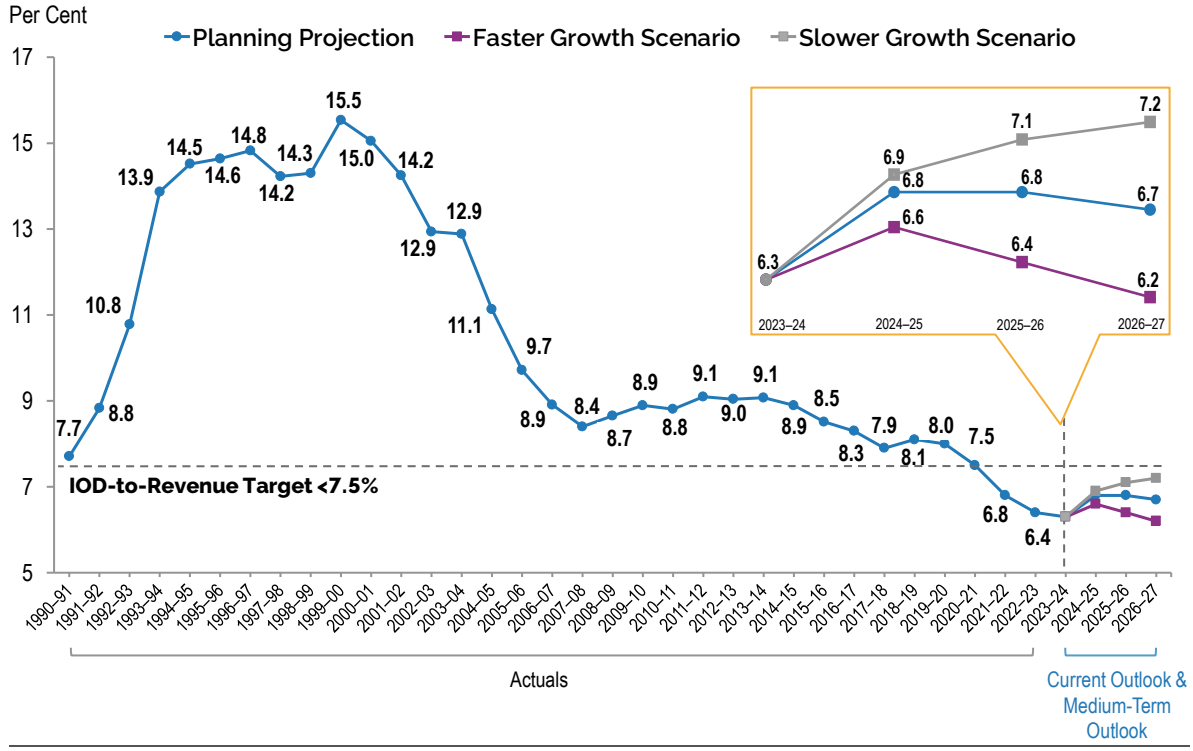


Note: See Chapter 3: *Continuing to Invest in the Plan to Build: Ontario's Fiscal Plan and Outlook* for details on the Faster Growth and Slower Growth scenarios.
Sources: *Public Accounts of Ontario* (1990–1991 to 2022–2023) and Ontario Financing Authority.

Ontario's IOD-to-revenue ratio is projected to be 6.3 per cent in 2023–24, 6.8 per cent in 2024–25 and 2025–26. In comparison to the *2023 Budget*, the ratio decreased by 0.6 percentage points in 2023–24, remained unchanged in 2024–25, and increased by 0.1 percentage points in 2025–26. The ratio is forecast to be 6.7 per cent in 2026–27. This ratio represents how much Ontario needs to spend on interest for every revenue dollar received. A lower IOD-to-revenue ratio frees up more resources for other priorities.

When comparing this ratio to the *2023 Ontario Economic Outlook and Fiscal Review* and the *2022 Budget*, for the years 2023–24 to 2025–26, the ratio improved by up to 1.3 percentage points. Ontario continues to show positive progress on the IOD-to-revenue ratio and is forecasting to meet the target and stay below 7.5 per cent over the medium-term outlook. This ratio remains close to the lowest levels it has been at since the 1980s.

Chart 4.13
Interest on Debt-to-Revenue



Note: See Chapter 3: *Continuing to Invest in the Plan to Build: Ontario's Fiscal Plan and Outlook* for details on the Faster Growth and Slower Growth scenarios.
Sources: *Public Accounts of Ontario* (1990–1991 to 2022–2023) and Ontario Financing Authority.

Consolidated Financial Tables

Table 4.3

Net Debt and Accumulated Deficit

($ Millions)

	2019–20	2020–21	2021–22	Actual 2022–23	Interim[1] 2023–24	Plan 2024–25
Debt[2]						
Publicly Held Debt						
Bonds[3]	348,589	381,492	399,628	403,398	416,517	428,080
Treasury Bills	19,175	24,097	22,301	22,276	20,866	25,866
U.S. Commercial Paper[3]	3,891	0	1,735	460	1,694	1,694
Infrastructure Ontario (IO)[4]	300	300	300	300	300	300
Other	264	250	231	217	202	186
Total Publicly Held Debt	**372,219**	**406,139**	**424,195**	**426,651**	**439,579**	**456,126**
Non-Public Debt	10,010	9,318	8,766	8,678	7,953	6,776
Gross Debt	**382,229**	**415,457**	**432,961**	**435,329**	**447,532**	**462,902**
Less: Holdings of own Ontario Bonds and Treasury Bills[5]	(9,938)	(11,122)	(7,098)	(10,154)	(5,586)	–
Less: Unamortized Discounts, Premiums and Commissions[6]				(3,376)	(4,495)	–
Total Debt	**372,291**	**404,335**	**425,863**	**421,799**	**437,451**	**462,902**
Other Net Financial (Assets)/Liabilities[7]	(33,808)	(44,396)	(54,729)	(37,876)	(34,669)	(34,864)
Broader Public Sector Net Debt	13,899	12,562	11,708	16,561	12,032	11,018
Net Debt	**352,382**	**372,501**	**382,842**	**400,484**	**414,814**	**439,056**
Non-Financial Assets[8]	(127,568)	(134,270)	(144,682)	(153,680)	(165,033)	(179,469)
Accumulated Deficit	**224,814**	**238,231**	**238,160**	**246,804**	**249,781**	**259,587**

1 Interim represents the *2024 Budget* projection for the 2023–24 fiscal year.
2 Includes debt issued by Ontario and all government organizations, including the Ontario Electricity Financial Corporation (OEFC).
3 All balances are expressed in Canadian dollars. The balances above reflect the effect of related derivative contracts.
4 IO debt is composed of Infrastructure Renewal Bonds. IO debt is not guaranteed by Ontario.
5 Ontario holds its own debt mainly to reduce the cash flow required to service large maturities, typically in June. For 2024–25, there are currently no significant holdings for maturities.
6 Effective April 1, 2022, Ontario adopted new PSAS standard on Financial Instruments on a prospective basis. Unamortized discounts and premiums are now amortized on an effective interest basis. These amounts are not forecasted for 2024–25.
7 Other Net Financial (Assets)/Liabilities include cash and temporary investments, accounts receivable, loans receivable, advances and investments in Government Business Enterprises (GBEs) offset by accounts payable, accrued liabilities, deferred revenue and capital contributions, pensions and other employee future benefits, and other liabilities.
8 Non-financial assets include the tangible capital assets of Ontario, including the broader public sector.

Sources: Ontario Financing Authority and Ontario Ministry of Finance.

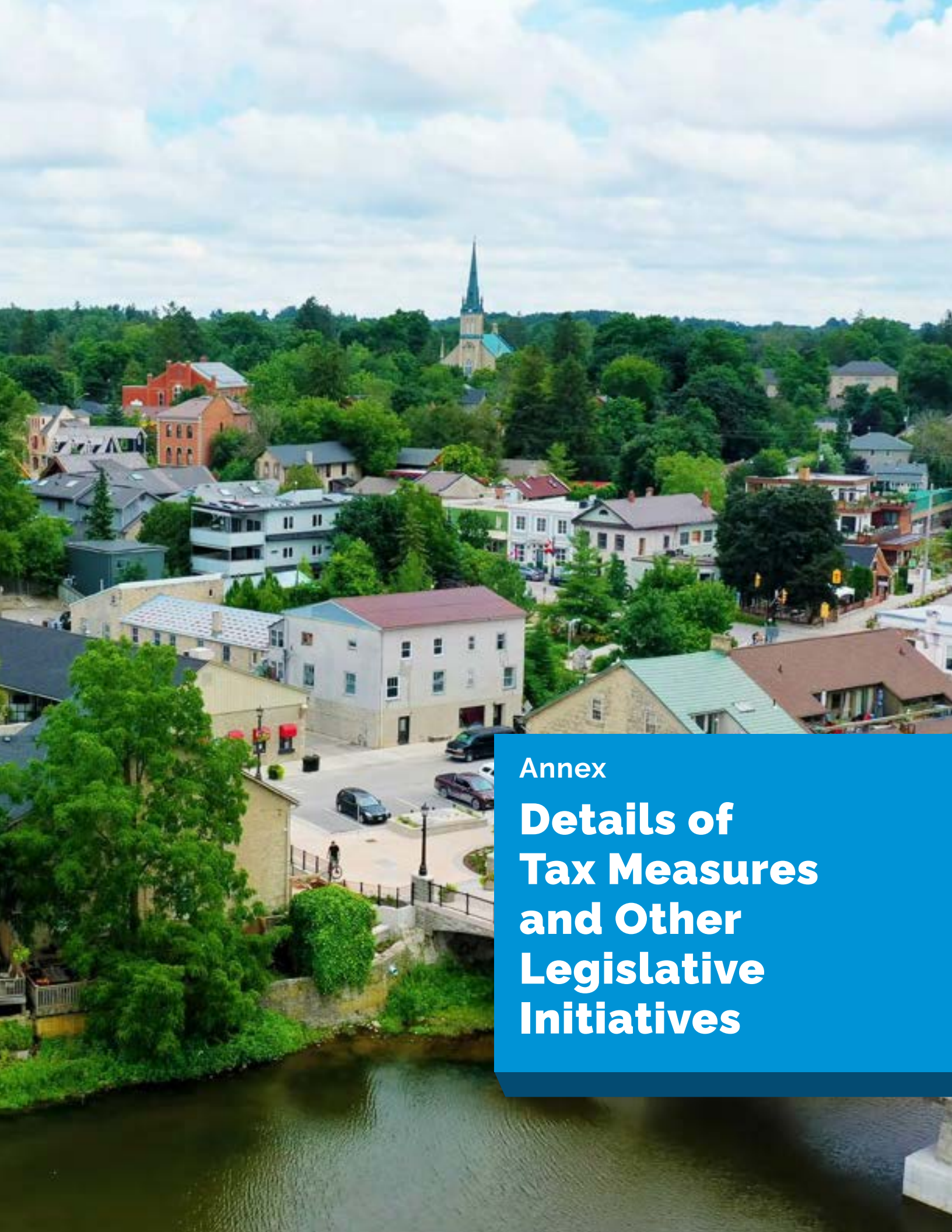
Table 4.4

Medium-Term Outlook: Net Debt and Accumulated Deficit

($ Millions)

	2024–25	2025–26	2026–27
Total Debt	**462,902**	**467,489**	**473,348**
Other Net Financial (Assets)/Liabilities	(34,864)	(18,148)	(10,467)
Broader Public Sector Net Debt	11,018	10,426	11,596
Net Debt	**439,056**	**459,767**	**474,477**
Non-Financial Assets	(179,469)	(195,567)	(210,757)
Accumulated Deficit	**259,587**	**264,200**	**263,720**

Note: Numbers may not add due to rounding.
Sources: Ontario Financing Authority and Ontario Ministry of Finance.



Annex

Details of Tax Measures and Other Legislative Initiatives

Overview

This Annex contains detailed information on certain tax measures and other legislative initiatives proposed in this Budget.

Simplifying the Ontario Computer Animation and Special Effects Tax Credit

The Ontario Computer Animation and Special Effects (OCASE) Tax Credit is an 18 per cent refundable corporate income tax credit available to companies that undertake computer animation and special effects activities on eligible film and television productions in Ontario. To be eligible for the OCASE Tax Credit, a film or television production must also be certified for either the Ontario Film and Television Tax Credit or the Ontario Production Services Tax Credit, "tethering" the OCASE Tax Credit to these other film and television tax credits.

The government is proposing to remove this tethering requirement and replace it with the following new eligibility rules to ensure the credit continues to only support professional productions. These new rules deliver on the government's commitment to explore opportunities to simplify tax credit support for computer animation and special effects activities:

- A qualifying corporation would be required to incur a minimum of $25,000 in Ontario labour expenditures for each film or television production for which the OCASE Tax Credit is claimed. The minimum labour expenditure threshold would be required to be incurred in the taxation year of the claim or cumulatively between the taxation year of the claim and the previous taxation year. Once a qualifying corporation incurs the minimum labour expenditure threshold within up to two taxation years for a specific production, expenditures related to that production in those taxation years and any subsequent taxation years would be eligible; and
- Certain types of productions would be excluded from eligibility, including but not limited to instructional videos, music videos and gaming videos.

The new rules would be effective for productions for which the qualifying corporation commences computer animation and/or special effects work on or after March 26, 2024.

Extending the Temporary Gas Tax and Fuel Tax Rate Cuts

The Ontario government temporarily cut the gasoline tax rate by 5.7 cents per litre and the fuel tax (diesel) rate by 5.3 cents per litre on July 1, 2022. The gasoline tax and fuel tax rates are currently 9 cents per litre. These tax reductions are set to end on June 30, 2024, when the tax rates would return to 14.7 cents per litre for gas and 14.3 cents per litre for fuel.

The government is introducing legislation that would amend the *Gasoline Tax Act* and the *Fuel Tax Act* to extend the rate cuts so that the rate of tax on gas and fuel would remain at 9 cents per litre for an additional six months until December 31, 2024.

Reviewing Ontario's Tax System

Since 2018, the government has taken significant action to lower costs for families and seniors, including with the introduction of the Low-income Individuals and Families Tax (LIFT) Credit, and the Ontario Seniors Care at Home Tax Credit. To help build Ontario's economy, the government introduced the Ontario Made Manufacturing Investment Tax Credit, brought in tax measures to support small business, and provided supports to the mining sector, along with a number of other tax measures. The government has also taken steps to enhance digital options for Ontario businesses to meet their tax compliance obligations, reduce red tape and simplify Ontario's tax administration.

As part of its plan to build a strong Ontario, the government announced a review of the province's tax system in the *2023 Budget*. Since then, the government has consulted with a focused group of tax experts, economists and business leaders.

Based on the input from the consultations the tax system review will focus on opportunities to update the tax system to support greater productivity, including on innovation and research, to promote fairness, to enable greater simplicity and transparency, and to modernize administration.

Property Assessment and Taxation Review

The government is undertaking a review of the property assessment and taxation system focusing on fairness, affordability, business competitiveness and modernized administration tools. Consultations have commenced to seek input on the scope and priority areas of the review. Consultations will continue with broader engagement of stakeholders from across the province starting early spring. To maintain stability for taxpayers, the provincewide property reassessment will continue to be deferred until this review is complete.

Reviewing Alcohol Taxation and Fees

The government is proposing to eliminate the wine basic tax that applies to sales of Ontario wine and wine coolers in on-site winery retail stores. The new rate would come into effect on April 1, 2024.

The government will also conduct a targeted review of taxes and fees on beer, wine and alcoholic beverages with the aim of promoting a more competitive marketplace for Ontario-based producers and consumers.

Summary of Measures

Table A.1 reflects the cost of proposed tax measures in this Budget.

Table A.1
Summary of Measures

($ Millions)

	2024–25	2025–26	2026–27
Simplifying the Ontario Computer Animation and Special Effects Tax Credit	s	s	s
Extending the Temporary Gas Tax and Fuel Tax Rate Cuts	620	–	–
Eliminating the Wine Basic Tax	8	8	8
Total	**628**	**8**	**8**

Notes: Numbers reflect the benefit to individuals, families, businesses and other beneficiaries. Numbers represent a decrease in government revenue. Total is based on the sum of rounded figures for the purpose of presentation.
"–" = a nil amount.
"s" = a small amount (less than $1 million).
Source: Ontario Ministry of Finance.

Technical Amendments

Amendments may be proposed to various statutes administered by the Ontario Minister of Finance, or other statutes, to improve administrative effectiveness or enforcement, maintain the integrity and equity of Ontario's tax and revenue collections system, or enhance legislative clarity or regulatory flexibility to preserve policy intent.

Proposed legislative amendments include:

- Amendments to the *Estate Administration Tax Act, 1998* to include the term "small estate certificate" and "amended small estate certificate" under the definition of the term "estate certificate."
- An amendment to the *Financial Administration Act* to provide express authority for intra-day credit for loans entered into by the province of Ontario.



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EXHIBIT 10

Managing Transformation

A Modernization Action Plan for Ontario

Line-by-line Review of Ontario Government Expenditures 2002/03 - 2017/18

September 21, 2018



Contents

A	A Platform for Modernizing the way Ontario Manages Provincial Expenditures: *Summary of Findings*	2
B	Review Mandate and Approach	4
C	Fifteen Years' Historical Expenditure Analysis: *What the Facts Tell Us*	7
D	A Framework for Better Public Finance Management in Ontario	20
E	Specific Ideas to Set the Ball Rolling	29
F	Building the *Modernization Action Plan*	44

NOTICE

Ernst & Young LLP (EY) prepared the attached report only for Treasury Board Secretariat ("TBS" "Client") pursuant to an agreement solely between EY and Client. EY did not perform its services on behalf of or to serve the needs of any other person or entity. Accordingly, EY expressly disclaims any duties or obligations to any other person or entity based on its use of the attached report. Any other person or entity must perform its own due diligence inquiries and procedures for all purposes, including, but not limited to, satisfying itself as to the financial condition and control environment of TBS, the Government of Ontario, and any of its funded operations, as well as the appropriateness of the accounting for any particular situation addressed by the report.

While EY undertook a thorough line by line review of government spending per the terms of agreement, EY did not perform an audit or review (as those terms are identified by the CPA Canada Handbook - Assurance) or otherwise verify the accuracy or completeness of any information provided to us of TBS, the Government of Ontario, or any of its funded operations financial statements. Accordingly, EY did not express any form of assurance on accounting matters, financial statements, any financial or other information or internal controls. EY did not conclude on the appropriate accounting treatment based on specific facts or recommend which accounting policy/treatment TBS, the Government of Ontario, or any funded operations should select or adopt.

The observations relating to all matters that EY provided to TBS were designed to assist TBS in reaching its own conclusions and do not constitute EY's concurrence with or support of Client's accounting or reporting or any other matters.

EY prepared the English language report. TBS is responsible for its translation into French.

A Platform for Modernizing the way Ontario Manages Provincial Expenditures: *Summary of Findings*

1. EY conducted a review over a six week period of Ontario Government expenditures for the fifteen years ending fiscal year 2017/18 based on data provided by the Ontario Treasury Board Secretariat. The Review covered expenditures and expenditure growth for every ministry, every major sector, every program, and collectively, for all transfer payment expenditures[1,2]. An extensive interview program with over 75 senior Government executives was engaged to support the Review, including elected and non-elected officials. In addition, the Review was supported by the Government's *Planning for Prosperity* consultations that received over 15,000 submissions.

2. The mandate of the Review was to analyze expenditures, conduct selected jurisdictional benchmarking, and based on the data available, identify programs and operations for which efficiencies could be generated through more focused review and subsequent execution. Such opportunities should not result in involuntary job losses, and instead focus on efficiency and effectiveness improvements.

3. The general context within which the Review was conducted is one of achieving fiscal sustainability by the Government over the medium term, and the Review is one input for Government's consideration. No specific target for efficiency dividends or expenditure reduction was set and none was considered. The Government has indicated an objective of efficiency gains in the order of four cents on the dollar; the findings of the Review are consistent with this objective.

4. Analysis of expenditures (2002/03 – 2017/18) reveals some key facts that indicate substantial growth in Ontario's public sector:

a) In real terms ($2018) total operating expenditures have increased by $46.4B or 55%. This means that per capita spending has increased a full $2,226 per person in today's dollars, a 32% increase over 2002/03 in real terms.

b) After adjusting for inflation, the compound annual growth rate (CAGR) of total operating expenditures is 3.0% and over the 15 years examined outpaced Ontario population growth by 1.9% (CAGR). Had expenditures increased in line with population growth, 2017/18 expenditures would have been $31.9B less, and in total, would have been $331B lower over 15 years.

c) Provincial debt over that same period almost doubled, increasing 87% or $158B ($2018) to $338B and annual interest on debt charges grew $2.4B ($2018) to $12.6B per annum in 2017/18. Interest on debt is Ontario's 4th largest expenditure

[1] Data for 2017/18 represents a point in time and was prior to finalizing the 2017/18 Public Accounts released on September 21, 2018.

[2] Figures in the report may exclude consolidation adjustments. Figures may also exclude one-time adjustments to allow for comparability.

item, higher than total operating expenditure in the entire Ontario Public Service (OPS).

d) A striking finding is shown by the breakdown of expenditures that reveals real operating expenditure in the OPS has remained flat (growth at just 0.0% CAGR), while operating expenditure through Transfer Payments (TP) including to the Broader Public Service (BPS) has grown $46.3B or 99.8% of total real growth in operating expenditures. This means that for every one dollar spent in the OPS, nine dollars are spent through the 35,000 separate TP arrangements that the Ontario Government manages.

5. The sheer volume of payment arrangements coupled with the fact that more than 90% of total operating expenditure is spent through TP agreements suggests there is significant opportunity to transform the way Ontario manages these expenditures.

6. This is an opportunity characterized by capturing the significant investments already made in the sector. The most important finding of the Review is that not only can significant operating efficiencies be found to support a more sustainable expenditure pattern for Government, pursuing efficiencies in the manner and areas outlined would lead to significant improvements in outcomes. The beneficiaries of carefully planned and executed efficiency and effectiveness would be citizens, clients, businesses, employees, delivery partners, and taxpayers.

7. The Review focuses on four major dimensions to implement a modernized Ontario Government:

a) A better framework for public expenditure management that commits to evidence-based decision-making, a modern relationship with labour, a citizen-centered and digital-first mindset, modern risk-based regulatory management, renewed funding models that incent productivity and performance, a strong focus on intergovernmental coordination, and a clear understanding of the role of government acting as steward of taxpayer investment.

b) Strong leadership by the centre of government working with ministries and various delivery partners, to strengthen horizontal coordination and establish a renewed focus on improving the efficiency, productivity, and outcomes of the BPS and broader transfer payment partners, while at the same time delivering the most efficient OPS possible.

c) Major areas for Government to focus on to achieve efficiencies and improvements for both the OPS and through TP partners include: service delivery modernization, cost efficiency, individual and business supports, and one-time savings.

d) *A Modernization Action Plan* that would establish strong governance, clearly prioritize those opportunities for short term and longer term efficiency and performance, initiate immediate steps to execute the Plan, and most importantly of all, drive the realization of benefits for all Ontarians.

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B Review Mandate and Approach

8. There is no shortage of commentary on the state of Ontario's public finances. From the statutory reporting of Ontario's Auditor General[3] or the Financial Accountability Officer[4] who both report directly to the Ontario Legislature, to the *Commission on the Reform of Ontario's Public Services* (the Drummond Report)[5] in 2012 , to recent publications from leading Canadian research entities such as the C.D. Howe[6] Institute or the Fraser Institute[7], to the regular analysis presented by debt rating agencies such as DBRS or Moody's, there is general concern about the sustainability of Ontario's fiscal position.

- "There was one overarching theme this year… the need to improve planning that supports timely and informed decision-making and oversight." (Auditor General Annual Report, 2017)
- "The slower pace of economic growth results in more modest growth in Ontario's revenues, which in turn, contributes to Ontario's worsening budget deficit." (Financial Accountability Office, Economic and Budget Outlook, 2018)
- "Unless policy-makers act swiftly and boldly to prevent such an outcome, Ontario faces a series of deficits that would undermine the province's economic and social future. Much of this task can be accomplished through reforms to the delivery of public services that not only contribute to deficit elimination, but are also desirable in their own right." (Commission on the Reform of Ontario's Public services, 2012)
- "The government must act to bring the long-term cost of government in line with the revenue-raising capacity of the province." (CD Howe, An Economic Program for Ontario, 2018)
- Ontario should deal with its fiscal challenges head on by reducing government spending. (Fraser Institute, Restoring Ontario's Public Spending, 2018)

[3] 2017 Auditor General Annual Report
[4] Financial Accountability Office of Ontario. Economic and Budget Outlook, Spring 2018.
[5] Commission on the Reform of Ontario's Public Services, 2012
[6] C.D. Howe Institute. Fiscal Soundness and Economic Growth: An Economic Program for Ontario. March 2018.
[7] Fraser Institute. Restoring Ontario's Public Finances. August 2018.

9. The current Review is complementary to other research and commentary, and takes a line-by-line look at the historical expenditures of the Ontario Government for the 15 year fiscal period 2002/03 to 2017/18. Its point of departure from previous assessments is to use the facts about how money has been spent over 15 years as a direct basis for how Ontario could realize a new strategy focused on efficiency, productivity, and results, including specific discussion of the enabling conditions that need to be in place to sustain performance. The Review proposes the development of a *Modernization Action Plan* for Government to consider as it works to address fiscal management over the coming years.

10. The Review's mandate was clear and focused: examine 15 years of historical expenditure data, compare Ontario's results to those in selected jurisdictions in Canada and internationally, and recommend areas for further examination by Government as it considers decisions about how it will manage Ontario's fiscal position.

11. The Review has been conducted in the context of Government's stated commitment that there should be no involuntary job losses as a result. This constraint has been respected fully.

12. The Review was conducted over a six week period in the late summer of 2018 and relied exclusively on various operational, financial, and program data collected from Ministries and Central Agencies by the Treasury Board Secretariat which, as is a key finding of the Review, is limited in some important ways. Publically available information was also reviewed to bolster the analysis. A key recommendation going forward is for a relentless focus on data and analysis to strengthen the government's ability to drive greater efficiencies and better outcomes.

13. The Review was not mandated to recommend a specific approach to achieving fiscal sustainability and had no connection with the *Independent Financial Commission of Inquiry*. The Review was conducted in parallel to the *Planning for Prosperity* initiative and the OPS *Big Bold Ideas Challenge*, and it incorporated important ideas from these efforts into the analysis

14. The approach requested by Government and taken by the Review, was to use the available data to guide all conclusions (including about when and where further data are required), to focus on a relatively small number of factors and strategies that could have the most meaningful impact on future fiscal performance and service results, and to identify necessary enabling conditions and governance arrangements for the work that lies ahead. These factors are viewed as necessary to achieve any strategy Government will choose for fiscal management but are not, on their own, guarantees of success. That would come only if there is sustained commitment to evidence-based decision-making and continual attention to the modernization of how Ontario designs, funds, manages, and delivers its public sector responsibilities.

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15. The Review's contribution is:

a) A step-wise examination of the facts and identification of what can be done in response to these facts to pursue efficiency, productivity, and results.

b) Identification of where better evidence is required.

c) A roadmap for implementation.

16. The data show considerable investment has been made in Ontario's public sector, primarily through the wide range of transfer payments that distribute the vast majority of Provincial expenditures. From an expenditure perspective, it is clear the Ontario public sector is characterized by the investments made outside the OPS. Any attempt to "bend the expenditure cost curve" in a way that will sustain fiscal results, must focus on realizing the value of investments made in the delivery agents that sit across the Province and whom deliver more than 80% of total public expenditure and more than 90% of direct operating spend.

17. The lasting result can achieve shorter-term efficiencies and longer-term modernization and productivity gains to deliver fiscal sustainability and a transformed, modern, public sector for Ontario.



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C

Fifteen Years' Historical Expenditure Analysis: *What the Facts Tell Us*

Where Ontario spends

18. Ontario spends its money in three main ways[8]:

a) On the government ministries and operations known as the Ontario Public Service (OPS).

b) On a series of Transfer Payments (TPs) that go to individuals, businesses, and a wide range of consolidated entities outside of the OPS including hospitals, schools, colleges, and Agencies, Boards and Commissions in the Broader Public Service (BPS), to a range of entities that receive significant public funding but are not consolidated such as universities and municipalities, and a significant number of delivery agents and TP recipients that work at arms-length to Government.

c) Interest on debt.

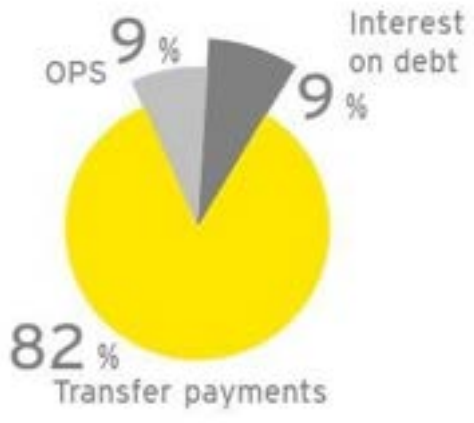


Figure 1 Total Government Expenditures (FY17/18)

The line by line review of Government of Ontario expenditures from 2002-03 to 2017-18 rests on a detailed analytical program that:

- Reviewed 15 years of financial records from the Government's general ledger system, comprising over 233,000 lines of financial account data
- Reviewed 22,000 additional lines of financial information related to transfer payments made by the Government over the 15 year review period
- Reviewed an additional 11 years of financial data for the broader public sector entities (hospitals, school boards, and colleges), comprising 286,000 lines of data
- Compared 15 years of historical data including revenue, expenditure, GDP, population, inflation, and program outcome measures for three other Canadian provinces and three subnational governments globally
- Received and disaggregated over 800 individual files, and over 1.7GB of data
- Analyzed planned future operating and capital expenditures, spanning as far forward as 2027-28 in certain cases
- Reviewed over 120 reports, briefings, and background documents across ministries
- Met and consulted with representatives from the Office of the Premier, Cabinet Office, and from all ministries
- Reviewed over 15,000 submissions to "Planning for Prosperity: A Consultation for the People"
- Reviewed recent reports from Office of the Auditor General, the Financial Accountability Office, and other recent reports commissioned by the Government on a variety of topics

[8] All expenditure data extracted from Government of Ontario financial systems and provided by TBS

19. Total government expenditure for the fifteen year period has grown from $95B to $144B in real terms; transfer payments grew by $46.3B (CAGR of 3.4%), interest on debt grew by $2.4B (CAGR of 1.4%), and direct OPS expenditures grew by $0.1B (CAGR of 0.0%).

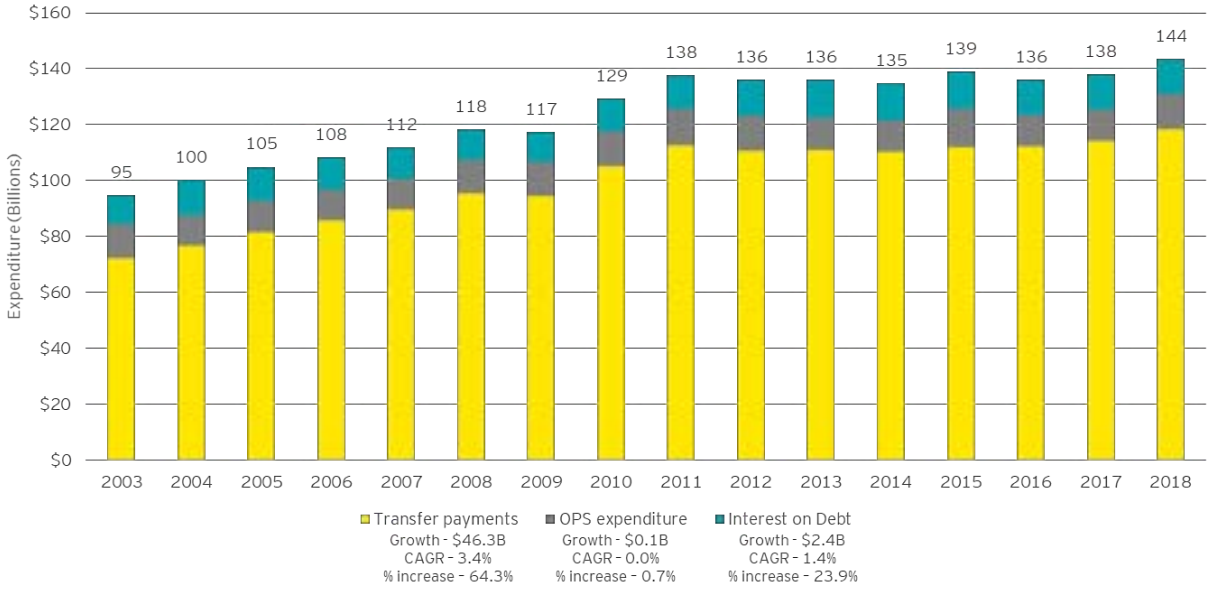


Figure 2 Total Government Expenditures FY2002/03-FY2017/18 (Real 2018 $)[9]

20. The review of historical operating expenditures (excluding interest on debt) can be summarized in three main points (see Figure 3):

a) Expressed in today's dollars ($2018), total operating expenditures have risen 55% or $46.4B, at a compound annual growth rate of 3.0%.

b) Of this real growth, 0.2% has gone to the OPS, which represents less than 10% of current operating spend; 99.8% has gone to Transfer Payments, which represents more than 90% of current operating spend.

[9] Forecast expenditures from 2018 Ontario Budget, Table 3.1; Forecast CPI from Oxford Economics

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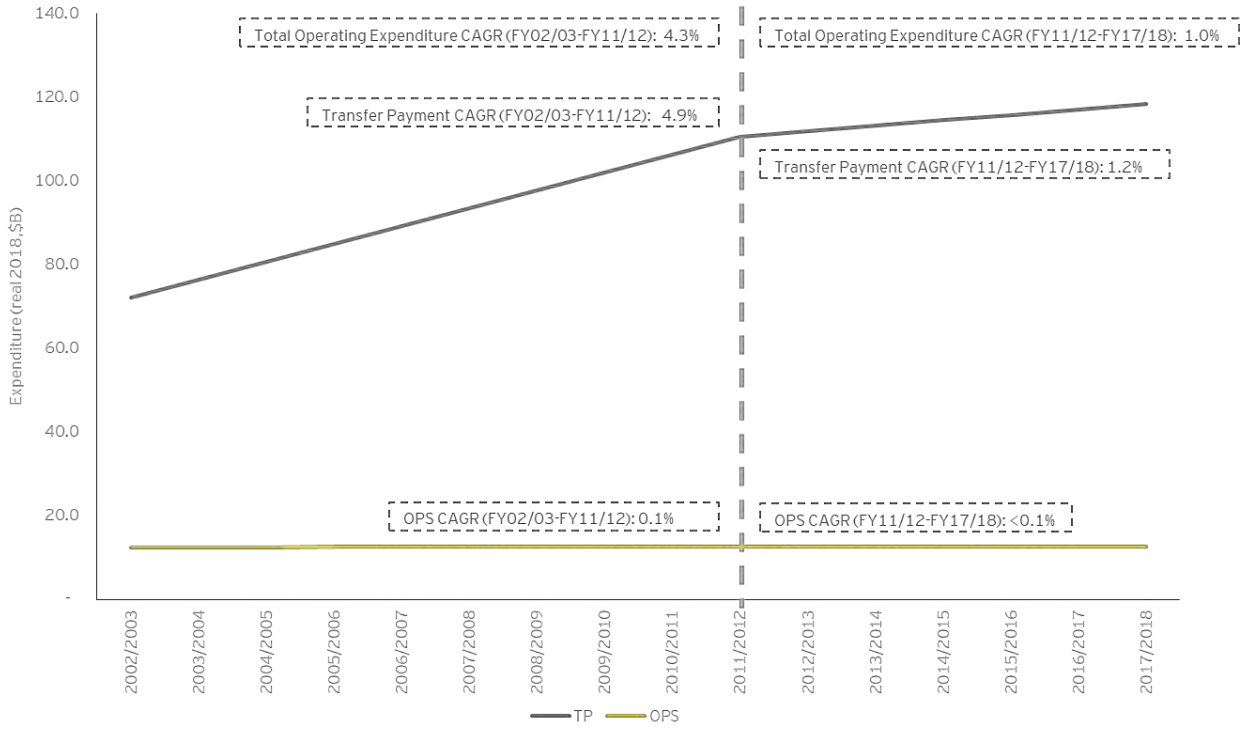


Figure 3 Total Operating Expenditure, FY02/03-FY17/18 (Real 2018 $)

c) Of the real growth in TPs, approximately 37% ($17.3B) has gone to individuals and business supports, and the remaining 63% ($29.0B) to various operations, of which 50% is spent on employee-related costs.

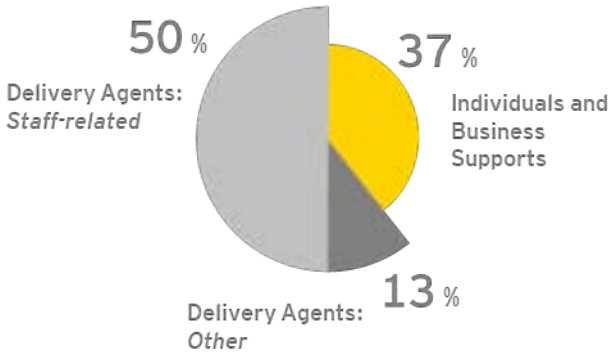


Figure 4 Real Growth in Transfer Payments, FY02/03-FY17/18 (Real 2018 $)

21. A sector-by-sector breakdown of expenditures for the major spending allocations reveals that the most significant proportion of spend is in the "Big Three" sectors: Health, Education, and Children, Community and Social Services. Although small in the overall context, growth in Environment, Resources, and Economic Development is a significant portion of the total growth,

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and is largely driven by transfers for transit capital projects, business supports, energy price mitigation programs, and programs related to the Greenhouse Gas Reduction Act[10].

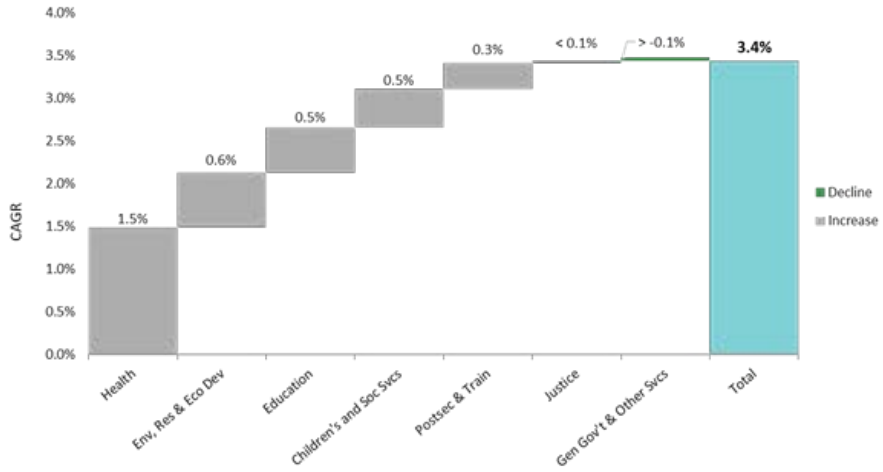


Figure 5 Compound Annual Transfer Payment Growth, Weight-Averaged by Sector FY02/03–FY17/18 ($B, 2018)

22. Below is a stylized view of each of the major sectors and a breakdown of the proportion of each sector spent directly by the OPS and through transfer payments.

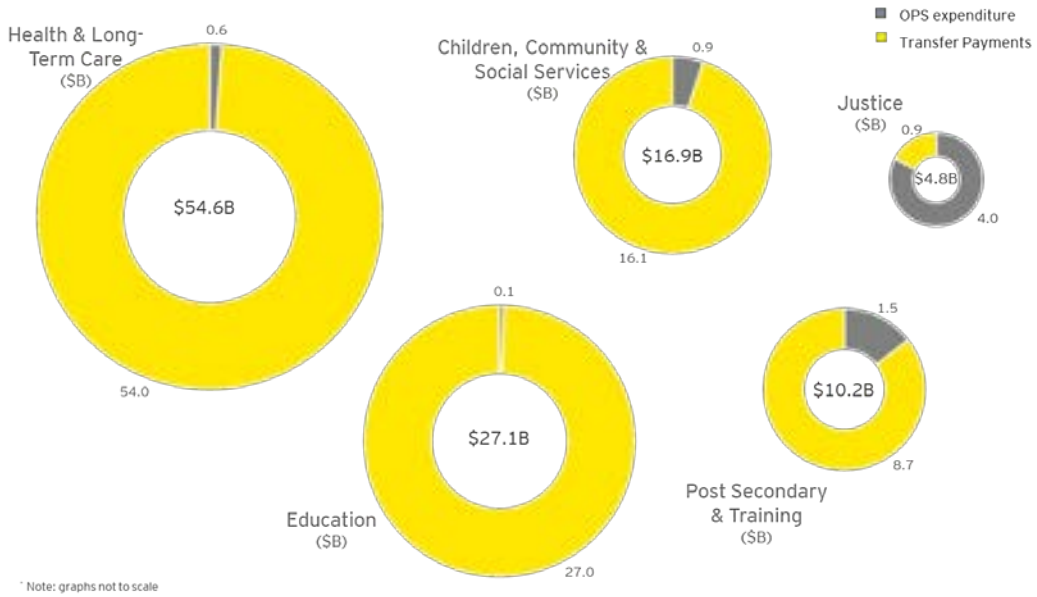


Figure 6 Total Operating Expenditure Growth by Sector, FY02/03-FY17/18 (Real 2018 $)

23. See "Sectoral Transfer Payments" at the end of this section of the report for a more detailed analysis of sectoral spending.

[10] Sectoral growth breakdown was weighted using the average of the FY2002/03 and FY2017/18 proportion of total expenditure

24. The 15 year expenditure growth has significantly out-paced population growth[11] (expenditures CAGR is higher than population CAGR by 1.9% over 15 years). Had expenditures increased in line with population growth, 2017/18 expenditures would have been $31.9B less and, in total, would have been $331B lower over 15 years.

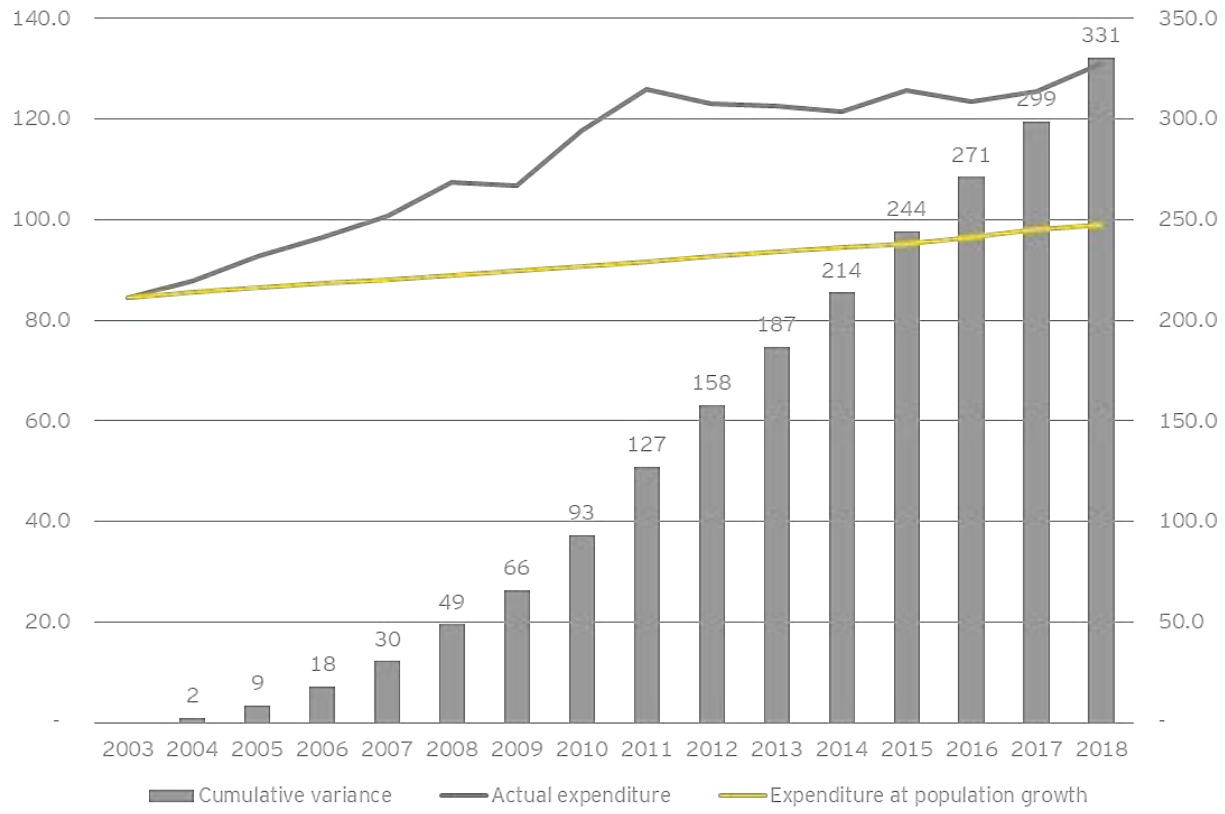


Figure 7 Actual Expenditure vs. Expenditure at Population Growth, FY02/03-FY17/18 (Real 2018 $)

25. This is evident in some important sectors as well, such as:

a) Education real expenditure (K-12) has grown by 1.7% CAGR while at the same time total student enrolment has declined by 0.5% CAGR[12].

b) Real expenditure in hospitals has grown by 2.3% CAGR in real terms while at the same time in-patient days have grown by 0.2% CAGR.[13]

[11] All population figures based on Statistics Canada data
[12] Quick Facts – Ontario Schools. Available at http://www.edu.gov.on.ca/eng/educationFacts.html.
[13] Canadian Institute for Health Information, Report CMDB3, 2017

Jurisdictional benchmarking

26. Ontario's 15 year[14], Whole of Government expenditure (including debt service) CAGR of 2.9% is higher than both BC (1.8%) and Quebec (1.6%), as can be seen in the figure below.

a) Government expenditures as a portion of GDP have shrunk over the relevant 15 year time period for Ontario (CAGR of -0.7%), BC (CAGR of -2.8%), and Quebec (CAGR of -1.9%).

b) Ontario's interest on debt is 9% of expenditures, compared to 5.3% in BC and 10.6% in Quebec.

c) In terms of operating expenditures per capita, Ontario's 15-year CAGR is 1.8%; BC's operating expenditures per capita CAGR for the same period is 0.7% and Quebec's CAGR is 0.8%. Note that both BC and Quebec have gone through expenditure management programs in recent years.

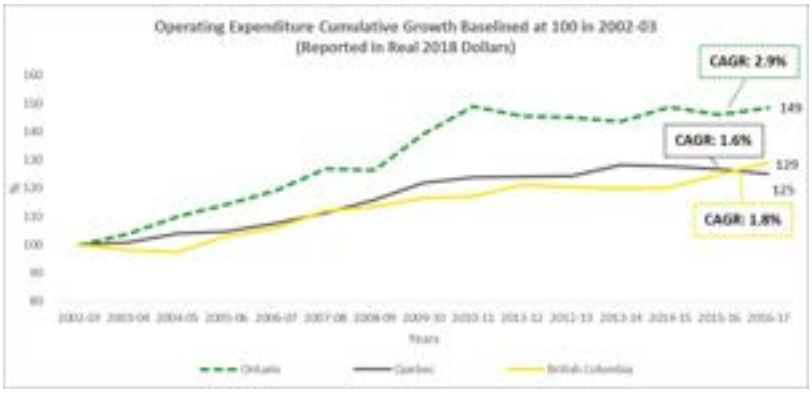


Figure 8 Comparative Cumulative Spending Growth, FY02/03-FY17/18 (Real 2018 $)

Evidence-Based Expenditure Management in Quebec

In 2014, the Government of Quebec made a decision to address the trend of Provincial expenditures consistently exceeding revenues. The Government developed annual expenditure management strategies with the aim of balancing the Provincial budget by the 2015-16 fiscal year. A balanced budget was achieved via detailed reviews of program spending and a resulting limit on expenditure growth. Quebec focused on making evidence-based decisions in an effort to both generate one-time savings and promote ongoing spending restraint. Now, Quebec is making efforts to develop a culture of continuous review intended to strengthen the sustainability and quality of government initiatives based on priority needs and available resources. Expenditure programs are now subject to reporting requirements that must enable realistic assessment of program results – this requirement is designed to help the Government provide effective programming while avoiding duplication of efforts between departments.

[14] For the purposes of jurisdictional comparisons, comparable data for other provinces was not available for FY2017/2018, so data series end at FY2016/2017. As a result, 15 year CAGR do not directly align with those provided elsewhere in this document.

27. At a sectoral level, Ontario expenditure has grown faster than either BC or Quebec in all four sectors considered, as shown in the figure below.

Low → High	Health	Education	Justice	Social Services
	Ontario: 3.2%	Ontario: 2.3%	Ontario: 1.3%	Ontario: 3.2%
	Quebec: 2.9%	Quebec: 1.0%	Quebec: 1.2%	British Columbia: 0.2%
	British Columbia: 2.3%	British Columbia: (0.7)%	British Columbia: (0.5)%	Quebec: (0.3)%

Figure 9 Comparative Sector-by-Sector Compound Annual Growth Rates, FY02/03-FY16/17 (Real 2018 $)

a) Health sector expenditures per capita have grown at an identical rate in Ontario and Quebec (15 year CAGR of 2.1%), and at a lower rate (15 year CAGR of 1.2%) in BC. Similar demographics explain a significant portion of the similarity in sectoral expenditure growth.

b) Quebec (1.0%) and BC (-0.7%) have lower 15 year CAGRs than Ontario (2.3%) in terms of total education expenditures. Ontario spends more on education as a percentage of total government operating expenditures (28% in 2016/17) than either BC (17%) or Quebec (25%). However, both Quebec and BC have higher PISA scores (2015 results) than Ontario in Mathematics, Science, and Reading. Understanding BC and Quebec's approach to managing education could point the way to improving the sustainability of the sector in Ontario.

c) Quebec (15 year CAGR of -0.3%) and BC (15 year CAGR of 0.2%) both have lower expenditure growth rates in social services than Ontario (15 year CAGR 3.2%). All three provinces have similar poverty rates (calculated as 50% of the national median income) after taxes and transfers[15], but Quebec's starting point for poverty is significantly higher than Ontario's, while BC's is approximately the same level. While differences in program delivery will account for a portion of the gap, further investigation into the strategies pursued by BC and Quebec should be carried out, while efforts are made to consider delivery models that may be driving systems costs in Ontario.

d) Ontario's 15 year CAGR in the justice sector is 1.3%, higher than BC (-0.5%) and Quebec (1.2%). Ontario also spends more on justice on a per capita basis ($327) than BC ($266) and Quebec ($265). However, all three jurisdictions have very similar rates of police officers per 100,000 people (183 in Ontario, compared to 186 in BC, and 189 in Quebec)[16].

[15] OECD.Stat. Regional Well-Being: Regional income distribution and poverty. Data for 2013.
[16] Statistics Canada. Canadian Centre for Justice Statistics. Police Administration Survey. 2017.

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A Strategy to optimize investment: The call for action

28. And yet this is not a story of dire straits, it is a story about opportunity to capture the benefit of significant investments made historically through a concerted effort to modernize delivery systems in the BPS and transform the way Ontario citizens and businesses experience the relationship with their cities, schools, higher education providers, health care providers, transportation systems, regulators and the full scope of the public sector that affects every dimension of their daily lives.

29. The dividends owed to taxpayers who continue to make significant investments are simple to define:

a) Improved productivity in all public delivery systems as measured from the perspective of the citizen, taxpayer and client, rather than the perspective of the suppliers – the first and last test of every decision must be that it results in greater levels of productivity and result for citizens, clients and taxpayers.

b) Through improved productivity, the capacity to focus more strongly than ever on delivering all public services and government responsibilities in the most modern, efficient and effective manner possible.

c) Better outcomes across the board.

30. Realizing substantial dividends is possible through some important foundational changes to the enabling conditions of how Ontario manages its public finances, coupled with on-going opportunities to drive day-to-day efficiencies in operations, which will underpin the sort of transformation in Ontario's public sector that is possible.

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Sectoral transfer payments

Below is a stylized view of sectors spending, split between what is directly spent by the OPS and what is spent through transfer payments. The pattern of the majority of spend occurring through transfer payments that is true at the whole-of-government level is also true at the sectoral level and, in fact, is more pronounced in the three largest sectors[17].

Health

The Health sector represents 42% of total government operating expenditure and substantially all of it is through transfer payments. Passed on through Local Health Integration Networks, about one-third of Health expenditures go to hospitals, or about 14% of total government operating expenditures.

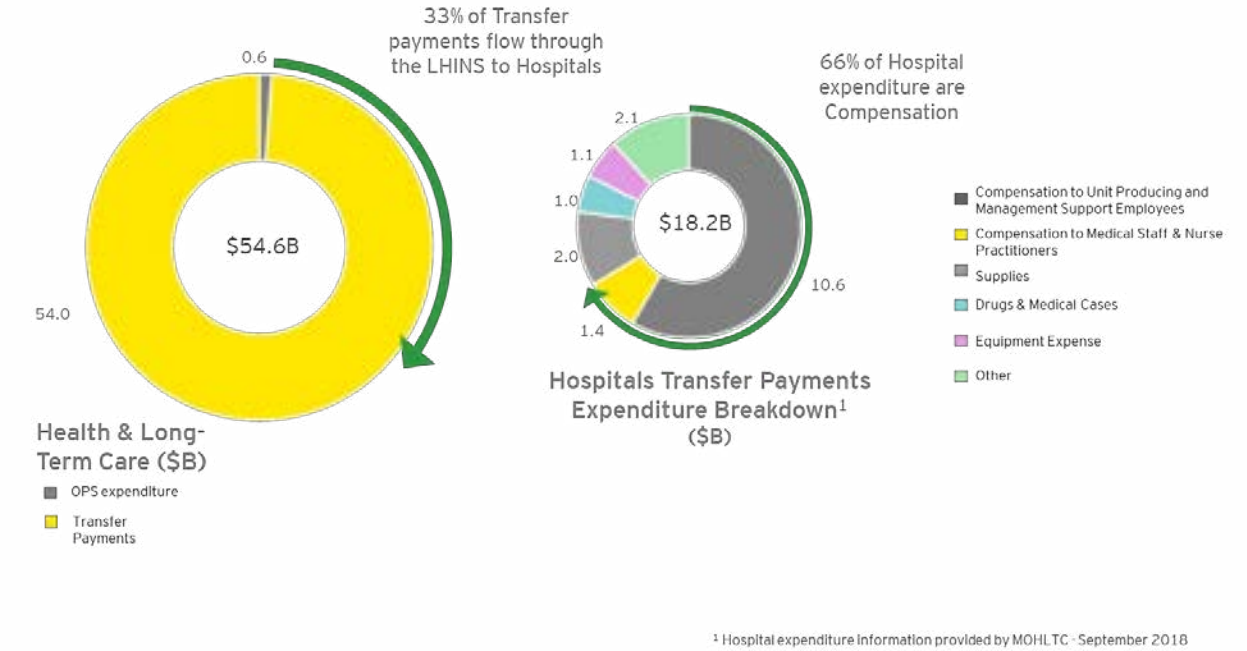


Figure 10 Ministry of Health and Long-Term Care and Hospital Expenditures, FY17/18

[17] For all Sectoral breakdowns, totals may not always add due to rounding

Education

Education is the second biggest sector, representing 21% of total operating expenditure. As with Health, substantially all of that goes through transfer payments, largely to school boards, which in turn, spend 77% of funding on employees. Of the employee spending more than two-thirds, or $14.2B, is on teachers and teachers' assistants, representing more than 10% of total government operating expenditures.

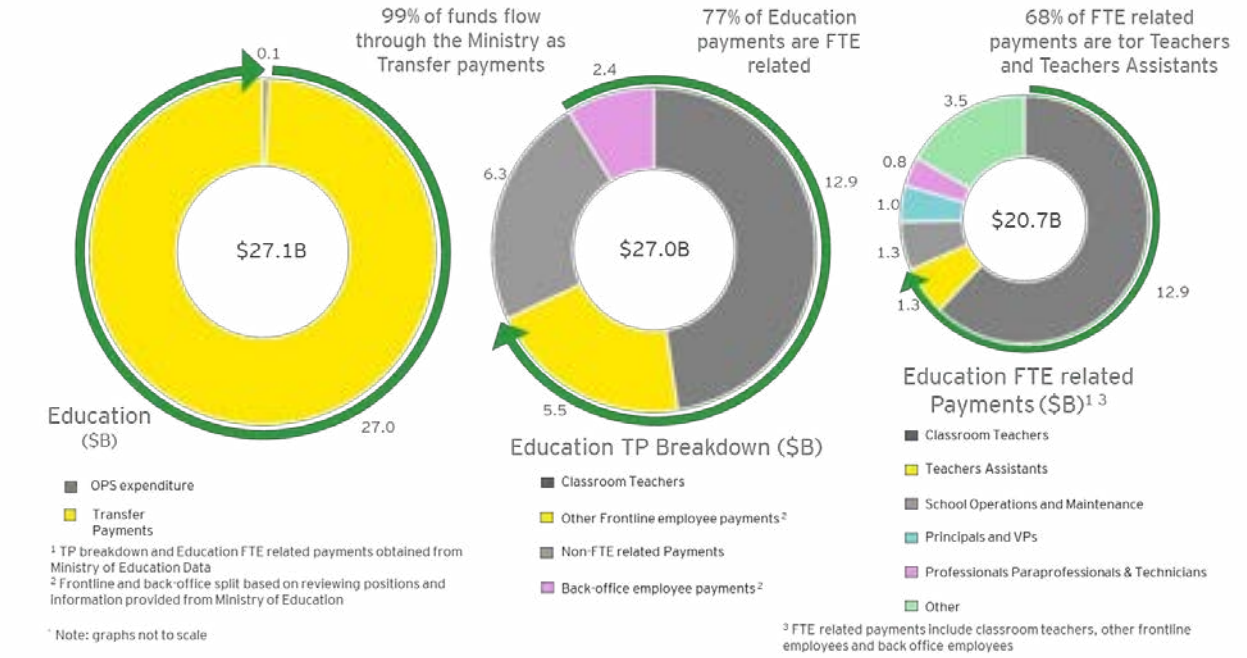


Figure 11 Ministry of Education and School Board Expenditures, FY17/18

Social Services

95% of Social Services expenditures flow through transfer payments, but in this case as a combination of statutory transfers to individuals and transfer payments to delivery agents. Even with that split, almost 28% of sectoral spending still occurs through transfer payments to delivery agents, or just under 4% of total government operating expenditures.

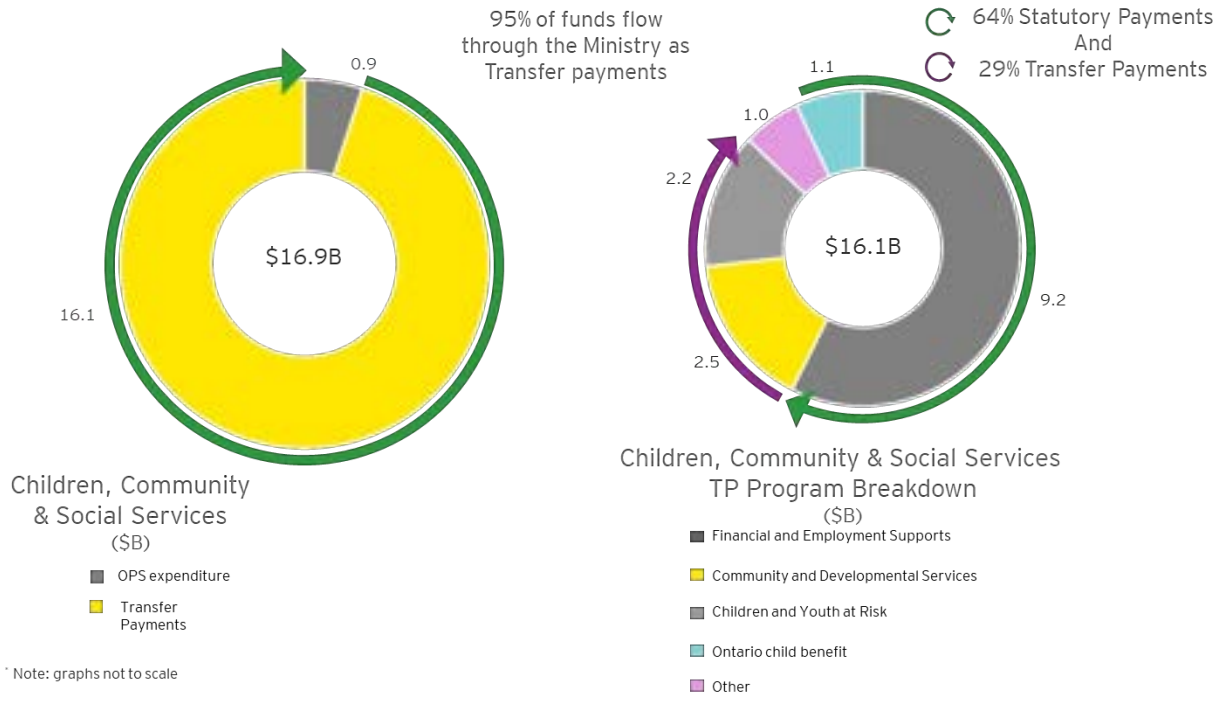


Figure 12 Social Services Sector Transfer Payment Breakdown, FY17/18

Post-secondary and training

Just under 4%, or $5.1B, of total government operating expenditure goes to colleges and universities for operating costs, with an additional $0.8B in capital support for post-secondary institutions, and $1.4B in direct student support, a significant portion of which flows through to colleges and universities in the form of tuition payments.

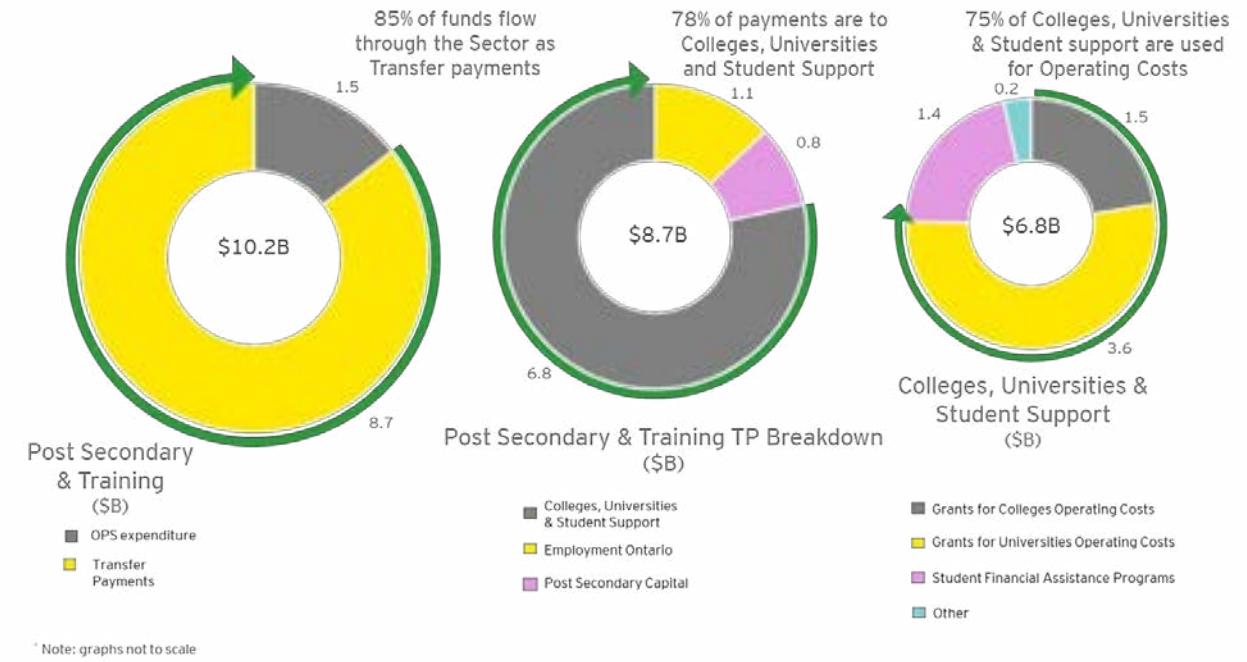


Figure 13 Post-Secondary and Training Sector Transfer Payment and Program Breakdown, FY17/18

Justice

Justice is the only sector in which expenditures are primarily directly through the OPS and not transfer payments. Since Justice only makes up a small portion of total operating expenditures, any line item in this sector does not have outsize impacts on total government expenditures in the same way as sectors discussed above. However, a significant portion of Justice expenditures are still on salaries and wages, primarily for OPP officers and corrections personnel.

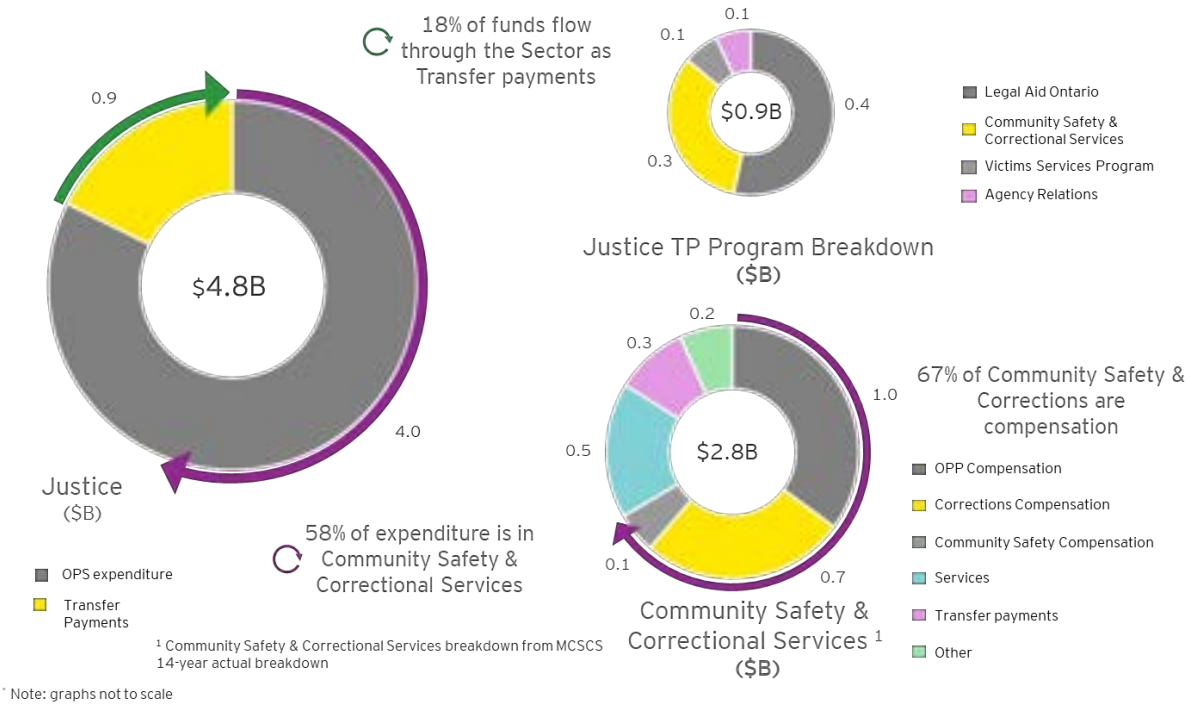


Figure 14 Justice Sector Transfer Payment and Community Safety and Correctional Services Expenditure Breakdown, FY17/18

D A Framework for Better Public Finance Management in Ontario

How Ontario manages its data

31. The data show that nearly all of the increase in expenditure has gone into funding Transfer Payments which, by design, are at arm's length. The evidence points to a more effective ability to manage the 15 year expenditure growth in the OPS to 0.0% in real terms, which is perhaps not surprising, as these are the expenditures over which Government can exert the strongest control and has done so repeatedly through a series of "efficiency dividend" exercises.

32. From an expenditure management perspective, this implies that any serious attempt to address expenditure growth in the Ontario public sector must focus on modernizing and ensuring better outcomes for delivery of programs. There can and should still be efficiencies in the OPS, particularly through modernization, but fiscal balance (should that be a policy objective) would need to strongly focus on what happens through TP expenditures.

33. From a data and governance perspective, this is made a much more difficult task by existing constraints on data:

a) Government financial systems provide a comprehensive source of information for major program and standard account expenditures (defined as Salaries and Wages, Benefits, Services, Supplies and Equipment, Transportation and Communication, and Other) within the OPS, but has limited – if any – information on standard accounts within the BPS.

b) There is limited standard account level information available for consolidated entities (Hospitals, School Boards and Colleges); combined with direct OPS expenditures, and this captures 45% of expenditure data; there is limited centralized data available on the remaining 55% of non-consolidated entities and other transfer payment recipients.

c) There is poor information available about labour allocation from internal government Human Resources systems.

d) The availability of standard account level data on OPS operations provides an indication about the efficiency and productivity of expenditures, but nowhere in the data at all, is there a sufficient basis of evidence to assess the productivity of expenditures.

e) This is further exacerbated by the sheer volume of separate entities receiving TPs, which currently runs at nearly 35,000, up 18% from 2002/03.

34. Even when the data exist, the decentralized nature of governance makes it very difficult to get timely and relevant information to support on-going fiscal management. What information is received (in many cases, in duplicative formats) is not integrated in a centralized database to allow for comparative analysis. No private sector business would operate under such conditions, and neither should the Ontario government. Significant opportunity exists to invest in the necessary capacity and capability for Ontario to improve its various fiscal frameworks including throughout its planning, budgeting and forecasting requirements not just for the OPS, but particularly for the relationship with the BPS and other transfer payment recipients. New technologies such as blockchain, could be instrumental to supporting this requirement.

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	OPS	BPS & TP's
Standard Account Level Data	ü	P
Detailed FTE Data	ü	P
Outputs	ü	P
Outcomes	P	P
ü - Available		P – Partially Available

Figure 15 Availability of Data

What this means overall

35. One of the most important conclusions from the Review is that there is a need for better data on public expenditures. This is particularly true given that the majority of expenditure through TPs is where Ontario has the weakest insight into efficiency, productivity and results. This is as much a cultural issue as it is a data availability issue, and ample evidence exists to indicate that much of the data reporting and oversight currently required does not provide decision-makers with the right information at the right time. A complex array of prescriptive compliance-oriented reporting should be replaced by centralized reporting only on those things matter most to the design, funding and delivery of results – namely, efficiency, productivity, and performance information.

The effective use of data in government: The Productivity Commission and The Report on Government Services in Australia

Initially founded as the Industries Assistance Commission in 1973, the Productivity Commission has a mandate to focus on ways of achieving a more efficient and productive economy, as the key to higher living standards. As an independent body that publishes its work and has a focus on advancing the Australian "community at-large," the Commission is unique globally. Annually, the Commission publishes the Report on Government Services (ROGS), which provides information on the equity, effectiveness and efficiency of government services in Australia. ROGS is a national report on the spending at a federal and state level, and enables comparisons across states, informs planning and evaluation of policies, is used for budgeting and demonstrates government accountability.

As an example of the level of detail provided in ROGS, the Education section of the 2018 report included data on student enrolment, achievement, retention, and engagement by region and among target groups; operating expenditures by type; the cost of capital to the government for school facilities; standardized test results; front-line staff levels; and student:staff ratios by state.

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36. Poor access to data and analysis on how every dollar of public funding is allocated and spent, and whether this has resulted in the most efficient and effective outputs and outcomes, impedes overall fiscal management. It also impedes Government's ability to prioritize its investments and budget allocations and weakens overall performance.

37. The result is that while Government understands and can report *what* it has made investments in, in the vast majority of cases it cannot assess whether the investment has maximized returns when measured in productivity and performance terms (i.e., *how* public money has been spent and what it has *achieved*). This must be changed, and beyond the short-term requirement to initiate a new expenditure management program, is the single most important thing Government can do from a financial management perspective.

38. This challenge is increasingly apparent the further expenditure management gets from the OPS but, paradoxically, it is where 90% of the operating money is spent and 99.8% of 15 year growth has occurred.

39. In addition, government decision-making processes have historically been biased towards incremental change for net new investments rather than comprehensive review and continual improvements to on-going funding that represents the vast majority of annual expenditure. This is exacerbated by decisions that are taken without full and comprehensive business cases that thoroughly assess the administrative and socio-economic impacts of decisions and clearly establish formal implementation plans and accountabilities for results. This has led to significant duplication of delivery mechanisms for the same purpose.

40. Poor data and analysis, coupled with a culture and incentives to always spend more and identify new investments, also make it exceedingly difficult for the *collective* position of ministers to defend whole of government strategies for fiscal management, in the face of strong incentives for *individual* ministers to spend more in their portfolios.

Commitment to evidence-based decision-making from the heart of Government

41. To a person, the elected and non-elected officials consulted as part of the Review indicated that a very strong and direct commitment to evidence-based decision-making is required. This should comprise two foundations:

a) Commitment to a robust data and analytics framework for decisions government faces including those about new and on-going funding requirements for *all* Provincial funding regardless of who the final delivery agent is. The framework established should result in the ability for decision-makers to understand precisely what demand and cost drivers are for all programs, functions and service channels. Most importantly, there must be assurance that policy, regulatory, funding, and delivery organizations are operating on a most efficient organizational basis, and that there is a clear understanding of results and how they are being improved continually. The focus should begin in high priority areas where the most significant expenditures are allocated and, over time, extend to all government expenditures. This should be led by Treasury Board Secretariat, working with ministry and external partners, to simplify, modernize, and enhance the data that underpins all Government decisions and on-going delivery of Provincial responsibilities whether directly or indirectly.

b) Thorough review of Cabinet processes and procedures to emphasize – and follow through on – evidence-based decision-making, strong forms of implementation planning as a prerequisite to any decision, and a clear and strongly reinforced commitment to the appropriate balance between collective and individual ministerial responsibility and accountability. This should be tied directly to an enhanced budget and expenditure management framework that emphasizes continual review and improvement to the base, as well as careful consideration of net new investments. In instances where processes and procedures are not followed, further investigation must occur to help ensure the objectives are being met.

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Efficient regulatory management and approvals

42. The Province has extensive regulatory responsibility across nearly every sector of Ontario's economy. There is an opportunity to continue modernizing approaches to regulatory management with two key benefits such that it:

a) Reduces the *external* regulatory and administrative cost burden placed on Ontario businesses and individuals with real opportunity to provide efficiency gains back into the economy (i.e. positive cost-benefit returns).

b) Reduces the *internal* regulatory and administrative cost burden placed on the regulator from outdated and inefficient regulatory management, including for all internal processes where one government entity is regulating another (i.e. lowers the cost of government).

43. Ontario is moving to outcome- and risk-based regulatory management frameworks in nearly all major regulatory areas. A further simplification and modernization of regulation can be achieved, with stronger focus on self-regulation, and use of digital technology and data and analytics. This is tied to the Citizen-Centered and Digital First enabling condition outlined below, and should also focus on integrating regulatory data and analytics across ministries/regulators.

Renewed funding models for major programs

44. Across government, a significant number of transfer payments and external delivery agents rely on funding models for resource allocation across the province. Examples of funding models include the Grants for Student Needs (GSN) which determines over 90% of school board funding, the Health-Based Allocation Model which determines about 40% of provincial hospital funding, and the Child Welfare funding model, which allocates substantially all of the funding to Children's Aid Societies.

45. Governments around the world are moving towards alternate arrangements for funding, including tying funding to the achievement of outcomes, and providing funding to individuals, who can then choose their service providers through a form of market activity and discipline.

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46. Research from the OECD[18], for example, suggests that the most important factor in driving efficiency into public services is not necessarily engaging private sector actors as is often thought, but imposing competitive pressure on public sector providers. Competitive pressure can only be applied through the use of information – both around efficiency and ability to achieve outcomes, but only if that information is used. The information should be provided to citizens so they can choose which provider they receive services from; it should be also used by government to inform funding, increasing allocations to those providers that demonstrate value and efficiency in delivering outcomes and reducing allocations to those that do not.

47. The opportunity for Ontario is to engage in a comprehensive review of its various funding models and to introduce the notion of an "efficient price" for services in as many cases as possible. This would be a strong enabler of delivering the productivity gains necessary for optimizing the investments in the BPS and broader delivery agency environment such as with municipal service managers. At the same time, a focus on measuring outcomes to determine an efficient price would help determine which providers are most effective when it comes to service delivery and client outcomes. Key next steps should include:

a) Develop an overall approach and set of principles to review funding models in the short-term and on an ongoing basis.

b) Improve the collection of data from transfer payment recipients, including the services they offer and deliver and their efficiency in doing so, and begin a focused collection of outcome metrics.

c) Consider the use of alternate approaches to funding, including direct funding to individuals and payment for outcomes.

The Government of New Zealand has taken an evidence-based approach to social services, gathering information on high-risk populations that will most benefit from early interventions to save costs down the line; this is enabled by paying for results and actively shifting funding to the delivery agents that are the most successful at delivering outcomes.

Details on the approach, including a guide to developing cost-benefit analysis in the context of social investments is available online.

[18] OECD. Improving Public Sector Efficiency: Challenges and Opportunities.

Clarity on intergovernmental relationships

48. Ontario receives approximately 17 per cent of its revenue from the Federal Government[19]. However, there is evidence that in some specific places federal transfers are not adequate to meet the growing costs of services, and are not allocated on clear and consistent principles, which has put Ontario at a disadvantage. Research from the Mowat Centre[20] shows that Ontarians contribute $12.9 billion more to the federal government through tax revenue than the province or its citizenry receives in federal spending:

a) In particular, federal support for health care, as a share of provincial spending, has declined from historical levels and will continue to decline in future. In 2017-18, the federal decision to reduce the annual growth rate of the Canada Health Transfer lowered support that year by $1.1 billion nationally, or $418 million in Ontario alone.

b) The second largest transfer to Ontario, the Canada Social Transfer, grows at a lower rate than other major federal funding, and represents less than ten per cent of Ontario's spending for related social programs. If the Canada Social Transfer had grown in-line with other major transfers, Ontario would have received nearly $600 million more in payments over the last five years.

c) In other areas, such as infrastructure transfers, federal programs impose significant costs and numerous restrictions on the Province, which can divert provincial spending away from priority areas and increase the administrative burden on provinces.

d) Finally, while recent new federal investments in labour market transfers have been provided on a principled and fair allocation basis, the majority of funding is still provided based on an outdated formula that disadvantages Ontarians. Ontario received only 30 per cent of national Labour Market Development Agreement funding in 2017-18, despite having about 39 per cent of the labour force population and 38 per cent of Canada's unemployed.

49. A thorough review of federal transfers should be conducted, with an aim towards recovering the accurate level of federal funding owed to Ontario.

50. Similarly, the Province funds regional and municipal levels of government to deliver significant services such as in the social services and employment and jobs training sectors. A close examination of whether a renewed funding model and/or granting structure is available to drive value for money in this relationship is required.

A modern relationship with labour

51. The Review has taken very seriously the mandate committed to by the Government to ensure that there will be no involuntary job losses as a result of the opportunities identified.

[19] Ontario Ministry of Finance.
[20] Mowat Centre, "A Fair Fiscal Deal", July 2018. This report is the source for the majority of data points in this section.

52. This is achievable through a two-pronged approach:

a) First, a commitment to a modern relationship with everyone whose employment is largely funded by Provincial expenditure that emphasizes capability, skills and an agile allocation of people to highest value work. This should be supported directly through a recruiting, re-training, and change management commitment to help ensure that any movements to new roles and responsibilities will be as smooth as possible from the employee's perspective, and meet the expectations of high productivity and performance that enable people to thrive in their jobs and deliver exceptional results.

b) Second, a renewed approach to formal labour relations that invites labour to participate directly in the benefits of productivity improvement and better outcomes for Ontarians.

Gains Sharing in British Colombia

Gains Sharing (also called mutual gains bargaining) was implemented as a collective bargaining strategy in BC in 2012 under the title Cooperative Gains. Gains Sharing encourages all sides of a negotiation to come together to find solutions. In the public sector, this can be applied to finding productivity gains.

In BC's case, the government published a mandate that public sector wage increases would only be allowed in those cases where labour and the employer found offsetting productivity gains – in other words, the funding envelope from the government would be held at zero. Conditions were placed under which productivity gains would be shared, including the inability to reduce services or raise costs on the general public and the necessity for all savings or productivity increases to be net new – that is, not previously identified. This approach helped BC manage public sector expenditure growth through a partnership with labour in a sustainable manner.

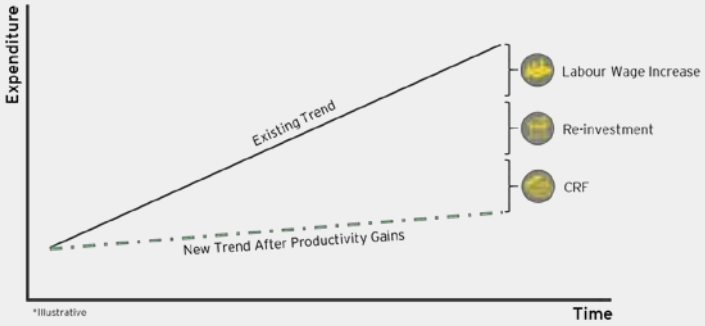


Figure 16 Potential Distribution of Productivity Increases through Gains Sharing

53. People are integral to every form of public service delivery in the Province. Providing employees with the tools and permission to focus on the front-line work they are experts at, without having to spend unproductive time on reporting obligations and internal administration, is not only empowering, it is more efficient. Gathering input and leveraging the experience and expertise of public servants to drive innovation and modernization can help to make services more efficient.

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54. Taken together, labour is the single largest expenditure across government at $71B annually[21], and 71% of the OPS labour force is unionized[22]. A 1% increase in compensation means an additional $710M in annual expenditures, which demonstrates the importance of being able to manage bargaining with the province's labour partners.

55. Currently, however, control over negotiations is fragmented. The government has full control over negotiations with direct employees, significant control over employees in consolidated sectors (Hospitals, School Boards, and Colleges), and very little in the remainder of the BPS, including transfer payment recipients. Greater control over growth in negotiated compensation expense would help the government better manage expenditure growth. The government could choose to exercise direct control through a centralized collective bargaining regime and direct control over all wage agreements. Or it could choose to exercise indirect control by requiring all bargaining mandates and tentative agreements to be approved by government. The first option would give greater control at the expense of disrupting normal business practices, while the second would allow for smoother operations at the expense of the degree of control. Either option would take a significant amount of time to come into effect with the BPS and transfer payment recipients – where control is weakest now – taking the longest amount of time, due to the structural reforms required in those areas. There are also hybrid options where the government would only dictate or approve mandates for wages, with all other issues remaining the purview of local bargaining.

Citizen-Centered and Digital First

56. The vision for a Citizen-Centered and Digital First approach is not just about technology, but rather about the most modern approach possible to everything the Ontario public sector does.

57. Citizen-Centered and Digital First is a philosophy that would put the client at the centre of every policy, regulation, program, process and delivery model, regardless of whether that is for administrative functions inside and across public sector organizations, or, more importantly, for any time the end recipient of a service or benefit is affected. And it would put data at the heart of every decision about design, administration and execution of public services.

58. Citizen-Centered and Digital First speaks to the requirement to share data and information across ministries and delivery organizations to the maximum extent possible and as the default position; the inverse is true today and must be overcome through a modernized legislative framework that defines data and information sharing as a public interest, while still reflecting the absolute protection of individual privacy. This is particularly important for the use of data across ministries, and a thorough review and reform of Ontario's information sharing and management legislation and framework should be completed as a priority.

[21] Treasury Board Secretariat, Centre for Public Sector Labour Relations and Compensation
[22] Ministry of Labour. 2018. Collective Agreements Database

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59. It also speaks to the opportunity and requirement for the Ontario public sector to significantly accelerate its leadership position in the Ontario economy to capture and provide further opportunity for maximizing the impact of Ontario innovation in artificial intelligence, blockchain, machine learning, and associated technologies.

60. Most importantly, while investment in digital and data is required, it cannot be viewed as a cost centre – it is at the heart of what the Government must become.

Ontario's modern role of government

61. The Review has been conducted with an eye to enhancing a general policy framework of modern government that would see the Province clearly commit to its role as:

a) Policy setter & system designer: overall strategy and vision for political economy; governance arrangements; overall regulatory frameworks, incentives, roles and responsibilities, standards and objectives.

b) System funder & steward: allocation of public resources including through choice of funding mechanisms such as lending and investment; untied block grants; transfer payments to intermediaries; purchasing, performance management, regulatory enforcement, capability & capacity management.

c) Direct deliverer: service provision to clients including operational services and capital infrastructure only in those situations where a higher value provider cannot be found.

62. The Review has identified a number of opportunities for Ontario to simplify and modernize its role as the steward of public investment and has been considered in three ways:

a) Accelerate the simplicity of Ontario's regulatory frameworks across all ministries. This will have direct positive economic impact for Ontario businesses and, depending on the delivery model chosen, result in positive fiscal impacts and further improvement to risk-based regulatory governance.

b) Significantly simplify all processes and procedures inside the core of Government to greatly reduce self-imposed administrative burden.

c) Simplify and modernize the relationship between the OPS and its TP partners in the BPS and beyond by rationalizing all reporting requirements and focusing only on the things that matter most: fiduciary compliance, productivity of Provincial funding, and results achieved.

63. This last point is intrinsic to the overall vision established by the Review – namely, that the Province can help enhance the autonomy and expertise of its various delivery partners by greatly simplifying its expectations and getting out of the way of day-to-day operations and eliminating weak policy prescriptions (those that begin the process of aiming at outcomes without compelling useful reporting or tying funding to the achievement of targeted outcomes). At the same time, a clear commitment to a modern role of government, supported by the right data for evidence-based decision-making, a strong role for labour in generating the productivity and performance gains expected by Ontarians, and an across-the-board commitment to Citizen-Centered and Digital First thinking and action, will help enable better public finance and better government in Ontario.

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E Specific Ideas to Set the Ball Rolling

64. The Review proposes an overall strategy with two dimensions for Government to consider:

a) Continue to drive efficiency and effectiveness improvements into the OPS through an on-going service delivery modernization, cost efficiency, and shareholder management strategy for Government operating assets and infrastructure.

b) Serious examination of Transfer Payments with an aim towards:
   i) Service delivery modernization and cost efficiency as for the OPS into the BPS.
   ii) Medium-term reform to funding models to optimize the productivity of all delivery systems and capture the full benefit of government investments, including driving the consolidation of TPs.

65. With the benefit of considerable public consultation, and based directly on the evidence gathered during the Review, the following is an overview of each of the recommended hypotheses across four distinct categories:

a) Service Delivery Modernization
b) Cost Efficiency
c) Individual and Business Supports
d) One-Time Savings

66. This is consistent with the advice given to Government through the *Planning for Prosperity initiative*.

Planning for Prosperity Consultation

On August 29, 2018 the Government launched '*Planning for Prosperity: A Consultation for the People*' and the OPS *Big Bold Ideas Challenge* as complements to the line-by-line review. The online consultation provided Ontarians with an opportunity to rank the importance and effectiveness of a range of government services. It allowed the general public and members of the Ontario Public Service to submit ideas related to the transformation of government service delivery and the path to fiscal sustainability.

The consultation was focused on receiving feedback in eight key areas:

- Children's and Social Services;
- Education;
- Environment and Resources;
- Economic Development;
- General Government and Other Services;
- Health;
- Justice; and
- Postsecondary and Training.

Over the course of the consultation period, Ontarians made their voices heard, through over 15,000 submissions. Through an initial analysis of submissions, the respondents identified a number of key themes that were important to them, including:

- Programs and Services - Improving existing ones, exploring the better ways to deliver them, combining them where appropriate, and closing out the ones that do not achieve outcomes;
- Increasing the voice of stakeholders in decision-making; and
- Making government spending more transparent, while paying down the Provincial debt.

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The comments received during the consultation period are reflected in the Review's Framework for Better Public Finance Management. Thematically, Ontarians recognize:

That evidence based decision-making is the foundation on which government should make decisions:

> Look very carefully at the data to determine where a program or service is inefficient

> Engage in evidence-based transportation planning that relies on data from experts

> Ensure that evidence-based decision making is used a key principle for all policy making

That a focused approach should be taken to managing people within the public service:

> There is too much decentralization, duplication of work, and siloing of resources across government

> Centralizing resources and transforming the workforce

> There is a great wealth of experience each ministry has and there are [few] opportunities to collaborate in an agile manner to serve Ontario in a meaningful way

That improved use of technology and data will allow for more efficient and effective delivery of public services:

> Make more services available online

> Use modern IT to achieve cost savings across all government services

> Share data across ministries to improve citizen's experience of government

That government should rationalize its role in the delivery of services to ensure that every taxpayer dollar spent is used as effectively as possible:

> Perform a comprehensive review and alignment of all government funding for businesses

> There is an opportunity to consolidate several small service providers in a geographical location to realize economy of scale and increase efficiency

> Consider means testing or co-payment so for some services so money goes further

Further and more detailed analysis of the suggestions put forward by survey respondents will follow as the government reports back on the findings of the *Planning for Prosperity* consultation.

67. As previously mentioned, the mandate of the Review was to analyze expenditures, conduct selected jurisdictional benchmarking, and based on the data available, identify programs and operations for which efficiencies could be generated through more focused review and subsequent execution. Such opportunities should not result in involuntary job losses, and instead focus on efficiency and effectiveness improvements.

68. The ideas identified in the following pages are based on the analysis of the evidence, and clearly point to the need for transformation and modernization. As such, while they would support the continual identification of day-to-day efficiencies that is part of ongoing budgeting in the Government, they are meant to be large-scale and cross-government – in fact, reaching past government into transfer payment delivery agents.

69. The ability to effectively implement the ideas below will require serious consideration on the part of Government about how to pursue and realize the potentially significant benefits associated with a relatively small number of concepts. In addition, ongoing internal and external consultation will be a precursor for success. Each idea presented will require further evidence to inform policy and legislative decisions and to understand service delivery impacts.

70. Pursuing any of the ideas presented below would be just the beginning of a process to achieve a fundamental shift in government towards a focus on the delivery of services based on their efficient price.

71. In each case, the government should move quickly to identify those opportunities that can be executed in the short term to show commitment, free up resources (including for reinvestment), inform forward planning, and begin the process of achieving a sustainable fiscal position.

72. As detailed business cases are completed, these should reflect what Government chooses as its priorities and expenditure path. Business cases should always consider, at a minimum:

a) Service impacts and opportunities for improvement.

b) Detailed financial evidence about investments, transition costs, and time to benefit realization.

c) Analysis of the public impact, including direct impacts on recipients or clients, taking a citizen-centric view.

d) Analysis of socio-economic impact.

e) Consideration of the implementation risk and potential actions to mitigate those risks.

f) Setting clear accountability so benefits can be realized.

73. These ideas are not new. In fact, many have been considered in detail by the Ontario government previously, but in light of the evidence around expenditures and their disconnect from results and outcomes, it is clear that taking decisive action is the only way forward to put Ontario on a sustainable fiscal footing.

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Service delivery modernization

Modernizing all back-office and front-line services through digital-first, automation, the use of shared service models for all major functions across ministries and the BPS, and the optimization of Ontario's public sector workforce

Digital First

A digital approach will both improve the services delivered to citizens, lower the internal administrative burden and cost of doing business, and open up new avenues for innovation and simplification of processes. This includes increasing the proportion of all Service Ontario transactions conducted on a digital platform, increasing the number of services online across government – starting with those that have the highest volume, and leveraging emerging technologies including blockchain, artificial intelligence and machine learning to improve service delivery and efficiency.

What we know	What you could do
▸ Delivering services to the public online costs significantly less than in-person ▸ A digital first transformation within government can also lower the internal administrative burden and cost of doing business, and enable better achievement of outcomes	▸ Enable greater uptake of digital services through reduced barriers such as information sharing, building capacity, and sharing staff across ministries ▸ Improving digital services and experience through enablement of technologies such as a single digital ID and Blockchain

Illustrative Example

- Services provided online by Service Ontario cost 57% less[23] than the same services provided in person, and yet only 30% of transactions are completed online[24].
- Determine the ten programs across government with the highest transactional volume and task the Ontario Digital Service with driving greater migration to online service; as legislative, regulatory, and policy barriers are identified, aggressively pursue their elimination to further enable online service delivery, and invest in necessary enabling platforms.

Jurisdictional Comparator

- The UK has launched Government as a Platform (GaaP) with more than 100 services across 26 departments and agencies currently using GaaP tools, guidance and components[25]
- Estonia has used Blockchain to protect national data, e-services and smart devices in both the public and private sectors. Blockchain is deployed in Estonia's data registry, national health, judicial, legislative, security and commercial code systems[26]

[23] Data provided by Ministry of Government and Consumer Services
[24] Office of the Auditor General of Ontario. Follow-up to 2013 Report on Value For Money, Chapter 3.09.
[25] GOV.UK, Blog - Government as a Platform
[26] E-Estonia, Estonian blockchain technology, Frequently Asked Questions

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Back Office Efficiencies

Increasing the efficiency of, and therefore reducing the spend on, back office functions by aggressively expanding the client base for Ontario Shared Services (for Finance, HR, Supply Chain, and IT Services) to the BPS were applicable. There is also an opportunity to thoroughly test whether the cost of service for back office functions can be reduced and services improved through the use of Alternative Service Delivery arrangements

What we know

- Consolidating key shared services functions (e.g., Finance, HR, IT, Supply Chain, etc.) can provide greater value to citizens and client organizations
- Some jurisdictions within Canada (e.g. BC, NS) have already moved to a consolidated, broader public sector shared services model to reduce administrative spend[27]

What you could do

- Expand existing Ontario Shared Services functions (Finance, Human Resources, Supply Chain) to clients in the BPS, and move I&IT support services across the BPS to I&T clusters in place within the OPS
- Drive further cost reductions by considering Alternative Service Delivery (ASD) of certain functions to reduce the cost of providing service on a life-cycle basis

Illustrative Example

- Allow BPS entities to leverage I&IT contracts negotiated by the OPS
- Encourage the close-to-700 delivery agents that receive transfer payments through Children and Youth at Risk to utilize Ontario Shared Services payroll and HR functions in order to lower the cost of hiring, onboarding, and paying employees

Jurisdictional Comparator

- BC's implementation of a broader public Shared Services Organization realized efficiencies of approximately $100M on spending of $1B[28]
- Nova Scotia realized savings of 31% through consolidation of its Finance, HR, IT Supply Chain and Asset Management functions[29]

27 EY Experience
28 Transforming Healthcare Supply Chains: An update on progress in BC. BC Health Authority Shared Service Organization.
29 Shared Services and Alternative Service Delivery, Tools for Transforming Government FMI Presentation, November 2011

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Process Optimization

Reduce the self-imposed administrative burden within the OPS, including cumbersome processes around tracking Key Performance Indicators, reporting, and chargebacks, by eliminating duplicative and non-value added processes. Consider the implementation of robotic process automation and Lean Management Systems where repetitive, routine tasks currently exist, resulting in savings from more efficient resource deployment, and minimizing manual data entry errors

What we know

- Process Optimization refers to adjusting or optimizing processes in order to improve efficiency or effectiveness
- Stakeholders believe the OPS and the BPS do not currently consistently apply leading practices or principles across processes[30]
- There are many examples of the application of Lean Management Systems, and Robotic Process Automation (RPA) to allow for great efficiency in resource deployment

What you could do

- Implement RPA to reduce resource effort in transactional, repetitive processes
- Reduce the internal administrative burden, including activities around reporting, compliance, delegation, etc.
- Optimize processes through techniques such as Lean Six Sigma

Illustrative Example

- Deploy RPA to automate transactional and repetitive processes, like processing new employee paperwork and automating the onboarding process
- Implement Lean Principles across functions such as performance reporting; as an example, all in-year budget forecasts at a branch level are prepared manually and then consolidated at a ministry level the same way

Jurisdictional Comparator

- In the UK, HM Revenue & Customs has been working with robotics for a number of years and has deployed over 11,500 robots across nearly 60 processes, including its system for registering new employers[31]
- The Government of British Columbia has been applying Lean to transform the business of government since 2012 through Lean BC. Outcomes include developing tools to improve both simple and complex business processes and reduce red tape for citizens and businesses across British Columbia[32]

[30] Interview with stakeholders, August-September 2018
[31] GOV.UK, Cabinet Office, Blog, Civil Service Quarterly, Robots lend government a helping hand
[32] LeanBC - Province of British Columbia - Government of BC

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Workforce Optimization and Rostering

There is an opportunity to transform areas of the current workforce, include the skill mix and ratios across some professional areas to increase the flexibility of the workforce and reduce the utilization of premium worked hours. Additionally, there is an opportunity to implement a modernized talent management strategy, overall, to optimize the OPS and BPS workforce and reduce costs over time

What we know

- Salary and wages account for a significant, and in some instances growing, portion of expenditures.
- Overtime in the Health and Community Safety sectors is significant, and although it is to maintain service levels, the result is costly, and can have negative impacts on employee morale, increased turnover, increased number of sick days
- Global trends in the future of work where digital, innovation, and flexibility are becoming the norm

What you could do

- Workforce transformation and improved scheduling practices and controls offer an opportunity to optimize the skills of Government employees and reduce wasted cost due to overtime premiums.
- Implement a rostering system to address costly premium worked hours resulting from overtime
- Shift towards an agile workforce dynamic, where resources are deployed across programs and ministries

Illustrative Example

- Implement rostering improvements across the Ministry of Community Safety and Correctional Services to better deploy staff and reduce the use of overtime.
- The current mix of skills in Healthcare could be evaluated to address current challenges of capacity demands. This could include including optimizing the ratio of Registered Nurses (RNs) to Registered Practical Nurses (RPNs), optimizing the ratio of Full Time to Part Time resources, and aligning the staffing complement to the level of patient acuity

Jurisdictional Comparator

- Through the use of rostering, New South Wales was able to reduce overtime costs and accruals of additional days off in the health care system, while at the same time increasing fairness and transparency for staff[33]

[33] NSW Government, Health, Rostering Resource Manual

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Consolidation of Transfer Payments

Reduce the cost of administration to both government and transfer payment agents by reducing the number of Transfer Payments agreements, and consolidate the total number of Transfer Payment agents, especially in high TP-volume programs, to reduce administration costs, increase value for money, enhance the client experience, and improve outcomes by making it easier to manage system-wide performance

What we know

- The vast majority of government operating expenditures are through transfer payments, either directly to individuals or to entities that deliver services on behalf of government
- To change the level or rate of growth of expenditures, the government will have to rethink how it funds transfer payment agents and who it funds to deliver services.

What you could do

- Rationalizing the source of transfer payments to individual service providers, to reduce administrative burden on both government and provider
- Consolidate the number of transfer payment agreements, and the number of service providers that receive transfer payment funding, to further reduce the cost of administration, and focus on building a system of providers that puts the needs of the citizen first

Illustrative Example

- In 2018, there were nearly 35,000 unique recipients of transfer payments across all ministries and programs[34]
- There are currently more than 20 health agencies across 11 priority areas[35]; these organizations operate independent of each other, and most have leadership teams and back-office functional teams
- Almost 1,000 different delivery agencies are funded by Employment Ontario in four regions across the province, with unclear results[36]

Jurisdictional Comparator

- The implementation of the National Disability Insurance Scheme in Australia resulted in a single body, co-funded by the national and state governments, to oversee the care for those with a significant disability. By implementing an insurance scheme (instead of payments from each states consolidated revenue funds) and merging the government agencies providing and overseeing care, early indicators suggest the scheme has resulted in simplified navigation for the disabled, better supports, and improved choice, while reducing the number of providers the government has to deal with directly[37]

[34] Government of Ontario. Data provided by TBS.
[35] Ministry of Health and Long-Term Care.
[36] Government of Ontario. Data provided by TBS.
[37] Productivity Commission. National Disability Insurance Scheme.

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Cost efficiency

Reducing the direct cost of government through strategies such as procurement reform, fraud reduction, full cost recovery in suitable areas, stopping non-priority major capital projects, and eliminating or modifying overlapping programs

Procurement

Significantly reduce overall procurement spend including across government (including the Health Sector, Core OPS and Core BPS sectors) by optimizing whole-of-government procurement practices

What we know

- There are several challenges across the supply chain operating model in government, including limited standardization, consolidation of contracts, and analytics that limit the ability to purchase efficiently
- Procurement transformation is a common initiative in government and commercial sectors, with an extensive record of finding cashable efficiencies

What you could do

- Standardization of products purchased across programs, ministries, and the BPS
- Aggregation of spend across vendors to realize economies of scale through better contracting
- Establish sector led value-based procurement teams (Procurement Innovation Program) for complex and specialized items
- Centralize procurement analytics capabilities to identify areas to better manage spend

Illustrative Example

- The Health sector presents a particularly large opportunity due to the high level of procurement related to consumables and specialized clinical materials; to the extent that other sectors provide institutional services, those institutions could leverage Health purchasing networks to lower their costs
- Standardization of products purchased across programs and ministries could leverage additional economies of scale and reduce per unit costs across the OPS and BPS
- Consolidation of contracts and aggregation of spend across vendors to further leverage economies of scale

Jurisdictional Comparator

- Experience in the Health system in New South Wales has shown that savings of up to 14% per healthcare spend category is achievable[38]
- Auckland City Council drove $168M (CAD) in procurement savings over two years on a $3.6b annual spend. Savings were achieved through conducting analytic analysis on existing spending, identifying categories that could be consolidated, and finding synergies across suppliers[39]

38 EY Australia, August 2018
39 EY Experience with Auckland City Council

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Full-Cost Recovery

Recover the full cost of providing transactional services wherever a direct beneficiary of a service can be determined

What we know

- The *Commission on the Reform of Ontario's Public Services* highlighted the opportunity to charge a full cost recovery fee for services provided by the Government
- Civil Court related fees recover less than the cost of service, as an example
- The balance of these costs are covered by the tax base

What you could do

- Fully recover the costs of civil court-related fees through the user pay model
- Identify additional programs which are currently not fee for service, which could adopt the user pay model
- Perform costing analysis of programs for which fees are charged, to ensure full costs are recovered

Illustrative Example

- Government funds a number of regulatory activities through a cost-recovery framework, and should test whether those frameworks have been optimized to recover full costs and whether scope of cost-recovery could be expanded

Jurisdictional Comparator

- The Australian government has a defined pricing model, with guidelines on cost recovery pricing, value-based pricing and commercial pricing. The model ensures that all pricing is based on transparency, efficiency, performance, equity, simplicity, and policy consistency[40]

[40] Australian Government Department of Finance, Charging for Commercial Activities

Underground Economy

Generate savings by reducing the impacts of fraudulent behaviour by aggressively targeting tax avoidance and enforcing the imposition and collection of excise taxes on tobacco

What we know

- The underground economy includes illegal activities, tax avoidance and often constitutes work for cash that is not reported, illegal sale of goods and services, and misreporting of revenue to tax authorities
- It is estimated that there is over $16B in underground economic activity in Ontario, with a significant tax gap resulting from this economic activity[41]

What you could do

- Addressing the underground economy could provide increases in revenues as a result of increased tax collection on economic activity
- Key areas to focus on include the contraband tobacco market, targeting unreported or underreported income, and pursuing grey market gaming revenues

Illustrative Example

- Ontario Lottery and Gaming (OLG) estimates there are 2,000 – 3,000 "grey market" online gambling sites accessible in Ontario, accounting for approximately 90% of the market[42]. By reducing the number of grey market operators in Ontario and increasing market share for OLG's offerings, lower loss of revenues might be achieved
- Contraband tobacco represents more than one third of the total tobacco market in Ontario, and over 80% of all contraband tobacco in Canada. This translates into $750m in lost provincial revenue annually[43]

Jurisdictional Comparator

- Australia has implemented the "Black Economy Taskforce", a partnership between government agencies and the private sector to develop an innovative approach to target the underground economy[44]
- The United Kingdom's HMRC (Her Majesty's Revenue Council) has created a tax evasion task force to tackle restaurants and fast food outlets who are at a high risk of evading taxes. The task force is made up of cross-functional specialists including tax and IT resources to target identified businesses[45]

[41] Ministry of Finance 2018.
[42] OLG Fiscal 2017/18 Business Plan
[43] EY Tobacco Tax Policy in Ontario. March 2018.
[44] Commonwealth of Australia, Black Economy Taskforce, Interim Report, March 2017
[45] Citywire. *HMRC targets fast food VAT evaders*. July 2011.

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Real Property and Infrastructure

Modernize the governments approach to real property and infrastructure by procuring and managing of all infrastructure assets on a lifecycle asset management basis

What we know

- Each ministry manages its own capital assets, either directly or through contracted arrangement
- Infrastructure Ontario (IO) also plays a role in the procurement, management, and contract management of a variety of capital assets
- The BPS is left to manage their own capital assets, with limited guidance around standards, policies, or procedures

What you could do

- Adopt a more structured and effective asset management lifecycle process
- Alignment of policies to allow for an enterprise-wide decision-making process
- Centralized approach to management of real property
- Regular reporting on utilization of assets and opportunities to consolidate and share across sectors

Illustrative Example

- Facilities management functions, which currently reside across the OPS in a majority of ministries could be consolidated to improve the coordination and effectiveness of real asset management
- Creation of a centralized contract management function to assist the OPS and BPS in implementing consistent standards for the use of outsourcing arrangements for capital maintenance. This could be initiated using Ministry of Transportation experience in managing a large volume of contracts
- Seeking opportunities to expand the AFP (Alternative Financing and Procurement) model where the size and scope of projects could lead to improved project outcomes based on a rigorous business case

Jurisdictional Comparator

- In Australia, the Department of Finance manages Property Services Coordinated Procurement (PSCP), which manages an external provider that assists with the development of a Whole-of-Government strategy around leased assets, and multiple Property Service Provider (PSP) contracts, which delivery facilities management across government[46]
- The Alberta Government in 2010 signed a public-private partnership (P3) agreement for the delivery of 10 new schools in the Calgary and Edmonton regions, projected to save $105M compared to the cost of delivering the schools through traditional delivery methods. The agreement also included financing for the 10 new schools and a 30-year maintenance term[47]

[46] Government of Australia. Department of Finance. Property Services Coordinated Procurement.
[47] Government of Alberta. *Construction of 10 new schools begins in Edmonton and Calgary Region*. April 2010.

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Individual and business supports

Ensure government funding is directed to those that require it the most by providing universal supports for core programs only, and rely on means-tests for all other individual and business related programming

Rationalization of Business Supports

Generate savings by reconsidering and rationalizing all business tax credits and grant programs where evidence of incremental job creation or economic growth does not exist or the government cannot clearly point to a policy (e.g. innovation), market failure (e.g. natural monopolies), or competitive (e.g. electricity rate mitigation) rationale for continuing a program.

What we know	What you could do
▸ The Government of Ontario currently spends significantly on Business Support programs in tax credits and grants ▸ Recent reports from the Financial Accountability Office of Ontario and the Auditor General indicate that at best, it is unclear as to whether or not any of these programs can demonstrate incremental value	▸ Rationalizing of business support programs through reduction of tax credits and grant programs ▸ Sustaining only those that produce incremental economic and desired regional outcomes, you could focus on creating the right conditions for investment and job creation as opposed to direct financial supports

Illustrative Example

- The ten largest tax credits that fall into this category have a total value of $2.9B in 2018-19, largely aligned to The Ministries of Economic Development, Job Creation and Trade and the Ministry of Tourism, Culture, and Sport. Adjustments could be made to eligibility criteria to ensure they add incremental value to Ontario's economy[48].
- There are over $930M in grants and loans to businesses in the areas of economic development, innovation and growth that could be rationalized to ensure they are meeting intended outcomes[49].

Jurisdictional Comparator

- According to data from Statistics Canada for every $100 generated by the economy, Ontario spends $0.40 on various forms of business supports. This is more than Alberta ($0.39) and New Brunswick ($0.29)[50]
- Literature suggests that business supports may not have a demonstrable positive impact upon the economy, employment, and tax revenues because of the substitution effect: a positive impact in one place that is then typically offset by losses elsewhere in the economy[51]

[48] EY Analysis based on data taken from The Effectiveness of Business Support Programs in Ontario. Financial Accountability Officer of Ontario.
[49] Ibid.
[50] https://business.financialpost.com/opinion/one-province-stands-far-far-above-the-rest-in-the-corporate-welfare-championship
[51] https://www.fraserinstitute.org/sites/default/files/government-subsidies-in-canada-a-684-billion-price-tag(1).pdf

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Means Testing

Reconsider application of universality to all programs by developing a consistent set of principles to apply means-testing to selected programs

What we know

- There are a number of benefit programs that are currently applied without any means testing, which could shift to a means-tested eligibility formula where ability to pay is the threshold for receiving funding/ support levels

What you could do

- Review programs to assess whether they are suitable for means tested eligibility
- Develop principle-based means tests for each selected program
- Where programs are means tested, assess tests for suitability, and/or consider the introduction of asset tests to assess eligibility

Illustrative Example

- Government should undertake cost-benefit analysis to ensure that means tests reflect policy priorities across programs that provide benefits on a discretionary basis

Jurisdictional Comparator

- Provinces that commit to means-testing such as through cost-benefit analysis include Alberta, Manitoba, and Quebec

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One-time savings

Maximizing the value of real and operating assets, to ensure that taxpayer investment being put to its most productive use for current and future generations.

Monetize Operating Assets

Evaluate all Government Business Enterprises (GBE's) and other operating entities and consider monetizing assets through divestiture or the use of Alternative Service Delivery where the business case is positive and meets with Government policy priorities

What we know

- While steps have been taken in recent years to maximize the value and revenue from GBE's, further value could potentially be extracted from these assets if alternative policy frameworks were established
- Significant work has been conducted in recent years investigating the use of Alternative Service Delivery models to help commercialize a wide range of agencies and/or operations

What you could do

- Ontario currently holds assets that could be monetized to generate a one-time cash payout by selling all or a portion of GBEs and/or owned real estate
- It is important to understand that the trade-off is foregoing future income; in light of the long-term impacts of monetization, robust business cases firmly rooted in evidence are required before proceeding

Illustrative Example

- GBEs could be evaluated across their operations; for example the LCBO liquidated their head office lands in downtown Toronto to generate $260 million for incremental investment in infrastructure[52]

Jurisdictional Comparator

- The New South Wales government has undertaken an asset recycling program to help fund investment in core assets and better services[53]. By selling property and assets deemed to be non-core, the NSW government has freed up capital for reinvestment in priority areas. A recent example of asset privatization is the Electricity Network Assets of Endeavour Energy for proceeds of $7.6B[54].

[52] Government of Ontario. News Release. May 2016.
[53] Asset Recycling Report, Property NSW, October 2016
[54] Privatization in NSW: a timeline and key sources, NSW Parliamentary Research Service, June 2017

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F Building the *Modernization Action Plan*

A Modernization Action Plan for Government

74. A clear lesson from jurisdictions globally that have successfully transformed government and achieved sustainable fiscal outcomes is that there are no short-cuts. Realizing benefits requires a considerable level of sustained effort, discipline and a healthy dose of resilience to manage complex programs over time.

75. The first imperative is for Government to develop a detailed and comprehensive *Action Plan* that should:

a) Articulate Government's future spending path and key areas and targets that will frame the overall *Plan* and drive focus and effort in the short, medium and longer terms.

b) Develop an overall roadmap that establishes what and when key decisions must be made to drive delivery of investment-ready business cases and implementation plans for specific targets. This must cover those targets that are to be realized in the immediate-to-short term, and those that require a longer development path.

c) Identify and formally allocate accountability and responsibility for all dimensions of *Plan* implementation.

d) Establish accountability and responsibility consistent with and reinforcing to the Mandate Letters for each Minister, and clearly articulate how those mandates fit into the overall expenditure management requirements of Government. The collective responsibility for achieving the fiscal plan must be clear and continually reinforced.

e) Make it clear collective responsibility goes two ways. Treasury Board Secretariat and Cabinet Office must set the overall targets and frameworks, and then work alongside ministry partners and external partners to realize benefits on a sector-wide basis. The objective is not only to modernize delivery systems and achieve fiscal management targets, but also to enhance the culture of performance and mutual interest shared by central agencies and ministries.

f) Focusing on the immediate-to-short term priorities, set clear expectations about what the benefits are, what specific targets are in quantitative terms, and specific time-lines for delivery.

g) Establish the funding parameters and protocols for the *Plan* including how to release resources for re-investment from immediate-to-short term savings, how to allocate re-investment resources, and how to deliver returns against firm business cases and implementation plans.

h) Make clear the linkages between the *Modernization Action Plan* and the on-going fiscal cycle and planning processes, including Cabinet and Treasury Board approvals.

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Continued leadership by Ontario Treasury Board

76. For a period commencing immediately and lasting at least until such time as all fiscal reform opportunities have been realized, very strong focus from TBS must be emphasized to help drive the fiscal reform. The pace of change will be irregular and TBS can help lead government-wide transformation through its ability to:

a) Enable partner ministries through direct support to business cases and implementation plans that are robust and have strongly commercial footing.

b) Jointly lead and participate on delivery teams with various ministries for the detailed implementation plans and business cases for further data collection, analysis, solution design and development, and implementation including risk management.

c) Report on and make recommendations to Treasury Board ministers on implementation of various opportunities including for binding commitments to realizing benefits.

d) Procure and manage all necessary external support to deliver opportunities.

e) Integrate with on-going fiscal cycle and planning processes to ensure the fiscal sustainability plan is fully integrated with broader Government financial management processes.

f) Support investment in overall program, project and change management capability necessary to support all affected parties throughout the design, delivery, implementation, and on-going monitoring phases of work.

77. More than anything else, Treasury Board Secretariat must work in partnership with peer ministries and external partners to embed a culture for the highest standards of efficiency, productivity, and performance for all funded activities of the Government.

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Expenditure Management in other jurisdictions

Ontario is certainly not alone in its pursuit of expenditure management, with significant programs having been undertaken by the European Commission, the UK Spending Reviews, the Australian Functional and Efficiency Reviews, and Canada's own Deficit Reduction Action Plan.

For example, the European Commission's 2014 experience suggests that targeted spending reviews typically deliver more sustainable results than "linear across-the-board" cuts to expenditures. The key success factors that were observed in these types of spending reviews include political commitment, anticipation of implementation, building of transformation capability, and performance culture at all levels of public service. The Commission found that successfully delivering savings via the spending review process involves significant time and resources and the willingness to address analytical, organizational, and political hurdles, and that a strong role for central leadership is required to achieve results.

Similarly, the UK National Audit Office promotes a framework for effective spending reviews. This framework would allow any new government to know what the baselines of performance and spending are, redefine objectives and reallocate resources according to its priorities, and quickly start to monitor progress, adjusting performance indicators or targets where necessary. A strong role for leadership from the centre of government including from Her Majesty's Treasury is viewed as a prerequisite.

The framework has six key elements:

- Understanding the environment
- Setting priorities
- Understanding levers for action
- Allocating resources
- Monitoring performance
- Making improvements

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Roadmap for Success

78. **The immediate priorities are for Government to prioritize specific opportunities, picking enough of them to generate excitement in the reform opportunities, while at the same time freeing up resources that can be re-invested to support detailed business case development and necessary investments in the medium-to-longer term modernization of Ontario's public sector.**



Figure 17 Implementation Roadmap

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79. The implementation roadmap focuses on three main phases of work:

a) Phase 1 – Establishment of a clear mandate and initiate overall program management. This must include the appointment of key responsibility areas and accountabilities to deliver results including for jointly-managed projects between TBS and Ministries. Immediate preparation of detailed business cases and implementation plans for those areas Government decides are priorities, including for any "cash release" required to fund further investments and the transformation support required for the *Modernization Action Plan*.

b) Phase 2 – On-going development of detailed business cases and implementation plans for those priorities that require longer lead-time to execute. Central to this is a focus on establishing a strong form of benefits realization that is required to manage transformation over time. This has been absent in prior Ontario initiatives and is required for success.

c) Phase 3 – Longer-term and more fundamental reforms that require commitment and involvement of major operating dimensions of the transfer payment operators including those in the BPS and wider public delivery arena.

Conclusion

80. The Review has outlined a detailed examination of historical expenditures in Ontario over the last 15 years and has provided insight into how the province has arrived at its current fiscal position from the expenditure growth perspective. Importantly, it identified an opportunity for the Government to enable conditions for significantly stronger public financial management, to realize efficiencies in line with its objective for movement towards fiscal sustainability, and to achieve success through a *Modernization Action Plan*. Moving immediately to connect the themes and findings of this Review with the multi-year plans for ministries and the public sector as a whole, would be a very strong next step.

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EXHIBIT 11

BANK OF CANADA
BANQUE DU CANADA

Staff Analytical Note/Note analytique du personnel—2023-3

Last updated: February 27, 2023



Firms' inflation expectations and price-setting behaviour in Canada: Evidence from a business survey

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Introduction

Economic conditions affect prices, and the behaviour of prices plays a role in the effectiveness of monetary policy. When prices adjust slowly, prolonged monetary policy measures may be needed to manage inflation. This is because monetary policy takes time to be transmitted through the economy and affect prices. High inflation expectations that become entrenched may delay the transmission of monetary policy such that measures are more aggressive or in place longer than would be conventionally expected.

Implementing effective monetary policy could be more challenging for central banks if firms expect inflation to be high. Tightening monetary policy slows price growth by reducing overall demand, slowing cost increases and raising competitive pressure on firms. But high inflation expectations may encourage large price increases if firms believe that cost growth will remain high after a tightening of monetary policy. If left unchecked, high inflation and elevated inflation expectations could cause a wage-price spiral, anchoring high inflation with harmful economic consequences.[1] Because of this risk, understanding whether high inflation expectations are influencing firms' price-setting behaviour is critical to know for an inflation-targeting central bank.

We investigate whether the recent period of high inflation has changed how Canadian firms set prices for their products and services. Firms note that during periods of low and stable inflation, their input prices and the degree of competition for their output are the two most important factors in setting prices.[2] For example, an increase in prices for inputs often motivates firms to raise their output prices, but the extent to which these increases are passed through to the customer is tempered by competitive pressures in the marketplace and the risk of irritating customers. We look for evidence of whether firms' high expectations for inflation are now influencing their price-setting decisions.

We use evidence from the Bank of Canada's Business Outlook Survey (BOS) to assess the price-setting behaviour of firms. The BOS collects structured survey responses as well as feedback from in-depth discussions with around 100 business leaders each quarter.[3] Combining both types of information give us a holistic view of price-setting decisions, motivations and reasoning.

We find little evidence that firms' price setting is directly based on high inflation expectations. However, we find that widespread growth in input prices during a period of strong customer demand and reduced competition may have contributed to price increases that were larger than usual. This may explain some of the inflationary pressure observed in 2021 and early 2022. Furthermore, early evidence suggests that in the second half of 2022, price-setting behaviour was gradually returning to pre-pandemic practices, supporting a path for inflation

[1] For more information on the wage-price spiral, see Bank of Canada (2022a).
[2] See Amirault, Kwan and Wilkinson (2005).
[3] See Amirault, Rai and Martin (2020) for a reference guide to the Business Outlook Survey.

to return to the inflation-control target range.[4] However, the risk remains that high inflation may start to be reflected directly in output prices, which would make it more difficult for monetary policy to reduce inflation.

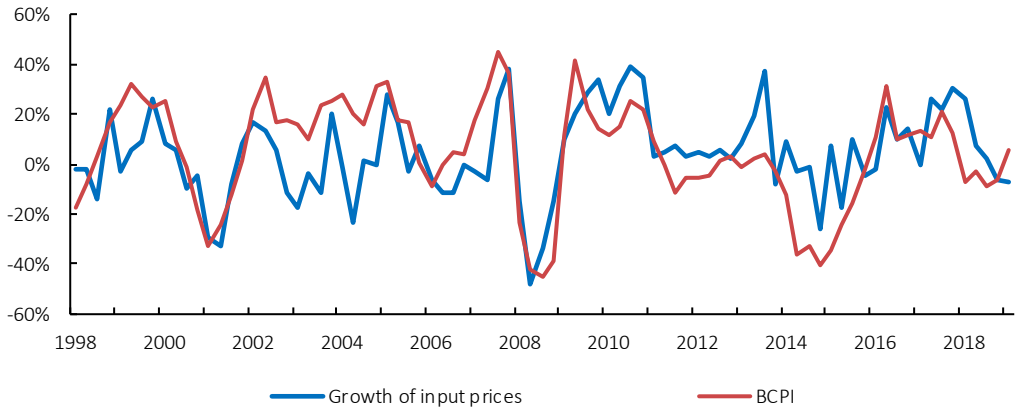
The pre-pandemic relationship between costs, prices and inflation expectations

In this section, we use BOS data from the third quarter of 1998 through to the end of 2019 to examine how closely firms' survey responses about costs, prices and inflation expectations match other macroeconomic data for the same period. We then determine which factors are most strongly related to output prices during this pre-pandemic period.

Changes in firms' reported costs reflect movements in macroeconomic data

We first compare firms' assessments of the input price environment with changes in other measures of economy-wide input prices. In the BOS, the Bank asks firms to compare their expected growth in labour costs (wages) and non-labour costs (input prices) in the next 12 months with that of the past 12 months.[5] We find that, when shifted ahead one quarter, the balance of opinion measured by the BOS on growth of non-labour input prices moves somewhat in line with the Bank of Canada commodity price index (**Chart 1**).

Chart 1: Firms' expected growth of input prices is moderately correlated with the Bank of Canada commodity price index



Source: Bank of Canada

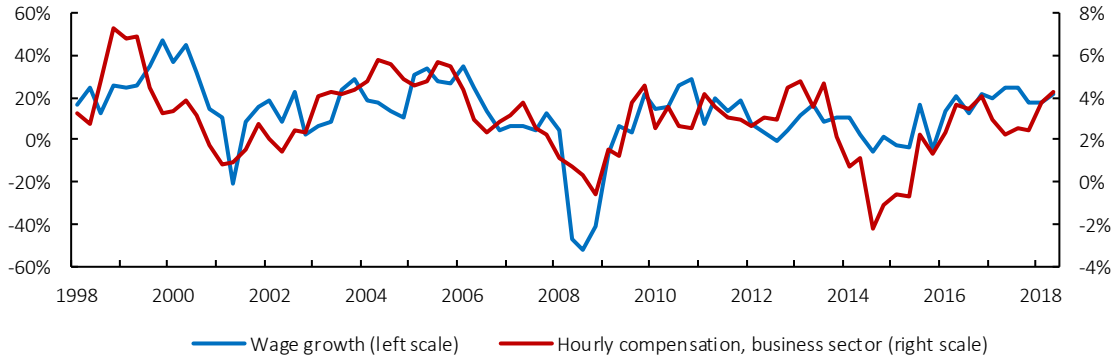
Last observations: Business Outlook Survey, 2019Q3; BCPI, 2019Q4

Note: *Growth of input prices* is the balance of opinion on input price growth from the Business Outlook Survey, shifted one quarter ahead. *BCPI* is the year-over-year percentage change in the Bank of Canada commodity price index.

[4] See the *Business Outlook Survey—Third Quarter of 2022* and *Business Outlook Survey—Fourth Quarter of 2022* for a summary of results from the second half of 2022.

[5] See Amirault, Rai and Martin (2020) for more details about the questions and balance of opinion calculations in the Business Outlook Survey.

Chart 2: Firms' expected wage growth also shows a moderate correlation with business sector compensation



Sources: Statistics Canada and Bank of Canada

Last observations: Business Outlook Survey, 2018Q4; Statistics Canada, 2019Q4

Note: *Wage growth* is the balance of opinion on expected increases in labour costs from the Business Outlook Survey, shifted four quarters ahead. *Hourly compensation, business sector* is the year-over-year percentage change in Statistics Canada's index of business sector total compensation per hour worked.

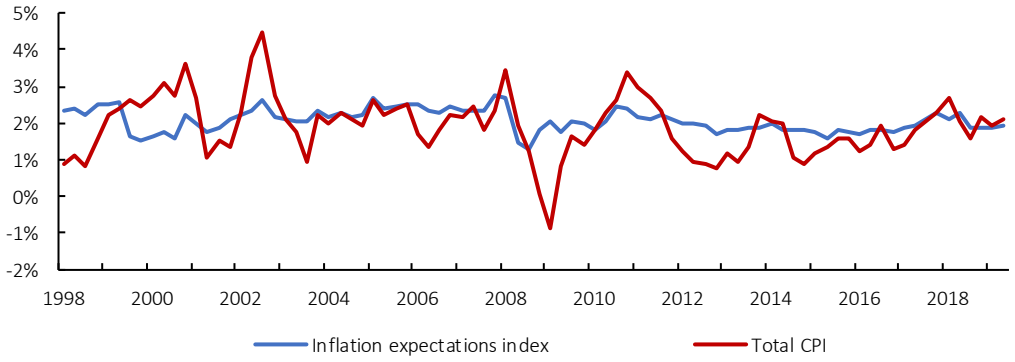
This implies that firms in the BOS sample anticipate growth in commodity prices one quarter in advance. The balance of opinion in the BOS on wage pressures moves most closely with the Statistics Canada measure of hourly compensation (with a correlation of 0.58) when the BOS measure for wage growth is shifted four quarters ahead (**Chart 2**). Thus, movements in the BOS measures for expected growth in wages and input prices show moderately strong correlation with those of their respective comparative measures.

Firms' inflation expectations are a weak indicator of actual inflation

BOS firms are asked what they expect average year-over-year growth in the consumer price index (CPI) to be over the next two years (**Chart 3**). We then compare those expectations with total CPI, a measure of actual inflation. We find that, before the pandemic, firms' inflation expectations reported in the BOS do not correlate well with actual inflation in the same time period (a correlation of 0.40).[6]

[6] Before the fourth quarter of 2010, the Bank used the inflation expectations index (IEI) to calculate an implied median estimate of inflation based on firms' responses to a BOS question about inflation expectations over the next two years (see page 38 in Amirault, Rai and Martin 2020). Since the fourth quarter of 2010, the IEI has been calculated by averaging firms' point estimates for inflation over the next two years, using midpoint estimates from categorical responses when point estimates are unavailable.

Chart 3: Correlation between firms' expectations for inflation and consumer price index is fairly weak



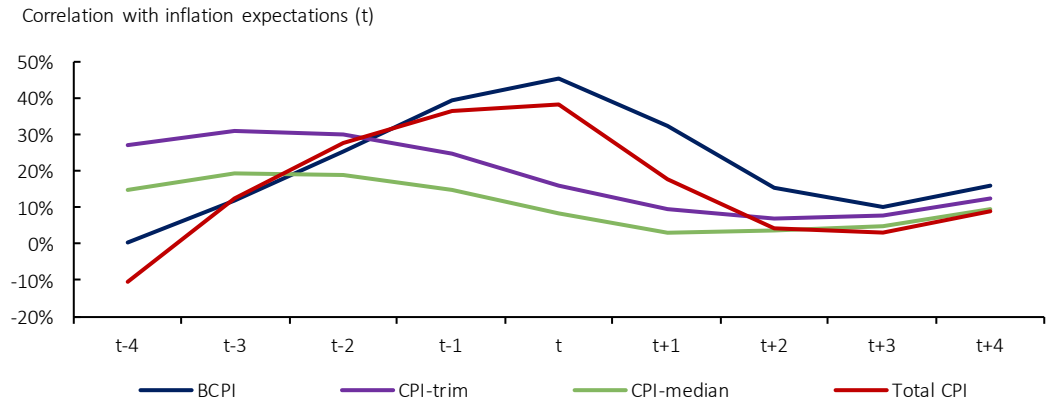
Sources: Statistics Canada and Bank of Canada

Last observation: 2019Q4

Note: *Inflation expectations index* is the average two-year inflation expectations from firms in the Business Outlook Survey. *Total CPI* is the consumer price index and shows the year-over-year percentage change (unadjusted).

This suggests that firms were using other information not reflected in the total CPI measure when setting their own inflation expectations. In fact, we find that overall, different measures of inflation—such as CPI-median or CPI-trim—are weak indicators of firms' inflation expectations (**Chart 4**).[7] This finding is consistent with previous results that suggest firms' inflation expectations in the BOS do not accurately predict average headline inflation over the next two years.[8]

Chart 4: Firms' inflation expectations and other measures of inflation have a moderately weak correlation at different time horizons



Sources: Statistics Canada and Bank of Canada

Last observation: 2019Q4

Note: *BCPI* is Bank of Canada commodity price index and *Total CPI* is consumer price index. *CPI-trim* excludes the most extreme (high and low) price changes each month. *CPI-median* represents the midpoint of the distribution of monthly price changes. *t* represents the contemporaneous correlation with the inflation expectations index.

[7] See Bank of Canada (2022b).

[8] For more on inflation expectations in the BOS, see Richards and Verstraete (2016).

Firms' costs are a key driver of their selling prices

Firms' expectations for growth in input prices and wages are strongly related to their expectations for growth in output prices (**Table 1**). This suggests that firms' expectations for cost growth are an important driver of their expectations for output prices. In contrast, the correlation between inflation expectations and expectations for output prices is weak. Furthermore, changes in wage pressures are more strongly correlated with expectations for input prices than with those for output prices. Therefore, in addition to having a direct effect on output prices from firms' own labour costs, wage pressures may have an indirect effect through the labour costs of input suppliers.

A somewhat stronger relationship exists between inflation expectations and input price pressures (correlation of 0.25) than between inflation expectations and output price pressures (correlation of 0.13). This may reflect the impact of commodity prices on both input prices and inflation expectations. An analysis of quarterly firm-level BOS data from 2001 to 2015 supports this idea, revealing that firms' inflation expectations respond to movements in oil prices.[9]

Table 1: Historically, pressures on firms' input prices strongly correlate with firms' output prices

	Correlation with:			
	Input prices	**Wage pressures**	**Inflation expectations index**	**Total CPI**
Output prices	0.748	0.431	0.129	0.337
Input prices		0.511	0.252	0.404
Wage pressures			0.367	0.565
Inflation expectations index				0.365

Note: Business Outlook Survey data are from 1998Q3 to 2019Q4. *Total CPI* is consumer price index.

These results provide evidence that firms' price-setting behaviour is related to their direct costs, but we find no evidence that inflation expectations play a role. However, this analysis using univariate correlations may miss causal relationships that are more complex. For example, inflation expectations show a stronger correlation with firms' wage growth expectations than with expectations for output price growth. Inflation expectations, then, may influence firms' wage growth expectations, which in turn may indirectly affect firms' price-setting behaviour.[10] We investigate the relationship between inflation expectations and price setting in two ways. First, we analyze the narratives that firms in the BOS use to explain their responses to survey questions. These often include an explicit discussion about causation. The

[9] See Richards and Verstraete (2016).

[10] The link between inflation expectations and price setting is tested in a structural vector autoregressive model (SVAR), described in the **Appendix**.

narratives reinforce the result that overall expectations for inflation are not related to firms' price setting. Second, we use multivariate and time-series analyses to further examine the statistical properties of the data. These results, presented in the **Appendix**, largely confirm the findings presented in this section.

What drove the gap between input and output price pressures during the pandemic?

In this section, we use data observed since the start of the pandemic (from the first quarter of 2020 to the end of 2022). We explore the unusually high balances of opinion on output prices relative to the balances of opinion on input prices, and investigate explanations, including the possibility that firms are now incorporating inflation expectations into price setting.

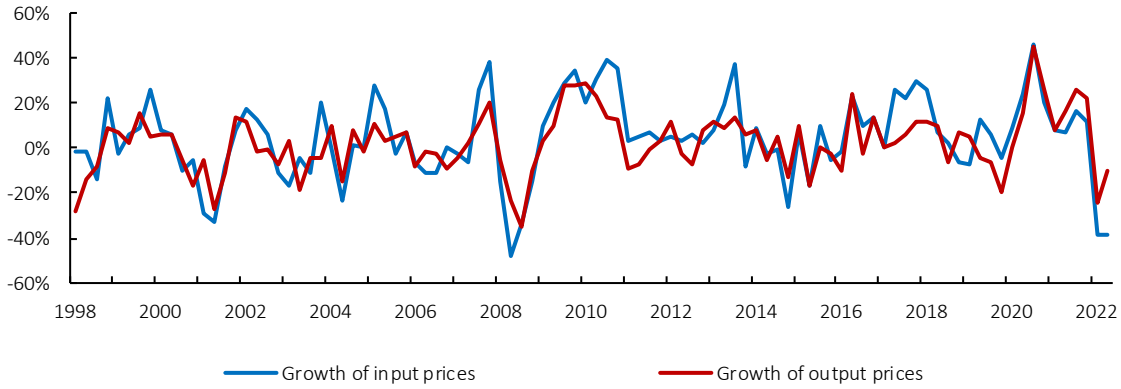
Pressures on output prices have become more widespread than those on input prices

In the BOS, the strong correlation between firms' expectations for input prices and those for output prices suggests that costs are a primary driver of output prices. However, the pass-through from input prices to output prices is rarely instantaneous or complete. In a 2006 Bank survey of price-setting behaviour, firms reported a variety of obstacles to fully passing on their cost increases to customers, including a fear of upsetting customers and a reluctance to adjust prices ahead of competitors.[11] These obstacles are reflected in BOS results for the balance of opinion on output prices. Shifts in the balance of opinion on output prices tend to be less volatile and smaller than changes in the balance of opinion on input prices (**Chart 5**).[12]

[11] In Amirault, Kwan and Wilkinson (2005), of 170 Canadian firms, 61% said they delay price changes if input costs increase.

[12] The historical average of the balance of opinion on input prices is 5%, compared with 2% for output prices. The standard deviation of the input price series is 0.18, compared with 0.14 for output prices.

Chart 5: Firms' outlook for output prices is less volatile than for input prices

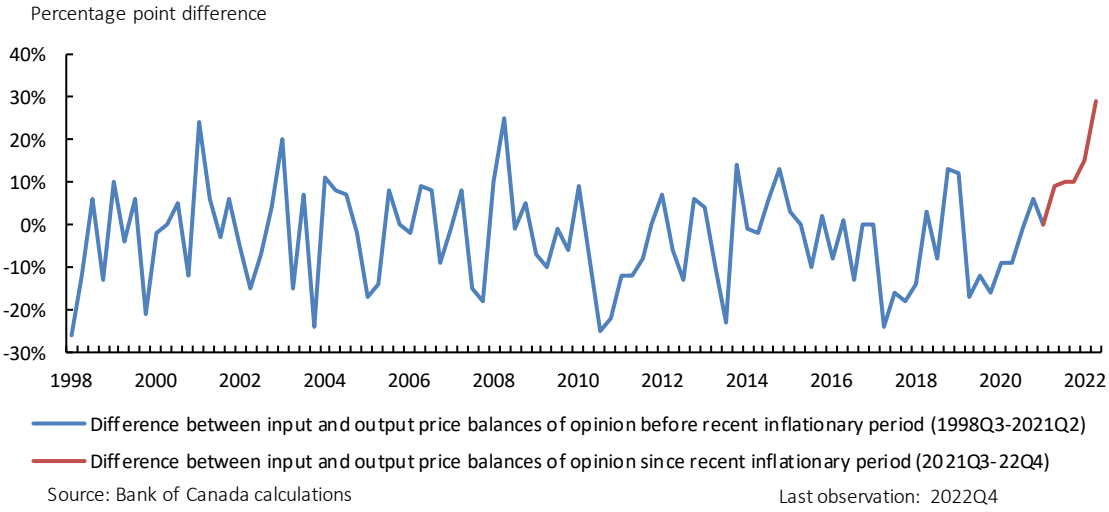


Source: Bank of Canada

Last observation: 2022Q4

Note: *Growth of input prices* and *Growth of output prices* show the balance of opinion of firms in the Business Outlook Survey.

Chart 6: The difference in firms' balance of opinion for increases in input and output prices is mostly negative



Source: Bank of Canada calculations

Last observation: 2022Q4

Note: *Input price growth* and *Output price growth* show the balance of opinion of firms in the Business Outlook Survey.

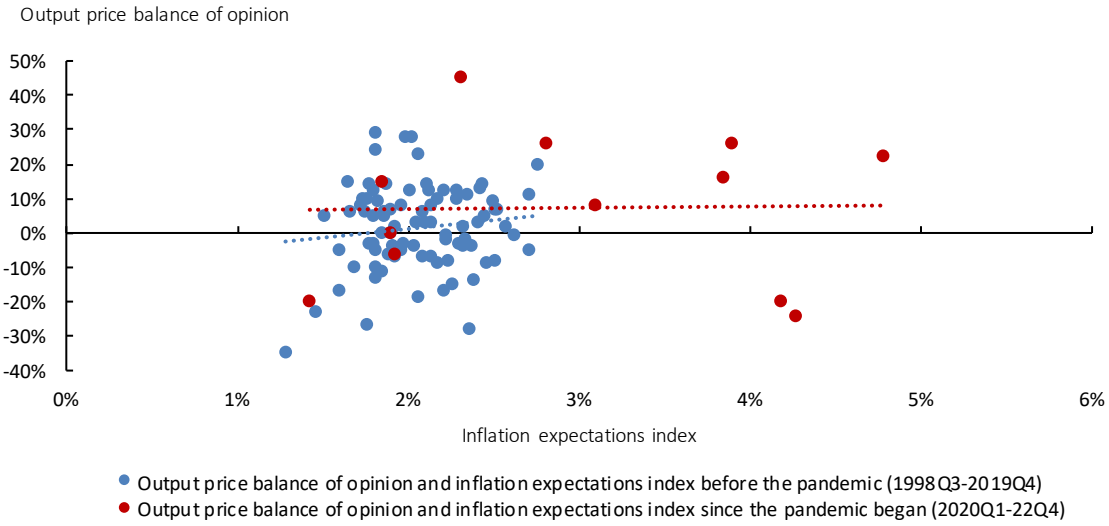
Firms have historically experienced changes in input prices more frequently than changes in output prices. This partly reflects the range of management strategies that can be used to avoid raising output prices if input prices increase. However, changes in output prices appear to have been more widely reported than changes in input prices since the second quarter of 2021 (**Chart 6**). This suggests the pass-through of higher expected input prices to output prices is more widespread than observed before the pandemic. Focusing on the period since the first quarter of 2020, we investigate whether the historical relationship between input

prices and output prices has changed, and whether inflation expectations may explain this growing gap.

Costs remain the top drivers of price setting during the pandemic

Recently, reports of increasing output prices have become more widespread than those of rising input prices among firms surveyed for the BOS. One possible explanation for this is that businesses' near-term inflation expectations—which have been elevated since mid-2021—are now having a direct effect on price setting. Firms, anticipating that inflation will remain persistently high, may be raising their output prices in advance, by more than the expected increase in input prices alone. If true, this could represent a new environment for price setting that could weaken the transmission of monetary policy.

Chart 7: The relationship between firms' inflation expectations and output price pressures has softened during the pandemic



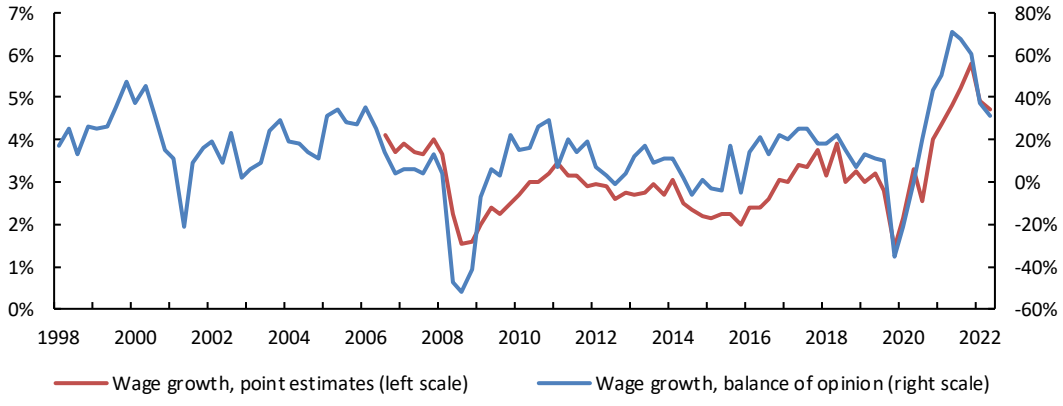
Source: Bank of Canada calculations Last observation: 2022Q4

Note: The dotted lines represent linear trends capturing the correlation between the inflation expectations index and output price balance of opinion for each quarter of the Business Outlook Survey before the COVID-19 pandemic (blue) and since the COVID-19 pandemic began (red).

We investigate this possibility by first examining whether the relationship between firms' expectations for inflation and for growth in output prices has changed since the pandemic began in the first quarter of 2020. We find that inflation expectations continue to have a weak relationship with firms' output prices (see **Table A-3** in the Appendix). Further, we find this relationship has in fact weakened somewhat during the pandemic, as indicated by a flatter slope between the observations in red in **Chart 7**. We find no evidence that high inflation expectations are contributing to more widespread growth in output prices.

Because the relationship between inflation expectations and price setting remains weak, we explore other factors that could be causing increases in output prices to be more widespread than increases in input prices in the current economic environment. One explanation is that firms' expectations for wage growth, a separate indicator from expectations for input price growth, have recently increased to survey highs and may be pushing firms to raise their output prices. BOS estimates of wage growth reveal widespread and large increases in wages that have reached survey highs (**Chart 8**). Furthermore, recent BOS results show that firms are more frequently passing on labour cost increases to output prices compared with the pre-pandemic period of 2014–19 (**Chart 9**).[13] This explanation fits well with our theoretical understanding that firms set prices based on costs, and wages are an important cost. In this case, widespread and high growth in labour costs may be setting the conditions for widespread and high growth in output prices.

Chart 8: Wage pressures are historically widespread and strong



Source: Bank of Canada

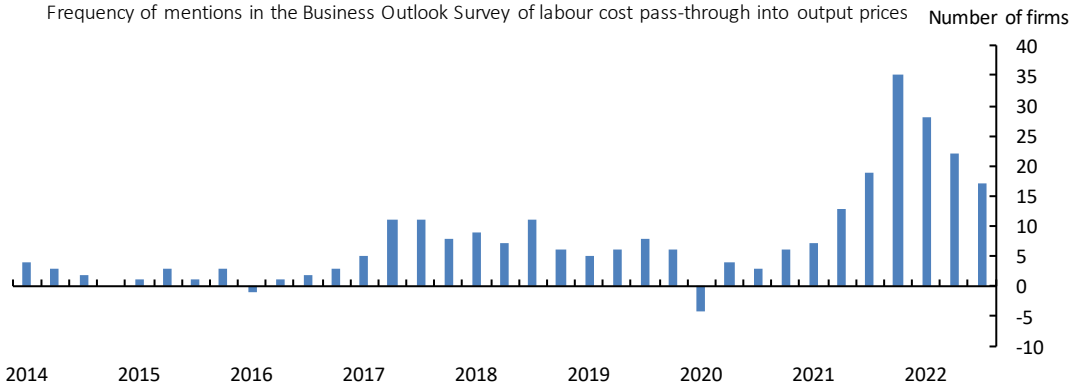
Last observation: 2022Q4

Note: *Wage growth, point estimates* represent the average point-estimate of firms' expected wage growth estimate from the Business Outlook Survey. For more information, see the backgrounder on the Business Outlook Survey question on firms' average expected wage increase.

[13] A question about the pass-through of labour costs to output prices was introduced in the BOS in the second quarter of 2014.

Chart 9: Pass-through of labour costs to output prices remains high

Frequency of mentions in the Business Outlook Survey of labour cost pass-through into output prices



Source: Bank of Canada

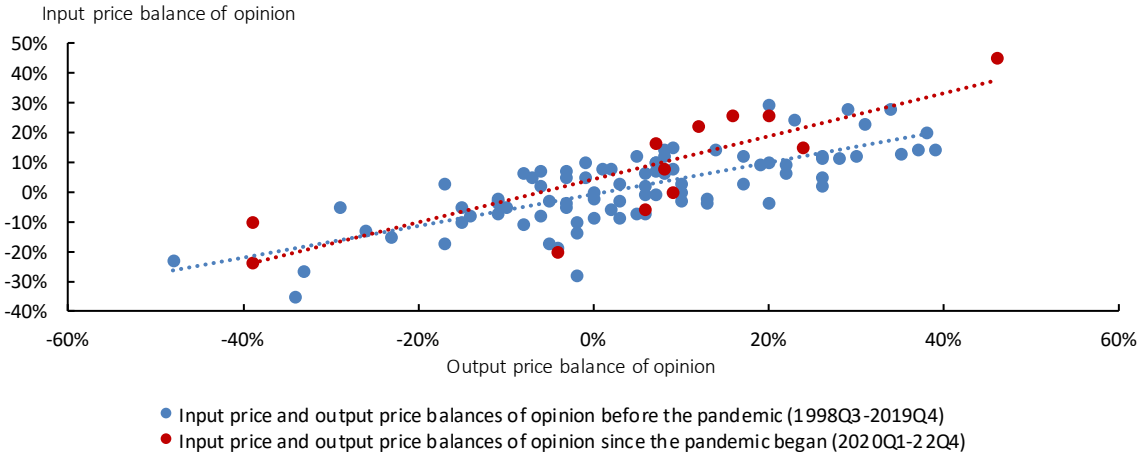
Last observation: 2022Q4

Note: The frequency counts represent the number of firms noting "labour cost pass-through" as a driver of their output price growth.

Another explanation could be that firms are passing through more of their input price increases than in the past. An unusual feature of the economic recovery phase of the pandemic is that demand rose alongside supply chain disruptions, which was noted in BOS results throughout 2021 and in early 2022. Price competition between firms diminished as customers sought a more limited set of products, allowing for unusually large price increases. In addition, firms reported that customers acknowledged the global nature of supply chain disruptions, which likely softened the fear of antagonizing buyers with price increases. Because of these circumstances, firms may have raised their output prices by the same magnitude as—or even beyond that of—the input price increases they experienced.

Indeed, we observe a stronger relationship between expected growth in firms' input prices and expected growth in their output prices since the start of the pandemic, as indicated by the steeper slope of the red dotted line compared with that of the blue dotted line in **Chart 10**. Furthermore, we find the relationship between commodity-driven pressures on input price growth, and the pass-through of those pressures to output prices, to be stronger during the pandemic (**Chart 11**). Thus, as a result of the increase in commodity price pressures throughout the pandemic, more firms have increased their output prices compared with the pre-pandemic trend.

Chart 10: Movements in balances of opinion for input and output price growth have been more similar since the pandemic began

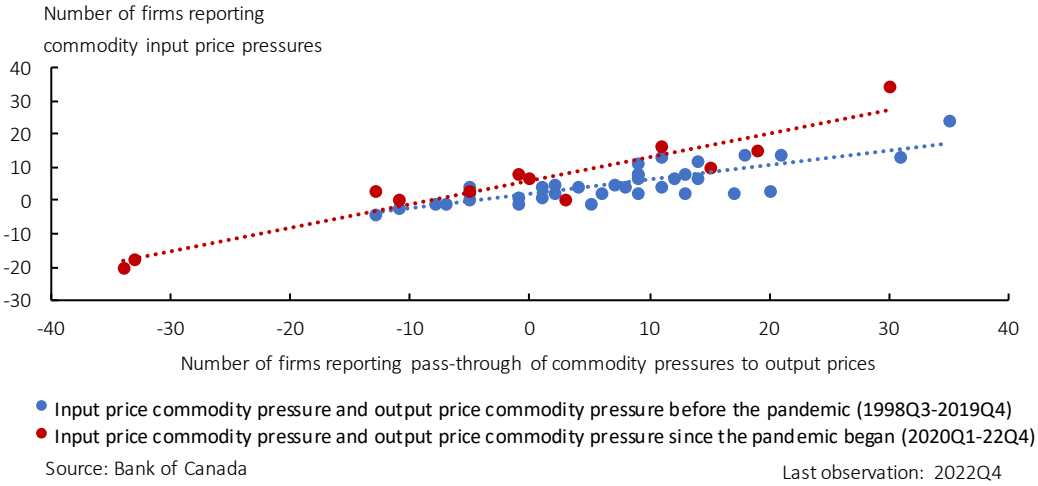


Source: Bank of Canada

Last observation: 2022Q4

Note: The dotted lines represent linear trends capturing the correlation between the input price and output price balances of opinion for each quarter of the Business Outlook Survey before the COVID-19 pandemic (blue) and since the COVID-19 pandemic began (red).

Chart 11: Commodity price pressures are more frequently being passed through to output prices since the pandemic began



Source: Bank of Canada

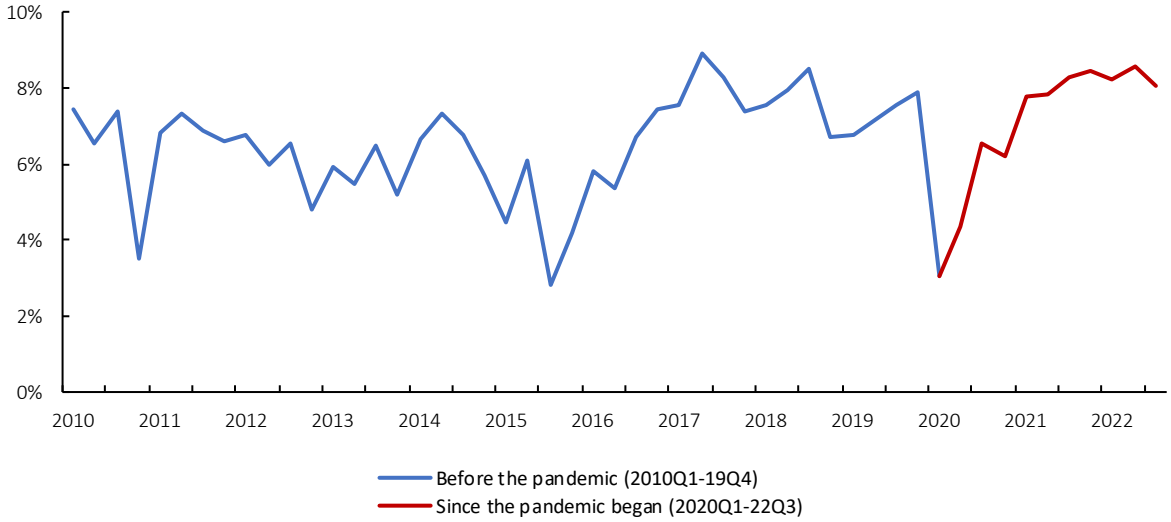
Last observation: 2022Q4

Note: The dotted lines represent linear trends capturing the correlation between firms noting higher commodity price pressures and firms noting higher commodity prices being passed through to output prices for each quarter of the Business Outlook Survey before the COVID-19 pandemic (blue) and since the COVID-19 pandemic began (red).

These measures do not reflect how much of an increase in input prices is passed through to output prices. But with more firms than usual noting an increase in their output prices, the environment for price increases has become more favourable. This is consistent with macroeconomic data showing that, after being squeezed in the first quarter of 2020, profit margins rose gradually during the recovery to eventually surpass the pre-pandemic average (**Chart 12**).

Chart 12: Overall profit margins have risen considerably since early 2020

Net income as a share of revenue, all non-financial industries



Source: Statistics Canada

Last observation: 2022Q3

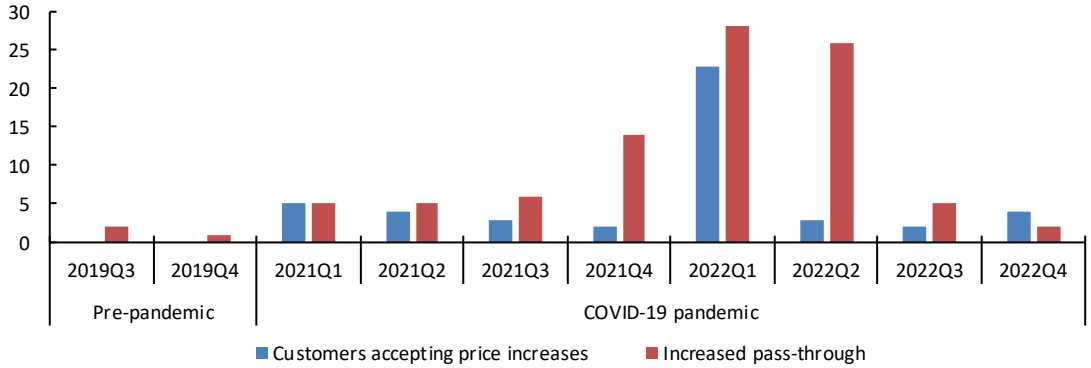
Unusual conditions are supporting more cost pass-through

We also review the narratives firms use to explain their responses to BOS questions on prices and inflation to look for evidence of changes in price-setting behaviour. In particular, we assess whether firms' narratives report unusual price-setting behaviour, such as incorporating high inflation expectations into their price setting or increasing their pass-through of higher input prices to output prices.

We find little evidence that firms are setting prices in anticipation of future cost increases that are tied to their inflation expectations. In fact, in many cases, when firms mention inflation, they are specifically referring to cost increases rather than general inflation. Mentions of general inflation also tend to be vague and are largely separate from discussions of a firm's own experiences with cost increases.

Chart 13: Fewer firms reporting increased pass-through of costs and customer acceptance of price increases

Frequency of narrative mentions in Business Outlook Survey responses



Source: Bank of Canada

Note: Figures represent counts of firms in the Business Outlook Survey mentioning customers being more accepting of price increases or noting greater pass-through of input price increases into output prices than typical in their responses to input and output price pressures.

However, we do observe a notable increase in the number of firms citing more favourable conditions to pass on costs since the start of the pandemic. This includes explicit mentions of more pass-through of input costs to output prices and greater customer acceptance of price increases compared with the pre-pandemic period (**Chart 13**). In the second half of 2022, these factors appear to have declined, and firms' expectations for inflation are starting to ease from the peaks observed earlier in the pandemic recovery.

Conclusion and risks to the inflation outlook

Our results indicate that firms are not currently setting prices based on their expectations for high inflation. Rather, firms raised their output prices due to higher costs and a greater ability to pass these costs on to customers. This suggests that firms' price-setting behaviour remains tied to typical drivers: changes in input prices and the degree of competition.

BOS results for the last two quarters of 2022 indicate that Canadian firms, on balance, expect the growth in output prices to slow. This is consistent with recent declines in commodity prices and fewer reports of customer acceptance of price increases. This also signifies that firms' prices remain flexible and are responding to changing economic conditions—a sign of effective monetary policy transmission. In addition, firms' expectations for inflation have come down, indicating that firms are more optimistic about inflation returning to target than they were in the first half of 2022. As the effects of monetary policy are felt throughout the economy, we expect firms to report a further slowing of output price growth and lower inflation expectations.

However, risks remain that inflation expectations may stay high and could begin to influence price setting, delaying inflation's return to target. The longer inflation remains above target, the greater the likelihood that firms may eventually embed high inflation expectations into their price setting. This may reduce price flexibility, making the path to restore inflation to target longer and more costly. Furthermore, firms' estimates in the BOS for wage growth remain high, indicating that pressures are widespread. Continued, widespread pressure on wages may force firms to increase prices, supporting high inflation and fuelling stronger wage growth in the future to preserve real wages. This cycle could generate a wage-price spiral with adverse economic consequences that would require even stronger monetary policy measures. We monitor these risks closely in our consultation with firms, and we will continue to publicly report our results.

Appendix

Statistical support for causality and importance of inflation expectations in firm price setting

Granger causality test

To assess whether a causal relation exists between output prices and changes in firms' costs or inflation expectations, we use the Granger causality test (**Table A-1**). We find evidence that changes in firms' expectations for input prices and for inflation Granger-cause output price changes at the 10% significance level. Most notably, wage growth and inflation expectations are Granger-causing output price pressures to change at the 5% level, while growth of input prices appears to Granger-cause output price growth at the 10% level.

However, this may be because wage growth and inflation expectations appear to Granger-cause growth in input prices. As we noted in the main paper, commodity prices (such as oil prices) are a statistically significant driver of firms' inflation expectations, and the Bank of Canada commodity price index has a moderately strong correlation with the Business Outlook Survey's (BOS) balance of opinion on input prices. We also noted that the balance of opinion on wage growth is more strongly correlated with growth in input prices than growth in output prices. These results could indicate that a shift in the balance of opinion on input prices may have less of an impact on output prices, after accounting for changes in commodity prices (through inflation expectations) and in wage growth expectations.

Table A-1: Inflation expectations and wage growth Granger-cause growth in input prices

Equation	Excluded	Chi-squared	Degrees of freedom	Prob > Chi-squared
Input prices	Output prices	4.8667	2	0.088
Input prices	Wage pressures	5.6875	2	0.058*
Input prices	Inflation expectations index	13.76	2	0.001***
Input prices	ALL	21.93	6	0.001***
Output prices	Input prices	4.8624	2	0.088*

Output prices	Wage pressures	7.0309	2	0.030**
Output prices	Inflation expectations index	6.7429	2	0.034**
Output prices	ALL	19.567	6	0.003***
Wage pressures	Input prices	2.2748	2	0.321
Wage pressures	Output prices	3.1269	2	0.209
Wage pressures	Inflation expectations index	4.0043	2	0.135
Wage pressures	ALL	13.977	6	0.030**
Inflation expectations index	Input prices	2.0958	2	0.351
Inflation expectations index	Output prices	0.0213	2	0.989
Inflation expectations index	Wage pressures	1.2565	2	0.534
Inflation expectations index	ALL	6.6541	6	0.354

Note: We removed seasonality from the Business Outlook Survey indicators using first differences because they were non-stationary (for more than one lag) based on the unit root test. The timeline for the time series is: 1998Q3–2022Q3. Statistical significance:

Ordinary least squares model for estimating pressure on output prices

Our results show that firms' expectations for costs and inflation Granger-cause growth in output prices. Thus, we construct an ordinary least squares (OLS) model to confirm whether these variables (cost and inflation expectations) are significant when firms set output prices. In our model, we include time-variant fixed effects for 100 observations from the third quarter

of 1998 to the third quarter of 2022. Our baseline specification for determining whether firms' inflation expectations have influenced their price-setting behaviour is:

$$y_t = \beta_0 + \beta_1 \theta_t + \beta_2 \mu_t + \beta_3 \alpha_t + \varepsilon_t, \quad (1)$$

where, θ_t is firms' inflation expectations indicator at time *t*; μ_t is firms' input price pressures at time *t*; α_t is firms' wage pressures; and ε_t is the error term.

Results from our model (see equation 1) suggest that as input price pressures become more or less widespread (i.e., a change in the balance of opinion), firms also adjust selling prices, though adjustments are less widespread. More specifically, before the pandemic, a 1% increase in firms' balance of opinion for input prices causes the balance of opinion for output prices to increase by 0.33% (**Table A-2**, column (1)). This effect has increased since the start of the pandemic (**Table A-2**, column (3)). Additionally, by including time-variant fixed effects in the model, we find a minor increase in the magnitude of this effect. However, our model shows that firms' price-setting behaviour is not influenced by their inflation expectations, unlike our findings in the Granger causality test. Since the pandemic began, the effect of wage growth on the growth of firms' output prices has remained the same but with higher levels of significance (**Table A-2**, column (3)).

Table A-2: Ordinary least squares results suggest input prices are a key driver of output prices both before and after the start of the pandemic

	(1)	(2)	(3)	(4)
Variable	Before the pandemic	Before the pandemic, including fixed effects	After the pandemic began	After the pandemic began, including fixed effects
Input price pressures	0.330***	0.320***	0.409***	0.392***
	(0.0805)	(0.0942)	(0.0729)	(0.0891)
Wage growth	0.229*	0.209	0.229**	0.227*
	(0.116)	(0.147)	(0.103)	(0.132)
Inflation expectations indicator	-2.507	-3.336	-1.517	-1.000
	(5.434)	(6.494)	(4.605)	(5.851)
Constant	0.00227	0.000778	0.00182	0.000384
	(0.0121)	(0.0136)	(0.0115)	(0.0129)
Observations	85	84	96	95
R-squared	0.306	0.356	0.397	0.439

Time fixed effects	No	Yes	No	Yes

Note: Standard errors in parentheses. *** p<0.01, ** p<0.05, * p<0.1.

We further decompose our results across different industries and find that changes in output prices are strongest in response to changes in input prices for trade and manufacturing industries. Wage growth has strong effects on the price-setting behaviour of firms in the commercial, personal and business services (CPBS) sector and the finance, insurance and real estate sector. Additionally, in contrast to our overall results presented in **Table A-2**, we find that inflation expectations influence the price-setting decisions of firms in the CPBS and primary sectors (**Table A-7**, columns (2) and (5)).[14]

Structural vector autoregression model of firms' output prices

Using a structural vector autoregression (SVAR) model, we examine the effect of inflation expectations on firms' price-setting behaviour. We present our results using the impulse response function and variance decomposition to see the relationships between our key BOS indicators: output prices, input prices, inflation expectations and wage pressures. In the SVAR, we treat gasoline prices (base year at 2002) as an exogenous shock. In this exercise, we are interested in the effects of the surge in inflation that took place during the pandemic, which was largely due to the rapid rise in commodity prices, specifically in energy prices. Thus, the exogenous shock in the model closely reflects the high inflationary environment of 2022. Our endogenous variables are pressures on firms' input prices, their inflation expectations, wage pressures and output prices. These variables are consistent with those presented in our OLS equation. The purpose of this exercise is to further examine the validity of our OLS results. The SVAR uses a lag length of one quarter, based on the results from the Hannan–Quinn information criterion.

The reduced form of the SVAR is as follows:

$$\boldsymbol{Y_t = A_1 Y_1 + \epsilon_t},$$

where

$$\boldsymbol{Y_t} = \begin{bmatrix} \boldsymbol{Gasoline\ prices_t} \\ \boldsymbol{IP_t} \\ \boldsymbol{IEI_t} \\ \boldsymbol{Wages_t} \\ \boldsymbol{OP_t} \end{bmatrix}.$$

For the SVAR, our identification method of recursive ordering is based on our interpretation of the link between the BOS indicators, which is supported by firms' narratives. To provide context for the links among BOS indicators, we looked exclusively at BOS narratives from economic cycles that experienced a surge in commodity prices. For this reason, we focused

[14] The primary sector is comprised of firms in agricultural and extractive industries (i.e., mining, oil and gas). Firms in these industries are classified under North American Industry Classification System (NAICS) codes 11 and 21.

specifically on the time periods of 2007Q4, 2008Q1, 2021Q2, and 2021Q3. In the narratives of firms' inflation expectations from these periods, firms mentioned the rise in raw materials and commodity price pressures as reasons for high inflation expectations. We associated pressures on input prices, which are strongly influenced by fluctuations in commodity prices, as drivers of firms' inflation expectations. Additionally, when discussing the drivers of wage pressures, most firms across the sample mentioned inflation, high demand for labour and cost-of-living adjustments. Finally, in firms' narratives about pressures on output prices after the pandemic started, businesses repeatedly mentioned labour shortages and rising demand for labour as key contributors to the pass-through of wages to firms' output prices. Additionally, the pent-up demand from consumers permitted the pass-through of rising commodity prices to firms' output prices. Based on this, we find the link between the BOS indicators to be as follows:

$$\boldsymbol{IP_t \rightarrow IEI_t \rightarrow Wages_t \rightarrow OP_t.}$$

In our SVAR, the Cholesky decomposition is calculated as follows:

$$\begin{bmatrix} \in_{Gas} \\ \in_{IP} \\ \in_{IEI} \\ \in_{Wages} \\ \in_{OP} \end{bmatrix} = \begin{bmatrix} a & 0 & 0 & 0 & 0 \\ b & e & 0 & 0 & 0 \\ c & f & h & 0 & 0 \\ d & g & i & k & 0 \\ e & h & j & l & m \end{bmatrix} \begin{bmatrix} \omega_{Gas} \\ \omega_{IP} \\ \omega_{IEI} \\ \omega_{Wages} \\ \omega_{OP} \end{bmatrix}$$

From this, we assume that $\in_{OP}$ endogenously responds to contemporaneous movement in oil prices. We believe this a fair assumption, given that the information is from firms' narratives about their price-setting behaviour after oil prices surged in 2021. Firms increasingly mentioned passing through commodity price increases in their narratives about output prices, suggesting an endogenous response to fluctuations in the price of oil.

The results of impulse response functions (**Chart A-1**) suggest that that in response to a decline in wage pressures, firms reduce their inflation expectations and slightly increase their prices within two quarters. Firms' prices then decline within two additional quarters. Prices and inflation expectations then stabilize at lower levels. We also find that wage pressures fluctuate the most in response to inflation expectations and output prices, with the impact of the latter declining after two quarters before tapering off. In line with the historical data, firms' growth in output prices declines slightly in response to pressures on input prices within two quarters and remains at a lower level thereafter. The effects of wage pressures and inflation expectations on firms' output prices offset each other, with an increase in output price growth from wage pressures cancelling out a decline in output price growth from firms' inflation expectations. The variance decomposition presented in **Table A-9** further solidifies these findings, suggesting that changes in input price pressures account for most of the variation in firms' output prices, and that this impact diminishes over time. Differences in firms' inflation expectations have the smallest impact on the variance in firms' output prices.

Appendix tables

Table A-3: Historical relationships between output prices and input prices have strengthened since the start of the pandemic

Correlations (1998Q3–2022Q4)	Input prices	Wage pressures	Inflation expectations index	Total CPI
Output prices	0.761	0.450	0.165	0.101
Input prices		0.36	-0.001	-0.079
Wage pressures			0.599	0.608
Inflation expectations index				0.803

Note: Business Outlook Survey data are from 1998Q3 to 2022Q4. *Total CPI* is consumer price index.

Table A-4: Global pandemic strengthened the relationship between firms' output prices and input prices

Correlations (2020Q1–2022Q4)	Input prices	Wage pressures	Inflation expectations index	Total CPI
Output prices	0.843	0.432	0.065	-0.028
Input prices		0.001	-0.421	-0.498
Wage pressures			0.826	0.802
Inflation expectations index				0.983

Note: Business Outlook Survey data are from 2020Q1 to 2022Q4. *Total CPI* is consumer price index.

Table A-5: Granger causality results: A one-quarter lag shows simultaneity bias between wage growth and input prices

Equation	Excluded	Chi-squared	Degrees of freedom	Prob > Chi-squared
Input prices	Output prices	0.26186	1	0.609
Input prices	Wage pressures	2.9558	1	0.086*
Input prices	Inflation expectations index	8.4228	1	0.004***
Input prices	ALL	8.8473	3	0.031**
Output prices	Input prices	6.5398	1	0.011**
Output prices	Wage pressures	5.6329	1	0.018**
Output prices	Inflation expectations index	5.4401	3	0.020**
Output prices	ALL	15.16	3	0.002***
Wage pressures	Input prices	4.5075	1	0.034**
Wage pressures	Output prices	0.1796	1	0.672
Wage pressures	Inflation expectations index	2.2e-0.5	1	0.996
Wage pressures	ALL	5.076	3	0.166

Inflation expectations index	Input prices	2.4334	1	0.119
Inflation expectations index	Output prices	0.00142	1	0.970
Inflation expectations index	Wage pressures	0.00102	1	0.975
Inflation expectations index	ALL	3.6125	3	0.306

Note: We removed seasonality from the *Business Outlook Survey* indicators using first differences since they were non-stationary (for more than one-lag) based on the unit root test. The timeline for the time series is: 1998Q3–2022Q3. Statistical significance: * 10% level, ** 5% level, *** 1% level.

Table A-6 Granger causality results: A three-quarter lag shows simultaneity bias between inflation expectations and input costs

Equation	Excluded	Chi-squared	Degrees of freedom	Prob > Chi-squared
Input prices	Output prices	6.4073	3	0.093
Input prices	Wage pressures	7.8633	3	0.049**
Input prices	Inflation expectations index	12.113	3	0.007***
Input prices	ALL	24.771	9	0.003***
Output prices	Input prices	7.863	3	0.049**
Output prices	Wage pressures	10.873	3	0.012**

Output prices	Inflation expectations index	6.8474	3	0.077*
Output prices	ALL	29.692	9	0.000***
Wage pressures	Input prices	3.6547	3	0.301
Wage pressures	Output prices	3.9714	3	0.265
Wage pressures	Inflation expectations index	4.0813	3	0.253
Wage pressures	ALL	15.238	9	0.085*
Inflation expectations index	Input prices	14.74	3	0.002***
Inflation expectations index	Output prices	0.93876	3	0.816
Inflation expectations index	Wage pressures	3.9024	3	0.272
Inflation expectations index	ALL	20.317	9	0.016**

Note: We removed seasonality from the *Business Outlook Survey* indicators using first differences since they were non-stationary (for more than one-lag) based on the unit root test. The timeline for the time series is: 1998Q3–2022Q3. Statistical significance: * 10% level, ** 5% level, *** 1% level.

Table A-7: Granger causality results: A four-quarter lag shows simultaneity bias between inflation expectations and input prices as well as input prices not Granger-causing output prices

Equation	Excluded	Chi-squared	Degrees of freedom	Prob > Chi-squared
Input prices	Output prices	5.6702	4	0.225
Input prices	Wage pressures	10.412	4	0.034**
Input prices	Inflation expectations index	9.6898	4	0.046**
Input prices	ALL	28.758	12	0.004***
Output prices	Input prices	7.1693	4	0.127
Output prices	Wage pressures	13.214	4	0.010***
Output prices	Inflation expectations index	5.7258	4	0.221
Output prices	ALL	29.932	12	0.003***
Wage pressures	Input prices	4.8935	4	0.298
Wage pressures	Output prices	3.7923	4	0.435
Wage pressures	Inflation expectations index	3.8643	4	0.425
Wage pressures	ALL	15.39	12	0.221

Inflation expectations index	Input prices	13.423	4	0.009***
Inflation expectations index	Output prices	4.2065	4	0.379
Inflation expectations index	Wage pressures	8.7551	4	0.068*
Inflation expectations index	ALL	26.748	12	0.008***

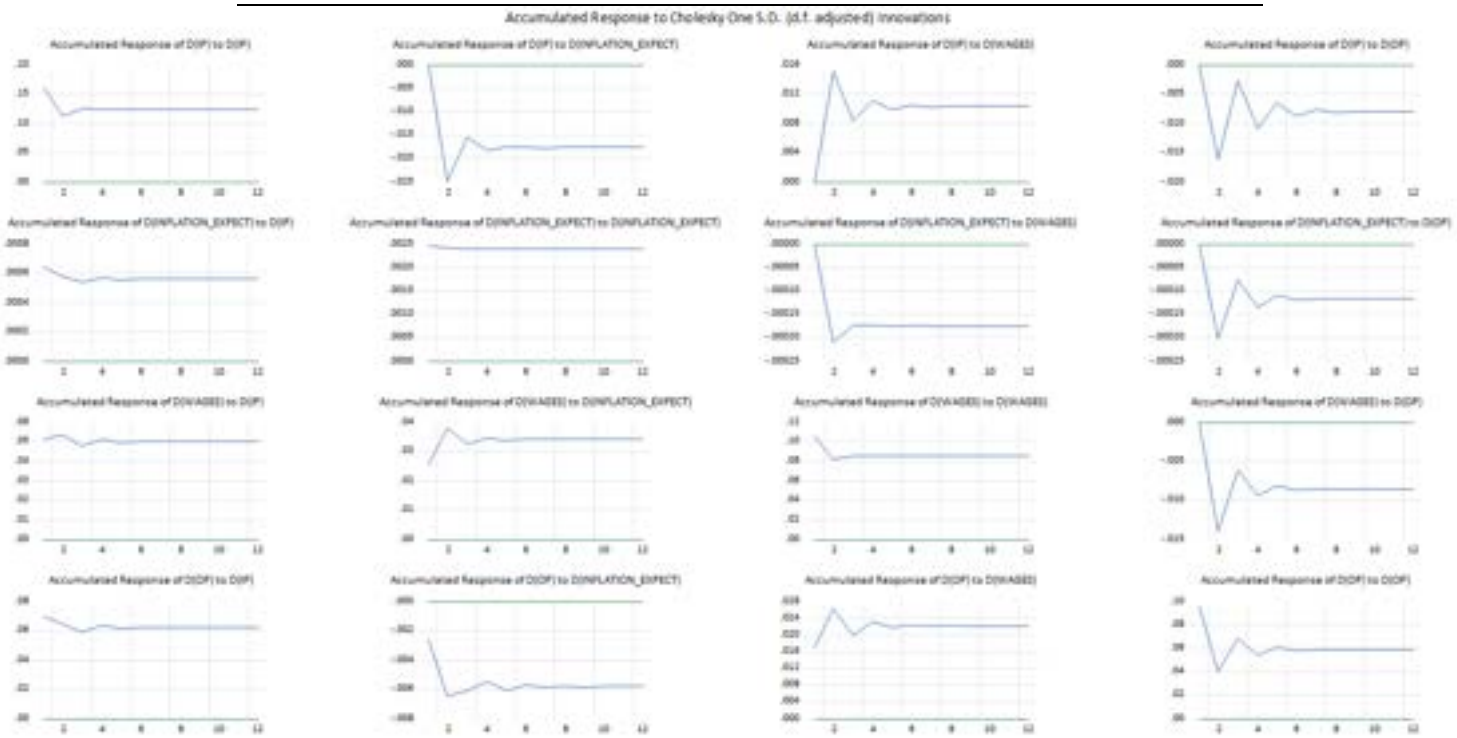
Note: We removed seasonality from the *Business Outlook Survey* indicators using first differences since they were non-stationary (for more than one-lag) based on the unit root test. The timeline for the time series is: 1998Q3–2022Q3. Statistical significance: * 10% level, ** 5% level, *** 1% level.

Table A8: Ordinary least squares results across industries

	(1)	(2)	(3)	(4)	(5)	(6)
Variables	CITU	CPBS	FIRE	Manufacturing	Primary	Trade
Input price pressures	0.231***	-0.041	0.371***	0.541***	0.323***	0.705***
	(0.075)	(0.106)	(0.101)	(0.085)	(0.090)	(0.082)
Wage pressures	0.081	0.380***	0.247***	0.216*	0.141	-0.028
	(0.085)	(0.099)	(0.090)	(0.116)	(0.126)	(0.096)
IEI	-9.257	25.129***	9.071	-0.064	-25.992*	3.485
	(7.376)	(8.137)	(9.344)	(8.998)	(13.766)	(8.122)
Constant	0.006	-0.005	-0.005	0.003	0.005	0.004
	(0.021)	(0.021)	(0.026)	(0.023)	(0.039)	(0.024)
Observations	94	96	96	96	96	96
R-squared	0.120	0.269	0.215	0.342	0.143	0.458
Time fixed effects	No	No	No	No	No	No

Note: Standard errors in parentheses. *** p<0.01, ** p<0.05, * p<0.1. *IEI* is inflation expectations index, *CITU* is construction, information, transportation and utilities; *CPBS* is commercial, personal and business services; and *FIRE* is finance, insurance and real estate.

Chart A-1: Structural vector autoregressive model results with one-quarter lag



Note: We removed seasonality from the *Business Outlook Survey* indicators using first differences since they were non-stationary (for more than one-lag) based on the unit root test. The timeline for the time series is: 1998Q3–2022Q3. D(OP): First difference in output prices; D(INFLATION_EXPECT): First difference in inflation expectations index; D(WAGES): First difference in wage pressures; and D(IP): First difference in input prices.

Table A-9: Variance decomposition using Cholesky factors

Variance decomposition of D(INFLATION_EXPECT):					
Period	S.E.	D(IP)	D(INFLATION_EXPECT)	D(WAGES)	D(OP)
1	0.002560	6.427159	93.57284	0.000000	0.000000
2	0.002577	6.408240	92.32688	0.659473	0.605407
3	0.002581	6.415906	92.06979	0.677027	0.837276
4	0.002582	6.428256	92.00675	0.676530	0.888467
5	0.002582	6.431834	91.99381	0.676562	0.897797
6	0.002582	6.432598	91.99147	0.676586	0.899350
7	0.002582	6.432742	91.99107	0.676590	0.899595
8	0.002582	6.432767	91.99101	0.676591	0.899632
9	0.002582	6.432771	91.99100	0.676591	0.899637
10	0.002582	6.432772	91.99100	0.676591	0.899638
11	0.002582	6.432772	91.99100	0.676591	0.899638
12	0.002582	6.432772	91.99100	0.676591	0.899638

Variance decomposition of D(WAGES):

Period	S.E.	D(IP)	D(INFLATION_EXPECT)	D(WAGES)	D(OP)
1	0.120242	18.32668	4.521396	77.15193	0.000000
2	0.123955	17.27710	5.226912	76.23859	1.257389
3	0.124479	17.33756	5.347870	75.68277	1.631806
4	0.124574	17.37263	5.359546	75.56900	1.698824
5	0.124589	17.38005	5.360765	75.55049	1.708695
6	0.124591	17.38130	5.360922	75.54778	1.709999
7	0.124591	17.38149	5.360945	75.54740	1.710156
8	0.124591	17.38152	5.360948	75.54736	1.710174
9	0.124591	17.38153	5.360949	75.54735	1.710175
10	0.124591	17.38153	5.360949	75.54735	1.710176
11	0.124591	17.38153	5.360949	75.54735	1.710176
12	0.124591	17.38153	5.360949	75.54735	1.710176

Variance decomposition of D(OP):

Period	S.E.	D(IP)	D(INFLATION_EXPECT)	D(WAGES)	D(OP)
1	0.119730	33.98367	0.047222	2.011871	63.95724
2	0.132681	27.85128	0.121912	2.142228	69.88458
3	0.135868	26.67975	0.116864	2.261498	70.94188
4	0.136614	26.48912	0.117895	2.287152	71.10584
5	0.136776	26.46284	0.119550	2.291474	71.12613
6	0.136809	26.46006	0.120236	2.292110	71.12760
7	0.136816	26.45993	0.120436	2.292193	71.12744
8	0.136817	26.45998	0.120485	2.292202	71.12734
9	0.136817	26.46000	0.120495	2.292202	71.12731
10	0.136817	26.46000	0.120497	2.292202	71.12730
11	0.136817	26.46000	0.120498	2.292202	71.12730
12	0.136817	26.46000	0.120498	2.292202	71.12730

Cholesky Ordering: D(IP) D(INFLATION_EXPECT) D(WAGES) D(OP)

Note: S.E. is standard error. D(OP): First difference in output prices; D(INFLATION_EXPECT): First difference in inflation expectations index; D(WAGES): First difference in wage pressures; D(IP): First difference in input prices; and D(OP): First different in output prices.

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EXHIBIT 12

British Columbia – LFP Model – Calculation of Proportion of Total Time Worked

A mathematical formula can determine the amount of time a physician in the LFP model spends on indirect/administrative work based on their billings:

Fee Code	Fee Code Description	Number of Services Billed Under LFP Model	Ratio of Services to Direct Care	Implied Minutes Worked per Unit of Direct Care Time	Portion of Total Time Worked
		[A] BC Data	[B] = [A] / 1,400,983	[C] = 15 Mins x [B]	[D] = [C] / 19.69 Mins
98010	LFP **DIRECT PATIENT CARE** TIME PER 15 MIN	1,400,983	1.00	15.00 Minutes	76.18%
98011	LFP **INDIRECT PATIENT CARE** TIME PER 15 MIN	416,397	0.30	4.46 Minutes	22.64%
98012	LFP **CLINICAL ADMIN TIME** PER 15 MIN	21,757	0.02	0.23 Minutes	1.18%
Total		**1,839,137**		**19.69**	**100.00%**

EXHIBIT 13

CLINICAL EVALUATION OF ARTIFICIAL INTELLIGENCE AND AUTOMATION TECHNOLOGY TO REDUCE ADMINISTRATIVE BURDEN IN PRIMARY CARE

Centre for Digital Health Evaluation,
Women's College Hospital Institute for Health System Solutions and Virtual Care

PRESENTED TO:
OntarioMD

DATED:
March 28, 2024 – Version 1.0

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centre for digital health evaluation

WHV

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Table of Contents

Acronyms i
Operational Definitions ii
Executive Summary I
Background I
Objectives I
Methods I
Key Takeaways I
Recommendations II
1.0 Introduction 1
1.1 Context 1
1.2 Purpose and Objectives 1
2.0 Methodology 2
2.1 Overview of Data Collection Activities 2
2.2 Environmental Scan 2
2.3 Semi-structured Interviews 3
2.4 Competitive Analysis 3
2.5 Simulated Encounters in the Virtual Care Lab 4
3.0 Results 5
3.1 Environmental Scan 5
3.2 Semi-Structured Interviews 7
3.3 Competitive Analysis 16
3.4 Facilitators and Barriers to Implementation 23
3.5 Simulated Encounters in the Virtual Care Lab 25
4.0 Discussion 26
4.1 Key Findings: AI Scribes and RPA 26
4.2 Recommendations 26
4.3 Limitations and Considerations 28
5.0 Phase 2 Evaluation 29
5.1 PCP Selection Criteria 30
5.2 AI Scribe Vendor Selection 30
5.3 Development and Evaluation of an Automation Process 32
6.0 Conclusion 34

7.0 References 35
Appendix A: Environmental Scan 39
Appendix B: Semi-structured Interviews 44
Appendix C: Competitive Analysis 48
Appendix D: Phase 2 Evaluation Activities 52

Acronyms

AI Artificial Intelligence

ASR Automatic Speech Recognition

CDHE Centre for Digital Health Evaluation

CMPA Canadian Medical Protective Association

CPSO College of Physicians and Surgeons of Ontario

DAX Dragon Ambient eXperience

eCE eHealth Centre for Excellence

EMR Electronic Medical Record

FA Factor Authentication

FAQ Frequently Asked Question(s)

HPI History of Presenting Illness

MOH Ministry of Health

NLP Natural Language Processing

OH Ontario Health

PAN Patient Advisors Network

PCP Primary Care Provider

PHI Personal Health Information

PHIPA Personal Health Information Protection Act

PIA Privacy Impact Assessment

PPE Patient Partner Evaluator

RPA Robotic Process Automation

SME Subject Matter Expert

SOAP Subjective, Objective, Assessment, and Plan

TRA Threat and Risk Assessment

VCL Virtual Care Laboratory

WCH Women's College Hospital

WIHV Women's College Hospital Institute for Health System Solutions and Virtual Care

Operational Definitions

Artificial Intelligence (AI) Scribe: AI technology that uses machine learning models, such as automatic speech recognition and natural language processing systems, to summarize conversations between patients and healthcare providers into written text. AI scribes can produce a transcript of the conversation, a medical note, referral letters, and patient-facing documents.[1–3] In this report, AI scribes may be referred to as a *product* if referencing a specific AI scribe vendor.

Artificial Intelligence (AI) Vendor: A company that developed an AI scribe (i.e., the product).

Clinical Encounter: An interaction between a patient and healthcare provider(s) for the purpose of providing healthcare service(s) or assessing the health status of a patient.[4]

Early Adopter: Primary care provider who has experience using AI scribe(s) in their practice.

Electronic Medical Record (EMR): A digital collection of medical information about an individual, including information about a patient's medical history, such as diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory test results.[5,6]

Medical Scribe(s): Allied health paraprofessional who specializes in charting provider-patient encounters in real time, such as during clinical encounters. Medical scribes also locate information for patients and providers and complete forms needed for patient care.[7]

Medical Note: A summary of essential information about a patient that is unique to each patient encounter. A medical note typically includes critical elements about a patient's health status and concerns, information that supports the treatment or procedure provided, and any other pertinent details that may be useful for the healthcare provider and other healthcare professionals using the medical note to get a synopsis of the patient's health.[8]

Non-user: Primary care provider who does not have experience using AI scribe(s) in their practice.

Primary Care Provider (PCP): Healthcare provider (e.g., family physician, nurse practitioner) that provides primary care services.[9,10]

Robotic Process Automation (RPA): RPA technology uses software to automate repetitive, rule-based tasks that involve data manipulation and integration across different systems.[11,12]

SOAP Note: One of the most widely recommended formats for documenting a clinical encounter is the Subjective Objective Assessment Plan (SOAP) format. The SOAP format is a structured method for documenting the patient encounter (i.e., Subjective, Objective, Assessment, and Plan) that satisfies the College of Physicians and Surgeons of Ontario (CPSO) guidelines and policies.[4]

Executive Summary

Background

Primary care providers (PCPs) in Ontario report significant burnout attributable to administrative tasks and shortages in healthcare personnel. With up to 40% of their time dedicated to administrative duties, PCPs are seeking solutions to alleviate this burden and improve patient care. Artificial intelligence (AI) scribes and robotic process automation (RPA) have emerged as possible solutions, having the potential to reduce burnout while enhancing efficiency. However, little is known about their effectiveness, technical performance, and workflow integration, highlighting the need for an evaluation of AI scribes and RPA in Ontario's healthcare landscape.

Objectives

The purpose of this evaluation was to 1) assess the impact and/or benefits of AI scribes and RPA on PCPs' experiences, administrative load, workflow efficiency, and patient experiences and 2) evaluate the functionality, technical performance, integration, and overall value proposition of AI scribes and RPA for PCPs, patients, and the healthcare system.

Methods

The Centre for Digital Health Evaluation (CDHE) conducted an environmental scan of peer-reviewed publications and grey literature; 13 semi-structured interviews with PCPs; a competitive analysis of six AI scribe vendors and their products; simulated encounters with three PCPs; and several consultations with subject matter experts (SMEs) and Patient Partner Evaluators (PPEs).

Key Takeaways

IMPACT OF AI SCRIBES ON ADMINISTRATIVE BURDEN

- All PCPs perceived AI scribes positively (n=13, 100%). All early adopters (n=7) reported significant reductions in administrative burden, cognitive fatigue, and afterhours charting.

EFFECTIVENESS OF AI SCRIBES

- AI scribes produced high-quality medical notes that were accurate. However, the medical notes still required review and editing by PCPs before saving and signing-off.
- Accuracy and quality of the medical note were impacted by a variety of factors, including interruptions, background noise, accents, speakers with similar voice tones, and appointment types.

- On average, AI scribes could generate a medical note within 1 minute for a 15-minute encounter and demonstrated time saved for documentation.

IMPLEMENTATION CONSIDERATIONS

- Main barriers to implementation were lack of compatibility of the technology with current workflow; out-of-pocket financial costs; data privacy and security concerns; lack of regulatory guidance regarding appropriate use of AI and RPA in healthcare; and ethical concerns, including potential biases that AI may perpetuate in healthcare.

CANDIDATE TASKS FOR AUTOMATION

- PCPs were receptive to workflow automation, including automated task managers, triaging of documents, and/or follow-up and appointment reminders.

EVALUATION HIGHLIGHTS

- AI scribes show early promise in reducing administrative burden, cognitive fatigue, and afterhours charting, with PCPs reporting significant reduction in time spent documenting and competitive analysis methods demonstrating time saved.
- Both early adopters and non-users positively perceived AI scribes, reporting improved provider and patient experience, better work-life balance, and reduced provider burnout.
- A comprehensive assessment of six AI scribe vendors and their products on a variety of factors demonstrated that in their current state, AI scribes produce a "good" medical note. However, PCPs should still review and edit the note to ensure accuracy and quality.
- As AI scribe and RPA continue to evolve at a rapid pace, the development of comprehensive evaluation frameworks and assessment of these technologies in real-life setting are needed to ensure effectiveness, efficiency, accuracy, quality, and safety for both patients and providers.

Recommendations

- **To address barriers to implementation:** Create adoption strategies and guidelines for PCPs; establish clear feedback channels for PCPs and patients; improve transparency regarding product benefits and limitations while aligning value proposition(s); and develop and validate algorithms using representative data to minimize potential bias.
- **To improve effectiveness of AI scribes and RPA:** Enable direct integration with Electronic Medical Record (EMR) systems; optimize user interfaces to be professional and clutter-free with minimal mouse clicks to sign-in and launch the AI scribe; and provide customizable and easy to edit templates.
- **To support PCPs using AI scribes and RPA in Ontario:** Establish regulatory frameworks or guidelines; provide training and education regarding use of AI in healthcare; address equity and accessibility concerns; and continue benchmarking and evaluation.

Overall, findings from this report should be interpreted as complementary to upcoming evaluations on the widespread implementation of AI scribes and RPA in real-world settings in the next phase.

1.0 Introduction

1.1 Context

In Ontario, more than 70% of primary care providers (PCPs) report feelings of burnout, largely attributable to an increase in administrative work and the chronic shortage of healthcare professionals.[13,14] In addition, while Electronic Medical Records (EMRs) streamlined access to patient information and facilitated more efficient and coordinated healthcare delivery, EMRs have been identified as one of the contributing causes of provider burnout.[15] In fact, PCPs report spending over 40% of their time on administrative tasks (19 hours per week), which impacts quality of care and access to care as some PCPs have had to reduce clinical hours.[16,17]

To help alleviate administrative burden and provider burnout, rapid advancements in technologies like automatic speech recognition (ASR) and natural language processing (NLP) have sparked interest in how automated processes can streamline and standardize clinical documentation.[1] Previous studies have shown that artificial intelligence (AI) scribes (also known as digital scribes) are being used to create medical notes, fill in billing information, and assist in diagnostic support.[2] Furthermore, robotic process automation (RPA) is increasingly being used to perform routine, rule-based, and repetitive administrative tasks.[12] Both AI scribes and RPA technologies require minimal training and have the potential to reduce a substantial portion of provider-driven documentation which may alleviate administrative-load related burnout.[1] However, the impact, benefits, and potential value of AI scribes and RPA technologies are not yet well understood, especially in the Ontario healthcare and technology landscape.

1.2 Purpose and Objectives

The aim of this project was to evaluate the potential benefits and/or impacts of AI scribes and RPA technology in the context of the Ontario healthcare system to inform future policy, funding, and purchasing decisions by PCPs, health systems, and vendors. The specific objectives are:

1. To describe and evaluate the potential impact of AI scribes and RPA on:
    a. Primary care providers' experiences and perceptions (e.g., satisfaction, acceptability, feasibility, perceived usefulness, usability, frequency of use) and barriers and facilitators to successful use.
    b. Administrative load and workflow (e.g., capacity creation, efficiency, time savings, errors, limitations).

c. Patient experience (e.g., patient-provider relationship, communication, and privacy and security).

2. To evaluate the functionality and technical performance of AI scribes during clinical encounters and other daily workflows (e.g., accuracy, speed, quality of data, errors) and the current and potential level of integration of AI scribes into EMRs in primary care.
3. To determine the value proposition and limitations of AI scribes and RPA for PCPs, patients, and the healthcare system, and develop recommendations around most appropriate uses in primary care.

To achieve these objectives, a comprehensive framework is being used to evaluate 1) the completion of a medical note using AI scribes and 2) the completion of recommended tasks by automation processes (i.e., RPA). The framework will be carried out in two phases: Discovery and Implementation. This report focuses on findings from Phase 1 (Discovery) and highlights how these findings informed the evaluation activities planned for Phase 2.

2.0 Methodology

2.1 Overview of Data Collection Activities

To address the objectives described above, the Centre for Digital Health Evaluation (CDHE) conducted the following research activities:

- Environmental scan of peer-reviewed publications and grey literature sources
- Semi-structured interviews with PCPs
- Competitive analysis across six AI scribes
- Simulated clinical encounters with PCPs in a Virtual Care Laboratory (VCL)
- Consultations with subject matter experts (SMEs) and Patient Partner Evaluators (PPEs)

Further details about each activity are provided below.

2.2 Environmental Scan

ACADEMIC LITERATURE SEARCH APPROACH

An environmental scan was conducted to identify current applications of medical scribes, AI scribes, and RPA in primary care. MEDLINE, SCOPUS, and PsycINFO databases were searched from 2018 to February 2024. The search strategy was developed in consultation with an experienced Librarian. Search terms included subject headings and free text. Covidence, a

systematic review software, was used to remove duplicate references and screen articles.[18] Supplemental searches of reference lists of included studies and related systematic reviews were conducted. A two-level screening process (titles/abstracts followed by full-text screening) was used to select eligible studies. Additional information is provided in Appendix A.

GREY LITERATURE SEARCH APPROACH

A broad review of grey literature on current applications of medical scribes, AI scribes, and RPA technologies in primary care was conducted. A keyword search of concepts related to "AI scribes" or "automation processes" or "medical scribes" and "primary care" was undertaken in 1) Google and 2) the websites of agencies or organizations that are involved in healthcare technology design and/or delivery. See Appendix A for further details on the grey literature search.

2.3 Semi-structured Interviews

Semi-structured interviews with seven PCPs who have implemented AI scribes in their practice ('early adopters') and six PCPs who have not implemented AI scribes in their practice (non-users) were conducted to supplement the environmental scan and to understand 1) perceptions and/or experiences with AI scribes and RPA; 2) impact on cognitive load, provider burnout, and administrative burden; 3) perceptions on the impact to the patient experience; 4) enablers and barriers to implementation and sustained use; and 5) valuable and desired features, functionalities, and integration capabilities. Interviews also explored what supports (e.g., education, technical support, training, etc.) PCPs need to confidently implement and use AI scribes and RPA in their respective practices. See Appendix B for the interview guides.

PCPs known to members of the research team or suggested by partners at Ontario Health (OH) were approached for participation, supporting representation of various practice types in Ontario. All interviews were audio recorded, transcribed, and analyzed using content and thematic analysis.

2.4 Competitive Analysis

A systematic comparison of six AI scribes was conducted using competitive analysis methods.[19,20] OntarioMD held broad discussions with AI scribe vendors in Canada and the United States, and selected six AI scribe vendors based on 1) the general availability of their product in the Ontario market; 2) compliance with Ontario's *Personal Health Information Protection Act (PHIPA)*; and 3) ability to support primary care use cases in Ontario. [redacted]

The process flow, user interface, technical performance, accuracy and quality in medical documentation, effectiveness, EMR integration and compatibility, and features of each AI scribe were evaluated within the context of medical documentation and clinical workflow support for PCPs and their patients.

To evaluate AI scribe functioning in the competitive analysis, audio files from different clinical encounters with standardized patients were played aloud for each of the six AI scribes. The encounters were representative of common clinical encounters observed in primary care, including new patient intake appointments, simple encounters, encounters for complex health condition(s) and/or multiple conditions, and diverse patient populations (e.g., accents, limited English proficiency, patients speaking in ways that are tangential or circumstantial, caregivers and families present as part of the circle of care). Given the novelty of AI scribes, outcomes of interest were assessed using an evaluation framework with a standard scoring system (poor, good, excellent) that was developed by the evaluation team and informed by medical documentation policies and guidelines by the College of Physicians and Surgeons (CPSO)[8], the Canadian Medical Protective Association (CMPA)[21], and peer-reviewed publications and validated quality frameworks.[3,22,23] To supplement, all AI scribe vendors completed a questionnaire about the capabilities of their product and a comprehensive review of publicly available information, including company websites, product documentation, user manuals, white papers, case studies, and user testimonies, was also performed. Appendix C provides a description of all standardized patient profiles and audio files, additional details on all outcome measures, and an overview of the evaluation framework used to assess documentation quality.

2.5 Simulated Encounters in the Virtual Care Lab

The VCL at Women's College Hospital (WCH) is a controlled research setting that allows for the evaluation of digital health tools and models of care in an environment that simulates real-world use.[24] The VCL is set up to resemble a primary care practice. For the simulations, each of the three PCPs conducted four different encounters with standardized patients: two with PCPs completing documentation in the EMR and two with an AI scribe without any PCP documentation.

To collect and analyze data, each encounter was audio and video recorded in its entirely. Quantitative ethnography, which employs both quantitative methods (e.g., collecting timestamped

and sequential information) and qualitative methods (e.g., documenting observed behaviours) to reduce observational data into distinct measurable units of behaviour and interactions over the observation time period (i.e., the clinical encounter), was used.[25,26] A coding scheme was developed based on a validated list of primary care administrative tasks to determine start and stop times for behaviors of interest, total visit time, and time spent documenting.[27,28]

3.0 Results

3.1 Environmental Scan

ENVIRONMENTAL SCAN CHARACTERISTICS

A total of 51 resources were identified (48 peer-reviewed articles and 3 grey literature sources). Figure A1 in Appendix A presents the flowchart of included academic and grey literature in the environmental scan. Studies were primarily published in the United States (n=43), with other countries including Australia (n=3), Canada (n=3), and the Netherlands (n=1). Among all resources, 37 (75%) articles focused on the use of medical scribes, 18 (35%) articles reported on the use of AI or digital scribes, and 5 (10%) articles reported on the use of RPA technologies.

CURRENT APPLICATIONS OF MEDICAL SCRIBES IN PRIMARY CARE

Results from the environmental scan revealed that medical scribes were primarily responsible for note-taking, data entry, coordinating clinical workflow, and other tasks such as printing and faxing, fetching paper forms, and preparing educational materials and after-visit instructions.[29] Notably, prior to the adoption of medical scribes, these tasks were often completed by PCPs after-hours.[2,7] Although there are known benefits of medical scribes for PCPs (e.g., increased productivity, time for clinical care, quality of notes, and clinical reasoning for PCPs), several studies identified limitations that prevent their widespread use, and in some instances, result in additional administrative burden for PCPs.[9] Appendix A provides a detailed description of the tasks performed by medical scribes in primary care and their benefits and limitations.

CURRENT APPLICATIONS OF AI SCRIBES IN PRIMARY CARE

Findings from the environmental scan identified several applications of AI scribes:

- **Documentation and note-taking**: Taking detailed notes during appointments and creating verbatim transcripts, alleviating data entry burden on PCPs.[30]
- **Patient communication and education:** Creating medical encounter summaries in lay terms for patients, which improved shared decision making and patient engagement.[3]

- **Workflow optimization:** Automating certain tasks (e.g., order entry, report filing) and administrative processes (e.g., appointment scheduling, billing documentation, patient registration) to streamline workflows and create efficiencies for PCPs.[31]
- **Clinical decision support:** Supporting clinical decisions by offering suggestions for diagnostic, prognostic, and therapeutic approaches. These features can assist PCPs in making informed and shared decisions with patients to improve patient outcomes. However, an evaluation of the validity and accuracy of these clinical decision support tools, and scope of use in primary care, have not been fully investigated.[30]
- **EMR compatibility and integration:** Pushing and pulling basic personal health information (PHI), reducing the time and effort required for manual documentation.[32] However, the level of compatibility and integration with EMRs varies.

CURRENT APPLICATIONS OF RPA IN PRIMARY CARE

The most common applications of RPA or "bots" in primary care settings are:

- **Screening and prevention**: Searching EMRs to identify patients who may benefit from screening or interventions based on factors such as age, gender, family history, and lifestyle habits. Once identified, these bots send personalized messages to patients, providing information about recommended screening.[33,34]
- **Online appointment booking:** Scheduling appointments, gathering patient information, and providing real-time updates to patients and PCPs via the PCPs' scheduling system (e.g., Ocean).[35,36]
- **Standardizing patient data:** Standardizing patient outcome data by searching EMRs for specific conditions and adding missing diagnostic codes.[2,37,38]

SUMMARY OF FINDINGS FROM THE ENVIRONMENTAL SCAN

Overall, studies found that the use of AI scribes and/or RPA in primary care were associated with increased patient and provider satisfaction.[39,40] Providers reported that the use of AI scribes led to increased overall productivity (e.g., increased number of patients seen per hour) and increased revenue as a result of reduced time spent charting per patient.[39] Patients reported satisfaction with increased provider engagement during consults, which led to improved quality of care.[39] Studies on specific RPAs beyond online appointment booking and screening were limited, although they suggested increased patient and provider satisfaction and productivity too.[33–35]

Despite numerous studies citing benefits of AI scribes and RPA, there remains uncertainty about their effectiveness in reducing administrative burden for providers. For example, although many

studies reported increased provider satisfaction, some studies found no change in the amount of time providers spent on afterhours charting[41] whereas others noted significant time saved.[3] Moreover, some studies found that the use of AI scribes resulted in high error rates, subsequently increasing documentation time to edit and revise the AI scribe generated notes.[3,30] Appendix A offers further insights into the benefits and limitations of AI scribes identified in literature.

While the environmental scan offers a preliminary understanding of the benefits and impacts of AI scribes in primary care, existing literature lacks specific data on the amount of time saved when using AI scribes in comparison to a PCPs' typical workflow, and a comprehensive comparison of the features and utility of various AI scribes has not been performed. In addition, there is lack of clarity on how AI scribes and RPA may complement each other to alleviate administrative burden.

3.2 Semi-Structured Interviews

CHARACTERISTICS OF SEMI-STRUCTURED INTERVIEWEES

Table 1 displays the demographics and practice characteristics of PCPs that were interviewed. In total, 17 PCPs were approached, and 13 interviews were conducted with 7 PCPs who currently use AI scribes in their practice (early adopters) and 6 PCPs who have not used AI scribes in their practice (non-users) (response rate: 76.5%). Most of these PCPs work in group-based practices that provide care for underserved communities and populations (e.g., racialized/ethnic communities, precarious status individuals, linguistically diverse populations, low socioeconomic status, persons with disabilities/disabled persons, non-binary sexual/gender orientation, geriatric populations) (n=11, 84.6%). Nearly half of the PCPs have been practicing for more than 10 years (n=6, 46.2%), and over half also hold a senior leadership position or administrative role (n=7, 53.8%). Overall, PCPs that were interviewed represent all OH regions, but the majority practice in Toronto (n=7, 53.8%).

Table 1. Sociodemographic and Practice Characteristics of Semi-Structured Interviewees

Characteristics	AI Scribe User Status (N=13)	
	Early Adopters (n=7)†	Non-Users (n=6)†
Sociodemographic Characteristics		
Gender, n (%)		
Woman	2 (28.6)	6 (100.0)
Man	5 (71.4)	0 (0.0)
Racial/Ethnic Group, n (%)		
White	4 (57.1)	2 (33.3)
Other	3 (42.9)	4 (66.7)
Professional designation and roles, n (%)		
Family Physician	7 (100.0)	6 (100.0)
Administrative and/or leadership role	5 (71.4)	2 (33.3)
Practice Characteristics		
Practice type, n (%)		
Group practice	6 (85.7)	5 (83.3)
Solo or other practice	1 (14.3)	1 (16.7)
Ontario Health Region, n (%)		
Central	2 (28.6)	0 (0.0)
East	1 (14.3)	0 (0.0)
North	0 (0.0)	1 (16.7)
Toronto	2 (28.6)	5 (83.3)
West	2 (28.6)	0 (0.0)
Years in practice, n (%)		
1–5 years	1 (14.3)	2 (33.3)
6–10 years	2 (28.6)	2 (33.3)
More than 10 years	4 (57.1)	2 (33.3)
Electronic Medical Record, n (%)		
[redacted]	4 (57.1)	5 (83.3)
[redacted]	3 (42.9)	1 (16.7)
Patient Population, n (%)		
Significant proportion historically underserved‡	5 (71.4)	6 (100.0)
All age ranges	7 (100.0)	6 (100.0)

†Early adopter refers to a PCP who currently uses or has experience using at least one AI scribe product in their daily practice. A non-user refers to a PCP who has no experience using an AI scribe product in their daily practice.
‡Underserved refers to an increased likelihood that individuals who belong to a certain population (and people can belong to more than one) may experience difficulties in obtaining needed care, receive less care or a lower standard of care, experience different treatment by healthcare providers, receive treatment that does not adequately meet their needs, or that they will be less satisfied with healthcare services than the general population.[42]

FACTORS THAT INFLUENCED INTEREST IN AI SCRIBES AND RPA

PCPs were interested in adopting AI scribes for a variety of reasons:

- **Finding solutions to alleviate administrative burden and burnout**: All PCPs (n=13, 100%) reported administrative burden and provider burnout. PCPs with over a decade of practice experience expressed greater difficulty maintaining motivation for work due to the amount of documentation required, leading them to seek solutions to alleviate burden.

- **Improving and/or creating efficiencies in workflow and processes:** In regions that use e-referrals and e-consults, PCPs reported that automating other parts of their workflow felt like a natural next step (n=10, 76.9%).
- **Building human resource capacity:** Adopting new technologies may make practices and/or regions more attractive to prospective PCPs entering the field (n=3, 23.1%).

IMPACT ON WORKFLOW

DURATION AND FREQUENCY OF USE OF AI SCRIBES

On average, early adopters (n=7) have been using AI scribes for six months (range: 3 months to 1 year). Over half (n=4, 57.1%) trialed at least three AI scribes before settling on one that met their needs, was customizable to complement their workflow, and was at a price point that they could afford as most paid out of pocket for the license. Nearly all early adopters reported using an AI scribe in their daily clinical encounters unless a patient has not provided consent or in scenarios where the PCP can complete documentation faster than the AI scribe (n=6, 85.7%).

CHANGES TO WORKFLOW

When initially implementing AI scribes, all early adopters reported "double documenting" (i.e., doing their own documentation with the AI scribe running ambiently) to compare the notes. PCPs cited that "the more they used it, the more they trusted it" and with consistent use, majority no longer document during a clinical encounter because an AI-generated medical note is "approximately 95% complete and generally only requires reviewing and minor edits afterwards" (n=6, 85.7%). Only one PCP reported using an AI scribe for other administrative tasks, including writing referral letters. Majority of PCPs noted that they preferred to write referral letters themselves to ensure sufficient information is captured.

IMPACT ON ADMINISTRATIVE BURDEN AND THE PROVIDER EXPERIENCE

In general, all PCPs viewed AI scribes favourably. The ways that AI scribes improved and/or benefited aspects of PCPs' workflow and experience are described below, with considerations of where AI scribes may have limited utility until further enhancements are made.

ADMINISTRATIVE BURDEN, AFTERHOURS CHARTING, AND WORK-LIFE BALANCE

All early adopters (n=7) reported a "significant" decrease in the amount of time spent on administrative tasks since implementing AI scribes in their practice. Examples of how AI scribes have positively benefited PCPs include:

- Most of the early adopters (n=5, 71.4%) reported that prior to using an AI scribe, they spent 2–3 hours after their workday completing documentation, but can now complete

nearly all documentation, including reviewing and minor editing, during the workday, typically between appointments.

- Four early adopters (57.1%) reported that they no longer work outside of their normal workday and two PCPs (28.6%) reported that they were able to achieve a better work-life balance, which included no longer needing to work on unscheduled days, outside of scheduled hours, or on weekends or holidays. Strikingly, 1 PCP reported that by achieving better work-life balance and alleviating burnout associated with documentation, they decided to continue practicing for "another 10 years at least," despite initially thinking about retiring.

> *"This is the first Christmas in [20+ years] that I haven't had to spend time catching up on my notes… Yeah, it's, it's really… I have decided, I'm a later physician in terms of my career, that I'm gonna practice for another 10 years at least and that will bring me well past 65. So [AI scribes have] been a game changer for me personally."*
> – Primary Care Provider

- Two early adopters (28.6%) reported that they sometimes see more than 40 patients a day. Despite the high case load, by using an AI scribe, they have minimal afterhours charting (<1 hour), which generally consists of reviewing AI-generated medical notes for completeness and making minor edits, which also requires minimal cognitive load.
- One early adopter conducted an internal audit and reported that over a 15-day period, they were able to save 1,100 minutes (~18 hours) in afterhours work, while another noted that using AI scribes helped them "cut down on documentation time by 80%."

> *"I've always enjoyed my work, like I'd say I'm one of those [PCPs] that has always enjoyed what I do. But certainly, [documentation] was one of the most irritating parts of what I did. And like if someone had to say, what's your least favorite part of your job? It would have been the documentation and writing notes after the fact, so I'm so much happier now that when I'm finished my clinic, within half an hour all of my notes are done… In general, when I looked at before and after AI, and even tested days where I didn't use the AI to see how much longer it would take me, it was at least an hour, if not more of time that it was saving me every day. And when you compound that over the course of a week, as I was saying to my colleagues, it's like adding a whole day of your life back."*
> – Primary Care Provider

PRODUCTIVITY AND TIME SAVED

Some early adopters (n=3, 42.9%) reported that using an AI scribe increased productivity by reducing consultation time; thus, enabling them to see more patients during the workday.

> *"So, I think the visit is shorter by a lot more significant time than the little bit of time it takes for me to edit the note at the end afterwards… and the more I use it, the more I tend to trust it, which is a good sign."*
> – Primary Care Provider

> *"So, a consult that would normally take 30 minutes to go through, including typing, can be reduced to 10 to 25 minutes and then I don't have to do the follow up typing because majority of it is already there."*
> – Primary Care Provider

However, others noted that using an AI scribe did not save them time nor increase the number of patients they were able to see in a day (n=4. 57.1%), but instead made work more enjoyable and allowed them to spend more time talking to their patients. Additionally, some PCPs re-allocated time saved to help with inbox management and referral letters, both of which were identified as other administrative tasks that take a lot of time.

PERCEIVED IMPACT TO THE PATIENT EXPERIENCE

INFORMED CONSENT & DATA AND PRIVACY CONCERNS

All early adopters reported obtaining some form of consent from patients prior to each encounter or upon first introduction of the AI scribe. The consent process varied based on the AI scribe product (e.g., Mika has a verbal consent process, AutoScribe has a written consent process). PCPs expressed that nearly all their patients (>90%) were receptive to them using an AI scribe. As a majority of early adopters had longstanding and trusting relationships with their patients, these factors likely helped patients feel more comfortable with their PCP using an AI scribe.

However, a few early adopters and non-users (n=5, 38.5%) expressed concerns regarding the consent process as they noted that patients may not be aware of the terms and conditions they were consenting to. Majority of PCPs noted that while the AI scribes they were using may be compliant with *PHIPA*, without guidance from governing bodies like the CPSO or CMPA, there may be inconsistencies across AI scribe products with regards to data privacy and security standards. To mitigate this, PCPs expressed a preference for AI scribes that are based in and store data in Canada only. In addition, particularly among non-users, PCPs felt like there was a lack of clear guidelines for what patients should be informed about when obtaining consent (e.g., data storage, data used to train and validate algorithms).

> *"I don't think there's yet been a patient that consented that [has] given informed consent for AI scribes. It might be documented that they [gave consent]. Maybe the doctor asked them if they consent, but was it informed? Does the patient know what's what they're consenting to? And I think that needs to be also clarified and nobody like the Medical Protective Association and the College, they're not caught up to that yet. For video visits, we have very clear this is what you need for consent. For AI scribes, we don't yet."*
> – Primary Care Provider

THE PATIENT EXPERIENCE AND QUALITY OF CARE

In general, early adopters (n=7) perceived that using an AI scribe positively impacted their ability to deliver care and the patient experience in the following ways:

- All PCPs (n=7, 100%) reported feeling **more present and engaged** during clinical encounters. By using an AI scribe, PCPs felt like they could directly face the patient, make more eye contact, and pay more attention rather than facing the computer screen.
- Some PCPs (n=5, 71.4%) reported feeling **less cognitively fatigued and more relaxed** during clinical encounters, which **increased diagnostic accuracy**, particularly differential diagnoses. PCPs also reported that using an AI scribe felt like a "second pair of ears listening to the conversation so any important information [would] not be missed."
- Some PCPs (n=5, 71.4%) felt like they could provide more **patient-centred care.** By articulating their observations and physical examinations to ensure the information was captured by the AI scribe, PCPs perceived that patients were able to better understand the care they were receiving.

Notably, all non-users (n=6) also perceived that using an AI scribe would enable them to provide **more comprehensive, better-quality care** as they could be more engaged with the patient during a clinical encounter without the risk of forgetting anything if they are not able to complete documentation during or immediately after the encounter. However, majority of non-users reported that they were waiting for guidance or direction from management regarding appropriate use of AI scribes and wanted to see more colleagues implement the technology before deciding to adopt AI scribes their own practices.

CHALLENGES AND STRATEGIES WHEN USING AI SCRIBES

Early adopters reported that certain clinical scenarios, complicating factors, and technical considerations presented issues during their use of AI scribes. A detailed overview of the limitations of AI scribe products in their current state, and the strategies that PCPs have used to

overcome some of these limitations, is provided below. These limitations were also identified in literature (Appendix A) and reported among non-users interviewed as areas of concern.

CHALLENGING CLINICAL SCENARIOS FOR AI SCRIBES

The following clinical scenarios present challenges for AI scribes, leading to medical notes that have minimal utility and/or require substantial editing by PCPs:

- **Common health concerns:** Prior to implementing an AI scribe in their practice, many PCPs used custom templates, forms, and/or stamps for common conditions (e.g., diabetes, hypertension) to help reduce documentation time. PCPs reported that because AI scribes could only produce narrative reports and were incapable of mapping clinical information to certain fields and/or diagnostic codes in the EMR, their custom templates, forms, and stamps enabled them to document faster than the AI scribe.
- **Physical examinations:** All PCPs noted AI scribes' limitations in capturing results from physical examinations. Overtime, PCPs learned to adapt their behaviour to verbalize and/or narrate the physical exam to "feed information" to the AI scribe. For instance, if a patient pointed or alluded to a specific part of their body, the PCP would verbally identify it so it could be captured in the AI-scribe generated note.
- **Mental health and/or psychiatric visits:** All PCPs found that AI scribes often considered "a significant amount of information as extra or unnecessary" when discussing mental health concerns with patients. In general, the AI-generated notes were overly concise, especially if the mental health issue(s) were not explicitly mentioned during the encounter. For example, if a patient discussed family problems, this information would not be included in the medical note unless terms like "depression" or "anxiety" were stated. Moreover, PCPs noted that AI scribes could not interpret body language, tone of voice, or subtle patient cues. In such instances, PCPs manually edited the AI-generated medical notes to ensure all relevant information was captured.
- **Symptoms and differential diagnoses:** A few PCPs reported that AI scribes often omitted the absence of symptoms or classified certain conditions incorrectly. For instance, if a PCP inquired as to whether a patient experiencing a stomach ache also experienced vomiting and the patient denied vomiting, the AI scribe failed to document the absence vomiting in the medical note. In another instance, during a cervical cancer screening which included STI testing and discussion of the Gardasil vaccine, a PCP reported that the AI scribe recorded these as separate conditions without mentioning the vaccine. PCPs reported that needing to identify information that was incorrectly captured by AI scribes and manually correcting these errors was challenging, time-consuming, and frustrating.

"It's not just what it puts in, it's what it filters out and that's tricky."
– Primary Care Provider

"I think [I am most concerned about] errors that are hard to detect. So, things where a patient was not short of breath and [the AI scribe] says patient was short of breath…And so it's almost the ones that are hard to notice. So those are probably the ones that concern me.
– Primary Care Provider

COMLPICATING FACTORS FOR AI SCRIBES

Early adopters reported that the following factors impacted the quality of transcripts and/or medical notes generated by AI scribes:

- **Voice diarization:** When the patient and provider have a similar voice tone, some AI scribes have difficulty differentiating speakers, making it difficult to identify the correct speaker labels in the transcript and note.
- **Multiple speakers:** When multiple speakers are present, such as a patient and caregiver, AI scribes tend to have difficulties differentiating speakers. The AI scribes may conflate speakers, such as mislabeling the caregiver as a patient. PCPs reported needing to edit the medical note to reflect the involvement of multiple speakers in the clinical encounter.
- **Non-English encounters with or without interpreters:** While some AI scribes are compatible with multiple languages, PCPs reported that sometimes this feature did not work, even if an interpreter was present. Both early adopters and non-users expressed equity concerns, especially for underserved populations whose first language is not English. In addition, non-users offering care in French noted existing challenges with EMRs due to lack of appropriate dictionaries and character recognition. Therefore, the variability in the market of AI scribes to support French could further complicate matters.
- **Accents, enunciation, and English language proficiency:** While accents have minimal effect on medical note quality, enunciation and English proficiency does. If a speaker corrects themselves after mispronouncing or misspeaking, the AI scribes can adjust accordingly. However, if the conversation is difficult to understand, either due to enunciation errors or limited English proficiency, the AI scribes often perform poorly.
- **Non-linear conversations:** PCPs reported that AI scribes often had difficulty creating accurate and comprehensive medical notes when conversations shifted between topics or included "chit chat or small talk." In these instances, PCPs found that AI scribes had difficultly classifying information and would often hallucinate (i.e., input false information without sound basis) and/or omit content it deemed as irrelevant in the medical note.

- **Visit-specific templates:** While some AI scribes have note templates for users to choose from based on the type of appointment, PCPs reported that if they switched templates after beginning to record a clinical encounter, they would lose anything that was captured and would need to start a new recording, This presents challenges when the cited reason for the visit is not correct, or the predominant complaint may not fit into a general template.

TECHNICAL CHALLENGES FOR AI SCRIBES

Although practices may be set up to support virtual care, both early adopters and non-users expressed concerns regarding reliability of AI scribes when experiencing technical difficulties, such as not having a stable wi-fi connection, not having a computer with technical specifications to support the AI scribe, or lacking IT support staff. For example, PCPs reported that most microphones built into laptops, tablets, and smartphones were sufficient to support use of an AI scribe if the speakers were close enough. However, most desktop computers with built-in microphones were insufficient, leading PCPs to use their phone or tablet to capture audio. In addition, for some AI scribes, a separate microphone was needed for virtual appointments.

Despite the aforementioned clinical scenarios, complicating factors, and technical considerations that present challenges for AI scribes in their current state, both early adopters and non-users viewed AI scribes favourably, as they understand that the note produced by an AI scribe "will not be perfect." All PCPs cited that regardless of how a medical note is created (e.g. AI generated, by a student resident, etc.), they will always review it before they sign and save the medical note into the EMR as they are the ones who are ultimately liable.

> *"And I think anyone who's interested in using ambient scribe or AI scribe needs to understand they have to let go of the this note has to be perfect because it won't work for them."*
> – Primary Care Provider

> *"[The AI scribe] is not gonna chart exactly like you... And what you can do is train it and give it guidance so it does the correct things most of the time, but you have to also accept too, and that's probably where like a bit more of my risk tolerance comes from, is that I accept that the AI is not going to be perfect. It's not gonna write a perfect note..."*
> – Primary Care Provider

CANDIDATE TASKS FOR AUTOMATION IN PRIMARY CARE

Complementary to AI scribes, all PCPs were asked if increased automation in their workflow could enhance their experience and further decreased administrative burden. Examples of tasks that PCPs identified as suitable for automation include:

- **Medical search and queries:** Bots that assists PCPs with searching for drug and dosage information or make searching in the EMR simpler.
- **Medical assistant:** Bots that recommend diagnoses and/or tests based on information discussed during a clinical encounter (e.g., suggests labs, tests, medications, etc.).
- **Document triaging service and inbox management**: Bots capable of identifying patients, classifying documents, and adding medical labels/titles without staff intervention, including directly adding files from a PCPs inbox to the patient's chart.
- **Automated task manager:** Bots capable of patient outreach tasks within the EMR by scanning through care plans from clinical encounters, identifying those needing completion, and automatically fulfilling them according to clinic specifications.
- **Knowledge translation and patient facing materials:** Bots that retrieve information from the patient history and medical notes to conduct follow-ups with patients. For example, if a patient was recently diagnosed with diabetes, the bot could send a secure message to remind the patient to adhere to discussed health behaviors, like a low salt diet.
- **Appointment reminders:** Bots that send secure messages to patients, reminding them to schedule appointments and/or send reminders between providers at the same clinic or across multiple clinics.

3.3 Competitive Analysis

All A[redacted]) participating in this evaluation were systematically evaluated across the following categories:

- **Process Flow and Form Factor:** Design and accessibility of platform(s) used to access the AI scribe and the number of steps and amount of time it takes to sign-in and launch.
- **Technical Performance:** Speed to generate a full medical note and the ability of the AI scribe to effectively transcribe and generate a medical note when faced with interruptions and other complicating factors (e.g., accents, slang, background noise, etc.)
- **Accuracy and Quality:** Precision and reliability of the transcript and medical note, ensuring comprehensive and clinically relevant information that reflects the patient encounter while adhering to medical standards and guidelines.
- **EMR Integration and Compatibility**: Degree of integration into existing EMR systems, ensuring efficient data exchange, interoperability, and adherence to standardized formats for streamlined healthcare workflows.

- **Features:** Types of features and functions available (e.g. technical support, availability of real-time transcription, ability to handle multilingual encounters, etc.).

The evaluation framework employed a 3-point scale, ranging from poor to excellent. A "poor" rating indicated low achievement or usability, while "good" signified satisfactory performance with room for improvement. An "excellent" rating was given to AI scribes that exceeded expectations and demonstrated a high level of proficiency. Certain categories, like available features and functions, were evaluated on a binary scale of "yes" or "no" based on their presence or absence.

PROCESS FLOW AND USER INTERFACE

The process flow of each AI scribe was evaluated by determining the number of steps required to sign-in and launch the AI scribe. Results are outlined in Table 2 and further details can be found in Appendix C. The approximate time for each process was averaged across three runs and did not include time spent typing when entering credentials or textual information.

All AI scribes required user authentication (sign-in) prior to launching the scribe. Two key processes that impacted usability were the:

1. **Sign-in Process**: Steps required to input log-in credentials, such as a username and password, to gain access. For all AI scribes, once signed in, PCPs were not required to sign-in again in between individual encounters unless the AI scribe was closed.
2. **Launch Process**: Steps required to start and use the AI scribe product. These steps were required to be carried out every time a provider began a new clinical encounter.

Majority of AI scribe products (n=4, 66.7%) were available on multiple platforms (e.g., Web browser and mobile/tablet), ensuring flexibility and accessibility for PCPs (Table 2). Two AI scribe products were only accessible on one platform. One of the processes that impacted sign-in was two-factor authentication (2FA). Some practice settings may be governed by policies that mandate 2FA for such tools, however, so this may not be a negotiable feature.

EASE OF RESTARTING

In general, restarting all AI scribes for the next patient was deemed to be a straightforward process that could be completed with minimal effort. Typically, this process involved saving the previous patient's data and medical note and initiating the next encounter via a series of clicks. Some AI scribes required users to load appointment information (e.g. patient name, appointment time) before use, whereas others could be restarted without any patient information.

Table 2. Overview of Characteristics and Sign-in-Launch-Scribe Step Count Across AI Scribes

Process	AI Scribe					
	Scribe #1	Scribe #2	Scribe #3	Scribe #4	Scribe #5	Scribe #6
Process Flow						
Total Steps	5	7	6	6	4	4
Approx. Time	10.01 sec	13.58 sec	26.36 sec	14.59 sec	11.63 sec	7.21 sec
Auth.†	1FA	1FA	2FA	1FA	2FA	1FA
User Interface						
Interface‡	Browser	Browser	Browser	Desktop	Extension	Mobile App
Form Factor±	Excellent	Excellent	Excellent	Poor	Excellent	Poor
Ease of Restarting	Good	Good	Good	Good	Good	Good

†Auth.: Authentication protocol; 1FA = single-factor authentication, 2FA = two-factor authentication
‡Interface: Platform used to access the AI scribe; Browser = a standalone browser-based website, Desktop = a desktop application, Extension = a browser extension
±Form factor: Design and accessibility of platform(s) required to use the AI scribe, particularly in relation to its ease of access and usability.

TECHNICAL PERFORMANCE

DOCUMENTATION TIME

Post-conversation documentation speed refers to the time it takes an AI scribe to generate a medical note after a clinical encounter ends (i.e., last word spoken). This measure was influenced by the length of an encounter and complexity of topics discussed. Shorter encounters typically resulted in faster documentation times. For a 15-minute encounter, nearly all AI scribes (n=5) could generate a Subjective, Objective, Assessment, and Plan (SOAP) note within 1 minute, except for AI Scribe #4, which approximately 1.5–2 times longer (Table 3).

RECOVERY FROM INTERRUPTIONS

To assess recovery from interruptions, clinical encounters were interrupted by a "knock on the door," followed by a brief discussion between the interrupter and the provider involving medical and non-medical terminology. AI Scribe #1 effectively filtered out the interruption, ensuring that the transcript and medical note contained only dialogue between the patient and provider. AI Scribes #2–5 incorporated short phrases from the interruptions in their transcripts, but the content was not found in the medical note. AI Scribe #6 included information from the interruption in both the transcript and medical note. Specifically, the interruption mentioned "administering antibiotics" and the medical note included information on antibiotic use.

COMPLICATING FACTORS

To assess the ability of an AI scribe to disregard irrelevant factors, secondary audio files were played aloud to mimic multiple speakers and background noise. All six AI scribes could omit non-

conversational background noise. In contrast, when there was conversational background noise, AI Scribes #1, 3, 4, and 6 successfully captured only the primary conversation between the patient and provider whereas AI Scribes #2 and 5 included many segments from the secondary conversation, affecting the accuracy and quality of the medical note. Overall, AI Scribes #1 and 3 produced the highest quality medical note and were able to disregard information that was not relevant to the patient's health concerns.

To assess accent adaptability and slang comprehension, audio samples of conversations featuring accents or local slang (e.g., Australian, European, Caribbean, African, and Asian) were played aloud for each AI scribe. AI Scribe #3 was the only product that accurately interpreted all five accents. AI Scribes #1 and 2 performed better with certain accents, while AI Scribes #4–6 did a poor job at understanding majority of the accents. All AI scribes except for AI Scribe #6 were able to recognize and comprehend local slang to produce a transcript and accurate medical note.

Table 3. Evaluation of the Technical Performance of Six AI Scribes

Technical Performance	AI Scribe					
	Scribe #1	Scribe #2	Scribe #3	Scribe #4	Scribe #5	Scribe #6
Post-Conversation Processing Speed†						
Sandra Jones (16 min encounter)	50.68 sec	42.08 sec	50.50 sec	1:48 min	38.71 sec	19.25 sec
Bill Snook (15 min encounter)	33.05 sec	1:05 min	35.10 sec	1:32 min	26.09 sec	22.07 sec
Recovery from Interruptions‡						
Non-medical interruption	Excellent	Good	Good	Good	Good	Good
Medical interruption	Excellent	Good	Excellent	Good	Good	Poor
Complicating Factors§						
Speaker Differentiation	Excellent	Good	Excellent	Good	Good	Good
Background Noise	Good	Good	Good	Good	Good	Good
Multiple Conversation	Good	Poor	Good	Good	Poor	Good
Irrelevant Information	Excellent	Good	Excellent	Good	Poor	Poor
Accent Adaptability	Good	Good	Excellent	Poor	Poor	Poor
Slang Recognition & Comprehension	Excellent	Excellent	Good	Good	Excellent	Poor

†Post-conversation documentation speed: Amount of time it takes to create the complete medical note after the clinical encounter ends (i.e., last word spoken).
‡Interruptions: Ability to recover from interruptions that include medical and non-medical terminology and omit information from the interruptions.
§Complicating factors: Ability to discern primary conversation amidst accents and slang, and ability to disregard irrelevant factors such as background noise and multiple speakers.

ACCURACY AND QUALITY

FRAMEWORK FOR ASSESSING DOCUMENTATION ACCURACY AND QUALITY

Given the novelty of AI scribes, established frameworks for assessing documentation quality were incompletely defined. The evaluation team at WIHV developed a standard scoring system that was informed by medical documentation policies and guidelines developed by the CPSO[8], the CMPA[21], peer-reviewed publications, and validated quality frameworks.[3,22,23] Table 4 provides an overview of attributes used to assess accuracy and quality and Table 5 presents the results.

Table 4. Description of Attributes Used to Evaluate Accuracy and Quality of the Medical Note Generated by the AI Scribe

Attribute	Description of the Ideal Note
Accuracy	
Accuracy	Medical note is true and free from errors, hallucinations, or contradictory information.
Comprehensiveness	Medical note includes complete documentation of all relevant patient information, including medical history, examination findings, diagnostic results, and treatment plans without omissions.
Care Plan	Medical note reflects understanding of the patient's status and ability to develop a plan of care.
Quality	
Organization	Medical note is well-structured, adhering to the structured format of the SOAP note. The medical note ensures clarity and coherence for efficient communication and reference.
Comprehension	Medical note is clear, easily accessible, and devoid from ambiguity or difficult to understand terms, phrases, or sections. The medical note allows healthcare professionals to readily interpret the patient's clinical status and make informed decisions.
Conciseness	Medical note succinctly and effectively conveys all essential information, avoiding unnecessary elaboration or redundancy while maintaining clarity and completeness.
Usefulness	Medical note presents pertinent clinical information in a clear, concise, and actionable manner, facilitating effective communication, decision-making, and continuity of care among healthcare providers involved in the patient's care.

ACCURACY AND QUALITY

Only one AI scribe (AI Scribe #1) consistently produced accurate and error-free transcripts and medical notes, which provided a clear and comprehensive overview of a patient's health status and treatment plan. In contrast, the remaining AI scribes (n=5, 83.3%) generated transcripts that were moderately accurate and of acceptable quality, yielding a "good" rating. While most information was transcribed correctly, with few grammatical or syntactical errors, there were typically minor omissions in the medical note related to the history of the presenting illness (HPI), lifestyle factors, and social history.

USEFULNESS

The usability of transcripts among the AI scribes varied greatly. While half of the AI scribes were capable of differentiating speakers to simplify information source tracing, the other half did not. The lack of speaker differentiation in the transcript obscured the flow of conversation and diminished the overall utility of the transcript for reference, analysis, or further action.

Three out of six AI scribes produced medical notes that were comprehensive, well-organized, and clear, and adhered to the SOAP note format, with minimal errors that did not significantly affect their utility (i.e., no critical errors). These notes closely resembled those written by PCPs for the same clinical scenario in terms of content, readability, organization, and comprehensiveness. Factors contributing to a medical note's "good" or "poor" rating for usefulness included: 1) deviation from the standard SOAP note structure despite selecting the SOAP template and/or inclusion of headings without accompanying information; 2) use of ambiguous or complex terms; and/or 3) lack of synthesis of information (e.g., SOAP note contained paragraphs that directly quoted phrases from the transcript opposed to synthesizing the information).

ERROR ANALYSIS

Error types were determined using methods by Goss et al. (2016)[43] and Blackley et al. (2020)[44] and are presented as a classification table (Appendix C). Two board-certified PCPs created a SOAP note based on the sample case. The SOAP note generated by each AI scribe was reviewed by two evaluators for errors against the SOAP note written by the PCPs and the patient summary.

Five out of six AI scribes had a deleted word or omission error where relevant components of the patient interaction were not included. Half (n=3, 50%) of AI scribes had critical errors, which included the absence of information that could potentially impact the patient's care. Four of the AI scribes reported plain terms opposed to medical terms. For example, in the sample case, the patient discussed their "Colles Fracture," a term used to describe a type of wrist fracture. Four AI scribes reported the Colles fracture in plain terms as opposed to the medical term, while one AI scribe reported it as a "dog fracture."

The SOAP format was also assessed for errors. One-third of AI scribes (n=2, 33.3%) reported objective data although a physical examination was not performed. Overall, details captured varied in granularity among the AI scribes, with minor discrepancies in outputs. Errors not observed included errors in names, numbers, punctuation, medical terminology, and homonyms.

Table 5. Evaluation of the Accuracy and Quality of the Medical Note Generated by the AI Scribe

Accuracy and Quality†	AI Scribe					
	Scribe #1	Scribe #2	Scribe #3	Scribe #4	Scribe #5	Scribe #6
Transcript						
Accuracy and Quality	Excellent	Good	Good	Good	Good	Excellent
Usefulness	Excellent	Poor	Good	Poor	Good	Excellent
Medical Note						
Accuracy and Quality	Excellent	Excellent	Excellent	Good	Good	Good
Usefulness	Excellent	Good	Excellent	Excellent	Good	Poor
Error Analysis						
Error Types	No errors observed	Omission of some HPI, lifestyle factors, and social history	Omission of some HPI and lifestyle factors	Omission of some HPI, lifestyle factors, and social history	Omission of some HPI	Omission of some HPI, lifestyle factors, and social history
Errors	Excellent	Good	Good	Good	Good	Poor

HPI = History of Presenting Illness
†Composite measure based on assessment of individual elements informed by the evaluation framework.

EMR INTEGRATION AND COMPATIBILITY

Four out of six AI scribes have some level of integration with EMR systems. [redacted], including being able to launch within EMRs and push and pull meta data (e.g., schedules, visit details) and patient details (e.g., full name, date of birth, health card number, gender, contact information). AI Scribe #5 can currently launch within one EMR system and enable multiple voice commands; however, no data exchange is available. AI Scribe #6 does not directly connect with EMRs to exchange data but has a separate program that enables users to transfer data from the medical note.

AI Scribes #1–4 require users to manually switch from the AI scribe browser/desktop interface to the EMR window to add the medical note. AI Scribe #5 is the only product with a seamless drag/copy/paste transfer into a patient's medical chart, which is attributed to the AI scribe's browser extension interface (i.e., the AI scribe and EMR can share the same window, so users do not have to switch between windows). For AI Scribe #6, users can transfer a copy the note from their mobile device to the EMR using a separate program. Otherwise, users may have to transfer the note via email or secure messaging.

Table 6. EMR Integration and Transferring Medical Note

Feature	AI Scribe					
	Scribe #1	Scribe #2	Scribe #3	Scribe #4	Scribe #5	Scribe #6
EMR Integration and Compatibility						
EMR Integration	Excellent	Poor	Excellent	Poor	Excellent	Good
Ability to Transfer Medical Note	Good	Good	Good	Good	Excellent	Poor

FEATURES AND FUNCTIONS

AI scribes were reviewed to determine the presence of several features and functions (Table 7).

Table 7. Overview of features available across six AI scribes

Feature	AI Scribe					
	Scribe #1	Scribe #2	Scribe #3	Scribe #4	Scribe #5	Scribe #6
Help Function Availability of technical support.	Yes	Yes	Yes	Yes	Yes	Yes
Multiple Languages Ability to understand languages other than English.	No	Yes	Yes	No	Yes	No
Multilingual Conversations Ability to support multilingual conversations involve interpreters.	Yes	Yes	Yes	No	Yes	No
Clinical Terminology Capture Recognition of medical and/or domain-specific vocabulary.	Yes	Yes	Yes	Yes	Yes	Yes
Human Scribe Involvement Involvement of human scribes to validate the medical notes.	No	No	No	No	No	No
Real-Time Transcription Instantaneous conversion of spoken language into written text.	Yes	Yes	Yes	No	Yes	No
Simultaneous Notetaking Ability to type cognitive thoughts within the AI scribe platform while the AI scribe is running.	Yes	Yes	Yes	No	No	No
Text-Based Editing Ability to type edits to the note directly within the AI scribe product.	Yes	Yes	Yes	Yes	Yes	Yes
Speech-based Editing Ability to dictate edits to the note within the AI scribe platform.	No	Yes	Yes	No	Yes	No
Structured (SOAP) format Availability of SOAP note template.	Yes	Yes	Yes	Yes	Yes	Yes

3.4 Facilitators and Barriers to Implementation

Table 8 presents facilitators and barriers to adoption and implementation of AI scribes in primary care. Considerations were informed by the environmental scan, interviews, and the competitive analysis. Some of these facilitators and barriers also apply to RPA solutions.

Table 8. Facilitators and Barriers to Adoption and Implementation of AI Scribes and RPA

Theme	Facilitators	Barriers
Workflow Compatibility	Tailoring AI scribe and RPA to align seamlessly with the workflow of PCPs, ensuring smooth change management while minimizing disruptions.[39] Seamless integration of AI scribe technology with existing EMR systems and other practice management tools, minimizing disruptions to workflow and maximizing efficiency.	Concerns regarding workflow disruptions and needing to adapt behaviour to accommodate AI scribes and RPA. Hesitancy to adopt new technology that was not co-designed with patients and providers to meet their needs.[1] Challenges in integrating AI scribes with existing EMR systems or other practice management tools.
Cost and Resources	Long-term cost savings due to reduced training needs (if compared to medical scribes) and increased productivity. Financial incentives such as subsidies or grants to assist in acquiring and implementing AI scribe and/or RPA technology, making it more financially feasible for practices of varying sizes.	Upfront costs to acquire and maintain AI scribe and/or RPA licenses and related hardware to support their use (e.g., audio equipment).
Training and Education	Access to thorough training programs tailored to PCPs and patients, covering AI scribes and RPA, integration into workflows, and addressing concerns regarding its implementation. Availability of research demonstrating the effectiveness and benefits of AI scribes and RPA in primary care settings, providing reassurance and inspiration for adoption.	Absence of comprehensive training and education programs for PCPs and patients regarding AI in healthcare.
Data Privacy and Security	Robust data privacy and security measures that provide PCPs with mitigation strategies about potential breaches or misuse of sensitive patient information.	Concerns regarding the inadequacy of existing privacy and security laws in preventing AI scribe and RPA developers and vendors from misusing sensitive patient information, which can undermine trust in the technology and pose legal and ethical risks.
Regulatory Support and Guidelines	Clear and supportive regulatory frameworks providing guidelines on the ethical and legal use of AI scribes and RPA, ensuring compliance, and easing patients and PCPs' concerns regarding privacy, security, and patient consent.	Lack of established regulations and governance frameworks regarding appropriate use of AI and automation processes in healthcare.[1]
Ethics and Biases	Assurances of bias mitigation strategies and transparent algorithms, including data sources used to train and validate algorithms.	Potential perpetuation of biases of the data used to train and validate the AI scribes and RPA, leading to inaccurate or discriminatory outcomes in patient care and documentation.
Informed Consent Process	Clear guidance for PCPs to understand the meaning and process of obtaining informed consent from patients.	Absence of clear guidance from regulatory bodies and vendors on the definition and procedure for obtaining informed consent from patients, particularly as most processes currently recommend verbal consent.

3.5 Simulated Encounters in the Virtual Care Lab

Preliminary analysis from the simulated encounters compared the total visit time, total charting time, and proportion of visit spent charting in four scenarios: two using an AI scribe and two without an AI scribe. Findings from the simulated encounters are based on observations from three PCPs and presented in Table 9.

Table 9. Proportion of Visit Spent Documenting with and without Use of an AI Scribe

Efficiency Measures	Scenario	
	PCP[a]	AI Scribe[b]
Total Visit Time (seconds)[†]	915.06	822.50
Total Documentation Time (seconds)[‡]	290.13	31.06
Proportion of Visit Spent Documenting (%)[±]	31.71%	3.78%

[a]PCPs conducting all documentation without an AI scribe.
[b]AI scribe conducting all documentation, but PCP may review and edit the medical note.
[†]Total visit time: Time from start of first word to last word spoken plus any post-visit documentation.
[‡]Total documentation time: Typing time (including time spent scrolling if less than 5 seconds between periods of hands on the keyboard and for the purposes of navigating the note) plus documentation time.

Preliminary results indicate that PCPs spent less time documenting when using an AI scribe compared to completing documentation on their own without the use of an AI scribe. When no AI scribe was used, PCPs spent on average 31.71% of the total visit time documenting. In contrast, when an AI scribe was used, PCPs spent approximately 3.78% of the total visit time documenting, which primarily consisted of reviewing and editing the AI scribe generated note. However, as results are preliminary, additional observations in the VCL are needed to further validate findings and to better understand the impact, benefits, and the value proposition of AI scribes on efficiency. This work is ongoing and will continue into Phase 2.

CONSIDERATIONS

Notably, PCPs varied in their documentation styles, with some using handwritten notes, some documenting throughout the encounter, and others not documenting at all during the encounter. The style of documentation may have differential impacts to time savings. Additional observations and attention should be put towards the use of AI scribes in complete workflows in naturalistic settings.

4.0 Discussion

4.1 Key Findings: AI Scribes and RPA

AI scribes show early promise in reducing administrative burden, cognitive fatigue, and afterhours charting, with PCPs reporting significant reduction in time spent documenting. Both early adopters and non-users positively perceive AI scribes, reporting improved provider and patient experience, better work-life balance, and reduced provider burnout.

A comprehensive assessment of six AI scribes and simulated clinical encounters demonstrated that using AI scribes resulted in time saved, and all AI scribes were capable of producing a "good" medical note. To complement AI scribes and the creation of a medical note, PCPs were also receptive of having other aspects of their workflow automated, such as automated medical assistants, automated task managers, and/or bots for follow-up and appointment reminders.

Despite the early promise demonstrated, continuous improvements to AI scribe technology are required, with a focus on direct and seamless integration with EMR systems, enhanced capabilities to support equitable access and use of AI scribes across different clinical scenarios, and personalized workflow options for PCPs. In addition, as AI scribes and RPA technology continue to evolve at a rapid pace, the development of comprehensive evaluations frameworks and assessment of these tools in real-life settings are needed to ensure effectiveness, efficiency, accuracy, quality, and safety for both patients and providers. The developed evaluation framework used in this report offers a comprehensive, feasible, and adaptable approach to assessing AI scribes and RPA.

4.2 Recommendations

Key recommendations to address barriers to implementation, improve integration with workflows, and to ensure appropriate use of AI and automation technology in primary care include:

RECOMMENDATIONS TO ADDRESS BARRIERS TO IMPLEMENTATION

1. **Adoption strategies and guidelines:** Create adoption strategies that enable users to ease into using AI scribe or RPA technology that are informed by consumer reports. Ensure that use does not require users to significantly adapt workflows and clinical processes to accommodate the technology.

2. **Co-design and co-development:** Create clear channels for users and patients to provide input and feedback (e.g., what works well, what might not work, improvements to be made). Enable all relevant stakeholders, including patients and healthcare providers, to participate in co-development conversations with policymakers and vendors.
3. **Value proposition and transparency:** Outline all the benefits and limitations of the technology to users to manage expectations. Disclose the potential errors that AI scribes may exhibit to prevent automation complacency among users, fostering trust, accountability, and informed decision-making in adopting this technology. Create clear value propositions for each user or individual affected (e.g., patients, administrative staff).
4. **Potential for bias and inequity:** Use representative, unbiased, and good quality data to develop and validate algorithms, especially for primary care. Perform routine assessments to ensure that AI tools and automation processes remain free from bias.

RECOMMENDATIONS TO IMPROVE USABILITY AND PROCESS FLOW

1. **Integration into EMRs:** Enable direct integration of AI and RPA into EMRs to seamlessly blend these technologies into workflows.
2. **Form factor and user design:** Optimize the design of the AI scribe to function as a customizable widget or incorporate features to seamlessly hide the AI scribe on the screen when not in use, promoting a professional, clutter-free interface. Ideally, users can launch the AI scribe within the EMR as soon as the encounter starts rather than opening a separate browser or desktop app.
3. **Process flow:** Minimize the number of mouse and keystrokes needed to sign in, launch, and use the AI scribe and RPA technology.
4. **Customizable and easy to edit templates:** Prioritize customization features and user-friendly editing templates to empower PCPs in tailoring documentation to their specific needs with ease and efficiency.

RECOMMENDATIONS FOR POLICY AND PRACTICE

Key recommendations to continue to support PCPs in Ontario to use AI scribes and other automation processes in their practice include:

1. **Establish regulatory frameworks:** Create clear and comprehensive regulatory frameworks governing the use of AI scribes and RPA in primary care, addressing issues such as data privacy and security, and liability. These regulations should foster trust among healthcare professionals and patients.

2. **Establish frameworks for oversight and collaboration with AI scribe vendors.** Create clear protocols for accountability and regulatory compliance, which include regular audits, certification processes, and ongoing communication to address emerging concerns and ensure adherence to privacy, security, and ethical standards.
3. **Provide training and education:** Develop and/or support training programs to familiarize healthcare professionals and patients with AI scribe and automation technology. Equip users with the necessary skills to effectively integrate them into their practice. Continuous education initiatives can ensure that PCPs and patients remain updated on best practices and new developments to reduce concerns regarding the unknown.
4. **Address equity and accessibility:** Ensure equitable access to AI scribe technology across different practice demographics and geographic locations. Investigate reasons why patient populations may not want to or may not be able to interact with AI tools and ensure considerations are made to avoid undermining trust in the health system and widening the care gap that already exists.
5. **Ongoing benchmarking and evaluation:** Encourage collaboration between governing bodies, technology developers, and researchers to drive innovation and evidence-based implementation of AI scribes and RPA systems. As the technology and regulations governing use are rapidly evolving, ongoing benchmarking, evaluation, and monitoring is needed as the technology changes and vendors bring new solutions to market.

4.3 Limitations and Considerations

Although methodologically rigorous data collection and synthesis activities were used, this study has some limitations. First, although PCPs cited significant reductions in administrative burden, better work-life balance, and improved patient and provider experience, AI scribes and RPA technology are quickly evolving. To demonstrate the scope of impact, findings from this report should be interpreted as complementary to upcoming evaluations on the widespread implementation in Phase 2 of this work.

Second, six AI scribe vendors were evaluated although there are over 35 AI scribes currently used in the global market. While the AI scribes evaluated in this study may be reflective of those used in the Ontario healthcare landscape, findings may not reflect the whole range of features and functions of all AI scribes that exist. However, the decision to evaluate six AI scribes was to prioritize compliance with *PHIPA* and capacity to support primary care use cases in the region.

Furthermore, these tools are constantly evolving, and the competitive analysis represents the relative performance at a point in time.

Third, documentation quality and time was assessed using a standard SOAP note in both the competitive analysis and simulated encounters, as this template was available across all AI scribes. Although this may not reflect the breadth of templates available nor the subject matter expertise that would be used to determine the most appropriate note template, the SOAP note is the most widely recommended method for documenting a clinical encounter.

Finally, although our findings align with the current literature on the impact of AI scribes on patient-provider interactions[45,46], engaging patients and gathering their perceptions is crucial to gain a comprehensive understanding of the impact that AI scribes and RPA may have on the patient experience, the patient-provider relationship, and quality of care. Considering the importance of patient perspective and engagement, Phase 2 of this evaluation will incorporate interviews with patients to understand their experience on the use of the AI scribes and RPA.

5.0 Phase 2 Evaluation

OntarioMD and the eHealth Centre for Excellence (eCE) are leading the implementation of AI scribes and RPA technology across 150 PCPs in Ontario. The Phase 2 (Implementation) evaluation, which is informed by Phase 1 evaluation findings and led by WIHV, aims to better understand the impacts, benefits, and value proposition of AI scribes and RPA in real-world settings. To prepare for Phase 2, OntarioMD, eCE, and WIHV undertook the following activities to facilitate a robust and comprehensive evaluation of AI scribes and RPA in real-world settings:

1. Recruitment and selection of 150 PCPs who will implement an AI scribe and RPA technology in their practice (where applicable)
2. Selection of three AI scribe vendors that will be implemented across the 150 PCPs
3. Development of an automation process (i.e., bot) to automate the completion of recommended tasks that are part of the medical note documentation workflow

A detailed explanation of each activity is described below.

5.1 PCP Selection Criteria

For Phase 2, OntarioMD and eCE led the selection and enrolment process of 150 PCPs to use an AI scribe and the developed bot in their practice. PCPs were enrolled into one of two cohorts: AI scribe only cohort (n=75) or the AI scribe and RPA cohort (n=75). WIHV is leading the evaluation of the widespread implementation of AI scribes and RPA across all 150 PCPs.

Criteria for participation in Phase 2 (Implementation) were developed by WIHV and amended by OntarioMD and eCE based on reference data sources available and communication channels with PCPs. The criteria aimed to ensure participating PCPs were representative of the province's diversity in primary care on a variety of factors, such as provider type (e.g., Family Physician, Nurse Practitioner), gender, practice type (e.g., Sole Practitioner, Group- or Team-Based Practice, Hospital-Based or Academic Practice, Community Health Centre, Nurse Practitioner Led Clinic, Aboriginal Health Access Centres), years in practice, patient population and catchment area, and EMR competency. Table E1 in Appendix E outlines the inclusion and exclusion criteria. PCPs were selected to match ratios based on the provincial profile.

5.2 AI Scribe Vendor Selection

For Phase 2, three out of the six AI scribe vendors were selected for implementation across 150 PCPs. The rationale to limit the selection to three AI scribes was to ensure that the AI scribe vendors can support deployment, training, and onboarding across 150 PCPs, and to safeguard evaluation quality by maintaining a certain sample size of participants allocated to each vendor.

FRAMEWORK TO SELECT AI SCRIBE VENDORS FOR PHASE 2

The framework to select three AI scribe vendors for implementation was developed by OntarioMD and WIHV, in collaboration with eCE and comprised of the following criteria:

- **Experience, Support, and Scalability:** Capacity, readiness, and experience of the AI scribe vendor to support deployment activities and provide onboarding, operational, and technical support for widespread implementation in primary care.
- **Data Privacy and Security:** Compliance of the AI scribe solution with privacy laws (e.g., *PHIPA*), hospital-grade standards for Privacy Impact Assessments (PIA) and Threat and Risk Assessments (TRA), and other industry standard privacy and security regulations.
- **Accuracy and Quality in Medical Documentation:** Completeness of information (including free from omissions) and absence of errors or discrepancies.

- **Effectiveness, Efficiency, and Usability of Outputs:** Adherence to medical documentation guidelines while presenting relevant and valuable information in a well-structured and comprehensible manner that helps the reader understand the patient's clinical course, including in continuity of care settings.
- **Integration and Compatibility:** Ability to seamlessly exchange data and synchronize with various EMR systems, including the efficiency of data transfer mechanisms and the ease of setup, configuration, and ongoing maintenance of the integration to ensure smooth interoperability between the AI scribe and EMR systems.
- **Form Factor and User interface:** Simplicity and user-centric design, including assessment of the platform(s) used to sign-in, launch, and use the AI scribe; the ease in which features and templates are accessible and useful; the ability of the solution to seamlessly integrate into PCPs workflows, offering maximum flexibility and accessibility.

ASSESSMENT APPROACH AND SCORING SYSTEM

OntarioMD led the assessment of the Experience, Support and Scalability and Data Privacy and Security criteria. WIHV led the assessment the Accuracy and Quality of Documentation; Effectiveness, Efficiency, and Usability of Outputs; Integration and Compatibility; and Form Factor and User Interface criteria, which were informed by the interviews with PCPs, competitive analysis, and simulated encounters.

Weights, on a scale from 1 to 3, were assigned to each criterion to denote their relative importance. This allowed the assessment to prioritize criteria considered more essential or impactful in the overall selection process. Essential criteria were assigned a weight of 3, while less crucial criteria were assigned a weight of 1. The weighting scale and assignment of weights was led by OntarioMD and informed by WIHV and eCE. This approach helped ensure that criteria deemed essential for widespread implementation in Ontario (e.g., vendor capacity to support widespread implementation and compliance with *PHIPA*) were given greater weight, leading to a more informed and balanced vendor selection process.

Each criterion was scored on a scale from 1 to 5, where higher scores indicated a higher level of achievement (i.e., better performance). The score for each criterion was calculated by multiplying the weight and score, and then scores from all criteria were added to obtain a final total score. The three AI scribes with the highest scores were selected for implementation in Phase 2. This structured scoring approach ensured a thorough selection process.

AI SCRIBE VENDORS FOR PHASE 2

The three AI scribes selected for implementation across 150 PCPs in Ontario are: [redacted]

The AI scribe vendors selected for Phase 2 met basic scalability, data privacy and security, and quality in medical documentation standards, and collectively, represent variability across the broader market of AI scribe products. The selection of the three AI scribe vendors at this stage does not necessarily reflect the "best" overall solutions, but those that are ready to support widespread implementation in Ontario.

5.3 Development and Evaluation of an Automation Process

IDENTIFYING CANDIDATE TASKS FOR AUTOMATION

To identify candidate tasks for automation, Phase 1 evaluation activities included a clinically informed engagement process with AI scribe vendors and their products, an environmental scan of current applications of RPA in primary care, and discussions with PCPs on tasks that would complement AI scribe use and reduce administrative burden (Section 3.1 and 3.2).

DEVELOPING AN RPA SOLUTION (BOT) – APPOINTMENT BOOKING REMINDERS

eCE led the development of an RPA solution (i.e., a bot) *to assist PCPs in the automated sending of reminders to patients to book follow-up appointments through secure messaging platform(s) based on information documented in the medical note generated by the AI scribe.* To achieve this task, the bot performs two sub-processes: patient identification and sending appointment reminders (Figure 1).

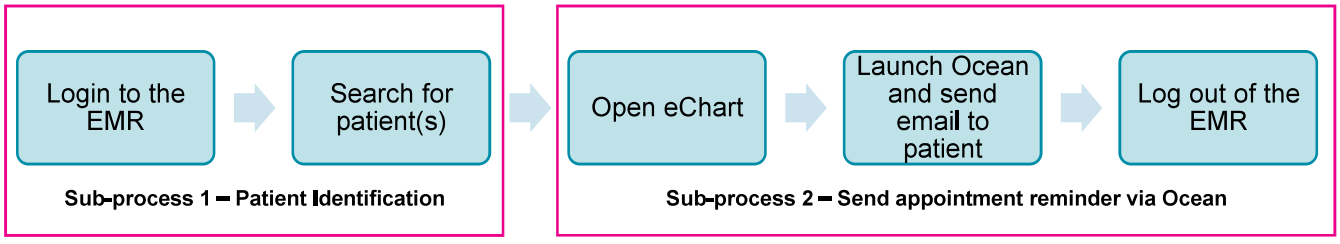


Figure 1. Process for the bot to assist PCPs in the automated sending of follow-up appointment reminders.

The selection of the task for automation (i.e., follow-up appointment reminders) was informed by Phase 1 evaluation findings by WIHV, validation from PCPs to confirm usefulness, and feasibility to develop a bot ready for implementation in Phase 2, as determined by eCE.

To support scalability of the bot and evaluation activities from Phase 1 to Phase 2, the approach to develop and modify the bot uses an incremental modular design:

- Phase 1: **Development of a base solution** to demonstrate feasibility of sending reminders to patients based on the medical note generated by an AI scribe.
- Phase 2: **Addition of new features and enhancements** to improve the patient and provider experience, as informed by ongoing evaluation activities.

EVALUATION OF THE BASE SOLUTION

PROOF-OF-CONCEPT EVALUATION

To complement the Phase 1 evaluation of AI scribes (Section 3.0), an evaluation of the base solution was conducted to verify its readiness for widespread implementation in Phase 2. The evaluation used a proof-of-concept methodology, primarily examining the bot's ability to execute its intended tasks (yes/no).[47,48] Findings are presented in Table 9.

Using the same standardized patients and cumulative patient profiles from the AI scribe evaluation, the developed bot successfully completed tasks such as logging into the EMR on behalf of PCPs, performing a search query using the medical note generated by the AI scribe, launching [redacted] and sending an appointment reminder, and logging out of the EMR.

Table 10. Evaluation Results of the RPA solution

Feature	Proof-of-Concept Outcome
EMR Integration	Bot is able to: ✓ Login to EMR on behalf of PCP using specified credentials ✓ Navigate through different functionalities of the EMR to search for patients who may need follow-up appointment reminders. ✓ Pull relevant information from the EMR to create a work list for the solution to perform subsequent tasks.
Connection with AI scribe	Bot is able to: ✓ Use the medical note developed by the AI scribe in the patient chart as the starting point of the bot process ✓ Locate predefined search template: Searches for a specific string of text that can be found in the medical note (e.g., follow-up with me, F/U with me, Follow up with me). ✓ Perform query to support patient identification
Task Performance	Bot is able to: ✓ Search for the appropriate patient and launch the patient chart ✓ Launch [redacted] through EMR ✓ Locate and select the correct email template to send to the patient ✓ Successfully email patient follow-up reminder.

TECHNICAL REQUIREMENTS AND CONSIDERATIONS

Importantly, only PCP workflows using the [redacted] patient messaging features were supported by the bot process. In addition, in its current state, the bot will send a reminder to any patient who has the specific string of text that indicates a follow-up appointment is recommended. It currently cannot differentiate between patients who have already booked follow-up appointments and/or if the string of text indicates that follow-up is in reference to a referral or specialist. However, these considerations will be further explored for solutions in Phase 2.

Overall, the proof-of-concept evaluation confirmed the bot's functionality. Additional assessments regarding its accuracy, effectiveness, and impact on administrative burden and the experiences of patients and providers are planned in the next phase of work. Evaluation of the bot will continue into Phase 2, where it will be offered for deployment in the practices of 75 out of 150 PCPs.

6.0 Conclusion

AI scribes and other automation processes are increasingly being used by PCPs and have great potential to reduce administrative burden while improving job satisfaction, work-life balance, and patient care. This clinical evaluation demonstrated that PCPs view AI scribes positively; with PCPs reporting that AI scribe use reduced administrative burden, afterhours charting, and cognitive fatigue; enabled more meaningful, engaging, and effective clinical interactions with patients; and improved the patient and provider experience and satisfaction. In addition, PCPs were receptive to automation processes and cited that aspects of their workflow that would benefit from automation include follow-up reminders to both patients and other healthcare professionals, document triaging or inbox management, and medical assistants or task managers.

Complementary to these findings, the competitive analysis and simulated encounters demonstrated that in general, AI scribes can produce high-quality, accurate medical notes that require minimal editing and that align with medical documentation policies and guidelines by the CPSO and CMPA. However, limitations of AI scribes still exist, including challenges with producing medical notes for certain clinical scenarios; equity considerations; lack of integration with EMRs; and ongoing concerns regarding data privacy and security. Although AI scribes and RPA demonstrate potential to alleviate administrative burden for PCPs, ongoing evaluation is necessary to ensure that these technologies continue to support PCPs while also enhancing accuracy, effectiveness, and safety for patients and providers.

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Appendix A: Environmental Scan

MEDLINE SEARCH STRATEGY

Two searches were run separately to capture literature on the current applications of medical scribes, AI scribes, and RPA: 1) AI scribe*.kf,tw. OR digital scribe*.kf,tw OR automated scribe*.kf,tw. 2) human scribe*.kf,tw. OR medical scribe*.kf,tw.

SCREENING ELIGIBILITY CRITERIA

Table A1. Environmental Scan Inclusion and Exclusion Criteria

INCLUSION	EXCLUSION
• English language full-text publications • Published after January 1, 2015 • Peer-reviewed articles, commentaries, opinion pieces, and editorials • Any studies reporting on medical scribes, AI scribes, and/or RPA technologies related to the delivery of healthcare, administrative burden, and patient-provider interactions • Any studies conducted in a primary care health setting	• Non-English language full-text publications • Published prior to January 1, 2015 • Dissertations • Any studies reporting on AI scribes, medical scribes, and/or RPA technologies solely focused on academic training and/or education • Any studies solely focused on individuals below the age of 18 (i.e., children or paediatric population)

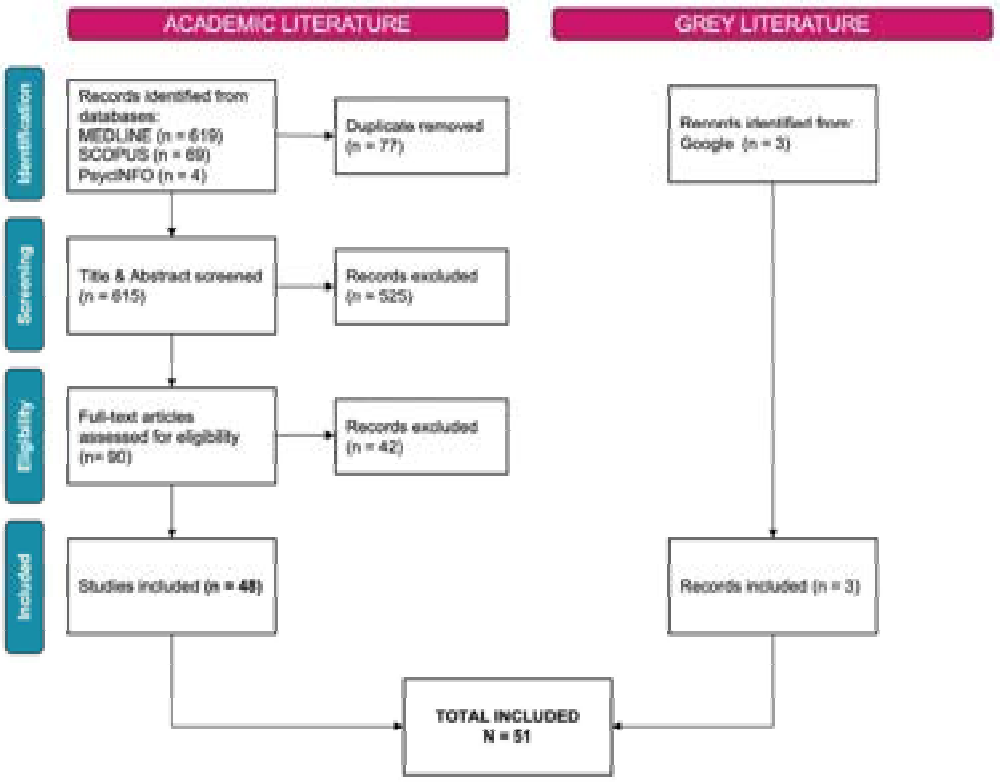


Figure A1. Flow chart of included academic and grey literature in the environmental scan

CURRENT APPLICATIONS OF MEDICAL SCRIBES IN PRIMARY CARE

In literature, medical scribes in primary care were mainly responsible for:

- **Note-taking and data-entry:** Medical scribes have played a role in for transforming patient-provider conversations into detailed medical notes for electronic clinical documentation and computerized order entry using predefined templates.[29]
- **Coordinating clinical workflow:** Medical scribes have supported clinical workflow by communicating with other members of the care team for actions instructed by a provider, relaying information to their patient on behalf of a provider, tracking the status of pending actions, and informing the provider about any abnormal results or findings.[7,29]
- **Clerical tasks:** Medical scribes have been tasked with printing and faxing, fetching paper forms, and preparing educational materials and after-visit instructions.[29]

BENEFITS AND LIMITATIONS OF MEDICAL SCRIBES

A list of benefits and limitations of medical scribes identified from literature is provided below.

BENEFITS OF MEDICAL SCRIBES

Medical scribes were found to benefit PCPs in the following ways:

- **Increased productivity:** Increased patient volume and decreased patient visit time and time spent charting during and after work hours for PCPs.
- **Increased time for clinical care:** Alleviated data entry burden for PCPs; thus, improving workflow and allowing PCPs to spend more time on clinical care.
- **Higher quality of clinical notes:** Produced higher quality of notes that were more thorough, comprehensible, and up to date compared to PCPs.
- **Improved quality of care and increased clinical reasoning:** Enabled PCPs to deliver better quality care and more patient-centered care as medical scribes were able to take over documentation; thus, granting PCPs greater mental capacity for cognitive reasoning and differential diagnoses.

LIMITATIONS OF MEDICAL SCRIBES

The following were identified in literature as limitations that prohibited the spread and scale of medical scribes to reduce administrative burden across primary care settings:

- **Limited authorization:** Policies prohibited medical scribes from conducting certain tasks, such as responding to inbox emails or entering orders into the patient's EMR. In these instances, medical scribes did not reduce administrative burden experienced by PCPs for out-of-visit tasks.

- **High turnover rate and training burden:** Medical scribes also reported experiencing increased administrative burden and burnout, leading to high turnover rates. PCPs reported the need to constantly train new medical scribes added administrative burden.
- **Lack clinical experience:** Lack of prior clinical experience or knowledge of medical terminology resulted in verbose or incomplete medical notes that increased the amount of time PCPs spent proofreading and editing.
- **Lack of standardized documentation and variance in structure and content:** Lack of documentation structure for medical scribes to follow when creating medical notes led to variance and inconsistences in notes produced; thus, impacting the amount of time spent by PCPs to review, edit, and sign-off on their chart notes.
- **Disincentives EMR improvement:** Reliance on medical scribes may diminish pressure to improve EMR usability as medical scribes are short-term solution to a border problem.
- **Unclear impact on patient satisfaction:** Lack of consensus in literature on the impact that medical scribes have on patient satisfaction. Some studies reported that employing medical scribes led to more efficient interactions and higher patient satisfaction, while other studies showed no effect of patient satisfaction.

BENEFITS AND LIMITATIONS OF AI SCRIBES

Studies have outlined several benefits and limitations of AI scribes for patients, PCPs, and the primary care sector.

BENEFITS OF AI SCRIBES

Literature highlights several overlapping advantages offered to PCPs by medical scribes and AI scribes, including the reduction of documentation time and enhancement of productivity and quality of care. However, AI scribes offer additional benefits, some of which specifically address the shortcomings of medical scribe, thereby facilitating wider adoption and scalability of AI scribes.

- **Minimal training required:** Onboarding and training for providers to use AI scribes was reported to be easy and straightforward.
- **Faster documentation turn-around time:** Speech recognition technology was reported to be able to synthesize patient-provider conversations into standard paragraphs quickly; thus, reducing documentation turn-around time.
- **Convenience:** PCPs recognized that the use of AI scribes was not limited by location, time, or situations, unlike medical scribes.

- **Increased engagement and efficiency:** Both patients and PCPs reported feeling more engaged during their encounters. PCPs reported that AI scribes. In addition, some AI scribes can generate patient-facing documents.
- **Task automation:** Some AI scribes had features to automate certain tasks (e.g., voice enabled EMR assistant) so PCPs could complete certain task while attending to patients; thus, enhancing workflow efficiency.

LIMITATIONS OR CHALLENGES EXPERIENCED BY AI SCRIBES

Users of AI scribes have noted the following limitations and/or considerations regarding instances where the accuracy and quality of the generated transcript and medical note may be affected:

- **Voice diarization:** AI scribes have difficulty distinguishing between speakers with similar voice tones, as well as difficulty receiving audio from soft-spoken individuals.
- **Factors impacting audio recording:** Clinical settings and other environmental factors degrading the quality of the ASR system, including ambient noise, multiple speakers, disfluencies in speech, and the complexity of medical vocabulary.
- **Knowledge extraction and structuring data:** Reported instances where the unstructured nature of encounters made it challenging for AI scribes to extract relevant information. For example, discrepancies between spoken and written language, as well as differences in lay versus expert terminology, led to inaccuracies in documentation.
- **Automation bias and complacency:** Perceived risks of PCPs becoming overly reliant on automated processes and losing vigilance to validate medical notes.
- **Algorithm generalizability**: Concerns regarding the generalizability of machine algorithms and how performance may change across different clinical or regional settings with different patient populations.
- **Change in clinician behaviour**: Using an AI scribe required PCPs to change their style of interaction. Some studies reported that those practicing for longer may be less comfortable in adopting new systems/technologies.
- **Accuracy and reliability concerns**: Cited risks, potential for harm, and legal concerns caused by inaccurate notes as patient histories are often non-linear, circuitous, multilayered, and sometime self-contradictory.

Several of the benefits and limitations identified in literature supplement key findings from the semi-structured interviews with early adopters and non-users of AI scribes. Refer to Section 3.2 for more details.

Appendix B: Semi-structured Interviews

In total, 7 PCPs who currently use AI scribes in their practice (early adopters) and 6 PCPs who have not used AI scribes in their practice (non-users) were interviewed. The interview guides for each group of PCPs are provided below.

EARLY ADOPTER INTERVIEW GUIDE

General Experience, Acceptability and Satisfaction

1. To understand the parameters of your experience, can you please tell me how long you have been using AI scribe technologies for in your practice.
    a. Probe: Which AI scribe technologies do you have experience with? ([redacted])
2. What made you interested in implementing AI scribe technologies into your practice?
3. How have you integrated AI scribes into your daily workflow?
    a. Probes: What tasks do you typically use an AI scribe for?
    b. How has your workflow changed since using an AI scribe?
4. What challenges or difficulties have you encountered while using an AI scribe?
    a. Probe: When reviewing generated transcripts, what do you consider to be an acceptable amount of errors? (e.g., Mistranslations, missed medication diagnoses)

**If the provider has used automation processes, can inquire about automation processes (bots).*

5. In addition to AI scribe technologies, do you have any experience in using automated processes or bots in your practice?
6. How do you feel about the level of automation in your current AI scribe setup? Is it aligned with your expectations?

Perception of Patient experience (Appropriateness)

**If the provider has used automation processes, can add prompts to each question to inquire about automation processes (bots).*

7. How has the use of AI scribes and/or automated processes (bots) affected your interactions with patients during appointments?
    a. Probes: How did you introduce your patients to your use of AI scribe during clinical encounters?
    b. Have your patients expressed any concerns?
8. Do you perceive any changes in the satisfaction or engagement of patients?

9. How do you think use of an AI scribe may impact different patient populations (e.g., sociodemographic and/or health concern)?

Usability

10. How would you rate the accuracy and reliability of the AI scribe in completing the desired tasks?
11. Based on your experiences and use so far, do you have any recommendations as to how AI scribe technologies could be improved?

**If the provider has used automation processes, can inquire about automation processes (bots).*

12. Are there specific aspects of your workflow where you believe increased automation, or the introduction of new bots could further optimize your experience with AI scribe technologies?

Implementation: Enablers and Barriers

13. Thinking back to when your clinic initially implemented AI scribe, what challenges did you encounter?
    a. Probe: What strategies did you use to address these challenges?
14. What support or training did you receive to use AI scribe technologies?
    a. Probe: If you didn't receive support/training, what would you have liked to have access to?
15. What continued training or support do you think would be valuable to PCPs or clinics?

**If the provider has used automation processes, can inquire about automation processes (bots).*

16. What support or training did you receive specifically related to the integration and management of automated processes or bots that complement your current AI scribe system?

Closing

14) Is there anything else you would like to share with me about your experiences with using AI scribe technologies and/or automation processes? Do you have any questions for me today?

NON-USER INTERVIEW GUIDE

Current Workflow

1. Can you describe your typical workflow during a clinical encounter? Specifically, please describe the typical administrative tasks during and following an encounter, and walk me through your experience with these tasks (e.g., time spent on tasks, proportion of workload, etc.)
2. What are the main challenges you face in terms of administrative tasks and EMR-related activities?
    a. Probe: What contributes/alleviates these challenges?
3. What strategies have you implemented, if any, to reduce the administrative burden?
    a. Probe: What did you like/not like about these strategies?

Acceptability/Appropriateness

4. How familiar are you with AI scribe technologies? ...How familiar are you with the concept of automation or bots in healthcare settings?
5. What are your general thoughts on using AI scribes and/or automated processes (bots) in a clinical setting? (e.g., to assist with documentation during clinical encounters)
6. What concerns, if any, do you have about using AI scribes or automated processes in your practice? (e.g., privacy, confidentiality, patient engagement, technical performance)
    a. Probe: If you were to use an AI scribe, what would you consider to be an acceptable number of errors in an AI generated transcript? (e.g., Mistranslations, missed medication diagnoses)
7. In your opinion, what potential benefits could AI scribes bring to your practice? What potential benefits could automation processes being to your practice?
    a. Probe: How do you think the introduction of AI scribes and/or automatic or bots might impact the overall workflow and efficiency of your practice?

Usability

8. How comfortable do you feel with adopting new technologies in your practice?
9. What features or functionalities would you find most useful in technology aimed at reducing administrative burden?

Adoption and Sustainability

10. Are there specific reasons you have not adopted AI scribes into your practice? Please describe. (e.g., workflow).
11. What conditions or support would make you more likely to adopt AI scribes or automated processes (bots) into your practice?
12. Beyond initial adoption, are there challenges or concerns you foresee in using AI scribes or integrating automated processes in your practice in the long term?
13. Are there specific resources or training that you believe would be important to sustain the use of AI scribes in the long term?
    a. Probes: what kind of support or training would you feel is necessary for healthcare providers who are considered implementing AI scribes, automation or bots in their practice?

Closing

14. Is there anything else you would like to share with me about your perceptions of using AI scribe technologies in primary care? Do you have any questions for me today?

Appendix C: Competitive Analysis

STANDARDIZED PATIENT PROFILES AND CLINICAL SCENARIOS

The standardized patient audio files were selected from The College of Family Physicians of Canada website to enable evaluation of the transcript and medical note generated by the AI scribe against a standard scoring to assess accuracy, quality, and effectiveness. Additional videos of clinical encounters with medical terminology relevant to primary care settings were used to examine accent adaptability. Table C1 provided a brief description of the case characteristics.

Table C1. Characteristics of Standardized Patients and Clinical Scenarios

Standardized Patient	Case Description
Sandra Jones	• **Chief complaints:** Osteoporosis and anxiety. • **History:** Family history of osteoporosis; heavy smoker and high alcohol and caffeine consumption; increased anxiety due to potential changes in work situation and pressure from having to take care of grandchildren. • **Management:** Schedule bone mineral density test to confirm osteoporosis diagnosis; referral to smoking cessation counselling; start weight-bearing and muscle-strengthening exercises; referral to occupational therapy; recommend non-pharmacological anxiety management; schedule follow-up appointment to discuss bone test results and reassess anxiety.
Bill Snook	• **Chief complaints:** Gastroesophageal reflux disease and gambling addiction. • **History:** No HPI or familial history; minimal alcohol consumption, current smoker, no recreational drug use; poor dietary habits; occasional Advil and Tums; financial stress from gambling. • **Management:** Test for *H. pylori*; conduct blood work; counsel patient about stress management and dietary habits; referral to mental health support for gambling issues.
Helen Pereira	• **Chief complaints:** Anxiety, caregiver burnout, and headaches. • **History:** History of migraines; minimal caffeine consumption; Tylenol and Gravol for headaches; Craniotomy for subdural hematoma 12 years ago. • **Management:** Short-term use of Ativan (1mg) to manage acute anxiety symptoms; counseling on box breathing and grounding techniques to manage anxiety; follow-up appointment in four weeks to discuss transition to long-term medication and therapy.
John Doe	• **Chief complaint:** High blood pressure and type 2 diabetes • **History:** Heart attack 3 months prior and underwent cardiac catheterization; no chest pain or SOB; Lipitor for cholesterol management, Ramipril for blood pressure control, aspirin for cardiac health, and metformin for diabetes control. • **Management:** Continue Lipitor 40mg OD, Ramipril 2mg OD; blood work to monitor diabetes; referral to diabetes education; follow-up appointment scheduled in one month.

HPI = history of presenting illness; mg = milligram; OD = once daily; SOB = shortness of breath

USABILITY AND PROCESS FLOW

Table C2. AI Scribe Sign-in Process

Process	AI Scribe					
	Scribe #1	Scribe #2	Scribe #3	Scribe #4	Scribe #5	Scribe #6
Total Steps	2	3	3	3	2	2
Approx. Time	4 sec.	5 sec.	20 sec.	8 sec.	5 sec.	2 sec.
Auth.†	1FA	1FA	2FA	1FA	1FA	1FA
Step						
1	Click "Clinic Login"	Click "Sign-in/up with Google"	Submit credentials	Click "Sign in"	Click "Sign in"	Tap "Sign in with device passcode"
2	Submit credentials	Submit email	Access authentication token	Enter credentials	Select credentials	Enter credentials
3		Submit password	Submit token	Select account type		

†Auth. = Authentication protocol: 1FA = single-factor authentication, 2FA = two-factor authentication

Table C3. AI Scribe Launch Process

Process	AI Scribe					
	Scribe #1	Scribe #2	Scribe #3	Scribe #4	Scribe #5	Scribe #6
Total Steps	3	4	3	3	2	2
Approx. Time	6 sec.	8 sec.	6 sec.	6 sec.	6 sec.	5 sec.
Interface†	Browser	Browser	Browser	Desktop	Extension	Mobile App
Step						
1	Click "Quick Start"	Click "Start Here"	Click "Start Listening"	Click "Start a new consultation"	Click docker tab	Tap "+" symbol
2	Click "Activate *NAME*"	Click "New Live Scribe"	Click "*NAME* Express"	Click microphone icon	Click "Record and Summarize a Patient Visit"	Tap microphone icon
3	Click "Allow" microphone access	Click microphone icon	Click "Allow" microphone access	Click "Allow" microphone access		
4		Click "Allow" microphone access				

†Interface = Format of the AI scribe's user interface; Browser = a standalone browser-based website, Desktop = a desktop application, Extension = a browser extension

Table C4. Error types of across all AI scribes

Error Types†	Description	AI Scribe					
		Scribe #1	Scribe #2	Scribe #3	Scribe #4	Scribe #5	Scribe #6
Deleted Words[1]	Word deleted or omitted		Omission: no reference to dairy intake, wrist fracture hasn't fully healed	Omission: no reference to dairy intake, wrist fracture hasn't fully healed	Omission: no reference to dairy intake, wrist fracture hasn't fully healed; no age noted		Omission: no reference to caregiving responsibilities that is contributing to anxiety
Critical Errors[1]	Potentially impact patient care			No mention of compression fracture in back		No mention of compression fracture in back;	No mention of compression fracture; wrist fracture reported as dog fracture; no mention of bone mineral density test; no mention of future discussion regarding bisphosphonates
Medical Terms[2]	Errors to diagnoses and procedure names, including abbreviations		Misses term "Colles Fracture", reports as wrist fracture	Misses term "Colles Fracture", reports as wrist fracture	Misses term "Colles Fracture", reports as wrist fracture	Misses term "Colles Fracture", reports as wrist fracture	Misses term "Colles Fracture", reports as dog fracture
SOAP Structure	Adheres to medical documentation policies and recommended SOAP format	No differentiation in Plan for each condition	Reports Objective data even though there was no exam; adds referral to dietician; adds decrease in caffeine consumption; no differentiation in Plan for each condition		Subjective: missing granular details on relevant history regarding anxiety	Reports Objective data even though there was no exam	

†Error types not observed: Name[2]: proper nouns e.g., place names or patient names; Number[2]: involving number or digit; Punctuation[2]: missing or inserted punctuation; Medication Name[2]: brand name and generic medication names; and Homonym errors[1]: resulting from substitution of a phonetically identical word.

1. Goss, F. R., Zhou, L., & Weiner, S. G. (2016). Incidence of speech recognition errors in the emergency department. *International Journal of Medical Informatics*, *93*, 70–73. https://doi.org/10.1016/j.ijmedinf.2016.05.005

2. Blackley, S. V., Schubert, V. D., Goss, F. R., Al Assad, W., Garabedian, P. M., & Zhou, L. (2020). Physician use of speech recognition versus typing in clinical documentation: A controlled observational study. *International Journal of Medical Informatics*, *141*, 104178. https://doi.org/10.1016/j.ijmedinf.2020.104178

FEATURE ANALYSIS

Table C5. Help Function and Supports Available for AI Scribe Users

AI Scribe	Evaluation	Notes†
AI Scribe #1	Yes	**Access Path:** Profile > Help **Available Resources:** • Product guide [Help] • FAQ [Help] • Call number [Help] • Support request form [Help] **Additional Notes:** • Provides emergency response within 15 minutes
AI Scribe #2	Yes	**Access Path:** Profile > Help Guide **Available Resources:** • Product Guide [Help] • FAQ [Home] • Live Help Chat [Dashboard] • Email support [Product Home]
AI Scribe #3	Yes	**Access Path:** User > Help **Available Resources:** • Product Guide • FAQ [Help, Home] • Email Support [FAQ]
AI Scribe #4	Yes	**Access Path:** Home > FAQs **Available Resources:** • FAQ [Dashboard] • Support request form [Dashboard]
AI Scribe #5	Yes	**Access Path:** Home > Resources **Available Resources:** • Product Guide • FAQ [Dashboard] • Email support [Dashboard]
AI Scribe #6	Yes	**Access Path:** Settings > Help **Available Resources:** • Product Guide [Help] • Live Help Chat [Help] • Email support [Settings] • Call number [Settings]

Appendix D: Phase 2 Evaluation Activities

SELECTION CRITERIA BASED ON PROVINCIAL PROFILE

Table E1 provides an outline of the criteria developed by OntarioMD and eCE to enroll 150 PCPs to use selected AI scribe vendors and RPA solutions in their practice. WIHV provided consultation on the list of practice demographics and characteristics to ensure a representative sample of PCPs in Ontario. The criteria are not mutually exclusive (e.g., a participant may be a Nurse Practitioner with intermediate EMR competency who identifies as a man, is part of a group or team-based practice and has been practicing for 1–4 years in a small town or rural location).

Table E1. Selection Criteria for Phase 2 PCP Participants

Criteria
Selection Criteria
• **Provider type** (Family Physician, Nurse Practitioner) • **Gender** (Woman, Man, Non-binary, Other) • **Practice type** (Sole Practitioner, Group- or Team-Based, Hospital-based or Academic practice, Community Health Centre, Aboriginal Health Access Centres, Other) • **Patient population** (Significant proportion historically underserved or equity-deserving) • **Years in practice** (Less than 1 year, 1–4 years, 5–10 years, More than 10 years) • **Patient catchment** (Urban/Suburban, Small Town/Rural, Northern/Remote) • **OH Region** (Central, East, North East, North West, Toronto, West) • **EMR competency** (Novice, Intermediate, Expert) • **AI scribe use** (Yes, No)
Exclusion Criteria
• Not a family physician or nurse practitioner in primary care • Primary care practice language is not predominantly English or French

EXHIBIT 14

BY AGE GROUP 20-65 FOR EMPLOYMENT INCOME (T4 DATA - BOX 14) NOT EQUAL $0
ALL ONTARIO
2022 TAX YEAR

EMPLOYMENT INCOME (T4 DATA - BOX 14) NOT EQUAL $0				
PERCENTILE	**COUNT OF INDIVIDUALS**	**TOTAL**	**MEAN**	**MEDIAN**
5	**359,710**	$500,003,000	$1,390	$1,260
10	**360,590**	$2,020,800,000	$5,605	$5,585
15	**358,830**	$3,761,754,000	$10,485	$10,495
20	**364,910**	$5,634,435,000	$15,440	$15,400
25	**354,510**	$7,324,144,000	$20,660	$20,630
30	**359,710**	$9,384,220,000	$26,090	$26,035
35	**359,710**	$11,363,863,000	$31,590	$31,570
40	**359,710**	$13,270,033,000	$36,890	$36,865
45	**359,710**	$15,124,586,000	$42,045	$42,015
50	**359,710**	$16,971,907,000	$47,180	$47,185
55	**359,710**	$18,864,859,000	$52,445	$52,415
60	**359,710**	$20,919,138,000	$58,155	$58,150
65	**359,710**	$23,137,407,000	$64,320	$64,355
70	**359,710**	$25,589,333,000	$71,140	$71,075
75	**359,710**	$28,448,902,000	$79,090	$79,035
80	**359,710**	$31,859,734,000	$88,570	$88,500
85	**359,710**	$35,830,149,000	$99,610	$99,900
90	**359,710**	$40,635,142,000	$112,965	$112,580
95	**359,710**	$49,536,364,000	$137,710	$136,365
100	**359,710**	$101,541,866,000	$282,285	$204,630
Total	**7,194,230**	$461,718,639,000	$64,180	$49,810

Notes:

1. The 'Count of Individuals' is the number of unique SINs in Ontario where Box 14 is greater than 0 using the most recent, non-deleted slips for the 2022 tax year.
2. The amount in Box 14 was rolled-up by individual for instances where an individual has more than one valid T4 slip.
3. Age group was determined based on an individual's age at December 31, 2022.
4. Records with missing SINs and/or Date-of-Birth were excluded.
5. Data are as of January 26, 2024.
6. All counts are rounded to the nearest multiple of 10, means and medians are rounded to the nearest 5, and amounts are rounded to the nearest 1,000.
7. Totals may not add up due to rounding.
8. All data are subject to change due to late-filers and re-assessments.

EXHIBIT 15

WORKLOAD AND POPULATION GROWTH ANALYSIS

2005/06 – 2023/24

April 30th, 2024

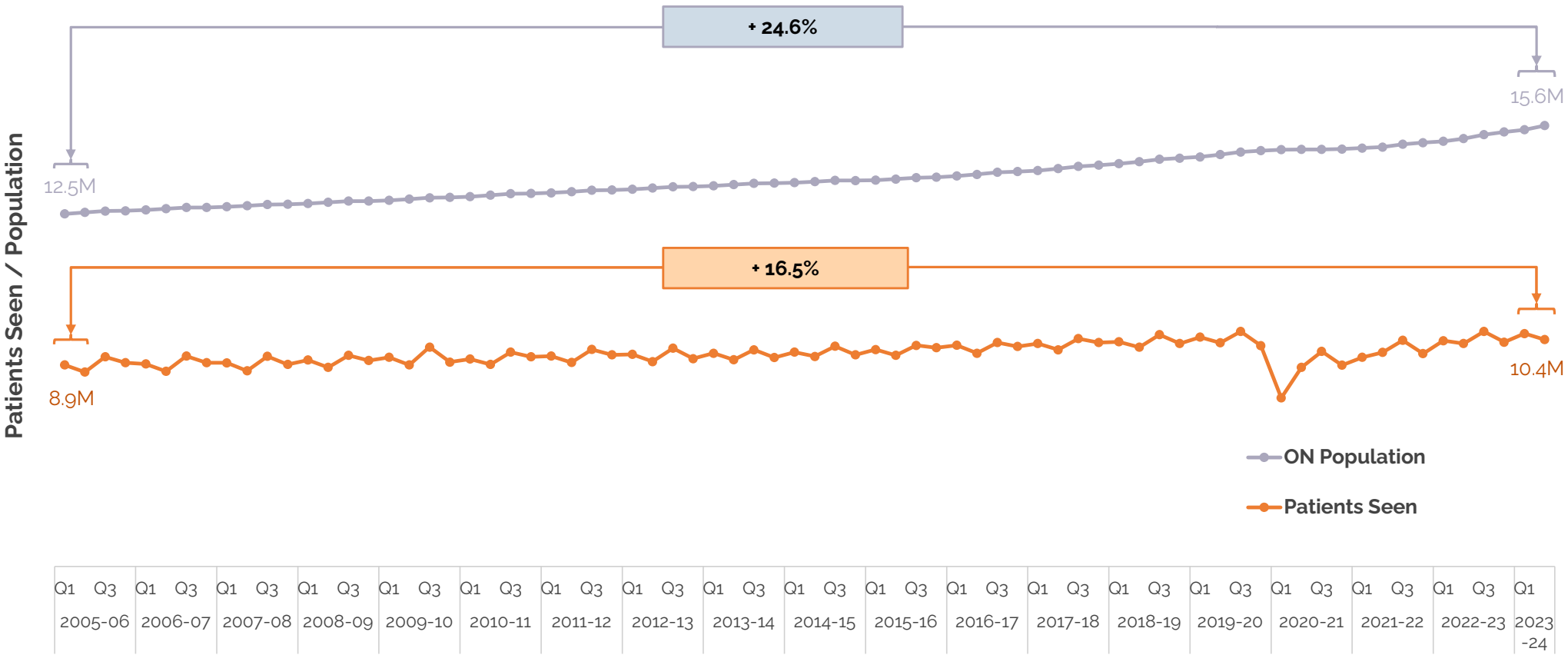
Ontario

Physician Supply vs. Patient Population – 2005/2006 to 2023/2024

Fiscal Year	Physician Supply	Physician Supply Increase (Cumulative)	Patient Population	Patient Population Increase (Cumulative)
2005-06	22,944	-	12,587,149	-
2006-07	23,334	1.7%	12,703,327	0.9%
2007-08	23,858	4.0%	12,814,686	1.8%
2008-09	24,451	6.6%	12,932,742	2.7%
2009-10	25,199	9.8%	13,059,426	3.8%
2010-11	26,063	13.6%	13,199,081	4.9%
2011-12	26,853	17.0%	13,325,337	5.9%
2012-13	27,678	20.6%	13,446,276	6.8%
2013-14	28,528	24.3%	13,563,311	7.8%
2014-15	29,411	28.2%	13,657,423	8.5%
2015-16	30,192	31.6%	13,774,364	9.4%
2016-17	30,916	34.7%	13,975,516	11.0%
2017-18	31,728	38.3%	14,199,811	12.8%
2018-19	32,567	41.9%	14,449,986	14.8%
2019-20	33,250	44.9%	14,718,155	16.9%
2020-21	33,548	46.2%	14,772,726	17.4%
2021-22	34,791	51.6%	14,999,441	19.2%
2022-23	35,324	54.0%	15,378,179	22.2%
2023-24	36,204	57.8%	15,848,654	25.9%

Methodology Notes:
Headcount captures all distinct PractNos with at least one claim billed in the given fiscal year.
2023-24 headcount is projected based on the multiplier between the headcount in first six months of the year (with complete data) to the full year. The multiple is calculated for FY 2022-23, and is then applied to 2023-24.
Patient Population from StatsCan is as of Q4 (Jan 1) of each fiscal year, retreived January 2024.

While the Ontario population has grown by 24.6%, the number of patients seen by physicians has grown by only 16.5%



Notes:

1. Statistics Canada Quarterly Population Estimates, Ontario (Link)

The average Ontario physician is seeing fewer distinct patients today than they did in 2005/06

Quarter	Avg. Distinct Patients Seen per Physician in 2005-06	Avg. Distinct Patients Seen per Physician in 2022-23 or 2023-24	% Difference from 2005-06
Q1	331	245 *(2023-24)*	**-25.8%**
Q2	313	233 *(2023-24)*	**-25.5%**
Q3	338	247 *(2022-23)*	**-26.8%**
Q4	329	237 *(2022-23)*	**-28.1%**
Average Across All Quarters	**328**	**241**	**-26.6%**

Notes:
1. Physician count includes all physicians with >0 claims billed within the fiscal year
2. Total patients seen capture all distinct patients with >0 visits
3. Q3 and Q4 uses 2022-23 data, as data for 2023-24 is not yet available

EXHIBIT 16

RESEARCH PAPER

The Induced Productivity Decline Hypothesis: More Physicians, Higher Compensation and Fewer Services

L'hypothèse du déclin induit de la productivité : plus de médecins, une rémunération plus élevée et moins de services



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Abstract

Public outrage regarding physician shortages during the past two decades have led to policies aimed at significantly increasing physician supply, yet access remains elusive. In this paper, we examine this puzzling trend and the causes underlying it by analyzing physician supply, compensation and productivity and the reasons behind productivity decline. We hypothesize that excess physician compensation beyond a target income induces productivity decline. In contrast to a wage–productivity gap for the average Canadian worker (where productivity

has increased but compensation has not kept pace), physicians are experiencing a "reverse wage–productivity gap" whereby compensation is increasing but productivity is decreasing, resulting in more physicians, higher compensation and fewer services. We conclude by discussing potential policy options to address how best to provide timely access to medical care for Canadians while keeping physician healthcare expenditures at sustainable levels.

Résumé

L'indignation de la population concernant les pénuries de médecins au cours des vingt dernières années a mené à des politiques qui visent à augmenter considérablement l'offre de médecins, mais l'accès reste difficile à atteindre. Dans cet article, nous examinons cette tendance déroutante et les causes qui la sous-tendent en analysant l'offre, la rémunération et la productivité des médecins ainsi que les raisons de la baisse de la productivité. Nous émettons l'hypothèse qu'une rémunération excessive des médecins au-delà d'un revenu cible induit une baisse de la productivité. Contrairement à un écart salaire–productivité pour le travailleur canadien moyen (où la productivité a augmenté mais la rémunération n'a pas suivi le rythme), les médecins connaissent un « écart salaire–productivité inversé » où la rémunération augmente mais la productivité diminue, ce qui entraîne un plus grand nombre de médecins, une rémunération plus élevée et moins de services. Nous concluons en discutant des options politiques permettant de déterminer la meilleure façon de fournir un accès rapide aux soins médicaux pour les Canadiens tout en maintenant les dépenses de santé des médecins à des niveaux durables.

Introduction

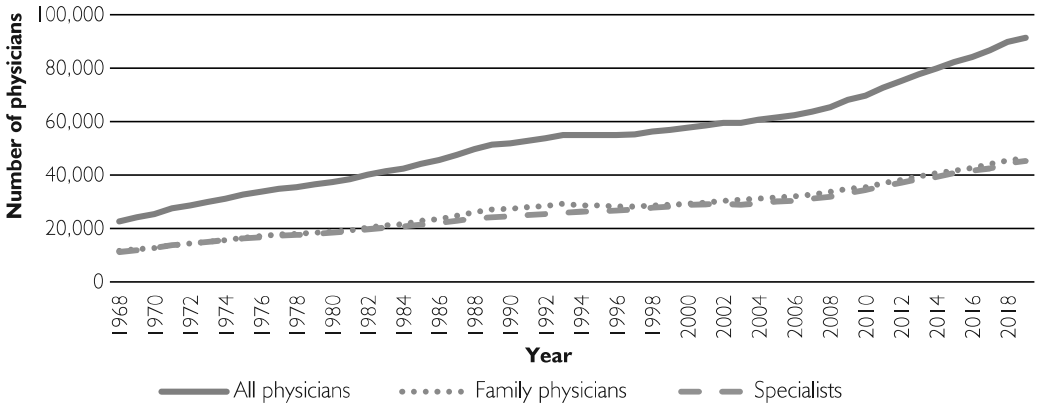
Physicians play an integral role in the Canadian healthcare system; however, consensus about the optimum ratio of physicians to population continues to be debated. During the past two decades, the public has expressed concerns about the availability of physicians, and physician supply has been significantly increased in response (Chan 2002b; CIHI 2020a). Notwithstanding these efforts, access remains a problem for many patients (Brend 2017; Martin et al. 2018). Previous authors have reported reduced physician productivity over short time frames (Ariste 2015), with older data (Chan 2002a) or by examining specific factors impacting productivity, such as sex (Weizblit et al. 2009) or intergenerational differences (Watson et al. 2006). Our objective was to examine recent trends of physician supply, compensation and productivity in Canada, the reasons for these trends and how their relationships may affect physician availability and policies for managing physician supply and demand. We hypothesize that excess physician compensation beyond a target income induces productivity decline (induced productivity decline hypothesis).

Physician supply in Canada

Physician supply in Canada has fluctuated over time. In the 1980s and early 1990s, there was a perceived surplus of physicians (Barer et al. 1991; Chan 2002b), leading to policies to

restrict physician supply in the 1990s (Barer et al. 1991; Malko and Huckfeldt 2017). Within a decade, public outcries regarding poor access to physicians and long wait times led provincial governments to reverse course and significantly boost physician supply through increased medical school enrollment and recruitment and retention strategies for foreign medical graduates (Malko and Huckfeldt 2017), especially in underserved areas. The increase in supply has led to the highest ratio of physicians per capita ever recorded in Canada (2.41 physicians/1,000 population in 2019 [CIHI 2020a]), with a growth rate more than double that of the Canadian population over the last five years (see Figure 1), and especially high in urban settings (CIHI 2020b). Yet Canadians continue to express concerns about obtaining timely medical care, particularly from family physicians (FPs) (Brend 2017; The Canadian Press 2019). In international rankings, Canada and Norway rank the lowest for same- or next-day appointments with a doctor or nurse (Schneider et al. 2017). To address these concerns, it is critical to understand why the increase in physician supply has failed to meet the public's medical care needs.

FIGURE 1. Physician supply (1968–2019)



International comparisons of physician supply

The ideal physician-to-population ratio in developed countries has been difficult to define. For example, physician-to-population ratios in Canada remain low compared with other developed nations. According to Organisation for Economic Co-operation and Development (OECD) data in 2016, Canada ranked 24th of 31 countries (2.6/1,000 population vs. an average of 3.4/1,000) in physician-to-population ratio, including medical interns and residents. Interestingly, however, the FP-to-population ratio in Canada is higher than the OECD average (1.3/1,000 vs. an average of 1.0/1,000, ranking Canada eighth), whereas the specialist ratios are lower (1.4/1,000 vs. an average of 2.2/1,000, ranking Canada 28th) (OECD 2020a). This may derive, at least in part, from Canada's deliberate policy to have FPs act as "gatekeepers" to the healthcare system and to use specialists mainly as consultants rather than primary care providers. Regardless of whether this is an appropriate policy, the

physician-to-population ratio in Canada has never been higher, and the number of FPs per capita is higher than in most OECD nations. Although many health systems in developed countries are similar to Canada's, they may differ in the way they are funded, which may impact health system outcomes differently.

Physician productivity

Productivity is key to the labour market, and physicians are no exception. For the purposes of this paper, physician productivity is defined as the number of patient services provided per physician per annum. In Canada, different fee for service (FFS) models, alternate payment plans (APPs) and salary and blended arrangements exist within and among provinces. Ariste (2015) reported that in the FFS model, the volume of services per physician decreased at an average annual rate of 0.6% from 2004 to 2010, indicating that physician productivity had fallen.

Data and Methods

We used data from the Canadian Institute for Health Information's (CIHI) National Physician Database from 1996 to 2019, which include data sets with both FFS and APP payments. However, the data sets include FFS-based services (defined as billable services under the FFS fee code) but not APP services, which have accounted for 20% to 28% of physician payments since 2004 (CIHI 2020a). Physicians were separated into two groups: FPs and specialists (including surgical and non-surgical). To estimate the average and total number of services per 100,000 population and per physician by year, we used Ariste's (2015) method of "same-fee assumption" to estimate the service volume for physicians receiving APP; this is achieved by deflating APP compensation by average FFS fees for physicians in the same specialty. To examine potential reasons for changing productivity, we examined data from the Canadian Medical Association's (CMA) National Physician Health Survey, which published the weekly working hours of physicians from 1998 to 2019 – grouped by sex, age group and specialty – and categorized the work according to direct and indirect (e.g., health committees, managing practice, indirect patient care, research, administration, teaching, continuing medical education and others) patient care activities. We compared the trends of physician payments (total and average per physician) with inflation and the gross domestic product (GDP) in Canada over time and with the median real hourly earnings growth for the average Canadian worker, as well as international physician expenditures.

Results

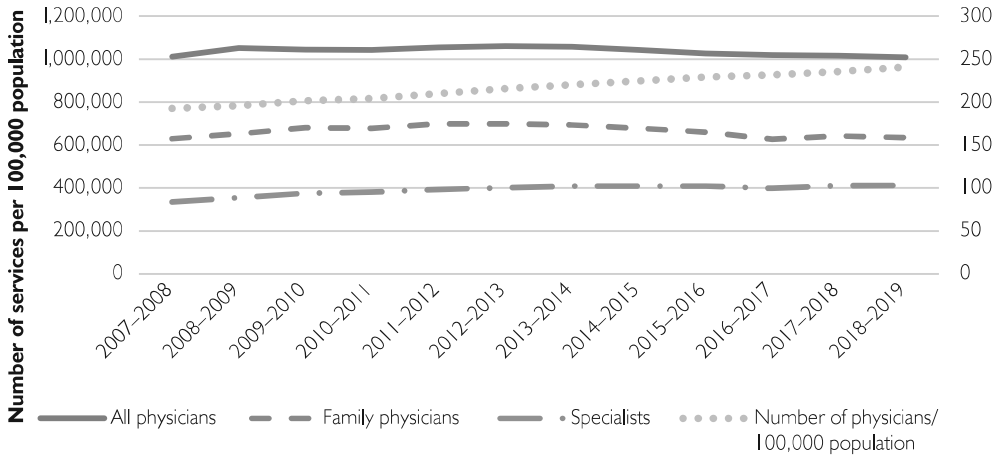
Reduced productivity

PHYSICIAN SERVICES PROVIDED PER CAPITA

Our results show that the number of physician services provided per capita (FFS and APP) has fallen by 5% despite a 7% growth in the number of physicians per capita during the

past five years, from 2014 to 2019 (Figure 2) (CIHI 2020c). The decline in total number of services provided was the greatest among FPs at 9% compared to an increase of 1% for specialists during the same five years. The pattern was similar over a 10-year period from 2008 to 2018, with the number of physician services per capita falling by 4%, while the number of physicians grew by 37%.

FIGURE 2. Number of services versus number of physicians per 100,000 population



PHYSICIAN SERVICES PROVIDED PER PHYSICIAN

Between 2013 and 2018, the number of services provided per physician (FFS and APP) decreased by 13%, with the decrease being greater among FPs (-16%) compared to specialists (-8%). Similarly, over the 10-year period between 2008 and 2018, the number of services provided per physician decreased by 23%, with the decrease greater among FPs (-21%) than among specialists (-4%) (Appendix 1: Figure A1, available online at longwoods.com/content/26655).

Reasons for reduced productivity

WORKING HOURS

Survey data from CMA's National Physician Health Survey from 1998 to 2019 (Figure 3) show that the total weekly working hours for physicians have declined by an average of 9% over the past 21 years (from 51.3 to 46.8 hours/week) (CMA n.d.).

SEX-BASED COMPARISONS

Male physicians report working longer hours than female physicians. Since 1998, there has been an overall decline in the number of weekly hours worked by both male and female physicians; however, the decline has been greater for men (11% vs. 2%) than women (Figure 3).

FIGURE 3. Weekly work hours

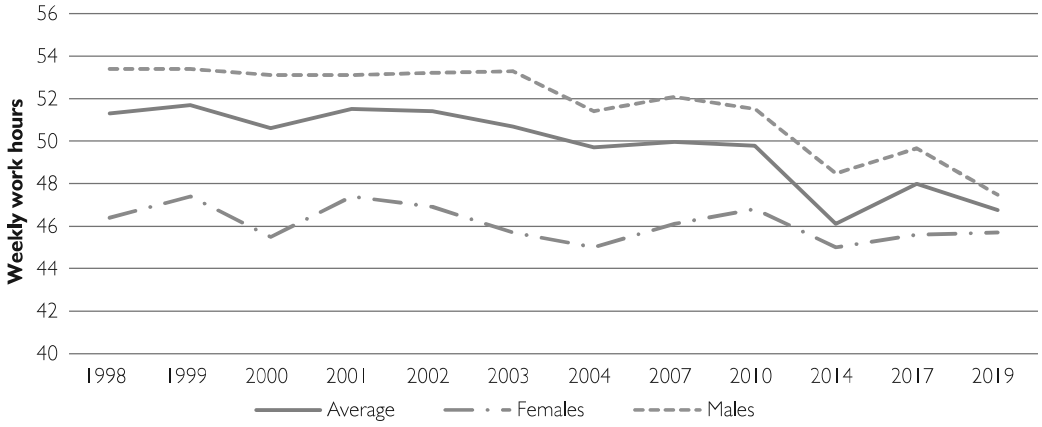


TABLE 1. Growth rate of weekly work hours by category (from 1998 to 2019)

Work activity	Growth rate (%)
Direct patient care	-12
Direct patient care without a teaching component*	-12
Direct patient care with a teaching component*	21
Health committees	-27
Managing your practice	-28
Indirect patient care	61
Research	-21
Administration	-42
Teaching	-10
Continuing medical education	-18
Other	-51

*Data for direct patient care with or without a teaching component are only available from 2004 to 2019.

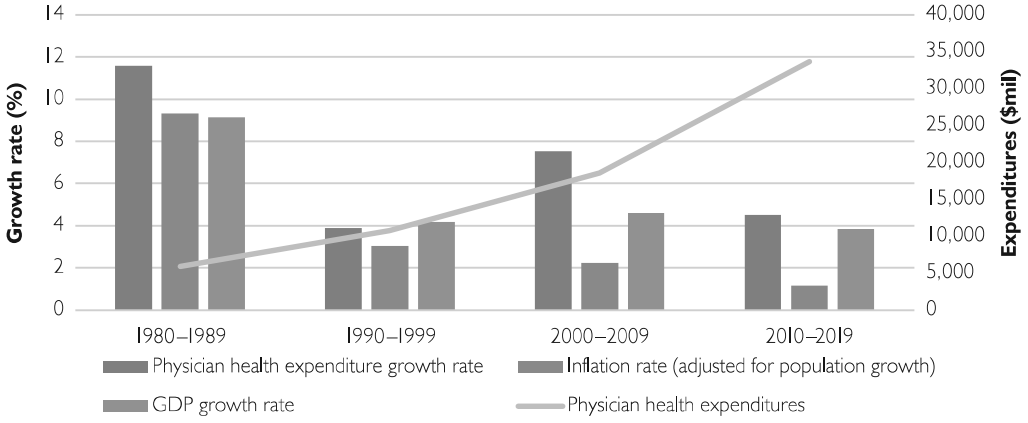
Age

In 1998, the average number of hours worked by physicians increased with age until 65 years, after which it decreased. This pattern has since changed. Physicians of all age groups report reduced working hours (Appendix 1: Figure A2, available online at longwoods.com/content/26655); however, the decline has been greater as age increased until the age of 65 years (in comparison to 1998, the age groups in 2019 reported a decline in working hours of 1% for <35 years, 8% for 35–54 years, 12% for 55–64 years and 5% for 65+ years).

Category of work activity

Table 1 shows categories of physician activity as published by CMA's National Physician Health Survey. Between 1998 and 2019, all categories of physician activity, except indirect

FIGURE 4. Physician health expenditure versus inflation and GDP growth rates



patient care, decreased between 10% and 51%. Most significantly, direct patient care hours decreased by 12%, or 4.5 hours per physician per week, while indirect patient care hours increased by 61%, or 2.8 hours per physician per week.

FPs versus Specialists

Specialists consistently work more hours than FPs; however, both groups have reduced their working hours since 1998 by approximately 8% and 9%, respectively. In 2019, FPs reported working 46 hours/week compared to specialists who reported working 49 hours/week.

Physician compensation: International comparison

In a recent study of healthcare spending in 10 high-income countries, Papanicolas et al. (2018) reported that Canadian physicians are well compensated compared to other countries. Not including the US, FPs in Canada earn more than FPs in any other country except for Germany, while specialists rank only behind those in Australia and the Netherlands (Appendix 1: Figure A3, available online at longwoods.com/content/26655). In addition, among the 31 OECD countries, Canada has some of the highest ratios of physician-to-average-worker income at a ratio of 3.1 for FPs – second only to Germany and on par with the UK – and 4.9 for specialists, on par with France and higher than all other countries apart from Belgium, Chile, Luxembourg and Germany (OECD 2019). The US was not included in the OECD analysis as physician compensation data were unavailable.

Physician compensation growth in Canada

CIHI data from 2019 show that the three largest health expenditure categories since 1975 have been hospitals (27%), physician payments (15%) and drugs (15%) (CIHI 2019). Physician expenditure growth rates have consistently exceeded both inflation (adjusted for population growth) and GDP growth rates, except for a short period in the early 1990s (Figure 4). Between 1999 and 2018, the average gross FFS-based physician income for those earning above

$60,000 increased from $210,812 to $332,233 at an average annual rate of 3.0% compared to the average annual inflation rate of 1.7% (CIHI 2019). Physician expenditure per capita increased by an average of 8% per annum from $408 in 1999 to $1,064 in 2019 (CIHI 2019).

Discussion

Our results show that after a brief slowdown in the early 1990s, physician supply has increased significantly, growing by 63% between 1998 and 2019, and more recently by 37% between 2008 and 2018, resulting in the highest physician–population ratio in Canadian history with 241 physicians/100,000 population by 2019. However, the expected increase in physician service provision has been offset by a dramatic decrease in physician productivity (or services provided) by 23% per physician between 2008 and 2018. The result has been a net increase in total physician services of only 0.2% per annum from 2013 to 2018. With Canada's population growing at just over 1% per annum, this translates into a net decrease of 5% in services per capita between 2013 and 2018. Our results support the "induced productivity decline hypothesis," whereby excess physician compensation beyond a target income induces productivity decline. It is a small wonder that public complaints about long wait times and difficulties with access to physicians have not abated (Brend 2017; Martin et al. 2018).

From the physician survey, we were able to discern the following, albeit an incomplete, picture. The reduction in physician services provided appears to be due to both decreased average physician work hours and changes in the types of work performed. Average physician work hours decreased by 9% or over 4.6 hours/week/physician between 1998 and 2019. The impact on service provision is further compounded by a decrease in direct patient care activities of 12% (or 4.5 hours/week/physician) between 1998 and 2019. In contrast, indirect patient care activities increased by 61% (from 4.5 to 7.3 hours/week/physician). The CMA defines indirect patient care activities as "reports, charting, patient or family phone calls" (CMA 2019b). Several *advances* in medical practice, such as electronic medical records, may improve documentation; however, they almost universally decrease productivity (Howley et al. 2015). Moreover, as the population ages and comorbidities increase, the patients' needs become more complex and require more time (CIHI 2011a; Pereles and Russell 1996).

The significant increase in indirect patient care activities merits further research to better understand why physician activities are changing, what value they provide to patients and how they are being compensated. Crossley et al. (2009) reported that increasing hours of direct patient care by 5% among currently practising physicians would have a greater impact on effective physician supply than large increases in Canadian medical school enrolments. We also observed that between 2008 and 2018, the number of services provided per physician decreased by 21% for FPs and 4% for specialists. It is unclear why the decrease has been especially marked for FPs. It is possible that this may reflect the changing roles and scope of practice of FPs and specialists as medical technologies advance. Chan (2002a) and a CIHI study reported that FP service provision has become less comprehensive (Tepper 2004); that is, FPs are referring more to specialists for services that they would have performed

themselves in the past. Sarma et al. (2018) reported that capitation models (APP) among FPs lead to more specialist referrals. The shift to virtual care in primary care practice during the COVID-19 pandemic on productivity will also need to be monitored once the pandemic is controlled (Glazier et al. 2021).

The reasons for decreased physician productivity are multifactorial and require further research. A major factor underlying decreased work hours may be a shift in attitudes of physicians toward a better work–life balance with reduced working hours and an increased focus on earlier retirement (Malko and Huckfeldt 2017; Weizblit et al. 2009). This is particularly relevant among female physicians, who work fewer hours and take more personal leaves (Weizblit et al. 2009). It is also pertinent in the context of the increasing female enrollment in medical schools, where the male–female ratio has shifted dramatically from 60:40 in the 1980s (Burton and Wong 2004) to 44:56 in 2018 (CMA 2019a). However, male physicians have recently also reduced their working hours to approximate their female colleagues more closely, narrowing the gap from seven hours in 1998 to two hours in 2019. Another important change is the reduction in working hours of older physicians, who traditionally worked more hours than younger physicians. This has since reversed and may be attributable at least in part to the attitudes of a younger generation as they age in the workforce. A greater supply of alternative providers, the development of group practices and the evolution of practice networks have also likely decreased the need for many physicians to work longer hours.

Our finding of rising physician compensation even while physician hours and productivity have decreased is paradoxical. In a comprehensive study of physician compensation, Grant and Hurley (2013) reported that between 2001 and 2010, the average gross income of physicians increased at their fastest rate since the introduction of medicare – rising by 33% from $187,134 to $248,113 (Grant and Hurley 2013). Data from CIHI show that this has since increased to $332,233 in 2018, indicating that gross FFS-based physician income has grown at a faster rate than inflation over the past 19 years (average of 3.0% vs 1.7% per annum) (CIHI 2020c), which is unsustainable when healthcare costs consume an ever-increasing proportion of the GDP. Buys et al. (2019) reported that younger cohorts of physicians received higher annual gross incomes compared to older cohorts at the same age, despite seeing similar or fewer numbers of patients. A study by CIHI (2011b) also reported that growth in physician fees is a major driver that accounts for over half (53%) of physician expenditure increases. At the same time, Ariste (2015) reported that services per physician in Canada decreased by 0.6% annually between 2004 and 2010, and we found that the number of services provided per physician on FFS decreased by 23% between 2008 and 2018, with a greater decrease occurring among FPs (-21%).

Some provinces have tried to reform primary care by trialling variants of the APP model using salaried, capitated or blended capitation variants, in part, to see whether these interventions improved care and cost efficiency compared to the FFS model. In Alberta, primary care networks (PCNs) were established in 2005, with physicians receiving either FFS-based or capitated payments (Peckham et al. 2018), and have been shown to lead to

decreased emergency department visits and hospital stays (McAlister et al. 2018), as well as better management of chronic diseases (Manns et al. 2011). However, several reviews of PCNs found an inconsistency in financial management and accountability (Peckham et al. 2018), and it is unclear whether there is a relationship between outcomes and FFS-based or capitation funding models. In Ontario, FFS-based physicians had higher productivity than APP-based physicians (Sarma et al. 2010), but through longer working hours and more time spent on direct patient care (Laberge et al. 2016), that is, financial incentives increased productivity. Marchildon and Hutchison (2016) reported that team-based capitation models provided better preventive care and chronic care management, although patient-reported outcomes were unchanged. Laberge et al. (2017) reported that enhanced FFS models using physician-based teams had the lowest primary care and total healthcare costs, whereas blended capitation models using multidisciplinary or physician-based teams were associated with higher primary care costs but lower total healthcare costs than FFS models. However, the annual report of the Office of the Auditor General of Ontario (2016) found that the patient enrolment model is more expensive than the FFS model, and the Ontario Ministry of Health and Long-Term Care could not demonstrate whether the new models improved patient access, quality of care or cost-effectiveness. Thus, primary care costs have increased with the reforms, although this may be offset by lower total healthcare costs per patient (Laberge et al. 2017). To date, various attempts to reform primary care have not led to significant changes in total physician expenditures.

In a recent study, Uguccioni (2016) described a "wage–productivity gap" in which median real hourly earnings grew by only 0.09% per annum for the average Canadian worker between 1976 and 2014, while productivity grew by 1.12%. The situation is reversed for physicians in Canada, where average gross FFS-based income increased by 20%, while productivity decreased by 23% between 2008 and 2018; that is, the price per service has increased significantly. This "reverse wage–productivity gap" lies at the heart of the failure to increase physician services through increasing physician supply and compensation. It is possible that the "induced productivity decline hypothesis" is at play, with physicians reducing services when compensation exceeds their income targets. It is also possible that governments are politically ill-equipped to deal with the monopoly power of physicians to set fee increases, and alternate strategies are needed to control physician expenditures. Physicians have a right to work less, but compensation should be based on a combination of productivity, quality of care and outcomes. Rising physician compensation also contributes to the increasing income inequality between the top 1% of earners and the average Canadian worker (Marchildon and Di Matteo 2014) and must be addressed by policy makers to ensure sustainability of the public healthcare system.

Finally, Canadian physicians are well compensated compared to physicians from other developed countries. Canadian physicians are among the best compensated in the OECD countries with reported data, with an average gross FP income of $163,000 (US$, Purchasing Power Parity [PPP]) (versus an OECD average of $127,000) and an average

gross specialist income of $257,000 (US$, PPP) (versus an OECD average of $231,000) for self-employed physicians in 2016 (OECD 2020b). Canadian physicians also have one of the highest ratios of physician-to-average-worker incomes at 3.1 for FPs and 4.9 for specialists, ranking Canada second and fifth highest, respectively, among 31 OECD countries (OECD 2019). In addition, physician expenditure growth rates have consistently exceeded inflation and GDP growth rates, which is financially unsustainable for the publicly funded healthcare system. To improve availability of physician services, it is imperative that governments understand the implications of the "induced productivity decline hypothesis" and address the physician "reverse wage–productivity gap" rather than rely on the current strategy of increasing both physician supply and compensation because it is not yielding the intended benefits and is financially unsustainable.

Policy Options

Having examined physician supply, productivity and physician availability, we now discuss policies for managing physician supply and demand. Our analysis highlights the importance of simultaneously addressing the twin problems of physician compensation increase and productivity decline. As previous research has demonstrated that systems with higher rates of private financing are negatively associated with universality, equity, accessibility and quality of care (Lee et al. 2021), private financing of healthcare is not a solution. Physician expenditure increases should be constrained by principle-based criteria (e.g., no more than either the rate of inflation or GDP growth). Physician compensation should be linked to productivity and important patient-centred outcomes such as evidence-based care and health outcomes. Healthcare processes such as documentation and referrals should be automated and streamlined to improve productivity, and reimbursement for indirect patient care services should be based on value to patients. Physician productivity may be increased by greater use of extenders such as physician assistants. In the case of primary care, alternate care providers, such as nurse practitioners and pharmacists, should be licensed and funded to practise independently. Primary care teams may improve care and reduce total health costs but their relationship with funding models is unclear and should be monitored and adjusted. Primary care fund-holding organizations based on geography could be employed to improve efficiency and distribution of physicians (Price et al. 2015).

Limitations

There are a number of limitations to our study. As APPs comprise 20% to 28% of physician expenditures, using "same fee assumptions" based on FFS service levels may be inaccurate. The data analyzed from the CIHI National Physician Database do not include anaesthesia, laboratory and imaging specialists, and services/capita calculations do not include data from Alberta or the Territories, which may bias the results. Overhead costs of physicians were not available. Physician productivity measures are impacted by the value and mix of

services provided, which change over time. Because the dollar value assigned to each service is determined through a bargaining process between the government funders and the medical associations at the provincial level, it may not reflect the true value that patients place on the services. Patient complexity is not measured in any of these databases, which varies widely by practice and location. Response rates for the CMA National Physician Health Surveys averaged 40% of a random sampling of 8,000 physicians across the country from 1998 to 2004 and 20% of all physicians between 2004 and 2019 and may not be generalizable to all physicians.

Conclusion

Although physician supply in Canada has increased significantly in recent decades, physician productivity has decreased, resulting in a net reduction of physician services per capita. At the same time, physician compensation has increased, resulting in a "reverse wage–productivity gap" of more physicians, higher compensation and fewer services, which supports the "induced productivity decline hypothesis." The current physician supply and compensation strategies do not improve physician availability, are not patient-focused, are not financially sustainable and need to be addressed comprehensively at a policy level.

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EXHIBIT 17

Research

Long-term trends in the work hours of physicians in Canada

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Abstract

Background: Physician work hours directly influence patient access to health care services and play a vital role in physician human resource planning. We sought to evaluate long-term trends in hours worked by physicians in Canada, overall and by subgroup.

Methods: We used Statistics Canada's Labour Force Survey to identify physicians via occupation and industry coding information. We estimated descriptive statistics and performed graphical analysis of the average weekly hours worked by physicians over the 1987–2021 period.

Results: Overall, weekly physician work hours remained stable from 1987 until 1997, after which they declined. Average weekly hours decreased by 6.9 hours ($p < 0.001$), from 52.8 in 1987–1991 to 45.9 in 2017–2021. Among male physicians, work hours declined notably after 1997, while those of female physicians remained relatively stable at around 45 per week. Hours worked by married physicians declined significantly, amounting to 7.4 fewer hours per week ($p = 0.001$). In contrast, unmarried physicians displayed a statistically insignificant decline of 2.2 hours ($p = 0.3$). The COVID-19 pandemic was associated with a sharp but brief disruption in weekly hours; by the end of 2020, physicians' work hours had returned to prepandemic levels.

Interpretation: These findings may indicate a long-term shift in work preferences among Canadian physicians; male physicians may be seeking a better work–life balance, which, in turn, has narrowed the gap in hours worked by sex, with potential implications for pay equity. Policymakers and planners should carefully consider changes in hours worked, rather than just the total number of physicians, to ensure an accurate evaluation of the physician workforce.

Physician work hours directly influence patient access to health care services and play a vital role in physician human resource planning, but the current understanding of work hour trends among physicians in Canada is limited. Changes in the work patterns of physicians can affect the effective supply of physician services and, subsequently, patients' access to care. Traditionally, physician workforce planning, and health workforce planning broadly, has focused on demographic considerations, evaluating the age and sex composition of the workforce to determine the supply required to replace retiring professionals.[1] Examples of such planning models in Canada include the Canadian Medical Association's Physician Resources Evaluation Template and the Ontario Ministry of Health's Assessing Doctor Inventories and Net-Flows models.[2,3]

In absolute terms and adjusted for population, the existing physician supply is considered high compared with previous years, but people in Canada are encountering challenges in accessing physician services.[4,5] As seen in the United States, current difficulties may not stem from changes in physicians per capita (i.e., extensive margin) but rather from decreases in physician labour supply (i.e., intensive margin), specifically, the number of hours worked per physician and its impact on service availability.[6] Several explanations for the decline in hours have been posited, including that physicians may be seeking improved work–life balance[6,7] or are reducing work hours in association with increased remuneration.[8] Traditional planning models have primarily focused on the extensive margin. To enhance the effectiveness of these models, a broader range of behavioural factors that underpin labor market choices should be incorporated, including hours worked.[7,9,10]

Most of the available information on hours worked has derived from surveys conducted by the Canadian Medical Association and affiliated organizations.[11] However, these surveys suffer from inconsistent survey instruments or methodologies and irregular or infrequent data collection, impeding rigorous analysis of trends. One notable study, focusing on direct patient care hours provided by family physicians, observed a secular decline in hours worked from 1982 to 2003.[12]

Incorporating work hour trends into planning models can provide insights to inform the medical profession, the public,

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and governments. We sought to evaluate long-term trends in work hours for physicians in Canada, overall and by subgroup, particularly by sex.

Methods

Study design and setting

We employed annual cross-sectional data sets from Canada, spanning 1987 to 2021, to evaluate temporal trends in physician work hours. These data sets incorporated individual-level data on hours, alongside a range of physician characteristics.

Data sources

Our analysis employed data on demographics and hours worked from Statistics Canada's Labour Force Survey (LFS), a mandatory monthly survey that sampled about 54 000 households (110 000 people) in 2020. Respondents were interviewed in 6 successive months, typically mid-month; we employed the first interview for each respondent.[13] We accessed and analyzed the confidential LFS master file (person-level data) through the Statistics Canada Research Data Centre (RDC) at McMaster University. We aggregated monthly files into annual ones. Hours of work were self-reported and collected in a consistent framework (Appendix 1, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.231166/tab-related-content).

The first part of our analysis covered the period from 1987 to 2019. We also evaluated trends during the COVID-19 pandemic with quarterly data covering January to March 2020 (Q1) to October to December 2021 (Q4), compared with prepandemic data. We used corresponding quarters averaged over 2015–2019 for comparison rather than 2019 only to provide a more statistically stable basis for comparison. We employed sampling weights provided by Statistics Canada.

Using the LFS to analyze physicians is not common, but we are aware of 1 recent study using this rich data source.[10]

Trends in physician income

To study whether trends in hours worked were coincident with trends in physician incomes, we constructed indices based on annual data from the Canadian Institute for Health Information (CIHI) on physician payments and supply.[14] We calculated annual average payments by dividing total physician payments by the number of physicians, and adjusted average payments for inflation using the all-item Consumer Price Index.[4,15] We calculated hourly payment rates using data on hours worked from the LFS and assumed that physicians worked 48 weeks per year. Payment data from CIHI spanned 1990 to 2019, and did not disaggregate by sex.

Statistical analysis

We estimated descriptive statistics and performed graphical analysis of hours worked per week by physicians in Canada. We determined average hours worked in 4 5-year blocks during the 35-year study period (1987–1991, 1997–2001, 2007–2011, 2017–2021). We also created figures showing mean weekly hours worked, calculated annually and reported as 3-year centred moving averages to smooth idiosyncratic oscillations (e.g., the 2000 estimate is the average of 1999, 2000, and 2001). We estimated the overall trend and, to identify associated variables, trends for various subgroups by sex, specialty, work status, marital status, or region. We tested whether the mean hours worked during the latest 5-year period (2017–2021) were equal to those of the first 5-year period (1987–1991) using univariate ordinary least squares regression with heteroskedasticity-consistent standard errors and LFS weights. We performed statistical analyses using STATA version 17.0 SE.

Ethics approval

Our analysis did not require institutional review board approval because the microdata were handled within an RDC.

Results

Table 1 depicts the characteristics of physicians in Canada over the past 3 decades. The proportion of female physicians doubled from 1987–1991 to 2017–2021, and that of self-employed and incorporated physicians tripled. The proportion of physicians with young children (aged ≤ 5 yr) declined, as did the percentage of married physicians. Mean hours worked per week by physicians — shown as a 3-year moving average in Figure 1 and reported at 5-year intervals in Table 2 — changed markedly during the sample period ($p < 0.001$). The 3-year moving average of physician weekly hours worked dropped 13.5%, from 52.7 (95% confidence interval [CI] 50.6–54.8) hours per week in 1988 to 45.6 (95% CI 44.3–46.9) hours per week in 2019. Weekly hours worked by female, and especially male, physicians remained fairly flat until the mid-1990s, although the overall average declined slightly as the proportion of female physicians increased (Figure 1). Starting around 1997, the average hours worked by male physicians declined markedly, although the rate of decrease fluctuated and the trend was not monotonic.

Table 2 provides data on mean weekly hours worked across several physician characteristics. Overall, the decline from 1987–1991 to 2017–2021 totaled 6.9 hours per week or 13.0% ($p < 0.001$). Declines were recorded for both family physicians and other specialists ($p < 0.001$). We observed no discernable differences in the declines in weekly hours for physicians in urban versus rural locations, those who were incorporated versus unincorporated, those aged 45 years or younger versus those older than 45 years, and those with versus without children aged 5 years or younger.

Trends by sex and marital status

Notable differences were evident in the work patterns of male and female physicians (Figure 1). Although the work hours of male physicians decreased markedly after 1997, no decline was observed among their female counterparts, whose hours remained relatively stable at around 45 hours per week. From 2003 onwards, female physicians' work hours declined slightly to around 43 hours per week, a level that persisted until 2019. Overall, the mean weekly hours worked by male physicians

Table 1: Physician workforce characteristics in Canada, 1987–2021

Characteristic	No. (%) of physicians*			
	1987–1991 *n* = 1769	1997–2001 *n* = 2419	2007–2011 *n* = 3187	2017–2021 *n* = 3425
Tenure†, yr, mean ± SD	12.1 ± 10.8	12.5 ± 10.6	13.5 ± 11.0	11.7 ± 11.4
Age, yr, mean ± SD	43.3 ± 11.7	44.6 ± 11.6	47.3 ± 12.1	46.2 ± 12.7
Sex, female	416 (23.5)	798 (33.0)	1131 (35.5)	1534 (44.8)
Family physician	973 (55.0)	1414 (58.5)	1697 (53.1)	2063 (60.2)
Full-time employment‡	1642 (92.8)	2213 (91.5)	2914 (91.4)	3128 (91.3)
Married	1623 (91.8)	2098 (86.7)	2582 (81.0)	2724 (79.5)
Based in Ontario	733 (41.4)	935 (38.6)	1276 (40.0)	1538 (44.9)
Urban location§	NA	2115 (87.4)	2813 (88.3)	3098 (90.4)
Self-employed and incorporated	297 (16.8)	362 (15.0)	1094 (34.3)	1745 (50.9)
Child aged ≤ 5 yr	401 (22.7)	565 (23.4)	615 (19.3)	616 (18.0)
Born in Canada	NA	NA	1971 (61.8)	2043 (59.7)

Note: NA = not available, data not collected by Statistics Canada's Labour Force Survey during this period; SD = standard deviation.
*Unless indicated otherwise.
†Tenure is defined as years in current job.
‡Full-time employment is defined as working 30 hours per week or more.
§Rural or urban location in the Labour Force Survey follows the Canadian census definitions.



Figure 1: Three-year moving average of physician weekly hours worked, by sex.

decreased by 7.5 hours or 13.6% ($p < 0.001$), while females exhibited a statistically insignificant decline of 1.0 hour ($p < 0.3$). The decline in overall weekly hours worked represented a combination of the decline for each sex, and the changing sex composition of the workforce. We calculated that the overall decrease in work hours was predominantly driven by male physicians, accounting for 5.7 of the 6.9-hour decline or 83% of the reduction. Consequently, the gap in weekly hours worked by sex, which was around 10 hours in the mid-1990s, narrowed to about 4 hours by 2019.

Table 2 (part 1 of 2): Mean hours worked per week by physicians in Canada, 1987–2021*

		1987–1991		1997–2001		2007–2011		2017–2021		
Group	Total no. of physicians	No. of physicians	Hours per week, mean (95% CI)	No. of physicians	Hours per week, mean (95% CI)	No. of physicians	Hours per week, mean (95% CI)	No. of physicians	Hours per week, mean (95% CI)	Change from 1987–1991 to 2017–2021, h (%)
All physicians	10 800	1769	52.8 (51.9–53.6)	2419	50.4 (49.7–51.2)	3187	47.5 (46.9–48.2)	3425	45.9 (45.3–46.5)	−6.9 (−13.0)¶
Sex										
Male	7105	1399	55.2 (54.3–56.2)	1687	53.2 (52.3–54.2)	2106	49.7 (48.9–50.5)	1913	47.7 (46.9–48.5)	−7.5 (−13.6)¶
Female	3695	370	44.7 (43.0–46.5)	732	44.7 (43.4–46.0)	1081	43.5 (42.4–44.6)	1512	43.7 (42.8–44.6)	−1.0 (−2.3)
Marital status										
Married	9205	1667	53.1 (52.2–54.0)	2150	50.9 (50.1–51.7)	2638	47.8 (47.1–48.6)	2750	45.7 (45.0–46.4)	−7.4 (−14.0)¶
Not married	1595	102	49.1 (45.7–52.6)	269	47.4 (45.2–49.6)	549	46.1 (44.6–47.6)	675	46.9 (45.4–48.4)	−2.2 (−4.6)
Marital status by sex										
Married male	6299	1323	55.4 (54.4–56.4)	1541	53.8 (52.8–54.8)	1833	50.0 (49.1–50.9)	1602	47.5 (46.6–48.4)	−7.8 (−14.8)¶
Not married male	806	76	53.6 (49.9–57.2)	146	48.6 (45.5–51.8)	273	48.1 (46.0–50.2)	311	48.5 (46.3–50.7)	−5.1 (−9.5)
Married female	2906	344	45.5 (43.7–47.3)	609	44.5 (43.0–45.9)	805	43.3 (41.9–44.6)	1148	43.2 (42.2–44.3)	−2.3 (−5.0)
Not married female	763	NAS	–	123	45.9 (42.9–48.9)	276	44.2 (42.1–46.3)	364	45.3 (43.3–47.3)	–
Physician type										
Family physician	6301	1011	53.0 (51.8–54.2)	1431	49.8 (48.8–50.7)	1796	47.7 (45.8–47.5)	2063	45.1 (44.3–45.9)	−7.9 (−14.9)¶
Other specialist	4999	758	52.5 (51.2–53.7)	988	51.4 (50.0–52.7)	1391	48.5 (47.5–49.5)	1362	47.2 (46.2–48.2)	−5.3 (−10.1)¶
Employment†										
Full-time	9930	1657	55.1 (54.3–55.9)	2218	53 (52.3–53.8)	2930	49.8 (49.2–50.5)	3125	48.1 (47.5–48.8)	−7.0 (−12.6)¶
Part-time	870	112	22.9 (20.8–25.1)	201	22.2 (20.6–23.8)	257	22.9 (21.3–24.5)	300	22.5 (21.0–24.0)	−0.4 (−1.8)
Location‡										
Urban	9288	NA	–	1987	50.4 (49.6–51.3)	2663	47.5 (46.8–48.2)	2869	45.8 (46.8–48.2)	–
Rural	1512	NA	–	432	50.4 (48.4–52.4)	524	47.5 (45.8–49.3)	556	46.9 (45.2–48.6)	–
Incorporation status										
Incorporated	3689	323	54.5 (52.4–56.5)	379	53.4 (51.4–55.5)	1205	50.1 (49.0–51.1)	1782	47.3 (46.4–48.1)	−7.2 (−13.2)¶
Not incorporated	7111	1446	52.4 (51.5–53.4)	2040	49.9 (49.1–50.7)	1982	46.2 (45.3–47.1)	1643	44.5 (43.6–45.4)	−7.9 (−15.1)¶
≤ 45 yr	5488	1099	53.9 (52.8–55.0)	1334	51.4 (50.4–52.4)	1409	47.7 (46.7–48.7)	1646	47.0 (46.1–47.9)	−6.9 (−12.8)¶
> 45 yr	5312	670	50.9 (49.5–52.4)	1085	49.1 (47.9–50.3)	1778	47.4 (46.5–48.3)	1779	44.8 (43.9–45.7)	−6.1 (−12.1)¶

Table 2 (part 2 of 2): Mean hours worked per week by physicians in Canada, 1987–2021*

		1987–1991		1997–2001		2007–2011		2017–2021		
Group	Total no. of physicians	No. of physicians	Hours per week, mean (95% CI)	No. of physicians	Hours per week, mean (95% CI)	No. of physicians	Hours per week, mean (95% CI)	No. of physicians	Hours per week, mean (95% CI)	Change from 1987–1991 to 2017–2021, h (%)
Young children										
Child ≤ 5 yr	2307	450	53.2 (51.4–54.9)	583	49.2 (47.6–50.8)	617	47.7 (46.2–49.2)	657	45.1 (43.6–46.5)	−8.1 (−15.3)¶
No child ≤ 5 yr	8493	1319	52.6 (51.7–53.6)	1836	50.8 (49.9–51.7)	2570	47.5 (46.7–48.2)	2768	46.1 (45.4–46.8)	−6.5 (−12.4)¶
Region										
Manitoba and Saskatchewan	1567	274	61.0 (58.4–63.6)	299	53.8 (51.3–56.2)	472	50.7 (48.9–52.5)	522	44.8 (43.1–46.5)	−16.2 (−26.5)¶
Atlantic§	1896	355	58.1 (56.0–60.3)	419	54.2 (52.4–56.1)	596	49.9 (48.3–51.5)	526	48.5 (46.7–50.3)	−9.6 (−16.6)¶
British Columbia	1252	162	55.8 (52.8–58.9)	257	51.2 (48.6–53.8)	424	46.9 (45.1–48.6)	409	42.7 (41.0–44.3)	−13.1 (−23.6)¶
Alberta	892	195	54.2 (51.4–57.0)	151	52.1 (48.9–55.4)	235	49.4 (46.6–52.2)	311	46.2 (44.0–48.3)	−8.0 (−14.8)¶
Ontario	3249	451	52.1 (50.5–53.8)	774	51.3 (49.9–52.7)	942	46.5 (45.2–47.7)	1082	46.6 (45.5–47.7)	−5.5 (−10.6)¶
Quebec	1944	332	48.2 (46.7–49.7)	519	46.9 (45.5–48.4)	518	47.4 (45.9–49.0)	575	46.2 (44.7–47.7)	−2.0 (−4.2)

Note: CI = confidence interval; NA = not available, data not collected; NAS = not available, sample size is below Statistics Canada's minimum observation release restriction.
*Means and 95% CIs were calculated using survey weights; the number of physicians are unweighted counts.
†Full-time employment is defined as working 30 hours per week or more. Part-time employement is defined as working less than 30 hours per week.
‡Rural or urban location in the Labour Force Survey follows the Canadian census definition.
§Atlantic region includes Newfoundland, Prince Edward Island, Nova Scotia, and New Brunswick.
¶$p < 0.001$.

We also observed diverging trends between married and unmarried physicians by sex (Table 2). The weekly work hours of married physicians declined significantly, amounting to 7.4 hours or 14.0% ($p < 0.001$). Within the subset of married physicians, the primary driver of the decline was male physicians, who exhibited a reduction of 7.8 hours or 14.8% ($p < 0.001$). The estimated 2.3-hour reduction in weekly hours among married females was not statistically significant.

Regional variation in trends

The regional data revealed notable disparities in both average weekly hours worked at the beginning of the study period and the extent of declines observed until 2019. In 1987–1991, the average weekly hours worked varied considerably across regions, ranging from a low of 48.2 hours in Quebec to a high of 61.0 hours in Manitoba and Saskatchewan. However, this disparity narrowed significantly over time. By 2017–2021, the range spanned from 42.7 hours in British Columbia to 48.5 hours in the Atlantic region. All regions had double-digit percentage decreases in weekly hours, except for Quebec, where time worked declined by only 2.0 hours or 4.2% ($p = 0.08$). Other regions gradually converged toward the level of hours worked by physicians in Quebec and inter-regional differences declined over time.

Impact of the COVID-19 pandemic

Figure 2 illustrates the weekly hours worked by physicians, by sex, following the onset of the COVID-19 pandemic. The overall reduction in hours worked in the second quarter of 2020 was about 15%, with a 20% decline observed among female physicians ($p < 0.001$) compared with the 11% ($p < 0.001$) decline observed for their male counterparts. However, this decline in hours worked was temporary. By the end of 2020, hours had fully recovered to prepandemic levels. Hours worked since the end of 2020 were not significantly different from the corresponding 2015–2019 levels for all physicians, male and female (Appendix 2, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.231166/tab-related-content).

Trends in payment

During the 1990s, average physician payments on an hourly and annual basis were relatively stable, closely matching inflation (Figure 3). However, from about 2000 to 2010, physician payments showed rapid growth, increasing by about 65% on an inflation-adjusted hourly basis and about 45% on an inflation-adjusted annual basis. Since 2010, inflation-adjusted payments declined slightly on an annual basis and were close to flat on an hourly basis. The past 3 decades saw periods of both increased



Figure 2: Physician weekly hours worked during the COVID-19 pandemic relative to 2015–2019 average. Note: Q1 = January–March, Q2 = April–June, Q3 = July–September, Q4 = October–December.

and stable average physician payments, even though the average weekly hours worked by physicians have consistently declined overall.

Interpretation

We observed that male physicians have been working fewer hours per week over the last 3 decades, representing a change in the intensive margin of physician labour supply. In contrast, work hours among female physicians have declined nonsignificantly. Declining hours worked does not appear to coincide with a decline in earnings.

Medicine has historically exhibited a culture of long hours of work, with an expectation of round-the-clock availability, which has contributed to unhealthy work environments. Although we did not not attempt to determine the causes behind the decrease in physicians' work hours, we propose that a shift in male physicians' preferences toward achieving better work–life balance is an important contributing factor. The question of whether these trends are related to physician burnout is relevant. Characterized by emotional exhaustion, depersonalization, detachment from work, and reduced personal accomplishment,[16–19] burnout can lead to negative effects on health, lower productivity, reduced work hours, and even exiting medical practice.[20] A recent study of Ontario physicians cited improved work–life balance among the top 3 potential solutions to burnout.[21] Even after the observed decline, compared with the entire Canadian workforce, physicians worked more hours per week. In 1987, workers aged 25 years and older who were employed full-time reported working 41.4 hours weekly in their main job; this declined by 4.6% to 39.5 hours by 2021.[22] Relative to other full-time workers, in 2021, physicians worked about 20% more hours per week. We speculate that, in part, the decline in working hours may be a response to burnout.[23]

Declining physician work hours is not unique to Canada. Comparable trends exist in the United States,[24] where average weekly physician hours dropped 7.6% between 2001 and 2021, predominantly because of the decline in hours worked by male physicians,[6] and in the United Kingdom, where average hours for general practitioners and hospital-based physicians dropped by 25% and 21%, respectively, between 1998 and 2020.[25] Similar observations in jurisdictions with different health care systems support our suggestion that these trends reflect a cultural shift, primarily among male physicians, toward more balanced home and work lives.

Another potential explanation for the decrease in physician hours could be the impact of payment increases exceeding target incomes.[8] Like others, physicians make decisions regarding time allocation between work and other pursuits. The effect of hourly pay raises on these decisions can vary depending on individual preferences, resulting in either an increase in working hours (substitution effect) or a decrease in working hours (income effect).[26] However, we found no evidence that increased physician payments and the resulting income effect contributed to reduced work hours. The decline in work hours occurred in periods of both rising and stable payments. The way forward will likely involve policy-makers increasing the size of the medical workforce — including physicians and other occupations involved in interdisciplinary care — faster than population growth to accommodate historical and potential future hour

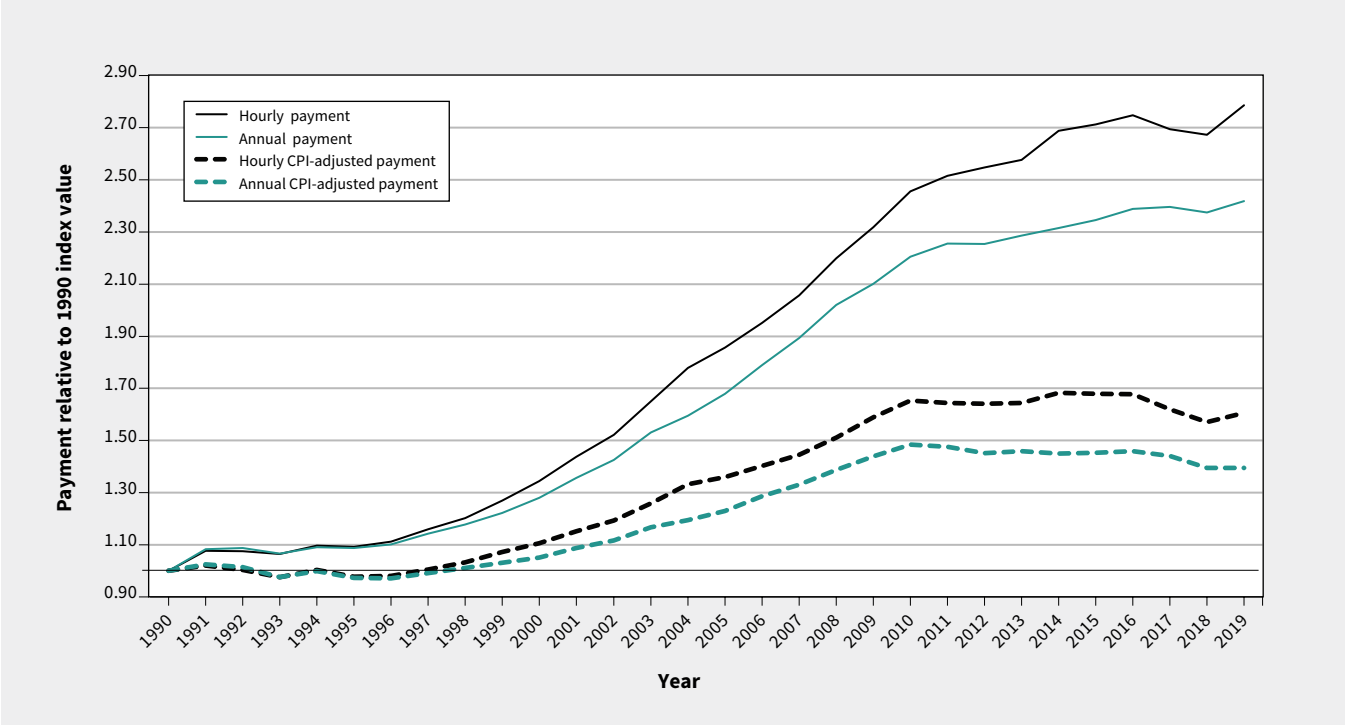


Figure 3: Average real annual and hourly payment per physician relative to 1990 index value. Note: CPI = Consumer Price Index.

reductions (and increasing demand from an aging population).[10]

Evidence documents an earnings gap between female and male physicians; in Canada, female physicians earn about 10%–15% less than their male counterparts.[27] The convergence in hours worked by sex will need to be considered in policies aimed at narrowing disparities in pay by sex. The gap in pay should have narrowed with the gap in hours.

More research is needed to establish the causes of declining hours and the resultant supply of physician services, as well as related changes in physician labour market behaviours, such as retirement ages.

Limitations

Although Statistics Canada's LFS has the advantage of being consistently defined and implemented, it measures self-reported hours of work and does not allow direct patient care to be disaggregated from, for example, administration and research. Measuring hours worked does not account for technological advances that may have improved physician efficiency and offset any decrease in patient access. Although the LFS provides estimates from a sample, and therefore should not be expected to match CIHI's counts exactly, it appears to systematically overestimate the share of physicians who are family physicians. For illustrative purposes, CIHI reported that 52% of all practising physicians were family physicians in 1987; this proportion was 50% in 2021.[5] In contrast, the LFS estimates in the relevant periods were 55% and 60%, respectively. We speculate that physicians who responded to the relevant occupation question with full information were correctly coded. However, some respondents may have provided limited or incomplete information, in which case they were coded as family physicians. Furthermore, the LFS is limited to these 2 broad specialty categories whereas a finer specialty-level examination would be informative. More broadly, although we limited the sample to those who reported working as practising physicians, some misclassification may be present. We do not know how any such misclassification may have evolved over time or their effect on our trend estimates.

Conclusion

Physicians continue to work longer hours than the average of the Canadian workforce, but over the last 3 decades, work hours have decreased among male physicians. Policy-makers and health workforce planners should consider the hours worked by physicians, rather than relying on counts of practitioners. Given reasonable expectations regarding productivity, the medical workforce likely needs to increase in size to offset the decline in work hours while gender pay equity in medicine should be addressed. Policy-makers and health workforce planners can leverage the timely LFS time-series data to monitor physician work patterns.

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EXHIBIT 18

RESEARCH

Trends in prevalence of chronic disease and multimorbidity in Ontario, Canada

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ABSTRACT

BACKGROUND: New case-mix tools from the Canadian Institute for Health Information offer a novel way of exploring the prevalence of chronic disease and multimorbidity using diagnostic data. We took a comprehensive approach to determine whether the prevalence of chronic disease and multimorbidity has been rising in Ontario, Canada.

METHODS: In this observational study, we applied case-mix methodology to a population-based cohort. We used 10 years of patient-level data (fiscal years 2008/09 to 2017/18) from multiple care settings to compute the rolling 5-year prevalence of 85 chronic diseases and multimorbidity (i.e., the co-occurrence of 2 or more diagnoses). Diseases were further classified based on type and severity. We report both crude and age- and sex-standardized trends.

RESULTS: The number of patients with chronic disease increased by 11.0% over the 10-year study period to 9.8 million in 2017/18, and the number with multimorbidity increased 12.2% to 6.5 million. Overall increases from 2008/09 to 2017/18 in the crude prevalence of chronic conditions and multimorbidity were driven by population aging. After adjustments for age and sex, the prevalence of patients with ≥ 1 chronic conditions decreased from 70.2% to 69.1%, and the prevalence of multimorbidity decreased from 47.1% to 45.6%. This downward trend was concentrated in minor and moderate diseases, whereas the prevalence of many major chronic diseases rose, along with instances of extreme multimorbidity (≥ 8 conditions). Age- and sex-standardized resource intensity weights, which reflect relative expected costs associated with patient diagnostic profiles, increased 4.6%.

INTERPRETATION: Evidence of an upward trend in the prevalence of chronic disease was mixed. However, the change in case mix toward more serious conditions, along with increasing patient resource intensity weights overall, may portend a future need for population health management and increased health system spending above that predicted by population aging.

Multimorbidity exists when a patient is diagnosed with 2 or more chronic diseases. Patients with multimorbidity present challenges for physicians managing their care and, as the proportion of these patients in the population increases, for health care system planning. The prevalence of multimorbidity and chronic disease has been strongly associated with primary care use, specialist consultations, number and intensity of inpatient hospital admissions and other types of care.[1–7] Among beneficiaries of fee-for-service Medicare in the United States, expenditures for those with 4 or more chronic diseases were reported to be 66 times higher than for those with none.[8] One study found that most health spending growth (77.6%) in the US between 1987 and 2011 could be attributed to patients with 4 or more diseases.[9]

Several recent studies have estimated the prevalence of chronic disease and multimorbidity in Canada.[3,10–13] Rates of multimorbidity ranged from 10% to 25%, owing to differences in classification systems used to identify chronic disease, including the choice of conditions, and variations in study population. Lack of standardization in measures of chronic disease prevalence and multimorbidity has hampered the evaluation of trends over time and across settings.

Ontario provides an ideal setting to evaluate trends in the prevalence of chronic disease because patients have access to a comprehensive set of publicly funded services. The Canadian Institute for Health Information (CIHI) has created a system that maps patient diagnosis data from all health care settings to a set of 226 clinically meaningful health conditions, covering the full spectrum of acute and chronic morbidity (Jeffrey Hatcher, Canadian Institute for Health Information, Ottawa: personal communication, 2017). CIHI's system has been independently compared with the Johns Hopkins ACG System; CIHI's system was deemed to be more specific and less sensitive in classifying diagnoses, making it more conservative in identifying health

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conditions (S. Cheng, ICES, unpublished data, 2016). The purpose of this study was to evaluate trends in the prevalence of chronic disease and multimorbidity in Ontario using CIHI's comprehensive disease classification system.

Methods

Study design and data sources

We evaluated population trends in the prevalence of chronic disease, multimorbidity and overall patient resource intensity in Ontario, Canada, from fiscal years 2008/09 to 2017/18. We obtained individual-level health care data from the Ontario Ministry of Health and we used CIHI's Population Grouping Methodology (version 1.1) software under a licence agreement.

We used the Registered Persons Database (RPDB) to assess eligibility for inclusion in the study population. We then linked the study population to the following Ontario health care administrative databases at the individual level, using unique encrypted identifiers: CIHI's Discharge Abstract Database (DAD), which contains records from hospital discharges; CIHI's National Ambulatory Care Reporting System (NACRS), which includes data from day surgeries, outpatient and community-based clinics and emergency departments; and the Ontario Health Insurance Plan (OHIP) claims database, which consists of physician billing records. Each data source contains diagnostic information that is used by CIHI's Population Grouping Methodology.

Study population

Beginning with people listed in the RPDB, we limited the study population to those who were eligible for OHIP coverage in 1 or more of the fiscal years (FYs), from 2008/09 (FY 2008) to 2017/18 (FY 2017). We excluded people older than 105 years at the end of a given fiscal year. Individuals were required to have had at least 1 health system contact within the previous 5 fiscal years, except for children younger than 2 years. These provisions limited the likelihood of including patients who had moved out of province or died during the study period without their change in status being recorded in the RPDB. Births, deaths and attritions were permitted across years (Appendix 1, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.201473/tab-related-content). We were unable to link between 0.2% (FY 2008) and 0.3% (FY 2017) of patients with DAD records, and about 0.02% of those with NACRS records, to a valid RPDB record; we linked nearly 100% of patients in the OHIP database.

Because we excluded people with no health care contacts in the previous 5 years from our analysis, the study population did not represent the full population of Ontario, particularly for young adults. At the same time, it is possible that we failed to exclude some unrecorded deaths and other exits, such that some groups may have been overrepresented, particularly older adults. To address these issues, we scaled our analysis to the actual population of Ontario by age group and sex using Census data from Statistics Canada; all prevalence statistics refer to the population of Ontario.[14]

Outcomes

CIHI's case-mix methodology translates diagnostic data into 226 clinically meaningful health condition codes. At the patient level, health condition codes are grouped into 164 health profile group branches, which map onto 16 clinical categories based on condition type and seriousness. We treated individual health conditions as chronic if the corresponding health profile group defined them as falling into 1 of the 7 following CIHI clinical categories: major chronic, moderate chronic, minor chronic, major mental health, other mental health, major cancer and other cancer. For reporting purposes, we combined both cancer categories in a single category: any cancer. Patients could have conditions in multiple categories. Using CIHI's methodology, we applied system overrides to avoid double counting chronic conditions that are part of the same disease pathway. Using this process, we identified a total of 85 unique chronic health conditions (Appendix 2, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.201473/tab-related-content).[15] We applied CIHI's tagging rules, which require a confirmatory diagnosis for conditions reported in physician billing data, to minimize false-positive results.

We tracked the prevalence of chronic diseases and multimorbidity by fiscal year, 2008 through 2017, using diagnoses recorded during a rolling 5-year lookback window. For example, conditions flagged as prevalent in FY 2008 were those identified from Apr. 1, 2004, through Mar. 31, 2009. We reported the 5-year prevalence (v. 1- or 2-year prevalence) to reduce false-negative results (i.e., unobserved chronic diseases) for patients receiving sporadic care. We expected this to increase the sensitivity of the model, consistent with other studies identifying chronic conditions from administrative data in Ontario.[10] We did not look back further as previous research has found decreasing returns with each additional year of lookback.[16,17]

We also used the CIHI methodology to produce resource intensity weights (RIWs), based on each patient's complete health condition code profile. An RIW is an indicator of relative expected resource use, calculated in the concurrent period using a 5-year lookback. A concurrent RIW of 1.5, for example, shows that a patient's expected resource use in that period is 1.5 times greater than for an average patient. The risk model, which is part of the CIHI case-mix methodology (Appendix 3, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.201473/tab-related-content), has been validated for use in Ontario.[15,18]

Statistical analysis

We counted the number of chronic diseases recorded during the 5-year lookback period to determine the percentage of individuals with 1, 2 and 3 or more chronic conditions. Condition severity categories (major, moderate, minor) provide context for the types of diseases driving overall trends. We report time trends both as crude and age- and sex-standardized rates. Crude rates were meant to measure the overall change in observed chronic disease caseload, and standardized rates accounted for aging of the population. We weighted age- and sex-standardized estimates to match the age group and sex characteristics of the 2017 Census population of Ontario. Controlling for the changing population structure allowed for a more meaningful comparison of trends over time.

We tested all trends over the study period for statistical significance by performing Student *t* tests on linear slope coefficients. We conducted sensitivity analysis using different age restrictions, data source restrictions, lookback periods and an alternative chronic disease classification system that included only those conditions that have been commonly studied. All analyses were descriptive and were conducted using SAS software version 9.4 (SAS Institute), STATA 15

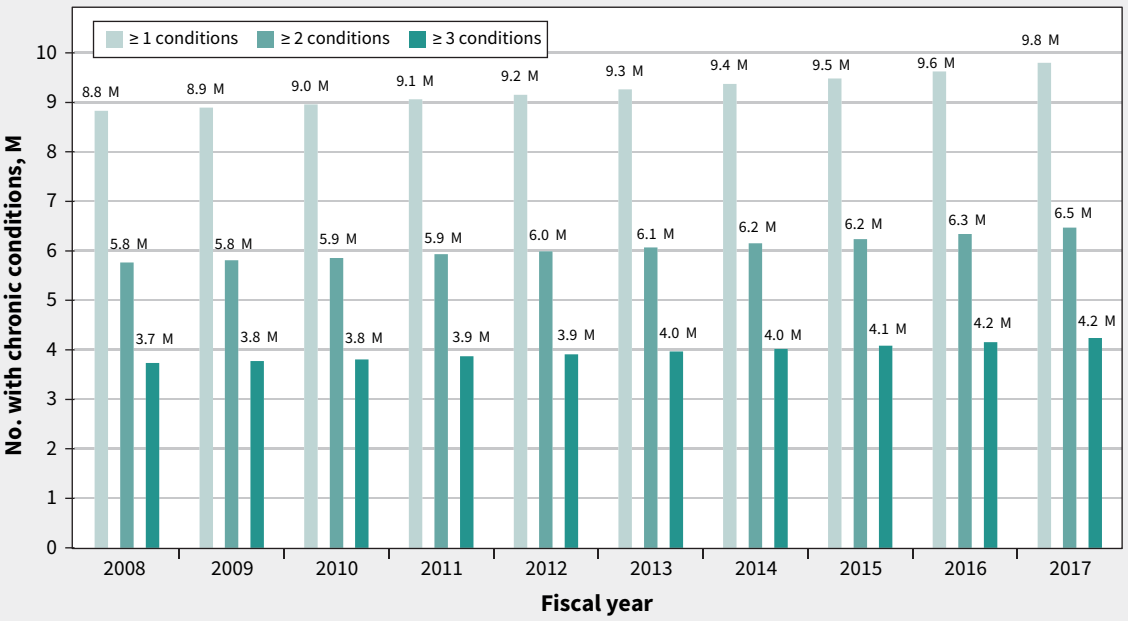


Figure 1: Number of patients with chronic conditions in Ontario from fiscal years 2008 to 2017. Note: M = millions.

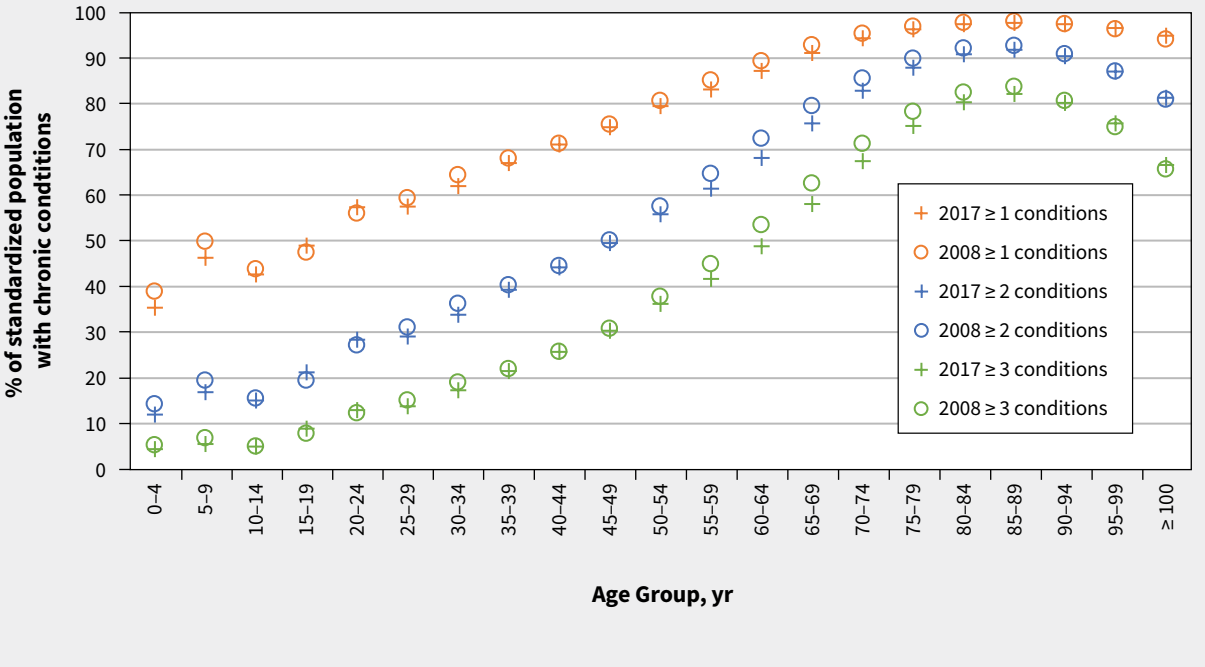


Figure 2: Five-year prevalence of 85 chronic conditions (fiscal year 2008 v. 2017) by age group. Note: Prevalence in both fiscal years was standardized to the 2017 population.

Table 1: Age- and sex-standardized prevalence of number of chronic disease conditions in Ontario, fiscal year 2008 versus 2017

	% prevalence*		
	2008	2017	*p* value†
≥ 1	70.20	69.05	0.002
≥ 2	47.11	45.57	< 0.001
≥ 3	31.33	29.87	< 0.001
≥ 4	20.61	19.50	< 0.001
≥ 5	13.34	12.66	< 0.001
≥ 6	8.48	8.14	< 0.001
≥ 7	5.28	5.16	0.071
≥ 8	3.21	3.23	0.031
≥ 9	1.90	1.98	< 0.001
≥ 10	1.10	1.19	< 0.001
≥ 11	0.62	0.70	< 0.001
≥ 12	0.34	0.40	< 0.001
≥ 13	0.19	0.22	< 0.001
≥ 14	0.10	0.13	< 0.001
≥ 15	0.05	0.07	< 0.001

*Age- and sex-standardized to the population in the 2017 fiscal year.
†The *p* value is reported for Student *t* tests on linear trends in standardized prevalence from fiscal year 2008 to 2017.

(Statacorp LLC) and Tableau Desktop Professional Edition version 10.4.1 (Tableau Software).

Ethics approval

Formal ethics approval was not required because this study used deidentified administrative health care data that were obtained from the Ontario Ministry of Health under an agreement with the Ontario Medical Association.

Results

The study population ranged from 12 770 341 in FY 2008 to 13 821 055 in FY 2017. Patients were excluded on an annual basis; on average, sample restrictions resulted in the removal of about 8.8% of person-observations, with only slight variation by year.

The number of people living with a chronic disease in Ontario exhibited substantial and statistically significant increases ($p < 0.001$) over the study period (Figure 1) (for statistical test results, see Appendix 4, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.201473/tab-related-content). As of FY 2017, the number of patients with at least 1 of the 85 chronic diseases was estimated to be 9.8 million, an increase of 11.0% from FY 2008. Multimorbidity also increased during this period. The number of patients with 2 or more chronic diseases increased by 12.2%, and those with 3 or more increased by 13.5% (Appendix 5, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.201473/tab-related-content).

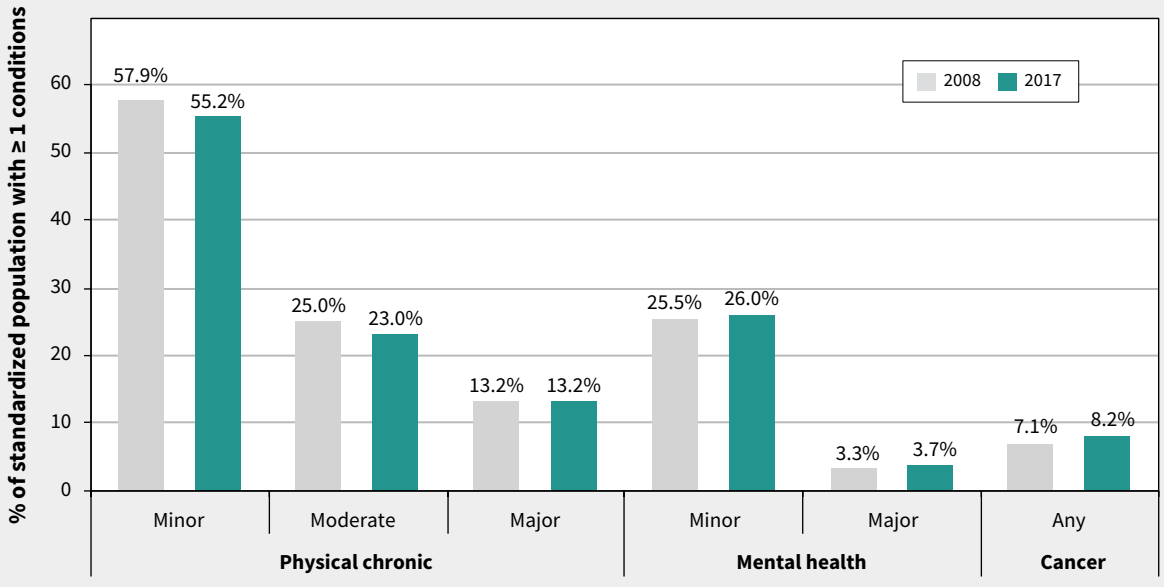


Figure 3: Age- and sex-standardized 5-year prevalence of ≥ 1 chronic conditions by category (fiscal year 2008 v. 2017). Note: Eighty-five conditions were classified based on type and severity into existing Canadian Institute for Health Information clinical categories (Appendix 2, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.201473/tab-related-content). Prevalence in both fiscal years was standardized to the 2017 population.

Age- and sex-standardized prevalence of chronic disease declined slightly over the study period, as 70.2% had 1 or more chronic conditions in FY 2008 compared with 69.1% in FY 2017 ($p < 0.01$). Overall, multimorbidity also declined modestly. The prevalence of 2 or more chronic diseases in the standardized population decreased from 47.1% in FY 2008 to 45.6% in FY 2017; for 3 or more chronic diseases, the prevalence decreased from 31.3% in FY 2008 to 29.9% in FY 2017 ($p < 0.001$). However, the trend varied by age. We noted small standardized increases in single disease prevalence and multimorbidity ($p < 0.05$) in adolescent and young adult populations (i.e., 15–24 yr), and small decreases in both ($p < 0.05$) among the older adult population (i.e., 45–89 yr) (Figure 2). Further, more extreme multimorbidity (≥ 8 to upwards of ≥ 15 co-occurring diseases) increased slightly on an age- and sex-standardized basis during the study period ($p < 0.05$) for the full population (Table 1).

Figure 3 shows statistically significant increases in the age- and sex-standardized prevalence of 1 or more major mental health disorders and cancer (0.5 and 0.9 percentage points, respectively), although the prevalence of minor and moderate physical chronic disease declined (2.7 and 2.0 percentage points, respectively). Changes in the prevalence of patients with ≥ 1 major chronic conditions and ≥ 1 other mental health conditions were not statistically significant.

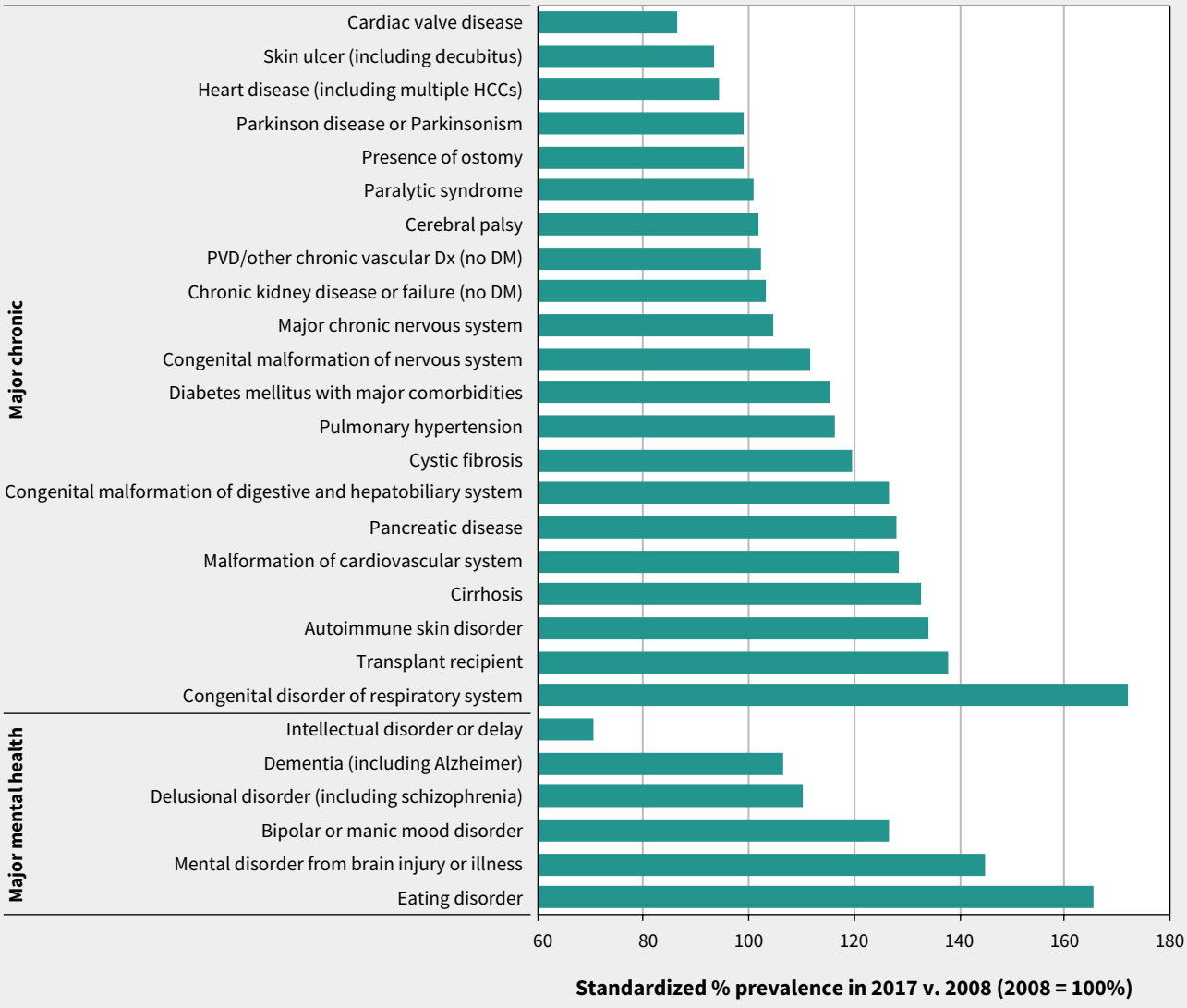


Figure 4: Change in age- and sex-standardized 5-year prevalence of major chronic and major mental health conditions (fiscal year 2008 v. 2017). The change is expressed as the relative prevalence in 2017 compared with 2008, where the prevalence in 2008 is equal to 100%. DM = diabetes mellitus, Dx = diagnosis, HCC = health condition code, PVD = peripheral vascular disease. Note: "No DM" indicates diabetes mellitus and hypoglycemia have not been diagnosed.

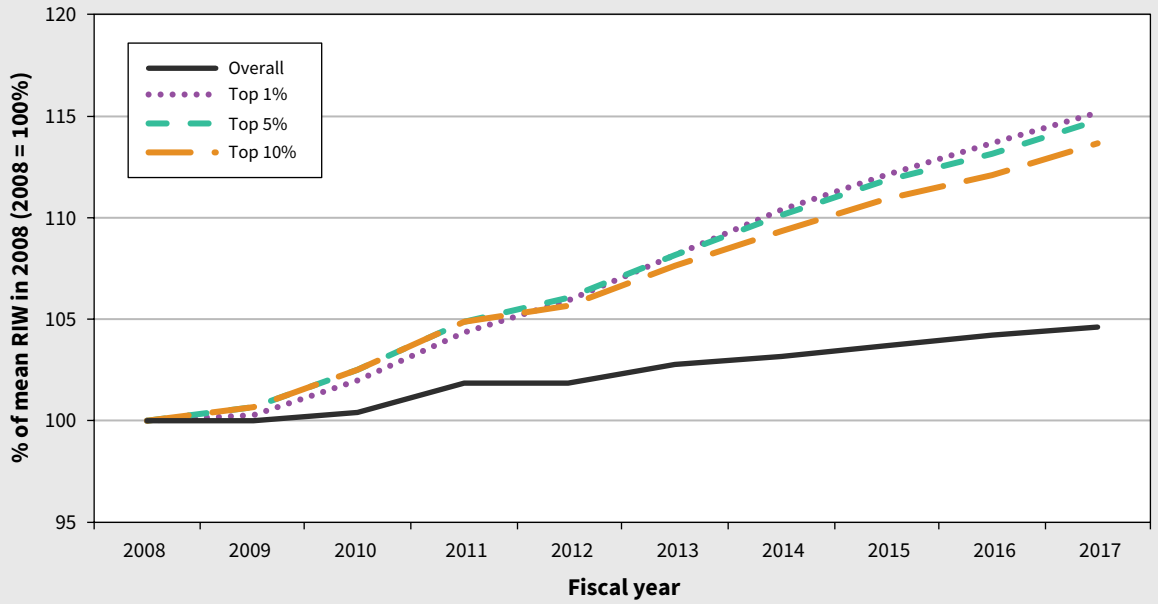


Figure 5: Age- and sex-standardized concurrent resource intensity weights (RIWs) from 2008 to 2017, by risk threshold (i.e., expected resource use percentiles selected to highlight patients in the top 10%, 5% and 1% of RIWs). Note: RIW is a measure of expected relative resource utilization based on a patient's diagnostic history and is an output of the Canadian Institute for Health Information's Population Grouping Methodology (Appendix 3, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.201473/tab-related-content).

Of the 85 chronic conditions, 51 showed a statistically significant increase in standardized prevalence from FY 2008 to 2017, and 23 showed declining prevalence (Appendix 6, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.201473/tab-related-content). The conditions with the largest declines tended to be minor or moderate. Only 3 of 21 major chronic conditions, and 1 of 6 major mental health conditions, showed statistically significant declines in standardized prevalence over the study period. Figure 4 highlights the increase in standardized prevalence of many major chronic and mental health conditions between 2008 and 2017.

The average concurrent RIW for the age- and sex-standardized population increased by 4.6% over the study period. The growth in expected resource use among patients in the top 10%, 5% and 1% of RIWs in each year exceeded that of the overall standard population, and trends were statistically significant. For the top 1% of cases specifically, the average RIW in FY 2017 was 115% of the FY 2008 value (Figure 5).

Sensitivity analysis

Several sample restrictions were imposed to test the robustness of our results. First, our analysis was reproduced using only DAD and NACRS, removing the possibility that physician billing data were driving our results. Overall, we found that the prevalence was lower. Although the slight downward trend in chronic disease prevalence over time remained, multimorbidity exhibited slight increases with this database restriction. Second, conducting the same analysis on separate age groups and removing those aged 85 years and older had little to no impact on our overall findings. Third, restricting the number of included conditions from 85 to 11 conditions that are more commonly studied — considering 5 Canadian studies on chronic disease — resulted in similar trends, albeit with lower levels of estimated comorbidity.[3,10–13] Slight differences in the grouping of *International Classification of Diseases, 10th Revision* codes prevented exact replication. (Appendix 7, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.201473/tab-related-content). Lastly, as with some previous studies,[16,17] we compared the 5-year lookback with a 2-year lookback period. This resulted in lower estimates of chronic disease prevalence (Appendix 8, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.201473/tab-related-content).

Interpretation

The number of patients with chronic diseases increased in Ontario between 2008 and 2017. Although age- and sex-standardized chronic disease prevalence and multimorbidity (≥ 2 and ≥ 3 conditions) fell slightly over this period, the decline was observed predominantly in minor or moderate conditions. Standardized rates of extreme multimorbidity (≥ 8 conditions) rose over this period. We also found that chronic disease prevalence increased for adolescents and young adults, which may portend an even greater future health risk for this cohort as it ages. Rising RIWs in the age- and sex-standardized patient

population show that the mix of health conditions in Ontario requires increasing amounts of health system resources, beyond what would be expected from population aging alone.

Our study showed a much higher prevalence of chronic disease than previous reports.[3,10–13] However, we did not find the same sharp increase in chronic disease in recent years that was noted in previous studies from Ontario. For example, one study found that rates of patients with ≥ 2 conditions increased from 22.2% in 2001 to 27.8% in 2011, adjusted for age and sex.[11] Another found that the prevalence of patients with ≥ 2 conditions rose from 17.4% in 2003 to 24.3% in 2009.[12]

The comparatively high prevalence of chronic disease reported in our study can be attributed to the comprehensiveness of the diagnostic tools used. Although efforts have been made to move toward a more standardized methodology for reporting the prevalence of multimorbidity in Canada,[19] the focus has been on improving tools for patient self-report, which is limited to a small number of common conditions.[20] Studies employing administrative data have relied on subsets of between 10 and 20 chronic conditions, which reduces comparability and greatly underestimates the overall prevalence of chronic disease.[21]

Limitations

The utility of CIHI's Population Grouping methodology depends on the completeness and accuracy of the diagnosis codes included in the model. Although previous studies have validated the use of diagnosis codes to capture disease prevalence in Ontario,[22–24] coding practices may have changed over time. Furthermore, the CIHI model attempts to minimize false-positive results by requiring at least 2 instances of a code to be recorded in physician billing records. Hence, the CIHI model may underestimate the prevalence of some conditions. The exclusion criteria removed patients with unreliable data and those with no health system contacts, which may be related to a patient's chronic disease status. Population characteristics like socioeconomic status, race, ethnicity and geography influence health care resource use, but were not considered. Finally, our inability to access the Ontario Mental Health Reporting System for inpatient mental health data and data from the Ontario Cancer Registry may bias our estimates for these conditions. However, diagnoses recorded in more than 1 setting contribute to establishing a patient's diagnostic record, mitigating the impact of missing data from any 1 source.

Conclusion

This study evaluates the prevalence of chronic disease and multimorbidity by estimating patient complexity using the CIHI Population Grouping Methodology. A strength of this approach is that the CIHI system uses diagnosis codes from all available health care settings to populate a complete set of clinically meaningful conditions at the patient level, which permits a fuller accounting of chronic disease prevalence than many existing approaches and allows for a richer characterization of trends over time. Consequently, we found evidence of much higher rates of chronic disease prevalence and multimorbidity than other studies have reported. A broader notion of patient complexity should be accounted for in health system planning in Canada and beyond; the CIHI Population Grouping Methodology is one tool to support this aim.

The CIHI Population Grouping Methodology has future applications for research in needs-based health resource planning, in chronic disease surveillance and in understanding the relation between patient illness and cost. Future research using this tool may compare the prevalence of chronic conditions between or within Canadian provinces to better understand geographic factors influencing health and health human resource needs.

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Contributors: Mitch Steffler, Sharada Weir and Jasmin Kantarevic conceived the study and developed the analysis plan. Jasmin Kantarevic acquired the data. Mitch Steffler, Sharada Weir, Yin Li and Farshad Murtada analyzed the data. Mitch Steffler drafted the manuscript. All authors contributed to the interpretation of the data, revised the manuscript for important intellectual content, approved the final version to be published and agreed to be accountable for the work

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Disclaimer: The Population Grouping Methodology is owned by the Canadian Institute for Health Information (CIHI) and used under license. Individual-level health care data were obtained from the Ontario Ministry of Health (MOH) under an agreement with the Ontario Medical Association. Both CIHI and the MOH had no involvement in or control over the design and conduct of the study; the collection, analysis, and interpretation of the data; the preparation of the data; the decision to publish; or the preparation, review, and approval of the manuscript. Interpretation and opinions expressed are those of the authors and do not necessarily reflect the views of the Ontario Medical Association.

Accepted: Dec. 1, 2020

Correspondence to: Mitch Steffler, mitch.steffler@oma.org

EXHIBIT 19

EXTENSION AGREEMENT

("The Agreement")

The Crown in Right of Ontario

as represented by Management Board of Cabinet

("the Employer")

- and -

Ontario Public Service Employees' Union

("the Union")

1. Subject to ratification by both parties, and subject to the terms of settlement stipulated herein, this Agreement forms the basis of the full and final settlement of an extension of the existing terms applicable to the Unified Bargaining Unit. The ratification process will be completed by both parties before the end of June, 2017, unless agreed otherwise. Ratification of the settlement shall be deemed to have occurred on the latest date on which ratification occurs by the employees in the bargaining unit and by Management Board of Cabinet ("date of ratification").

2. Both parties agree not to serve notice on the other that it wishes to bargain for a new collective agreement covering the period of January 1, 2018 to December 31, 2021 in accordance with the *Labour Relations Act, 1995* or *Crown Employees Collective Bargaining Act, 1993* provided this Agreement is ratified by both parties.

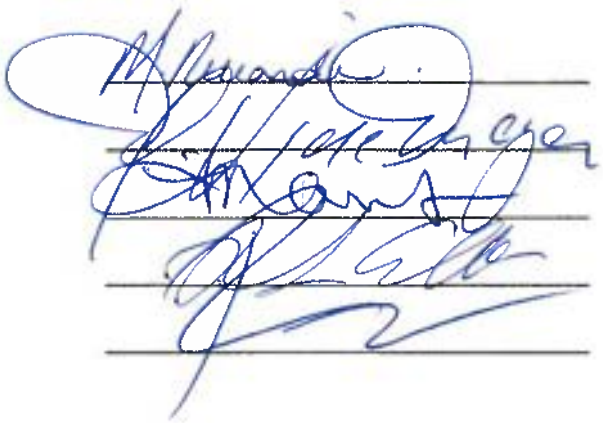
3. The terms of this Extension Agreement shall be effective on January 1, 2018, except as otherwise provided in this Extension Agreement.

4. The undersigned unanimously agree to recommend the terms of settlement as outlined in Appendix A, to their respective principals and, in the case of the signatories for the Union, to the bargaining unit employees.

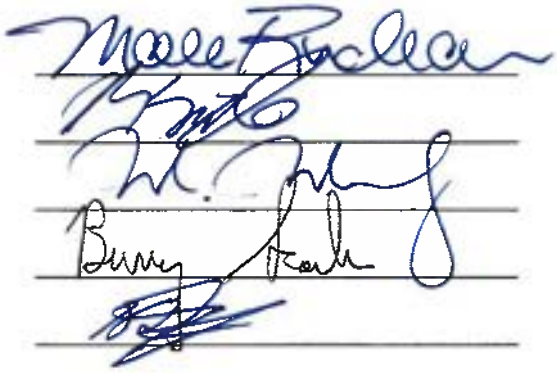
5. The terms of this agreement shall remain confidential until 11:59 p.m. June 9, 2017.

Dated at Toronto, this 2nd day of June 2017.

For the Union:



For the Employer:



Appendix A – Unified Bargaining Unit

Term:

- Four (4) year term (January 1, 2018 - December 31, 2021)

Wages (Across the Board (ATB)):

- 1.5% ATB (July 1, 2017 or date of ratification, whichever is later)
- 1.0% ATB (January 1, 2019)
- 1.0% ATB (July 1, 2019)
- 1.0% ATB (January 1, 2020)
- 1.0% ATB (July 1, 2020)
- 1.0% ATB (January 1, 2021)
- 1.0% ATB (July 1, 2021)

Attendance Support and Management Program (ASMP):

(Outside of the Collective Agreement)

- Effective January 1, 2018 the Attendance Support and Management Program (ASMP) will no longer apply to the Unified Bargaining Unit, except for:
    - Those employees who are already in Level 3 or 4 of the ASMP on December 31, 2017. These employees will continue to have their attendance managed under the ASMP until they move below Level 3.

Other:

- Optional, employee-paid Out of Country medical coverage will be made available effective January 1, 2018.
    - Application to enrol may occur upon hire or at anytime thereafter. If the employee enrols and later decides to end coverage, their decision is irrevocable and they will not be able to re-enrol.
- Mandatory, employee-paid catastrophic drug coverage plan effective January 1, 2018.
- Effective January 1, 2018, the current per half-hour cap for the services of a psychologist will increase to forty dollars ($40).
    - The annual cap of $1400 remains unchanged.

Nurses:

- Confirmation that regardless of any potential future change in reporting ministry, nurses working in institutions as identified in the December 15, 2016 agreement shall remain in the Correctional Bargaining Unit.

Collective Agreements:

- Parties to establish a joint committee to address consequential collective agreement changes required as a result of December 8, 2016 changes to the *Crown Employees Collective Bargaining Act, 1993 (CECBA)* and the December 15, 2016 agreement between the parties.
- Any matters in dispute with respect to the consequential collective agreement changes noted above may be referred to mediation-arbitration. The mediator/arbitrator will be jointly appointed and agreed by the parties.
- For clarity, the mediator/arbitrator will have no jurisdiction to alter, modify, amend or make any decision inconsistent with the entitlements set out in the current collective agreement.

All other Terms and Conditions:

- Confirm all other terms and conditions of the current collective agreement will remain status quo for the term of the collective agreement.

EXHIBIT 20

EXTENSION AGREEMENT

("The Agreement")
The Crown in Right of Ontario
as represented by Management Board of Cabinet
("the Employer")
- and -
Association of Management, Administrative and Professional Crown Employees of Ontario (AMAPCEO)
("the Association")

1. Subject to ratification by both parties, and subject to the terms of settlement stipulated herein, this Agreement forms the basis of the full and final settlement of an extension of the existing terms applicable to the AMAPCEO Bargaining Unit. The ratification process will be completed by both parties by July 7, 2017, unless agreed otherwise. Ratification of the settlement shall be deemed to have occurred on the latest date on which ratification occurs by the employees in the bargaining unit and by Management Board of Cabinet ("date of ratification").

2. Both parties agree not to serve notice on the other that it wishes to bargain for a new collective agreement covering the period of April 1, 2018 to March 31, 2022 in accordance with the *Labour Relations Act, 1995* or *Crown Employees Collective Bargaining Act, 1993* provided this Agreement is ratified by both parties.

3. The terms of this Extension Agreement shall be effective on April 1, 2018 and expire on March 31, 2022.

4. The extension Collective Agreement shall be in the form of the Collective Agreement that expires March 31, 2018, as amended by the attached. It is understood that some editing and renumbering may be necessary and the parties shall appoint an editing committee for that purpose.

5. The undersigned unanimously agree to recommend the terms of settlement as outlined in Appendix A, B and C to their respective principals and, in the case of the signatories for the Association, to the bargaining unit employees.

6. The terms of this agreement shall remain confidential until 9:00 a.m. June 14, 2017.

Dated at Toronto, this 13 day of June 2017.

For the Union:

For the Employer:

Appendix A - AMAPCEO Bargaining Unit

1. Term:

- Four (4) year term (April 1, 2018 - March 31, 2022)

2. Wages (Across the Board (ATB)):

- 1.5% ATB (October 1, 2017)
- 1.0% ATB (April 1, 2019)
- 1.0% ATB (October 1, 2019)
- 1.0% ATB (April 1, 2020)
- 1.0% ATB (October, 2020)
- 1.0% ATB (April 1, 2021)
- 1.0% ATB (October 1, 2021)

3. Attendance Support and Management Program (ASMP):

(Commitment outside of the collective agreement)

- Effective January 1, 2018 the Attendance Support and Management Program (ASMP) will no longer apply to the AMAPCEO Bargaining Unit, except for:
    - Those employees who are already in Level 3 or 4 of the ASMP on December 31, 2017. These employees will continue to have their attendance managed under the ASMP until they move below Level 3.

- Employees to be notified of the right to AMAPCEO representation at Level 4, with signed waiver if representation is declined.

4. Other:

- Optional, employee-paid Out of Country medical coverage will be made available effective January 1, 2018.
    - Application to enrol may occur upon hire or at anytime thereafter. If the employee enrols and later decides to end coverage, their decision is irrevocable and they will not be able to re-enrol.

5. Recognition Clause – HROntario Exclusion:

- The parties agree to amend the recognition clause in accordance with the changes identified in Appendix B.

6. Special and Compassionate Leave – For Dependent and Elder care:

- The Parties agree to amend Article 23.3 (Special or Compassionate Leave) in accordance with the following changes:

...

23.3.4.1 An employee shall be entitled to special leave of up to 2 days per year to attend to unforeseen dependent and elder related care for the leave referenced in Article 23.3.1. For clarity, the parties agree this leave shall be granted so long as the employee has remaining special and compassionate leave under Article 23.3.1. The employee will attempt to give reasonable notice, where possible, in respect of any leave of absence under Article 23.3.4.1.

...

7. Lump Sum Payment:

- Following the implementation of the October 1, 2017 1.5% ATB, the 352 AMAPCEO-represented employees identified in Appendix C that were impacted by implementation of the October 1, 2013 Job Evaluation System, shall be awarded a 1.5% non-pensionable lump sum payment.
- Further, following implementation of the April 1, 2019 1.0% ATB, AMAPCEO-represented employees identified in Appendix C who continue to be red circled shall be awarded a 1.0% non-pensionable lump sum payment.
- Lump sum payments will be pro-rated for employees working less than full-time hours.
- The parties agree that additional employees who may have been inadvertently left off this list may be added by mutual agreement of the parties. The Association retains the right to file a dispute should the parties not be able to agree.

8. All other Terms and Conditions:

- Confirm all other terms and conditions of the current collective agreement will remain status quo for the term of the collective agreement.

Appendix B –Collective Agreement Language (Recognition Clause):

ARTICLE 1 - RECOGNITION

1.1 ~~The Government recognizes the Association of Management, Administrative and Professional Crown Employees of Ontario as the exclusive bargaining agent for a bargaining unit composed of all Crown employees as defined in Section 1 of CECBA, 1993 who are Public Servants in the classifications set out in the list of classifications attached as Schedule 1 to this collective agreement, all Go Temp employees, students and interns working in those classifications, and all employees in any newly established classification that is subsequently agreed, or determined by the OLRB, to be materially similar to a classification in the unit, (save and except persons who exercise managerial functions or who are employed in a confidential capacity relating to labour relations, or lawyers and engineers who are employed in their professional capacity, or those employed in HR Ontario including Regional Service Delivery Centres and Strategic HR Units, or persons employed in the Correctional Bargaining Unit or persons employed at the Ontario Police College, the Ontario Provincial Police Academy, or under the supervision of the Commissioner of the OPP or the Chief Firearms Officer for Ontario.)~~

~~The parties agree that paragraphs 3, 4, 5 and 6 and Appendix B of the September 10, 2008 Agreement form part of the collective agreement, and that the September 10, 2008 Agreement overrides and replaces all prior agreements and settlements between these parties concerning the recognition, treatment and scope of AMAPCEO as a tag-end bargaining unit, as well as replacing, in respect of the seventh unit, OIC 243/94. For clarity, paragraph 5 of the recognition clause settlement dated September 8, 2004, providing for parallel classifications in the AMAPCEO unit where a deleted MCP classification is reinstated, continues to apply, and nothing herein affects the revised recognition clause set out in this article.~~

~~Effective October 1, 2013 the following recognition clause will apply:~~

The Government recognizes the Association of Management, Administrative and Professional Crown Employees of Ontario as the exclusive bargaining agent for a bargaining unit composed of all Crown employees as defined in Section 1 of CECBA, 1993 who are Public Servants in the positions and classifications set out in Schedule 2 to this collective agreement. For clarity, Schedule 2 includes all classifications and positions previously encompassed by Schedule 1 that have been assigned to a classification level as of the signing of this collective agreement, as well as any positions or classifications included in Schedule 1 that have not, as of the signing of this collective agreement, been assigned to a level in the new job evaluation/classification system, ~~as well as all Go Temp employees,~~ students and interns working in those classifications and positions, and all employees in any newly established classification or position that is subsequently agreed, or determined by the OLRB, to be materially similar to a classification or position in the unit, (save and except persons who exercise managerial functions or who are employed in a confidential capacity relating to labour relations, or lawyers and engineers who are employed in their professional capacity, ~~or those employed in HR Ontario including Regional Service Delivery Centres and Strategic HR Units~~ or persons employed in the Correctional Bargaining Unit or persons employed at the Ontario Police College, the Ontario Provincial Police Academy, or under the supervision of the Commissioner of the OPP or the Chief Firearms Officer for Ontario).~~)~~ **The parties agree that the positions performing functions carried out by the Centre for Public**

Sector Labour Relations and Compensation; Centre for Leadership and Learning (excluding Green Office positions); HR Service Delivery Division; and Strategic Business Units within any ministry; (including any form of successor organization(s) that perform these functions) are excluded under Section 1.1 (3) 9 of CECBA, 1993.

The parties agree that paragraphs 3, 4, 5 and 6 and Appendix B of the September 10, 2008 Agreement form part of the collective agreement, and that the September 10, 2008 Agreement overrides and replaces all prior agreements and settlements between these parties concerning the recognition, treatment and scope of AMAPCEO as a tag-end bargaining unit, as well as replacing, in respect of the seventh unit, OIC 243/94. For clarity, paragraph 5 of the recognition clause settlement dated September 8, 2004, providing for parallel classifications in the AMAPCEO unit where a deleted MCP classification is reinstated, continues to apply, and nothing herein affects the revised recognition clause set out in this article.

For further clarity, the parties agree that the Government continues to recognize AMAPCEO as the exclusive bargaining agent for all classifications and positions, previously covered by the recognition clause contained in Article 1.1 of the collective agreement, and that the change to the new job evaluation/ classification system structure and the amendments to the recognition clause neither alter, expand nor erode the scope of the bargaining unit.

EXHIBIT 21

IN THE MATTER OF AN INTEREST ARBITRATION

Between:

The Crown in Right of Ontario

(Treasury Board)

and

The Ontario Secondary School Teachers' Federation

and

The Elementary Teachers' Federation of Ontario

Before:	William Kaplan, Chair Bob Bass, Crown Nominee David Wright, OSSTF & ETFO Nominee
Appearances	
For the Crown:	Sunil Kapur Kate McNeill-Keller Jessical Wuergler Aya Schechner McCarthy Tetrault Barristers & Solicitors
For OSSTF:	Susan Ursel Karen Ensslen Emily Home Ursel Phillips Barristers & Solicitors
For ETFO:	Howard Goldblatt Colleen Bauman Goldblatt Partners Barristers & Solicitors

The matters in dispute proceeded to a hearing held in Toronto on January 16, 2024. The Board met in Executive Session on January 19, 2024.

Background

On November 7, 2019, Bill 124, *Protecting a Sustainable Public Sector for Future Generations Act, 2019*, received Royal Assent. Bill 124 introduced a three-year moderation period during which annual compensation increases were limited to 1%. Both the Ontario Secondary School Teachers' Federation (OSSTF) and the Elementary Teachers' Federation of Ontario (ETFO) were impacted by the legislation and their three-year collective agreements – September 1, 2019, to August 31, 2022 – were subject to its terms (the Moderated Collective Agreements). Both OSSTF and ETFO initiated constitutional challenges. On November 29, 2022, Mr. Justice Markus Koehnen of the Ontario Superior Court declared Bill 124 contrary to section 2(d) of the *Charter of Rights and Freedoms* and not justified under Section 1. The judgment of the court deferred remedy to a further hearing. An appeal was filed and heard in June 2023. It remains under reserve. However, as no stay was sought, Bill 124 is of no force and effect.

This interest arbitration arises out of settlements reached between the parties – the Crown in Right of Ontario and OSSTF and the Crown in Right of Ontario and ETFO – resolving the remedy portion of litigation, the litigation brought by each federation, and several individual applicants, challenging the constitutionality of Bill 124 (the Remedy MOS's). Under the Remedy MOS's (and one is applicable to OSSTF and two to ETFO), the parties agreed on the amount of compensation increases for the first two years of their Moderated Collective Agreements – which otherwise remained unchanged – but referred the quantum for the third year (Year 3) – September 1, 2021, to August 31, 2022 – to interest arbitration with set parameters: it could not be below 1.5% or above 3.25% (in addition to the 1% previously prescribed under Bill 124).

Accordingly, the sole issue before us is the determination of the amount within this agreed-upon range.

The parties agreed that in determining this sole outstanding issue, the Board could take into consideration any factors that it considered relevant, including the criteria set out in section 38 of the *School Boards Collective Bargaining Act* (SBCBA) set out below. Detailed briefs and reply briefs were filed, and the single issue proceeded to a hearing in Toronto on January 16, 2024. The Board met in Executive Session on January 19, 2024.

Legislative Framework

By and large, labour relations in the education sector have, since 2014, been governed by SBCBA (with some limited application of the *Labour Relations Act* (LRA)). Under SBCBA, collective bargaining is two-tiered: central bargaining at the central table with the participation of the Crown, and local bargaining at local tables between various unions, including OSSTF and ETFO, and individual school boards.

The Parties

The Crown

The Crown in Right of Ontario (Crown), represented in these proceedings by the President of the Treasury Board, is not the employer. However, it funds the public education system and participates in central bargaining with OSSTF and ETFO by negotiating all central terms, including compensation. The school board employers – represented by the Ontario Public School Boards' Association (OPSBA) for teachers and occasional teachers and the Council of Trustees

Association (CTA) for education worker bargaining units – did not participate in these proceedings as they were not parties to the Bill 124 litigation and are not parties to the Remedy MOS's.

OSSTF

OSSTF represents secondary school teachers and occasional teachers employed by Ontario's public district school boards. It also represents education workers, including educational assistants, who often work with students with special education needs (EAs), early childhood educators (ECEs), professional student services personnel – psychologists, social workers, speech language pathologists – office, technical and clerical staff, custodial, maintenance, plant support personnel, continuing education teachers and instructors, and noon hour assistants.

ETFO

ETFO – the largest teaching federation in Canada – represents elementary teachers/occasional teachers and education workers, such as EAs, Early Childhood Educators (ECEs), Educational Support Personnel (ESPs), and Professional Support Personnel (PSPs).

OSSTF Submissions

In the OSSTF's submission, an additional 3.25% should be awarded for six reasons:

1. Teacher and education worker wages have been significantly eroded by inflation and below-market wage increases, a situation contributed to and exacerbated by Bill 124, which limited compensation to 1%, and substantially interfered with free collective bargaining, and deprived the OSSTF of its right to strike. Bill 124 compounded earlier

unconstitutional legislation – Bill 115: *Putting Students First Act* – which, among other things, imposed a two-year wage freeze.

2. There was a true recruitment and retention crisis in public education with demand for teachers far outstripping supply. This crisis, and that is what it was, showed no sign of abating. The problem was real, and worsening, with school boards across the province left with no option other than to hire unqualified staff to fill pressing vacancies.
3. Economic and labour market conditions were positive and supported a general improvement in wages.
4. Ontario's fiscal outlook was strong. Budgetary deficits did not reflect an inability to pay (and inability to pay was not raised by the Crown). In fact, Ontario's debt to GDP ratio was improving and debt service cost to revenues was favourable and also improving. There were many other positive economic indicators, meaning no economic impediment to awarding an additional 3.25%.
5. Replication of free collective bargaining and awarded settlements justified the full 3.25% increase. The fact of the matter was that freely negotiated settlement and interest arbitration awards – especially in the Bill 124 re-opener context – established a normative range of between 3 and 3.75% over and above the original 1% in the Moderated Collective Agreements.
6. A 3.25% initial increase in Year 3 would compensate OSSTF and its members for working conditions that could not be bargained because of the imposition of unconstitutional legislation.

Each of these arguments was expanded upon by OSSTF in its brief, and at the hearing.

Inflation

OSSTF pointed out that teacher, occasional teacher, and education worker wages have been significantly eroded by inflation over the past decade: falling 17.5% behind from 2012 to 2022. This was especially problematic in Year 3, when OSSTF members received 1% when inflation soared to 6.8%. Even if the full 3.25% were awarded, OSSTF members would still lag inflation on a compound cumulative basis. Consideration of this issue alone, the OSSTF argued, fully justified awarding the full 3.25%.

That conclusion was reinforced when actual teacher, occasional teacher and education worker compensation was carefully examined. While approximately 77% of Ontario teachers were at the highest level of their respective salary grid, a sizeable number were at or near the bottom. Many occasional teachers were denied the suite of benefits full-time teachers enjoyed and were paid at the lowest category on the permanent teacher grid.

The situation was even worse for education workers, most of whom were only employed for ten months of the year, with recurring summer layoffs. A large proportion of these education workers met the definition of low wage employees, earning less than $30 an hour. For ten-month employees, that meant annual incomes below $46,000 (far below the average Ontario income). But this notional annual income was, in many respects, misleading. Many of the education workers were working in part-time or casual positions and earned nothing close to that annualized amount. Their employment was precarious. Notably, women were over-represented in the education worker group.

Recruitment and Retention

Also justifying the full 3.25% increase in the OSSTF submission was recruitment and retention. School boards across the province were struggling to find qualified individuals to fill teacher, occasional teacher and education worker positions, a situation that could only be described, in the OSSTF's view, as a crisis. According to the Ontario College of Teachers (College), there was a general teacher shortage with demand far outstripping supply and no relief expected any time soon. The occasional teacher supply was also dire; it had reached problematic lows. This led the government in 2021 to introduce a temporary certificate program as an emergency measure, allowing thousands of Ontario teacher candidates to be hired on daily occasional rosters and for short-term teaching contracts (a measure made necessary by the anticipated shortfall of 7000 occasional teachers across the province). Notably, this temporary measure has been renewed every year since, reflecting the depth of the recruitment and retention crisis.

Another measure – also renewed – and reflecting the growing gap between supply and demand, was the government's decision to increase the number of days that retired teachers were permitted to work while still receiving their pension. Likewise, Letters of Permission – allowing unqualified individuals to teach in Ontario schools – were on the upswing, as the data which the OSSTF pointed to clearly established. Other data, from the College and from the Ontario Teachers' Pension Plan, demonstrated that large numbers of qualified teachers were leaving the public education system early. Notably, there were some 37,000 teaching certificate holders in Ontario who were not employed in public education. Undoubtedly, OSSTF argued, there were many reasons for this, but inadequate compensation was surely at the top of the list. Recruitment and retention of EAs and ECEs was especially problematic, and the OSSTF reviewed the data on

point. In the OSSTF's submission, recruitment and retention were among the most important factors to be considered in determining compensation. Demand far exceeded supply and application of well-accepted principles directed that this key fact inform the arbitration award amount. For all these reasons, and others, OSSTF urged that the full 3.25% be awarded.

Economic Conditions

Another reason, the OSSTF argued, in favour of awarding 3.25% was the state of the Ontario economy: it was strong in 2022 and has remained so since with real economic growth, reflected, for example, by falling unemployment rolls which, in turn, led to a measurable increase in wages, except for teachers, occasional teachers and education workers. Ontario's credit rating was positive, interest on debt as a share of revenue was decreasing, the debt-to-GDP ratio illustrated fiscal health and the sustainability of government finances (also demonstrated by $2 billion over four years in direct education transfers to families). All in all, a robust recovery has been underway since 2022. Notably, the OSSTF emphasized, at no point did the government assert that there was an inability to pay; the Crown's proposal reflected an unwillingness to pay justified wage increases.

The Impact of Unconstitutional Legislation

Finally, the OSSTF made some submissions about the need to address Bill 124's impact on bargaining: it precluded the OSSTF from pursuing its many legitimate bargaining proposals including job security, class size, improved hiring processes, addressing workplace violence, and benefit improvements. Instead, teachers, occasional teachers and other education workers fell behind inflation while left to grapple with increased class sizes, all the while working under

stressful and challenging conditions of the pandemic. There had been a constitutional breach, and there was, therefore, an entitlement to a constitutional remedy. In fact, there was no dispute about that: the parties in the Remedy MOS's said as much and then went on to identify that remedy – an across-the-board increase – but leaving to the Board the responsibility for determining the amount.

Application of the Criteria

The Remedy MOS's were clear: in determining the appropriate result for Year 3, the Board was, the OSSTF argued, to consider any factor it considered relevant, together with the statutory SBCBA criteria (below). Of all the governing criteria, replication was perhaps the most important: to replicate the results that the parties would have reached had they freely negotiated their collective agreements. What would have happened if Bill 124 had not unconstitutionally prevented the parties from bargaining and reaching a collective agreement? This question could be answered by asking another one: What did free collective bargaining results and interest arbitration awards indicate? Re-opener after re-opener award convincingly demonstrated – and the relevant awards were canvassed in the OSSTF brief and at the hearing – that for the period in question, additional across-the-board increases – over and above the prescribed 1% – ranged from 3% to 3.75%. These awards were ubiquitous (and often contained other economic improvements beyond across-the-board increases).

Arbitrators, the OSSTF pointed out – and quoting from awards which were characterized as governing – reached these compensation results for numerous reasons. Addressing inflation clearly played a large part, but so too did recruitment and retention. Both were factors present

here. And both inflation and recruitment and retention led to one conclusion: the award of an additional 3.25%. The OSSTF concluded by asking that the Board award an additional 3.25%.

ETFO Submissions

The Context

This interest arbitration, ETFO observed, did not occur in a vacuum. There was a context that needed to be considered, and it included Bill 124, imposing an unconstitutional outcome on collective bargaining. ETFO served notice to bargain in June 2019. Bargaining priorities included negotiating additional special education supports and achieving real increases in all forms of compensation for all members, reduction of class sizes, reforming occasional teacher hiring practices and addressing pressing health and safety challenges, particularly classroom violence, among a number of other key demands.

To be sure, OPSBA and CTA also had bargaining priorities (described by ETFO as concessions). Neither party could, however, engage in free collective bargaining because the government introduced and then proclaimed Bill 124, imposing the three-year moderation period and limiting compensation in each of the three years to 1%. At the same time, as bargaining progressed through the fall of 2019 and into early 2020, ETFO was told that the government bargaining team had no authority to negotiate some of its non-monetary proposals, for example, those addressing classroom violence.

The declaration of the pandemic in early March 2020 was another important part of the overall context. It created unprecedented challenges for educators, students, and the education system as

a whole. When schools were closed, and when they were open, ETFO members quickly pivoted to ensure that students could continue to learn – for example, they moved to distance learning modes when the schools were shut down and they ensured that health and safety guidelines were followed when schools were reopened. The objective was straightforward: putting the interests of students first so that public education continued with as little disruption as possible, notwithstanding the enormous increases in workload that followed.

Bargaining ended on March 20, 2020, when tentative collective agreements were reached. The Moderated Collective Agreements made it crystal clear that they were reached without prejudice to ETFO's rights to challenge the provisions of Bill 124 and to seek an appropriate remedy in the event the challenge was successful, which it was on November 29, 2022, when Bill 124 was struck down. The Moderated Collective Agreements explicitly provided for ETFO's right to pursue remedies if Bill 124 was ruled unconstitutional, which it was, leading to the Remedy MOS's and this proceeding.

Criteria

The Remedy MOS's directed the Board to take into account any factor it considered relevant, along with the statutory criteria set out in the SBCBA (below). In ETFO's view, replication, the economy and inflation, and recruitment and retention were of particular relevance to this proceeding. ETFO pointed out that the government had not argued any inability to pay, and the reason for that was obvious: Ontario was and remains in an excellent fiscal situation and there was no question as to its ability to fully fund an additional 3.25% increase.

Replication

The overarching goal of interest arbitration, ETFO observed, was to replicate free collective bargaining. In doing so, it was now well established that boards of interest arbitration must examine all relevant information from all sectors, not just information that was available at some specific point in time, such as when negotiations were underway or an agreement reached. This approach was not only now normative, it was necessary as there were no directly applicable bargaining patterns or re-opener awards for teacher and education bargaining units to refer to. Various authorities setting out these principles were canvassed by ETFO in its brief and at the hearing.

The Economy and Inflation

The economic situation in Ontario was both important and relevant. Economic conditions in 2021-2022 were not, ETFO observed, a matter of prediction – as they would have been had bargaining not been fettered by unconstitutional legislation (assuming for the sake of argument it had been completed in a timely way, which was not the norm for bargaining in this sector). In any event, the prevailing economic circumstances in Year 3 could now be identified with precision. On the one hand, in Year 3, the provincial fiscal situation was excellent, employment was up, all the generally relied upon economic indicators were good, while on the other, inflation was ravaging employee pay (and the particulars of these submissions mirrored in many respects those advanced by OSSTF).

Inflation – especially on non-discretionary essentials – had, and continues to have, a real impact on employees, particularly those who are less well paid. ETFO estimated that coming out of the

Moderated Collective Agreements, real wages for teachers and occasional teachers were effectively cut by 15.6%, and for education workers by 13.8%. Even if the maximum 3.25% was awarded, wages would still trail inflation and not come close to remedying the losses suffered by ETFO members over the past decade. In these circumstances – namely, a robust economy, not a recession, positive economic indicators and a compelling and established need to address inflation –the full 3.25% should be awarded (an outcome that was also completely consistent with the weight of Bill 124 re-opener awards, which ETFO reviewed in detail).

Recruitment and Retention

Recruitment and retention were among the statutory criteria to be considered, and when the evidence was objectively assessed it convincingly established that there were growing shortages of teachers, occasional teachers and education workers (and here too, ETFO's submissions and data mirrored that found in the OSSTF submissions). The number of new teachers was plummeting and enrolment in teacher colleges was declining. At the same time, demand was increasing, a not surprising situation considering the rapidly growing Canadian population. The result was inevitable: schools cannot meet their staffing requirements. The evidence of this was dispositive and set out in the ETFO brief. The College predicted that an additional 32,000 educators would be needed within the next five years. Recruitment in some classifications was particularly challenging, but this was a problem that affected all job groupings. The Ontario Principals' Council was categorical: the "Ministry of Education [needed] to step in immediately to deal with this crisis…." The first step, ETFO argued, was awarding an additional 3.25%.

Crown Submissions

The Remedy MOS's are not Wage Re-openers

In the Crown's view, this proceeding did not arise from a negotiated Bill 124 wage re-opener, and that was legally and factually material. Unlike negotiated collective agreement re-openers, the Remedy MOS's were entered into by it and the OSSTF and ETFO to fully and finally settle any and all claims arising out of their constitutional challenges to Bill 124.

Elaborating on this submission, the Crown pointed out that the Remedy MOS's were completely different from negotiated collective agreement wage re-opener provisions. Instead of negotiating re-opener provisions, OSSTF and ETFO negotiated provisions in their Moderated Collective Agreements indicating that agreement to the prescribed 1% was without prejudice to their rights to seek an appropriate remedy should their constitutional challenges of Bill 124 prove successful. At no time did the parties agree to a collective agreement re-opener.

Another distinguishing feature of this case – with its unique purpose-driven Remedy MOS's, compared to standard negotiated re-opener provisions – was the nature of collective bargaining: collective bargaining in the Ontario educational sector is two-tiered. The legislative framework provides for central and local bargaining. The Crown must agree to compensation before a central agreement can come into effect. In re-opener clauses under collective agreements that were invoked after Bill 124 was held to be unconstitutional, the Crown was not at the table.

The Remedy MOS's, the Crown continued, were straightforward: the OSSTF and ETFO gave up their rights to seek relief from the court, and the Crown gave up its appeal of the court's decision

as it applied to OSSTF and ETFO. The Remedy MOS's set out the quantum increase in Years 1 and 2 – .75% – and remitted to the Board the amount for Year 3 within the agreed-upon range. The Remedy MOS's made this arbitration completely different, therefore, from a classic Bill 124 collective agreement re-opener. Its architecture was completely different: deliberately designed to put the parties back back in the position they would have been in but for Bill 124.

Given this legal framework, the central question that needed to be asked is what would the parties have agreed upon but for Bill 124? That question could only be answered by adopting a point in time approach, meaning looking at the outstanding proposals when bargaining commenced and when the Moderated Collective Agreements were reached. The monetary asks for Year 3, at that time, were significantly less than the 3.25% being sought now, but demonstrated in a legally and factually governing manner what each of these parties' thought was the appropriate outcome. In these circumstances, given the remedial nature of the proceeding, and application of accepted remedial principles, the Board should award no more than what would have been freely negotiated but for Bill 124, and that meant an additional 1.5%.

The Remedy MOS's provided that the Board could consider any factor it considered relevant together with those set out in statute. The Crown did not dispute that but asserted that in considering those factors the Board had to restrict its analysis to the circumstances that prevailed in early 2020 when the parties were bargaining, leading up to them executing the Moderated Collective Agreements. Damages, the authorities indicate, are assessed at the time of the wrong, not at the time of adjudication. The Remedy MOS's stood in place of a court-ordered remedy and must therefore, and to the extent possible, place the unions and their members in the position

they would have otherwise been in, no more and no less. And that meant awarding an across-the-board increase that would have been agreed to at the time; or in other words, what the Crown had on offer.

Accordingly, the Crown urged the Board not to consider any subsequent economic or other evidence. It would improperly skew the result in a process where the parties deliberately did not choose a collective agreement re-opener process when they reserved their rights. In the re-opener cases, the parties (or as directed by boards of arbitration) agreed to re-open their collective agreement on a triggering event: Bill 124 being declared unconstitutional (for the most part). In marked contrast, when they signed off on the Moderated Collective Agreements, the parties intended to preserve litigation related rights, not to re-open those collective agreements in a re-opener proceeding where current economic events could be considered years after the fact. Current economic information was undoubtedly relevant, but to future proceedings, not this one.

The Factors

Replication/Bargaining History

In the Crown's submission, replication was important, and the starting point was bargaining history. Both OSSTF and ETFO voluntarily agreed on an additional .75% in each of Year 1 and 2. That decision was determinative: if they agreed on .75% in each of the first two years, awarding more than 1.5% in Year 3 would be a radical departure from the pattern the parties themselves set. This conclusion was reinforced by a review of bargaining over time. For the past fifteen years, these parties have a pattern of bargaining outcomes between 1.5 and 3% (excluding net zero and Bill 124 years) with – generally speaking – lower across-the-board increases at the

start of the term and a higher one at the end, just as was being proposed by the Crown here. Deviating from this pattern – in other words, not replicating what the parties have done for a very long time – would constitute a breakthrough and it would be one without established demonstrated need.

Comparators

Even assuming, for the sake of argument, that it was appropriate to turn to other comparators – and away from this established bargaining pattern – the comparators to look to first were teachers and other education workers elsewhere in Canada. Ontario's teachers were the highest paid in the country both when Bill 124 was in effect and today (and the Crown contested wage results relied by OSSTF and ETFO as misleading, methodologically suspect, incomplete, inaccurate and failing to reflect total compensation in complete contrast to the apples to apples data it presented). Even within Ontario, education worker classifications were largely among the very best paid when similar positions in other sectors were examined.

ECE's, for example, working in Ontario's public education system, were paid substantially more than those in the childcare sector outside of education. When the data was reviewed, it was clear that wage settlements outside and inside Ontario for comparable employees did not, the Crown pointed out, support the OSSTF and ETFO case. Comparability was a factor and appropriately applied supported the Crown's 1.5% offer. (The notion that many classifications of education workers were precariously employed was rejected for reasons set out in the written materials and at the hearing.)

Recruitment and Retention

While recruitment and retention as a factor were often considered in interest arbitration proceedings, this interest arbitration, the Crown argued, was not the appropriate forum to do so. In the Crown's view, issues around labour supply and demand in the education sector are complex and multi-faceted. There was certainly no basis to conclude that any of the challenges were either wage-driven or wage-sensitive, a conclusion that was reinforced by the fact that Ontario's teachers, occasional teachers and education workers were already the highest paid.

Demonstrating the complexity and multi-faceted nature of the problem, other factors were clearly at play, for example, high employee absenteeism explained many of the staffing challenges. The Crown and the parties were not unaware of or indifferent to these issues. A Sick Leave Utilization Task Force had been launched, as well as the Teacher Supply and Demand Action Table to consider how to best address these issues with the participation of multiple stakeholders. These, and other initiatives, were the preferred method of addressing recruitment and retention. There was no reason to believe that a non-normative wage increase to the highest paid teachers, occasional teachers and education workers in the country, as requested by both OSSTF and ETFO, would change the staffing picture in any respect.

The State of the Economy

Likewise, the state of the Ontario economy did not justify the OSSTF and ETFO ask. In late 2019 and early 2020 – the relevant time period as required by the point in time analysis – the Province was facing a $15 billion deficit (with substantially larger deficits predicted on the horizon) and the largest subnational debt in the world. Other economic indicators, for example,

the high level of net debt-to-GDP ratios, were similarly negative, with credit rating agencies taking notice of Ontario's deteriorating fiscal situation. The OSSTF and ETFO demands for 3.25% had to be considered in that context, and when they were it was inconceivable that the Crown – the participant in central bargaining for compensation purposes – would ever have agreed to anything other than the most modest of wage increases. That being the case, 3.25% should not be awarded now.

This same conclusion was readily reached when current economic indicators were reviewed – the situation was at worst deteriorating and economic growth was projected to slow; at best, little near-term improvement was predicted. On the other hand, inflation had begun to abate. In any event, both OSSTF and ETFO exaggerated the impact of inflation on wages. In all these circumstances, available public monies – separate and apart from an appropriate wage increase for teachers, occasional teachers and education workers – were needed to pay down debt, not fund unaffordable and unjustifiable collective bargaining demands, especially in circumstances where Ontario's teachers, occasional teachers and educational workers were already the best paid in the country.

Re-opener Outcomes

The Crown also urged caution, again assuming for the sake of argument that it was appropriate to look at re-opener outcomes – which for reasons already set out, it was not – in focusing on cherry-picked results from sectors that were simply not comparable such as energy and hospitals. The evidence established that overall the wage re-opener processes across all sectors yielded in 2021 an average total increase of 1.82% (including the original 1%). The average wage increase

awarded in respect of the 2021-2022 period, regardless of sector, was 1.75% (including the original 1%). The Moderated Collective Agreements commenced in 2021, and there were no wage re-opener results for 2021 of an aggregate 4.25% for that year, or even close. An additional increase of 3.25% would not have been the outcome then and cannot be the outcome now. The Crown asked that its quantum amount of 1.5% be awarded.

Discussion

It is appropriate to begin by quoting from the Crown brief: "The Crown respects and values the importance of public education and the critical work performed by … bargaining unit members represented by OSSTF and ETFO." It is also appropriate to acknowledge that teachers, occasional teachers, and education workers made an extraordinary contribution to our students and society during the pandemic, often in very trying, stressful and demanding circumstances.

According to the Remedy MOS's, in determining the outstanding issues we are to take into account any factors we consider relevant, together with the statutory criteria found in section 38 of SBCBA:

1. The school boards' ability to pay in light of their fiscal situation.
2. The extent to which services may have to be reduced, in light of the decision or award, if current funding and taxation levels are not increased.
3. The economic situation in Ontario.
4. A comparison, as between the employees and other comparable employees in the public and private sectors, of the terms and conditions of employment and the nature of work performed.
5. The school boards' ability to attract and retain qualified employees.

This is a Re-opener

Notwithstanding the Crown's submissions on point, it is our view that this proceeding is a re-opener. It is quite correct that the parties, in the Moderated Collective Agreements, did not include a classic collective agreement re-opener provision. What they did do was agree to the Moderated Collective Agreements – in a matter of weeks after the worldwide health emergency was declared – and did so without prejudice to their right to challenge Bill 124 before the courts and to seek appropriate relief if their constitutional challenge was successful. In its April 20, 2020, media release, the OSSTF observed, "these are extraordinary times…while this tentative agreement does not satisfy all our concerns, we recognize the current environment we are in and the need for students to have stability…."

After Bill 124 was declared of no force and effect, the parties met and negotiated the Remedy MOS's. They agreed on Years 1 and 2 and referred to this Board determination of the quantum for Year 3. There is nothing in the language of those Remedy MOS's that has persuaded us that in our task of determining the number for Year 3 we should adopt an approach that is in any way different than if this were a regular Bill 124 collective agreement re-opener.

In this case, and in the re-opener cases, the Board is charged with determining the appropriate level of compensation for one or more years where Bill 124 applied. The jurisdiction in the re-opener cases and this one is the same: to consider any factor we consider relevant, together, if applicable, with the statutory ones, and come up with a result. The process is the same, albeit the scope is slightly different: in most re-openers the re-opening of compensation was not limited to across-the-board increases as it is here. In the present context the terms "re-opener" and

"remedy" are identical. In re-openers, and in this remedy case, the mechanism chosen to resolve the dispute is also identical: interest arbitration, an interest arbitration where the parties agreed that the Board could consider any factors that it considered relevant, together with the statutory factors, and then come up with a quantum for Year 3. There is really no need, in these circumstances, for us to delve deeply into otherwise applicable *Charter* remedial principles. The remedy for the *Charter* breach has been conclusively and finally addressed by agreement between the parties.

Point in Time Analysis

There is nothing about this process that could lead one to conclude that we should apply a point in time analysis, as urged by the Crown. It would also be contrary to the weight of authority in almost all the re-opener cases where all relevant information – up to the date of hearing and sometimes even beyond (and there were post-hearing filings by the Crown of relevant authorities) – is considered. Bluntly put, to rely only on economic data – mostly projections – from 2019 and 2020, when actual data is available about what happened in 2022 and following – high and then persistent inflation – would constitute wilful blindness. Stated somewhat differently, bargaining began in 2019, and continued in 2020 when the Moderated Collective Agreements were reached. It is now 2024 and we are deciding the re-opener quantum for 2022.

We know that inflation was 6.8% in 2022. We know that many of the fiscal projections when bargaining commenced were inaccurate. To restrict ourselves to out-of-date and incorrect data in deciding the 2022 increase would be a triumph of form over substance. It would also be completely unfair: not in a values-driven sense but as a matter of due process. And that is why

this broader approach is now normative and generally followed (other than one early outlier award that has been generally rejected).

Bargaining Pattern not Dispositive

Likewise, we are not persuaded that there is some governing bargaining pattern. There is a pattern of results – between 1.5% and 3% over time (except when Bill 115 imposed zeros and the annual 1%'s mandated by Bill 124). There is a pattern where larger increases appear at the end of the term rather than the beginning. And there is a pattern of bargaining in this sector taking forever. These parties almost always bargain in arrears. There is no reason to believe that but for Bill 124 and the pandemic, bargaining would have concluded in early 2020. To apply a point in time analysis anchored to the date when the Moderated Collective Agreements were reached, apart from other expressed concerns about this approach, is not persuasive given how long these parties take to bargain.

To be sure, in some cases, bargaining patterns are governing – the Crown cited one such case – but this is not that case. Bargaining patterns can be and often are important, but even if there was one here, the situation dramatically changed in 2022 when inflation peaked at 6.8%. (Year 3 of the Moderated Collective Agreements began on September 1, 2021, and ran until August 31, 2022. For all intents and purposes, the year at issue is 2022). To hold the parties to a bargaining pattern, even one that was long standing, or bargaining positions tabled in 2019, by adopting a point in time analysis, in the face of dramatically changed economic circumstances, would require us to completely ignore the impact of actual inflation on wages and serious issues in

recruitment and retention. It would require us to rely on economic projections that never materialized and to ignore the emergence of recruitment and retention challenges.

Inflation

The onset of high inflation in 2022 broke any pattern (the existence of which was, in any event, contested by both OSSTF and ETFO). Another distinguishing feature is that the bargaining pattern relied on by the Crown arose when inflation was at normative levels and there was a teacher surplus. This is the exact opposite of the situation in 2022 and following. The bargaining patterns relied on by the Crown simply do not account for material changes in circumstances that occurred after the Moderated Collective Agreements were ratified.

In considering inflation, it has been both dramatic and persistent; its effects are now baked into prices, especially necessities – increased prices that are more profoundly impactful on lower paid workers. Even if inflation may have now begun to slow, for Year 3 it was 6.8%. Economists are not predicting a return to historical norms – 2% – any time soon. Significant and sustained inflation is normatively addressed by the parties and by interest arbitrators. Addressing inflation replicates free collective bargaining and replicates the overwhelming weight of relevant re-opener cases and voluntary settlements (discussed further below).

Recruitment and Retention

There is, for example, an anticipated shortfall of approximately 7000 occasional teachers. This is just but one aspect of the recruitment and retention challenges in education.

The College reported in 2021 that:

Ontario's decade-long teacher surplus is over, and a new teacher shortage is underway … this situation warrants early action to increase the province's annual supply of new teachers … unemployment is now at levels not seen in 15 years. Province-wide unemployment among Ontario education graduates in their first five years after licensing is now just two per cent. There is no longer any reserve pool … to staff daily occasional rosters and future LTO and permanent job vacancies.

There is also more demand than supply in other classifications, notably EA's. Ontario's population is growing at a rapid rate. Schools cannot meet their staffing needs, and the Crown has had no choice but to resort to ad hoc temporary but then renewed measures to fill vacancies. A comprehensive staffing strategy is obviously called for (perhaps revisiting an earlier policy decision to increase the time required to obtain the qualifying degree put into place when there was a teacher surplus). Recruitment and retention is one of the statutory factors to be considered in assessing compensation, and by any metric there is a staffing shortage, and it is expected to continue.

Application of Relevant Criteria

No one seriously believes that compensation alone will turn the recruitment and retention situation around. Increases to compensation are not a panacea because recruitment and retention issues are complicated and demand a curated and targeted approach. However, there is no question but that compensation is a driver in attracting employees to a field and retaining them once they are there. We must point out that the Remedy MOS's require us to arrive at a specific across-the-board percentage, depriving us of the ability to target increases to, for example, the lower (start) end of the teacher grid, or the daily stipend for occasional teachers, or rates for

certain classifications of education workers. Perhaps these are matters that can be addressed in subsequent rounds.

In these circumstances, of high 2022 inflation and an established recruitment and retention problem, one is hard pressed to see how the Crown's offer of 1.5% as the additional quantum for Year 3 comes even close to giving effect to the factors that must be considered in arriving at a result. An additional award of 1.5% would not in any way account for 2022 inflation; nor does it reflect the serious recruitment and retention issues identified in the briefs and at the hearing, a situation described by both OSSTF and ETFO as a crisis, and an issue not persuasively refuted by the Crown given the deployment of temporary measures to promote staffing and other initiatives. This does not mean, however, that the award should come in at the very top of the agreed-upon range in the Remedy MOS's because inflation and recruitment and retention are not the only factors to address.

Obviously, the state of provincial finances must be carefully considered, and has been. Public funds are not unlimited even if there is no inability to pay. We need to be prudent, not profligate, and fiscally responsible, but we must do so in a context, one in which normative and statutory criteria are considered, as they have been, and one where other relevant factors are also taken into account.

The Crown pointed out that compensation for teachers and education workers in Ontario is already at or near the Canadian top and this should lead to the conclusion that any increase must be modest. Justice Koehnen, in his decision invalidating Bill 124, found that "77% of teachers

are at the top step of their salary grid" (2022 ONSC 6658, para. 76). Ontario's teachers are the best paid, or close to best paid, in Canada. OSSTF and ETFO submit this is not even relevant to the determination of quantum in this re-opener proceeding as Ontario has the highest cost of living in Canada and Ontario education wages have never been set by looking to teacher wages in other Canadian jurisdictions.

To be sure, comparability is one of the statutory criteria and one interest arbitrators always examine. These parties have not generally looked to teachers elsewhere in the country as a relevant comparator (although it certainly is relevant – at least to us – to consider how teachers are paid across Canada). Rarely, however, is comparability singularly dispositive; it cannot be applied in the abstract, or without consideration of other criteria. Likewise, higher incomes do not, in our view, necessarily lead to the conclusion that a sub-normative across-the-board increase should follow in a re-opener or in the general course of bargaining. There is no general agreement with the proposition that just because a group of employees is already the best or well-paid that they should not receive an economic increase, or that they should receive a much smaller one than everyone else, in circumstances where there is widespread agreement that inflation and recruitment and retention necessarily drive higher wage increases.

Seventy-seven percent of the teachers are already at the top of the grid, and so there is no grid movement for them. The only increase they receive are the general wage increases. There is no reason to segregate one factor – highest paid teachers in the country – and conclude from that that Ontario's teachers and education workers should get less than everyone else, in the re-opener context and otherwise, in circumstances where inflation and recruitment and retention have led to

higher results in many different sectors. Adopting this approach would be without any rational justification. Inflation, no matter where one lives, or how much one is paid, is relevant and has been considered by parties across the broad swath of the Canadian economy in their voluntary settlements and as imposed in interest arbitration. The same is true about recruitment and retention. These factors have led to re-opener and other collective bargaining outcomes well beyond what is proposed by the Crown.

OSSTF and ETFO relied on a number of Bill 124 re-opener awards and urged that those results be replicated here. For example, in *The Participating Hospitals and ONA* (unreported award dated April 25, 2023), additional across-the-board increases and grid adjustments for a total value of 3.85% (1% + 2.85%) were awarded for 2022. In *The Participating Hospitals & CUPE/SEIU* (unreported award dated June 13, 2023), an additional 3.75% was awarded for 2021-2022 (along with many other economic improvements for a year that is almost identical to Year 3). In *The Participating Hospitals & OPSEU* (unreported award dated August 3, 2023), an additional 3.75% was awarded (along with many other economic improvements). In *OHA & PARO* (unreported award dated September 14, 2023), an additional 3.75% was awarded in 2022 (along with many other economic improvements) In *The Crown & OPSEU* (Corrections) (unreported award dated December 4, 2023), which was technically not a re-opener because, as a result of timing, Bill 124 had not applied, 3% was awarded for 2022, along with an additional 1% as a special adjustment that applied to most of the bargaining unit (along with other economic improvements).

Free collective bargaining results are also instructive, for example between OPG and PWU – 4.75% effective April 1, 2022 (although an outcome influenced in part by private sector comparators) – and 4.75% also for 2022 agreed to by the Government of Canada & PSAC (a settlement that set the pattern for hundreds of thousands of employees federally). In neither of these outcomes was there any recruitment or retention issue.

Also relevant are results from the post-secondary sector. In August 2023, the College Employer Council and OPSEU, representing Ontario's community college academic employees (immediately followed by support workers represented in a different bargaining unit), voluntarily settled their Bill 124 re-opener with an additional 2% in the first and second year of the moderation period, and 2.5% in in the third (total 3%, 3% and 3.5%). The number for 2022 was an additional 2%. Other results mirror these community colleges results, for example, University of Toronto (10% over three years) and Metropolitan Toronto University (8.25% over three years). Queen's University faculty settled their 2022-2025 collective agreement with 3.5% in 2022, and 3% in each of the successive years. There are no recruitment and retention issues with community college and university professors.

Accepting that the parties never previously considered teacher, occasional teacher and education worker outcomes in other jurisdictions, it is also most certainly the case that they have never previously looked to central hospital settlements either. The health care cases are, however, extremely relevant because of inflation and because of recruitment and retention. There is no question whatsoever – the awards are categorical – that the results in those cases arose in large

part in recognition of the impact of inflation and because of serious problems in recruitment and retention.

After these proceedings were concluded, the Crown forwarded two consent awards settling the re-opener issues between the Crown and the OPSEU unified bargaining unit and with AMAPCEO. In *The Crown & OPSEU* (unreported award dated January 21, 2022), covering the Ontario Public Service, re-opener amounts of 3%, 3.5% and 3% (inclusive of the Bill 124 1%) were awarded for 2022, 2023 and 2024, along with a relatively small number of classification adjustments of varying value (covering 8.18% of the bargaining unit) and significant increases for government nurses. The same across-the-board pattern was followed in AMAPCEO (although the classification adjustments in that award are irrelevant). Inexplicably, as inflation was substantially higher in 2022 than in 2023, these awards provided for 3.5% in the second year (2023).

A few observations are in order. There are no recruitment and retention issues in either of these bargaining units (other than what is presumably reflected by the small number of individual classification adjustments). While the Crown submits that these consent awards are highly relevant, and should be followed, we both agree and disagree. We agree to the extent that they are important from a replication perspective as they indicate what the Crown has agreed to with other large bargaining units with which it collectively bargains. That is surely relevant when it comes to replicating free collective bargaining. The fact that they are consent awards amplifies this point. But the overall impact of these awards is also diminished by the absence of

recruitment and retention as a factor (other than as reflected by the small number of classification adjustments) as is also the case with the awards from the post-secondary sector.

If there had been comparable recruitment and retention issues with the unified bargaining unit, with AMAPCEO, with post-secondary, all circumstances where the government was either the party in collective bargaining or the principal funder, that would have been extremely compelling. There are serious recruitment and retention challenges in the publicly funded elementary and secondary education sector. Serious recruitment and retention challenges have been taken into account in other sectors and we are of the view that that must occur here. To adopt the outcomes of these recent consent awards without adjusting for recruitment and retention would be to ignore several of the most relevant factors considered by interest arbitrators. Accordingly, these awards assist only somewhat.

Definitely not instructive are the average re-opener results for 2021 and 2022. Averages can be distorting, and relying on re-opener averages drawn largely from the long-term sector is not compelling. There is no comparison for present purposes between employees working in long-term care facilities and teachers, occasional teachers and education workers in our schools, and their re-opener results are factually distinguishable in every respect.

Taking all the evidence into account, the application of criteria and the overall weight of re-opener awards and settlements – especially those where inflation and recruitment and retention were addressed as they must be here – we have concluded that we should award an increase at the higher end of the agreed-upon range.

Conclusion

Accordingly, and for the foregoing reasons, we award an additional 2.75%, for a total of 3.75% (inclusive of the 1% already paid), for teachers, occasional teachers and education workers in the applicable OSSTF and ETFO Teacher/Occasional Teacher/Education Workers Moderated Collective Agreements. This amount is somewhat less than the outcomes in the energy sector (which have private sector comparators), and in the health care sector – where the recruitment and retention challenges are more severe – but somewhat more than the trend in the OPS, and post-secondary sectors where there are no real recruitment and retention issues.

The Remedy MOS's detail the process for implementation of our award and other steps to be taken by the parties. As provided in the Remedy MOS's, and as is normative, we remain seized with respect to the implementation of our award.

DATED at Toronto this 9th day of February 2024.

"William Kaplan"

William Kaplan, Chair

I dissent. Dissent attached.

Bob Bass, Employer Nominee

I dissent. Dissent attached.

David Wright, OSSTF & ETFO Nominee

Dissent of the Crown Nominee

I must strenuously dissent from the decision of the Chair.

In my respectful submission, the Year 3 ATB awarded is not supported by the replication principle (in particular in relation to the OPS awards received by the Board), over-emphasizes the impact of inflation, and fails to address key evidence on the question of recruitment and retention.
The Replication Principle is widely accepted as the principal criterion referenced and utilized when resolving disputes at interest arbitration. In reviewing the various Bill 124 outcomes that were presented by the parties, the two key ones are he awards for OPSEU Unified and AMAPCEO. No better examples can be found to apply the Replication Principle. The Crown is the Employer in both cases, both Unions are strong and the bargaining units are amongst the largest in Ontario, representing tens of thousands of Ontario Public Service employees in diverse job classifications. Notwithstanding the Crown's submissions, if the Chair accepts the Unions' position that these are consent awards, that would mean that they represent an agreement of the parties and as such, are much stronger examples for replication than a contested award.

While it is factually accurate that inflation peaked at 6.8% for the period in question, this does not justify the result. The OPSEU Unified and AMAPCEO awards with the OPS were issued in January 2024, with full knowledge of the inflation level during the period (with both awards covering a term that commences on January 1, 2022). The Chair has determined that the "point in time" to be considered must be the present, not the past. In each of the OPSEU Unified and AMAPCEO awards, that is exactly the case - these awards were determined in January 2024, with a full view to the period from January 2022 forward (including the impact of inflation through that period) – as such, they are fully reflective of the present, not the past, arriving at results which have the full benefit of that perspective and information, taking inflation into account. In my view, the application of the Replication Principle "trumps", particularly where inflation was obviously taken into account in such comparator awards. To use inflation to go beyond those comparators is not justified.

The other factor that clearly influenced the award here to a higher level is the Chair's view of issues of recruitment and retention. A number of facts before the Board lead me to a completely different conclusion. First, the extremely significant percentage of the bargaining unit members who are at the top rate of a very long grid. This datapoint alone confirms for me that there are no "retention" issues. Second, the artificial restriction on the supply of teachers created by the requirement of a second year of teacher's college, which reflects that there are clearly issues in the system that may be impacting recruitment that are not wage-driven. And third, and most significantly, there is no dispute that these Ontario employees are the highest paid in Canada. If one accepts that wages are a motivator for recruitment (and the chair must hold that view if the higher increase in this award is based on a view to enhance recruitment), then paying the highest incomes in Canada solves that concern alone and no special further adjustment above the base increase proposed by the Crown is required. There were additional explanations in the evidence before us for current staffing challenges (e.g. extraordinary (and increasing) absenteeism and sick leave usage) and the Crown highlighted the fact that the various sector stakeholders are actively

engaged in an ongoing committee trying to understand the reasons for any staffing shortages (which are complex, multi-faceted and not, in the Crown's view, wage-driven), but from my perspective the three primary reasons I identified make it clear that unlike other cases cited at the hearing, this is not a case where an extra adjustment is justified to address issues of retention and recruitment.

In summary, on the basis of the principle of replication and on a close review of the evidence before this Board, a 3% increase in total (the Bill 124 1% plus an additional 2%), would have been the more appropriate outcome, justified by the OPSEU Unified and AMAPCEO awards, reflective of the impact of inflation on the settlement trends for the year in question, and giving due consideration to all of the evidence presented on recruitment and retention.

Respectfully submitted,

Bob Bass

DISSENT OF DAVID WRIGHT
OSSTF & ETFO NOMINEE

I respectfully dissent from the award of the Chair.

While I concur with much of the Chair's reasoning, it is my view that his reasoning does not support the result the Chair ultimately reaches – that it is sufficient to award an additional 2.75% increase (for a total of 3.75%) for year 3 of the applicable OSSTF and ETFO Teacher/Occasional Teacher/Education Workers Moderated Collective Agreements.

It is my conclusion that the reasoning of the Chair, and the arguments and evidence advanced by each of the OSSTF and ETFO, clearly support an award of an additional 3.25% (for a total of 4.25%) for year 3 of each of the applicable collective agreements and I would have awarded that amount.

In my view the Chair correctly concludes that this is in fact a Re-opener; that a Point in Time Analysis is not proper or normative; and that there is no pattern of bargaining between these parties in the circumstances at hand that can be relied on to determine the appropriate increase to be awarded.

I also concur with the Chair's findings that in order to replicate free collective bargaining we must consider the dramatic and persistent increase in inflation experienced in 2022 and the significant recruitment and retention issues in the education sector.

Further, I share his conclusion that the fact that compensation for teachers and education workers in Ontario may already be at or near the top in the country does not warrant awarding these workers a lower economic increase than that obtained by others, particularly in the circumstances of high inflation and recruitment and retention issues.

The evidence before us demonstrated that other highly paid workers received large economic increases, even where recruitment and retention were not at issue (for example in the energy, federal, and post-secondary sectors). As the Chair notes, inflation is a highly relevant factor for our consideration, no matter where one lives or how much one is paid.

I also join with the Chair in his acceptance of the relevance of the awards and settlements in the health care, energy, post-secondary and federal public service sectors advanced by the Unions as being highly relevant in our efforts to replicate free collective bargaining.

For the reasons given by the Chair, I share his rejection of the awards and settlements in the long-term care sector, the OPSEU unified and AMAPCEO consent awards and the alleged "average" re-opener results for 2021 and 2022 advanced by the Crown. These are not instructive for us in seeking to replicate free collective bargaining.

I would add to the reasons given by the Chair for the rejection of the alleged "average" re-opener results advanced by the Crown the fact that, as demonstrated by the OSSTF and ETFO, those alleged "average" results were skewed and incomplete. The alleged "average" was simply not something that can be relied on.

Where I dissent from the Chair's award is with respect to his conclusion that the application of the various factors he has identified as relevant warrants only an additional 2.75 increase in year 3 of the applicable collective agreements.

Rather, given the reopener increases negotiated where recruitment and retention has, as is the case here, been a material factor, and given the increases in the energy and federal sectors where retention and recruitment was not a factor at all, it is my view that the application of the relevant criteria and factors leads to the conclusion that an award of 3.25% for year 3, the reasonable and fair position advanced by the OSSTF and ETFO, is more than warranted.

As a result, I would have awarded an increase of 3.25% (in addition to the 1% already paid, for a total of 4.25%) for year 3 of each of the applicable OSSTF and ETFO Teacher/Occasional Teacher/Education Workers Moderated Collective Agreements.



_____

David Wright
OSSTF and ETFO Nominee

EXHIBIT 22

IN THE MATTER OF AN INTEREST ARBITRATION BETWEEN:

The Crown in Right of Ontario

and

OPSEU/SEFPO Unified Bargaining Unit

Before: **Gerry Lee**
Sole Arbitrator

Appearances

For the Crown: **Sunil Kapur**
Patrick Pengelly
McCarthy Tetrault
Barristers & Solicitors

For OPSEU/
SEFPO Unified: **Coleen Houlder, OPS Unified Bargaining Team Chair**
2021 OPS Unified Bargaining Team
Len Elliott, OPS Supervisor

The matters in dispute proceeded to a mediation-arbitration on January 20th and 21st, 2024.

Introduction

This mediation-arbitration was convened to address the wage reopener agreement in the collective agreement for the term of January 1, 2022 to December 31, 2024 between The Crown in right of Ontario (hereafter the "Employer") and the OPSEU/SEFPO Unified Bargaining Unit (hereafter the "Unified Bargaining Unit"). In resolving the wage reopener issues, careful attention has been paid to the relevant criteria. Both parties identified various classifications in the bargaining unit that they viewed warranted exceptional consideration in the form of a special wage adjustment. These matters are addressed below. Any outstanding issue not specifically addressed in this award is deemed dismissed.

Wage Increases

1. **Wage Increases inclusive of 1% already negotiated (for all classifications in the Unified Bargaining Unit except Non-Law Student Employees).**

   January 1, 2022: 3.0%
   January 1, 2023: 3.5%
   January 1, 2024: 3.0%

   The wage increases would be applied to all current and past employees, including members on any leave including LTIP, who were employed during the period of January 1, 2022, to current.

Special Wage Adjustments

Both parties identified and each made submissions for special wage adjustments for certain Unified Bargaining Unit classifications. Many of the classifications identified in specific ministries by the parties have experienced very significant attraction and retention challenges related directly to compensation issues. The compensation issues for the identified classifications have led to material staffing challenges, and, in certain cases, concerns around continuity of critical frontline services and services concerning public health and safety. Accordingly, I award the following special wage adjustments for the specific classifications in certain ministries set out below in Appendix A. Special wage adjustments shall be effective January 1, 2024.

2. **Wage Increases for First and Second Year Summer Law Students**

   First and second year law students have not had a change in their wages since 1999 (other than the 1% wage increases already negotiated for 2022, 2023 and 2024). As a result, there have been material recruitment and retention issues. Accordingly, a one-time special adjustment to apply all ATBs reached with the Unified Bargaining Unit between January 1, 2000 and January 1, 2024 (inclusive). The special wage adjustment shall be effective January 1, 2024 and is set out in Appendix A.

3. Nursing Experience Credit

The parties shall amend the OPSEU/SEFPO Unified Bargaining Unit collective agreement with the following language in respect of Nursing Experience Credit, which is consistent with the recent OPSEU/SEFPO Corrections Bargaining Unit interest arbitration award dated December 4, 2023:

This letter shall apply to full-time, part-time, and fixed-term nursing positions. Claims for related clinical experience, if any, shall be made in writing by the nurse within 90-days of the date of hire to the Employer. Credit for related experience will be retroactive to the nurse's date of hire. The nurse shall co-operate with the Employer by providing verification of previous experience. Having established the related clinical experience, the Employer will credit a new nurse with 1904 or 1725.50 hours as applicable for each year of experience, up to the maximum of the salary grid. The nurse shall be placed at the corresponding step on the salary grid commensurate with their years of experience. Merit dates/hours shall be adjusted to reflect a partial year's credit.

For clarity, this credit for clinical experience shall only be used for placement on the wage grid and will have no impact on fixed-term seniority or Continuous Service Date (Articles 18 and 31A.17).

If a period of more than two (2) years has elapsed since the nurse has occupied a full-time or a part-time nursing position, then the number of increments to be paid, if any, shall be at the discretion of the Employer. The Employer will give due consideration to an internationally educated nurse's experience where the process for registration with the College of Nurses of Ontario has prevented them from occupying a nursing position for a period of more than two (2) years. For full-time nurses, the Employer shall give effect to part-time nursing experience, and for part-time nurses the Employer shall give effect to full-time nursing experience. NOTE: For greater clarity, related nursing experience includes related nursing experience out of province and out of country.

Within 180 days from date of this award, current employees in nursing positions will have a one (1) time opportunity to submit in writing a claim for related clinical experience to the Employer. The nurse shall co-operate with the Employer by providing verification of previous experience. These claims shall be reviewed by the Employer and employees shall be placed at the corresponding step on the salary grid commensurate with their years of experience. Merit dates/hours shall be adjusted to reflect a partial year's credit. Any retroactive amounts owed shall be limited to the date of the interest arbitration award.

Conclusion

At the request of the parties, I remain seized with respect to the implementation of this award.

DATED at Toronto this 21 day of January 2024.

Original signed by:

Gerry Lee, Sole Arbitrator

Appendix A

Various Classifications in Certain Ministries

Effective January 1, 2024:

16710	AMBULANCE COMMUNICATIONS OFFICER 1 (MOH)							
	01/01/2024	37.36	38.52	39.31	40.22	41.87	44.36	45.69
16711	AMBULANCE COMMUNICATIONS OFFICER 2 (MOH)							
	01/01/2024	38.95	40.15	41.39	42.75	44.51	47.05	48.44
95504	OPERATIONAL (BU) OST15 (OCWA)							
	01/01/2024	1,226.83	1,264.80	1,314.73	1,366.80	1,420.23	1,477.15	1,521.52
95504P	OPERATIONAL (BU) OST15 (PEEL) (OCWA)							
	01/01/2024	1,691.73	1,737.64	1,797.98	1,860.88	1,925.46	1,994.28	2,047.87
95505	OPERATIONAL (BU) OST16 (OCWA)							
	01/01/2024	1,316.68	1,357.40	1,411.82	1,468.45	1,527.40	1,588.62	1,636.27
93032	UTILITY PLANT ELECTRICIAN (OCWA)							
	01/01/2024	34.62	35.69	36.49	37.58			
93030P	MAINTENANCE ELECTRICIAN (PEEL) (OCWA)							
SA	01/01/2024	39.26	40.34	41.12	42.22			
93034	MAINTENANCE ELECTRICIAN, FOREMAN/WOMAN (OCWA)							
	01/01/2024	36.74	37.85	38.82	40.00			
93034P	MAINTENANCE ELECTRICIAN, FOREMAN/WOMAN (PEEL) (OCWA)							
	01/01/2024	42.06	43.21	44.18	45.40			
93010	MAINTENANCE FOREMAN/WOMAN (OCWA)							
	01/01/2024	33.17	34.20	34.92	35.96			
93010P	MAINTENANCE FOREMAN/WOMAN (PEEL) (OCWA)							
	01/01/2024	39.91	41.01	41.73	42.86			
93006	MAINTENANCE MECHANIC 3 (K7 SALARY NOTE) (OCWA)							

SA	01/01/2024	30.92	31.88	32.55	33.55	
93006P	MAINTENANCE MECHANIC 3 (PEEL) (OCWA)					
SA	01/01/2024	38.14	39.19	39.91	40.98	
40402	WASTE AND WATER PROJECT OPERATOR 1 (OCWA)					
	01/01/2024	27.92	28.79	29.50	30.14	31.06
40402P	WASTE AND WATER PROJECT OPERATOR 1 (PEEL) (OCWA)					
	01/01/2024	34.08	34.95	35.66	36.30	37.21
40404	WASTE AND WATER PROJECT OPERATOR 2 (OCWA)					
	01/01/2024	29.49	30.41	31.13	31.89	32.83
40404P	WASTE AND WATER PROJECT OPERATOR 2 (PEEL) (OCWA)					
	01/01/2024	35.68	36.58	37.32	38.06	38.99
41100G	RESOURCE TECHNICIAN 1 (G29 SALARY NOTE) (MNRF)					
	01/01/2024	25.38	26.16	26.72	27.53	
41102G	RESOURCE TECHNICIAN 2 (G29 SALARY NOTE) (MNRF)					
	01/01/2024	27.36	28.20	28.92	29.60	30.48
41104G	RESOURCE TECHNICIAN 3 (G29 SALARY NOTE) (MNRF)					
	01/01/2024	29.16	30.07	30.74	31.52	32.43

Nursing Classifications for OPS Unified

Effective January 1, 2024, a one-time special adjustment such that the following Unified Bargaining Unit Nurse classification nurse wages rates will be at parity with the OPS Correctional Bargaining Unit Nurse classification wage rates:

41500	Psychiatric Nursing Assistant 1(P1 Salary Note)
41502	Psychiatric Nursing Assistant 2 (P1 Salary Note
41504	Psychiatric Nursing Assistant 3 (P1 Salary Note)
41506	Psychiatric Nursing Assistant 4 (P1 Salary Note)
50052	Nurse 2, General (N2, N3 Salary Note)
50054	Nurse 3, General (N1, N2, N3 Salary Note)
50072	Nurse 2, Clinic (N2 Salary Note)
50110	Nurse 2, Special Schools (N2 Salary Note)
50112	Nurse 3, Special Schools (N1, N3 Salary Note)
50120	Nurse 1, Public Health (N2 Salary Note)
50050	Nurse 1, General

50064 Nurse, Outpatient Clinics (N2, N3 Salary Note)
50070 Nurse 1, Clinic (N2 Salary Note)
50075 Head Nurse, Output Clinics (N1, N2, N3 Salary Note)
50080 Nurse 1, Nursing Education
50082 Nurse 2, Nursing Education (N3 Salary Note)
50084 Nurse 3, Nursing Education
50122 Nurse 2, Public Health
50124 Nurse 3, Public Health
50128 Nurse, Occupational Health & Safety (N2 Salary Note)

Salary notes N1, N2 and N3 from the General Notes and Allowances deleted effective January 1, 2024).

No nurse to see reduction in wages as a result of implementation of this award.

First and Second Year Law Students

Effective January 1, 2024:

U0164 First Year Law Student $26.52
U0165 Second Year Law Student $29.75

EXHIBIT 23

IN THE MATTER OF AN INTEREST ARBITRATION

BETWEEN:

The Crown in Right of Ontario

and

AMAPCEO Bargaining Unit

Before: **Gerry Lee**
Sole Arbitrator

Appearances

For the Crown: David Au, Assistant Deputy Minister
Steven MacKay, Director
Stephanie Borcsok, Manager

For AMAPCEO: Marisa Pollock, Counsel, Goldblatt Partners LLP

The matters in dispute proceeded to a mediation-arbitration on January 26, 2024.

Introduction

This mediation-arbitration was convened to address Bill 124 remedy issues between the Crown in right of Ontario (hereafter "Employer") and the Ontario Public Service (OPS) AMAPCEO Bargaining Unit, pursuant to the parties' interest arbitration agreement.

The Employer and AMAPCEO began negotiations for their current collective agreement, which covers the period of April 1, 2022 to March 31, 2025, in March 2022 and, following several months of negotiations, reached an agreement in October 2022. During that time, the *Protecting a Sustainable Public Sector for Future Generations Act, 2019* ("PSPSFGA" or "Bill 124") was in effect and the parties were subject to the terms and conditions of the PSPSFGA, which included a 3-year "moderation period" during which the parties were required to restrict any increases to wages or total compensation to 1% per year. Accordingly, the parties agreed in a letter of understanding that the compensation increases agreed to under the collective agreement are without prejudice to the rights of AMAPCEO to challenge the provisions of Bill 124 and to seek any appropriate remedy in the event such challenge is successful.

Subsequently, Bill 124 was declared unconstitutional on November 29, 2023. The parties have since entered into an agreement to refer the remedy issues to interest arbitration.

In this award, all relevant criteria, including statutory and other criteria, have been carefully considered in resolving the outstanding remedy issues. Any outstanding issue not specifically addressed in this award is deemed dismissed.

Wages Increases inclusive of 1% already negotiated (for all classifications in the AMAPCEO Bargaining Unit)

April 1, 2022:	3.0%
April 1, 2023:	3.5%
April 1, 2024:	3.0%

The wage increases would be applied to all current and past employees, including members on any leave including LTIP, who were employed during the period of April 1, 2022 to current.

Special Wage Adjustments

Both parties recognize that nursing positions in other OPS bargaining units (e.g., OPSEU Corrections) have recently been awarded market pay adjustments that

better reflect the going wage rate for nursing positions in Ontario. As such, and in consideration of the parties' mutual interest to address this same issue in the AMAPCEO bargaining unit, I award the following special wage adjustment for the following specific jobs: Clinical Nurse Advisor, Nurse Case Manager, Nurse Advisor, and Senior Nurse Consultant.

Effective January 1, 2024:

- Clinical Nurse Advisor (6A012), Nurse Case Manager (6A012), and Senior Nurse Consultant (6A012) will be adjusted as follows: $82,810 - $122,028 / annum.

- Nurse Advisor (5A012) will be adjusted as follows: $76,790 - $110,635 / annum.

Conclusion

- At the request of the parties, I remain seized with respect to the implementation of this award.

DATED at Toronto this 26th day of January 2024.



Gerry Lee, Sole Arbitrator

EXHIBIT 24

Notes on Calculation of each provincial payment model:

1. Patient visit payment rate represents the weighted average payment rate for LFP visits based on the publicly available statistical supplement for FY 2022/23. Rate incudes all work (including procedures) billed under BC's LFP model.
2. Nova Scotia visit rate is calculated by simulating a weighted average visit fee between 03.03 (patients age 65 and under) and 03.03A (patients age above 65). Weights are calculated using visit frequency between the two age groups for FHOs in 2022/23. Assumes all services billed are eligible for ME=CARE comprehensive care rate, and uses the 2023/24 tariff of $2.76 per MSU. Rate shown accounts for 30% flow-through rate.
3. Saskatchewan visit rate is calculated using average payment per service by GPs as per the publicly available 2021/22 MSB statistical supplement, plus a 14.8% lump-sum payment awarded for 2023/24. Assumes that one service is one visit.
4. Saskatchewan capitation payments vary by panel size and the number of encounters a physician holds with enrolled patients. The average FHO physician activity is entered into the Saskatchewan capitation formula to obtain an average for comparison to Ontario. The average payment FHOs would receive in Saskatchewan is divided by their panel size as of March 31st, 2023, to obtain the patient-weighted average panel size payment.
5. Weighted average of limited assessment (03.03A) and comprehensive assessment (03.04A) using Ontario billing ratio costed at GP specialty rate. Assumes 1/3 of services are eligible for each complexity premium, ¾ of 03.03A visits require 1 exta call with CMGP premium, and 15% or 20% of visits have TELE premium for 03.03A and 03.04A respectively.
6. Takes a weighted average of Newfoundland basket of services using Ontario billing frequency mapped to the 2022 fee schedule, and applies 13.31% increase received in the most recent agreement. The rate shown includes 25% flow-through rate.
7. Assumes the average enrolled patient has the benchmark 1.00 complexity modifier adjustment

8. Details on Panel Management Payments are found here (Link). Assumes physicians receive the maximum possible payment
9. Uses data from Ontario to estimate a ratio between basic, intermediate and complex visit tariffs. Once the weighted average is established, pelvic/pap fee add-on volumes are estimated using fee code G365 volumes. Age premiums are captured using actual patient age data for A001, A003, and A007 visits in FY 2022/23.
10. Includes Age Tariffs (8181 – 8185) modelled via RPDB, Comprehensive Chronic Disease Tariffs (8186 – 8189) modelled via FY22 CIHI Grouper w/ 2-year lookback, and Mental Health Tariff (8190) modelled using CIHI Grouper. Patient data is then linked with CAPE to determine actual capitation payments that would have been made for FHO-enrolled patients had they been under the Manitoba model
11. Includes 2.8% increase awarded for Year 3 of the 2021 PSA. Approximated the impact of the increase by applying 2.8% increase to all payment elements for Ontario FHOs

Breakdown of Total Compensation by Payment Type

Model Element	Ontario FHO Model	British Columbia LFP Model	Nova Scotia LFM Model	Newfoundland and Labrador Blended Capitation Model	Manitoba Family Medicine Plus	Alberta FFS GP Model	Saskatchewan TPM Model
Patient Visit Payment	14.6%	28.1%	15.7%	14.3%	46.4%	80.9%	62.4%
Hourly Payment	0.0%	57.5%	41.4%	0.0%	10.0%	0.0%	0.0%
Panel Size Payment	72.3%	14.5%	42.9%	82.0%	42.2%	0.0%	37.6%
Other Payments	13.1%	0.0%	0.0%	3.7%	1.4%	19.1%	0.0%
Total Payments	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

A key difference between the primary care models in Ontario (and Newfoundland) compared to the other provinces is the portion of total compensation derived from panel-size payments. Where other Canadian jurisdictions derive no more than 43% of total income via panel payments, in Ontario and Newfoundland physicians earn more than 70% of their income via panel payments. The other Canadian provinces (BC, Alberta, Saskatchewan, Manitoba, Nova Scotia) all derive well more than half of their payments from patient visits and hourly rates, measures that have a more direct link to workload.

EXHIBIT 25

Estimating physician overhead costs in Ontario.

This exhibit summarizes analysis that was performed with the objective of estimating physician overhead costs in Ontario.

The methodology used for this analysis assigns a unique overhead cost for each physician practicing in Ontario. The overhead cost is a function of the FTE attributed to each physician, the specialty of each physician, the primary practice location (geography) of each physician and the practice setting of each physician. The practice setting and FTE are derived inputs and are explained in detail in this document.

Physician Practice Setting Methodology

Physician practice setting is used as an input for overhead costs.

Overview of Physician Practice Setting Methodology



Data Source: OHIP Claims Data FY 2022-23

Methodology:

As a first step, all OHIP claims were analyzed and assigned a facility type based on the MNI field in claims. Facility types that are funded through Ministry were then identified. Finally, physicians were assigned to one of three practice setting categories based on the percentage of their billings (fee approved amount) in institutions directly funded by the Ministry:

- **Institution-Based**: More than 95 percent of the physician's billings are provided in a Ministry-funded institution
- **Physician Office:** Between 0 and 5 percent of the physician's billings are provided in a Ministry-funded institution
- **Mixed Setting Group**: Between 5 and 95 percent of the physician's billings are provided in a Ministry-funded institution

The following facility types were defined as Ministry-funded:

- *Acute Care Treatment Hospital*
- *Ambulatory Care*
- *Nursing Home (Long Term Care Beds)*
- *General Rehabilitation Hospital and Units of Hospital*
- *Mental Health Unit*
- *Chronic Care Treatment Hospital and Units of Hospital*
- *Home for the Aged*
- *Special Rehabilitation Hospital and Units of Hospital*

Exclusions:

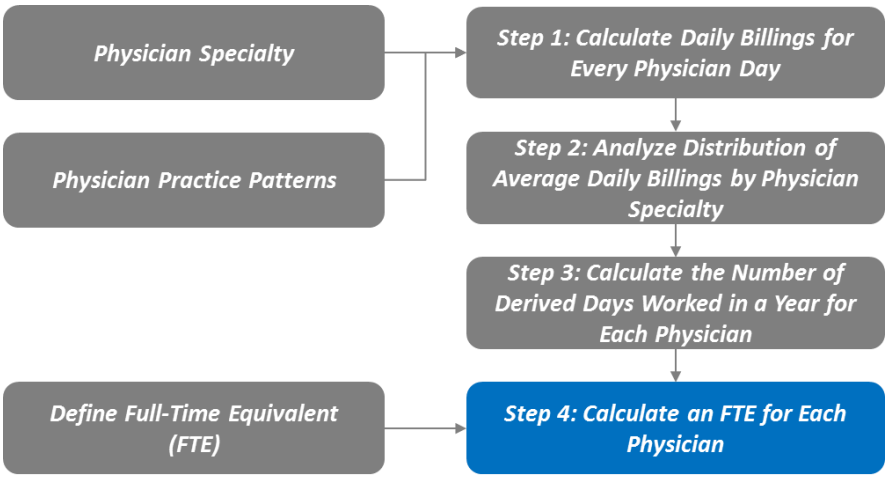
When allocating physicians into each practice setting, codes that represent addons to the regular service codes and not actual services provided were excluded from a physician's billings during practice setting assignment. Appendix A has a complete list of these codes. These codes include:

- Primary care Q codes between Q100A and Q899C
- Fee code premiums: Special Visit Premiums, Care Premiums, Afterhours Premiums

FTE Methodology

FTEs are calculated based on physician specialty, and the billing patterns derived from OHIP claims data, as outlined in the figure below.

Overview of FTE Calculation Methodology



Data Sources:

- OHIP Claims Data FY2022-23
- Practice Setting: Institutional-based, Mixed, Physician Office

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Methodology:

Workload at the individual physician level was calculated using a five-step process:

Step 1: Calculate the daily billings for every physician day

Based on the claims submitted by each physician, determine the daily billings for each physician as the sum of each physician's total billings (approved amounts) on distinct days on which the physician billed for at least one service.

Step 2: Analyze the distribution of daily billings by physician specialty

Determine the distribution of daily income of all physicians within the same specialty and calculate the 33rd and 66th percentile of average daily billings (approved amounts) to define a single day worked.

Step 3: Calculate the number of derived days worked in a year for each physician

Using the percentiles calculated in Step 1, calculate a "derived day" worked for each day a physician bills at least one service. Daily billing amounts between the 33rd to 66th percentile of the calculations in Step 1 are considered one full derived day. Any daily billings outside of this range are prorated as follows:

$$\textbf{Total Derived Days Worked per Physician} = \sum \begin{cases} \dfrac{\text{Daily Billings Amount}}{\text{Lower Benchmark}} & \text{If daily billings amount... } < 33\text{rd percentile} \\ 1 & \geq 33^{rd} \text{ percentile and } \leq 66^{th} \text{ percentile} \\ 1 + \ln\left(\dfrac{Daily\ billing\ amount}{Upper\ Benchmark}\right) & > 60^{th} \text{ percentile} \end{cases}$$

Day worked =

- Daily billings below the 33rd percentile are prorated based on the 33rd percentile value for the physician's specialty
- For physicians seeing more patients than the upper benchmark (66th percentile), one day worked was taken as a function of the natural logarithm of the upper limit (similar to CIHI definition)
- Approved billing amounts were used to calculate daily billings amounts as opposed to fee paid billing amounts
- Billings for Q codes, were excluded in calculating daily billings amounts (add-ons not associated with specific service volumes

Step 4: Define an FTE based on days worked

Using a standard definition of a full-time physician, 220 days of work were considered full time. The definition is based on the number of days worked with a set amount of days for holiday time, statutory holidays and training. *A full-time equivalent was defined as*:

- *220 derived days worked (44 standard weeks of work; 5 days per week[1] with;*
- *20 days (4 standard work weeks) of vacation and*
- *11 days (approx. 2 standard work weeks) for statutory holidays[2];*
- *10 days (2 weeks) assigned for personal development or training*

Step 5: Calculate an FTE for each physician

Calculate each physician's FTE based on a standard definition of a full-time physician and the total number of annual derived days worked, as outlined in the formula below.

$$FTE = \frac{\sum(Number\ of\ Annual\ Derived\ Days)}{220\ derived\ days}$$

Exclusions:

When calculating the average daily billing of physicians within each specialty, codes that represent add-ons to the regular service codes and not actual services provided were excluded. These codes include:

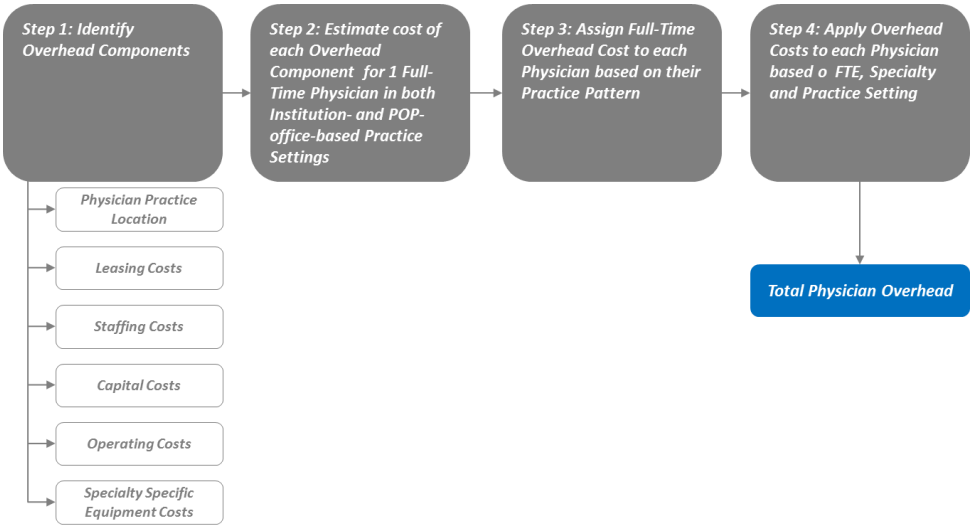
- Primary care Q codes between Q100A and Q899C
- Fee code premiums (Special Visit Premiums, Care Premiums, Afterhours Premiums)

[1] http://www.workingdays.ca/ *from 2022-04-01 to 2023-03-31*
[2] See Appendix A for details

Physician Overhead Cost Methodology

This methodology assigns a unique overhead cost for each physician practicing in Ontario. The overhead cost is a function of the FTE attributed to each physician, the specialty of each physician, the primary practice location (geography) of each physician and the practice setting of each physician.

Figure 1: Components of Physician Overhead Costs



Data Sources:

- Practice Setting: OHIP Claims Data 2022-23
- General Equipment Costs: *The Business side of Medicine, Canadian Medical Association, 2015* (updated with 2024 costs)
- Office lease rates: *JLL Q4 Office Market Statistics* and commercial office gross lease listings (2024)
- Physician FTEs: As described previously

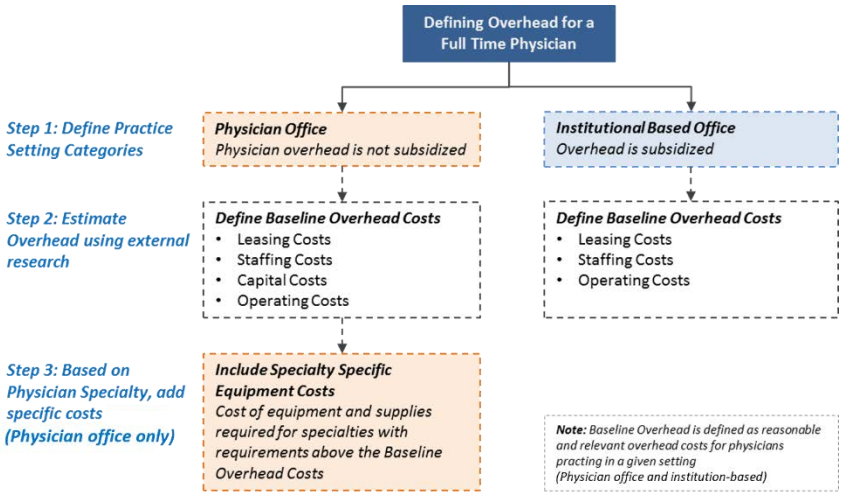
Components of Overhead

Physician Overhead was estimated using a bottom-up approach and accounts for differences in cost between physician offices and institution settings. The key components of these requirements include:

- Leasing Costs: Estimated using the size requirements of the office space and the leasing rate of the location
- Staffing Costs: Estimated using administrative and clinical staffing ratios
- Operating Costs: Includes annual costs such as insurance, membership dues, medical supplies and professional services
- Capital Costs: Represents basic equipment requirements of medical offices such as instruments and furniture as well as IT requirements (e.g. computers and printers)
- Specialty Specific Equipment and Supplies: Includes costs for specific equipment required for specialties with unique costs and technical requirements

For each of these overhead components, external research was used to generate cost estimates for a full-time physician practicing in a physician office and a full-time physician practicing in an institution-based setting (as shown in the figure below). From there, an overhead value for each physician was estimated based on the share of their work in an office setting vs. institution-based setting.

Methodology for determining overhead for one full-time physician



Leasing Costs

Cost per Square Foot

The first step in determining physician leasing costs is to understand the commercial leasing market in Ontario. The province was separated into 5 key regions in which average leasing costs for these regions could be applied based on the physician practicing location. Physician practice locations were determined using CPDB practice address data.

Table 7: Average Gross Leasing Costs by Main Practice Address Location

Practice Region	First Letter of Practice Postal Code	Average Gross Leasing Cost
Toronto	M	$43.99
Central Ontario	L	$35.23
Eastern Ontario	K	$33.52
Southwestern Ontario	N	$29.40
Northern Ontario	P	$26.35

Physician Office Size

Physician office size requirements for one full-time physician were estimated for both physician office and institution-based physicians. The table below summarizes the sources and estimates for approximating office size requirements in both settings for one full time physician.

Table 1: Office Size Requirements by Practice Setting[3]

Practice Setting	Physician Office Setting		Institution Setting	
Size Requirements	Combined Office / Exam Room (1FT Physician)	160 s.f.	Combined Office / Exam Room (1FT Physician)	200 s.f.
	Multipurpose Exam Room (x3)	360 s.f.		
	Waiting Area (10 patient capacity)	160 s.f.		
	Reception Desk	65 s.f.		
	Total Net s.f.	745 s.f.		
	Component Grossing Factor (35%)	261 s.f.		

[3] Ministry - Space Standards for Community Health Care Facilities (March 2017)

	Total Required Square Footage	1,006 s.f.	Total Required Square Footage	200 s.f.

Staffing Costs

Staffing costs have three major components: the type of staff required, the annual costs of each staff member and the number of FTEs required to run a practice. Similar to office size requirements, different assumptions were used for physicians practicing in physician office versus an institution-based practice. The three types of staff considered in the overhead component of the model include:

- Medical Office Assistant
- Medical Receptionist
- Registered Nurse
- Registered Practical Nurse

Table 9: Summary of annual staffing costs per full time physician in a Physician Office and institutional based setting

	Medical Office Assistant	Medical Receptionist	Registered Nurse	Registered Practical Nurse	Total
Annual Salary[4]	$42,722	$42,722	$77,564	$55,612	
Benefits (23%)[5]	$9,826	$9,826	$17,840	$12,791	
Number of FTEs per Physician					
Physician Office[6]	0.33	0.33	0.08	0.10	
Institution[5]	0.33	0	0	0	
Total Annual Staffing Costs (per full time physician)					
Physician Office	$17,341	$17,341	$8,097	$6,614	$49,392
Institution	$17,341	$0	$0	$0	$17,341

Capital Costs

Capital costs are defined as costs that can be amortized over a period greater than one year. These costs were separated into three main segments: furniture, medical equipment and medical instruments. Each segment of capital costs was amortized over different periods to reflect the nature of these capital requirements. The total capital costs and annualized costs of a physician office is shown in the table below**Error! Reference source not found.**.

Table 10: Summary of Capital Costs for a physician office

Type[7]	Amortization[8]	Cost	
		Total[9]	Annual
Furniture	10 years	$28,982	$2,898
Equipment	10 years	$32,718	$3,272
Instruments	5 years	$1,868	$374
Total Annual Cost			**$6,544**

Operating Costs

Operating costs include expenses that are incurred by a physician on an annual and recurring basis. It was assumed that these costs are consistent across all physicians within a physician office-based setting as well as physicians in an institution-based setting. The breakdown of these costs is shown below in the

[4] Annual staffing salaries are based on average rates for staff in Family Health Teams for 40 hours per week, 51 weeks per year
[5] Ontario Nursing Association – Base plan; Extended Health Care plan
[6] Medical Office Assistant and Receptionist FTE ratios were derived based on Community Health Center (CHC) ratio of clinician FTEs to administrative FTEs; Nursing Staff Ratios were derived based on the number of nurses practicing in Physician's offices in Ontario (See Appendix)
[7] A detailed summary of all capital costs can be found in Appendix
[8] Amortization lengths were based on the expected useful life of the equipment, furniture and instruments used by physicians
[9] The business side of medicine, Canadian Medical Association, 2015 (updated with 2024 costs)

table below. CMPA premiums are derived based on the net cost of the premium (total premium cost less government subsidies) of the physician's specialty and type of practice.

Table 11: Summary of Physician Operating Expenses[10]

Operating Cost Item	Annual Expense
Professional Dues	$6,096
Supplies (one year)	$4,963
Accounting	$2,500
Parking	$800
Insurance[11]	$4,243
CMPA[12]	Variable
Total	**$18,602**

Specialty Specific Equipment Costs

It was assumed that physicians who are paid technical fees are adequately compensated for any additional overhead (beyond what is outlined in the tables above) through these fees. Therefore, technical fees are excluded from both the physician's income as well as the overhead costs they are intended to compensate. Two specialties were given special consideration for specific equipment that is required to perform their services. Ophthalmologists and Dermatologists were specialties requiring specific consideration. The table below summarizes the specialty specific equipment costs of these two specialties practicing in a physician office setting. No consideration was given for Ophthalmologists and Dermatologists practicing in Ministry-funded institutions.

Table 12: Specialty Specific Equipment Cost of Physician Office Based Physicians[13]

Specialty	Amortization	Cost	
		Total	Annual
Dermatology	10 years	$6,514	$651
Ophthalmology	10 years	$460,000	$46,000

[10] A detailed summary of all operating costs can be found in Appendix

[11] Insurance includes office insurance, practice overhead insurance, disability insurance

[12] CMPA premiums were calculated separately for each physician based on specialty and type of work (See Appendix for details)

[13] See Appendix for details on the equipment lists and sources to derive the total costs

Calculating Physician Overhead

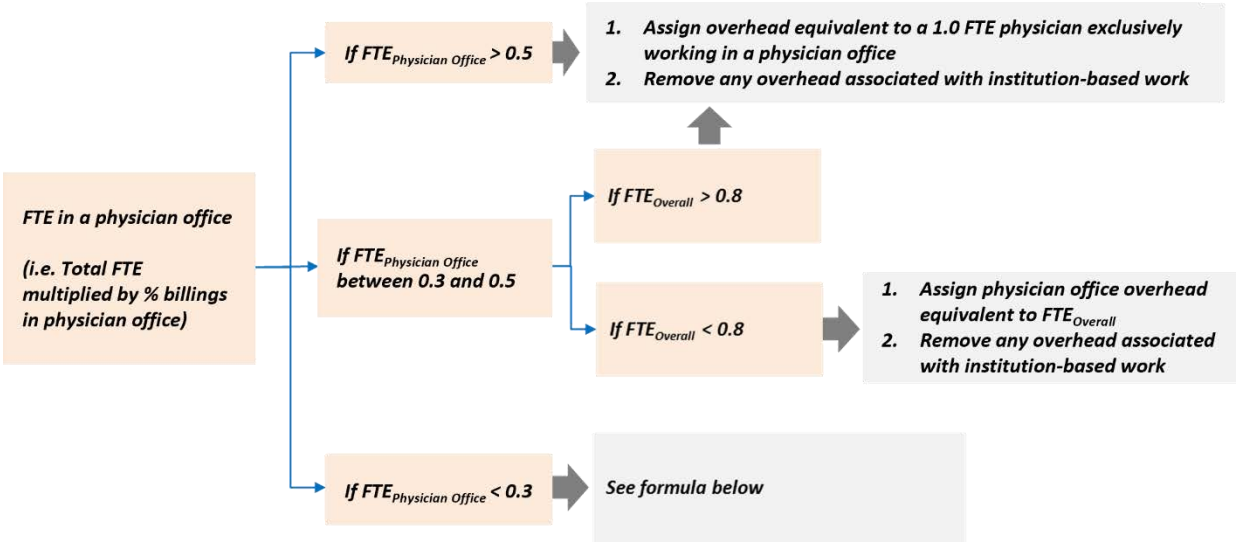
A two-step process was used to compute the total overhead for each physician:

Step 1: Total the relevant overhead expenses (for a 1.0 physician FTE) for both the physician office setting and institution setting

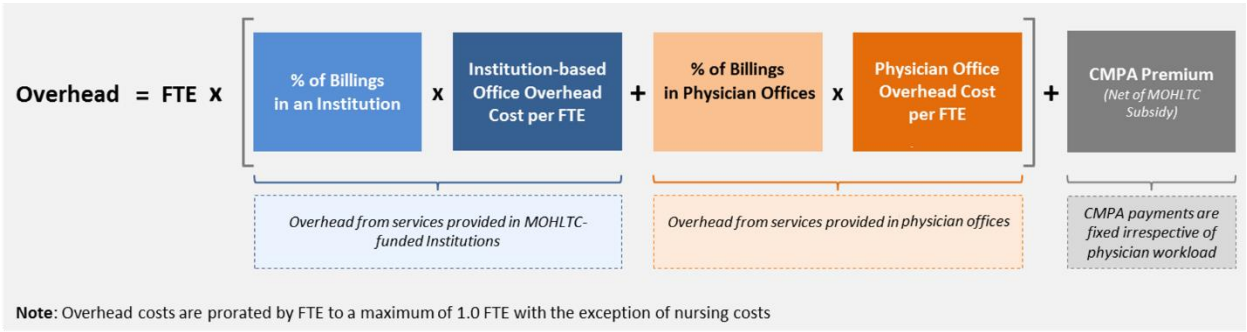
Step 2: Compute the overhead cost of each physician in Ontario by adjusting for the physician's unique FTE weight and the percentage of services provided in the physician office and institution settings

The figure below outlines the assignment of costs for physicians based on their FTEs and the above overhead estimates. Physicians are assigned the full costs of an office when they reach more than 0.5 FTE or 110 full working days in a year for services provided in a physician office. For these physicians who are allocated a full office, overhead costs are assumed to be primarily fixed and do not change with changes in the number of days worked. Physicians who have less than 0.5 FTE in a physician office are assumed to have variable overhead.

Calculation used to compute Overhead Costs for Physicians



Formula for $FTE_{Physician\ Office}$ < 0.3:



Note that nursing staff costs (RNs and RPNs) are applied to physicians who are assigned to physician office and mixed practice settings and these costs prorated by their $FTE_{Physician\ Office}$. CMPA fees (net after government subsidies), professional dues, insurance premiums, accounting costs, and parking costs are fixed costs regardless of the physician's FTE and applied to all physicians.

Appendix: Supporting Overhead Data and Analysis

Deriving Nursing Staff Ratios in Ontario

Estimating Nursing staff ratios in Physician Offices is a three-step process:

1. Determine the number Registered Nurses (RN) and Registered Practical Nurses (RPN) that work in Physician offices
2. Determine Nurse Full-time equivalents (FTE)
3. Calculate the ratio of Physicians to Nurses

Distribution of Nurses working across Practice Settings

To determine the number of Nurses working in physician offices, we used the College of Nurses of Ontario (CNO) Data Query Tool[14]:

Table 2. Distribution of Nurses across Practice Settings

	Registered Nurses (RN)		Registered Practical Nurses (RPN)	
Practice Setting (2023)	**Headcount**	**% of total**	**Headcount**	**% of total**
Hospital	74,599	61%	25,988	41%
Community				
Community health centre	1,257	1%	854	1%
Family health team	1,075	1%	782	1%
Physician's office	1,952	2%	1,921	3%
Rest of Community	20,358	17%	10,110	16%
Long-Term Care	9,770	8%	20,088	31%
Other	13,379	11%	4,383	7%
Total	122,413		64,146	

The CNO defines a Physician's office as a group or solo practice that provides episodic or continuing, comprehensive primary care (e.g. doctor's office, walk-in clinic, urgent care centre).[15] Based on total counts, there were 1,952 RNs and 1,921 RPNs working a Physician's office in 2023.

[14] CNO Data Query Tool: https://data.cno.org/
[15] Nursing employees in Ontario, RN and RPN. College of Nurses of Ontario – Membership Statistics 2023

Number of FTE Nurses working in a Physician's office

The CNO does not report on FTE in its Membership Statistics (2023). To derive FTEs, we used the Data Query tool to further dissect the Physician office to determine the number of full time, part time and casual Nurses working in this practice setting:

Table 3. Full-time equivalent (FTE) Nurses working in a Physician's office

	RNs working in Physician's Office			RPNs working in Physician's Office		
Working Status	**Headcount**	**FTE Assumption**	**RN FTEs**	**Headcount**	**FTE Assumption**	**RN FTEs**
Full time	704	1	704	1,103	1	1,103
Part time	722	0.5	361	581	0.5	291
Casual	526	0.5	263	237	0.5	119
Total	1,952		1,328	1,921		1,513

RN and RPN FTEs were calculated by multiplying Headcount by the assumed FTE value (1 for Full time, 0.5 for Part time and casual working status). Following this conversion, the number of FTE RN and RNPs working in a Physician's office was 1,328 and 1,513, respectively.

Estimating the ratio of Nurses to Physicians working in physician offices or Mixed Group settings

To estimate the ratio of Nurses to Physicians, the total RN and RPN FTEs were divided by the number of Physician FTEs that provide their services in Physician Offices (15,648 FTEs). The calculations were performed as follows:

$$Physician\ FTE_{Office} = Derived\ FTEs\ \times Billings\ Delivered\ in\ POP\ offices$$

$$Nurse{:}\,Physician\ Ratio = \sum \frac{Nurse\ FTE_{Office}}{Physician\ FTE_{Office}}$$

Table 4. Ratio of Nurses to Physicians

Description	FTEs	Ratios	
Registered Nurse (RN) FTEs in Physician offices (2023)	1,328	RN : Physicians	**0.0848**
Registered Practical Nurse (RPN) FTEs in Physician offices (2023)	1,513	RPN : Physicians	**0.0967**
Physician FTEs for services provided in physician offices	15,648		

Relative to the number of Physicians that provide the majority of services in physician offices or in a mixed setting (i.e. physician office and hospital), the findings demonstrate that RN and RPNs are rarely employed in these settings (RN: 0.08, RPN: 0.10).

Capital and Operational Costs for the Baseline Model Physician Office

To estimate the Capital (e.g. furniture, equipment, instruments) and Operational (e.g. supplies, annual professional dues, office insurance, other expenses) costs, we used the Canadian Medical Associations guidelines for setting up a baseline physician office and costs were updated to 2024 pricing[16].

Table 5. Capital Cost for Baseline Model Physician Office

Capital Costs		
	Cost per unit	**Total cost**
OFFICE FURNITURE		
Consult room		
Desk	$600	$1,200
Swivel chair	$190	$380
Patient chairs (2)	$266	$532
Bookshelves	$300	$600
File cabinet (optional, lateral 5-drawer)	$1,500	$3,000
Dictation system and software	$1,886	$1,886
Computer workstations (2)	$1,500	$3,000
	Consult room total	**$10,598**
Nursing/Reception station		
Desk	$600	$600
Chair	$350	$350
Wall open lateral filing cabinet	$1,550	$1,550
Answering machine	$200	$200
Refrigerator	$700	$700
Base, sink and wall cabinets	$3,125	$3,125
Requisition cabinet	$300	$300
Patient chair (for injections)	$589	$589
Fax/copy/printer	$600	$600
Computer and software for 3 terminals	$1,500	$4,500
Telephone system (5 units) Entry level	$3,000	$3,000
Blood pressure machine	$540	$540
	Nursing station total	**$16,054**
Waiting room		
Chairs (10)	$100	$1,000
Tables (2)	$150	$300
Magazine racks	$100	$100
Pictures and mirrors	$600	$600
Coat rack	$300	$300
Bulletin board	$30	$30
	Waiting room total	**$2,330**
	OFFICE FURNITURE TOTAL	**$28,982**
EQUIPMENT		
Office equipment		
Exam tables (2)	$4,494	$8,988
Swivel stools, hydraulic (2)	$190	$380
Footstools (2)	$130	$260
Utility table (1)	$150	$150
Patient chairs, 2 per room (4)	$266	$1,064
Magazine racks (2)	$10	$20
Bulletin boards (2)	$20	$40

[16] Canadian Medical Association – Business side of Medicine (2015). https://www.cma.ca/Assets/assets-library/document/en/practice-management-and-wellness/2015-Chapter2_The_business_side_of_medicine-e.pdf

Capital Costs		
	Cost per unit	Total cost
Requisition racks (2)	$30	$60
Flexible gooseneck exam lights (2)	$435	$870
Tape measures (2)	$5	$10
Wall transformers (2)	$1,550	$3,100
Otoscopes (2)	$350	$700
Ophthalmoscopes (2)	$225	$450
Reflex hammers (2)	$15	$30
Tape scissors (2)	$17	$34
Wall sphygmomanometers (2)	$239	$478
Extra cuffs (pediatric & large) for both rooms (4)	$61	$244
Tuning forks (2)	$20	$40
Cupboards [sink/base/desk, if not supplied] (2)	$3,125	$6,250
Office equipment total		**$23,168**
Individual equipment		
Hyfrecator (1)	$1,582	$1,582
Steam sterilizer	$5,399	$5,399
Adult scale, digital (1)	$700	$700
Baby scale, digital	$370	$370
Sigmoidoscope (1)	$700	$700
Fetal Doppler (1)	$799	$799
Individual equipment total		**$9,550**
	EQUIPMENT TOTAL	**$32,718**
INSTRUMENTS		
Vaginal specula (16)	$43	$680
Ear syringe (1)	$35	$35
K-basin (2)	$12	$24
Scalpel handles (3)	$7	$21
Adson forceps (2)	$12	$24
Tissue forceps (2)	$14	$28
Sponge forceps (2)	$30	$60
Dressing forceps (2)	$9	$18
Mosquito forceps (2)	$15	$30
Ear curettes (4 sizes)	$15	$60
2-mm punch biopsy (50)	$120	$120
5-mm dermal curette, disposable (50)	$147	$147
2-mm dermal curette, disposable (50)	$147	$147
Needle driver (2)	$40	$80
Nasal speculum (1)	$40	$40
Nasal forceps (1)	$45	$45
Metzenbaum scissors (1)	$35	$35
Straight iris scissors (2)	$36	$72
Curved iris scissors (2)	$38	$76
Uterine tenaculum (1)	$33	$33
Uterine sound instrument (1)	$15	$15
2-ounce glasses (2)	$6	$12
Thermometers, digital (2)	$18	$36
Sundry glass jars, set of 5 (1)	$30	$30
	INSTRUMENTS TOTAL	**$1,868**
	TOTAL CAPITAL COST	**$63,568**

Table 6. Operational Cost for Baseline Model Physician Office[17]

Operational Costs		
	Cost per unit	**Total cost**
MEDICAL SUPPLIES		
Syringe 60cc (used infrequently)	$45 per 25	$23
Syringe 10cc (used infrequently)	$45 per 100	$12
Syringe 3cc, 25Gx 5/8 (used a lot)	$30 per 100	$420
Syringe 3cc, no needle	$25 per 100	$10
Syringe TB, 26G (allergy)	$18 per 100	$186
Scalpel blades #15	$37.95 per 100	$38
Needles #23	$13 per 100	$8
Needles #20	$13 per 100	$8
Exam table paper, 12 rolls per box	$50 per box	$300
Sutures, nylon 3.0, 4.0, 5.0, and chromic 3.0	$42 per doz.	$105
Gauze, 4x4	$5 per 100	$20
Gauze, 2x2	$4 per 100	$16
Sigmoidoscope tubes, 25 per box	$170 per box	$70
Anoscopes, 25 per box	$139 per box	$139
Sharps containers	$9	$72
Tape, bandages	$2.50 per box	$17
Reagent strips, urine GP	$40 per 100	$400
Reagent strips, urine 4MD	$42.75 per 100	$86
Reagent strips, blood glucose	$42 per 100	$42
Reagent strips, urine pregnancy	$31 per 25	$31
Lancets	$6 per 100	$6
AgN03 [rarely used if hyfrecator available]	$34 per 100	$17
Ethanol swabs	$3.95 per 200	$59
Eye patches	$12 per 20	$12
Gloves, vinyl (assumes use of app. 20 per day)	$6.95 per 100	$306
Tongue depressors	$12 per 500	$24
Cotton swabs	$1.25 per 100	$2
Personal lubricant gel	$2.40	$41

[17] Canadian Medical Association – Business side of Medicine (2015). https://www.cma.ca/Assets/assets-library/document/en/practice-management-and-wellness/2015-Chapter2_The_business_side_of_medicine-e.pdf

Operational Costs		
	Cost per unit	**Total cost**
Lidocaine 1% and 2%	$4.19-12.50 ea	$33
Steroid for joint/tendon injection	$42 per vial	$210
Medical Supplies		**$2,713**
OFFICE SUPPLIES		
Paper, photocopy/fax/progress notes	$80 per box	$160
Appointment cards	$30 per 500	$480
Letterhead and envelopes	$100 per 1,000	$100
Pens, pencils, staples, sundry office supplies	-	$100
Window envelopes	$40 per 1,000	$80
Prescription pads	$300 per 5,000	$300
Database sheets	$40 per 1,000	$40
Files, heavy bond (2000 in year one - 200/yr thereafter)	$450 per 1,000	$900
Appointment books, if not computerized	-	$30
Personal phone book	-	$20
Chart stickers, etc.	-	$40
	Paper and Stationery	$2,250
	SUPPLIES TOTAL	**$4,963**
PROFESSIONAL DUES		
Provincial medical association dues, incl. CMA	1	$2,235
Provincial College of Physicians and Surgeons	1	$1,725
College of Family Physicians of Canada	1	$1,076
Royal College of Physicians and Surgeons of Canada	1	$1,060
PROFESSIONAL DUES TOTAL		**$6,096**
INSURANCE		
Office insurance	-	$1,268
Practice overhead insurance	-	$975
Disability insurance	-	$2,000
	INSURANCE TOTAL	**$4,243**
OTHER EXPENSES		
Accounting services	-	$2,500
Parking	-	$800
OTHER EXPENSES TOTAL		**$3,300**
	TOTAL OPERATIONAL COST	**$18,602**

Specialty-Specific Equipment Cost

Table 7. Specialty-specific equipment costs - Dermatology

Dermatology				
Equipment Type	**Cost**	**Amortization (Years)**	**Quantity**	**Annual Cost**
O2 Monitor	$686	10	1	$69
Liquid nitrogen tank and gun	$1,470	10	0.9	$132
Microscope	$1,319	10	0.9	$119
Automated External Defibrillator	$2,244	10	0.6	$135
Crash Cart	$3,202	10	0.3	$96
Cryostat	$1,372	10	0.3	$41
Hyfrecator	$1,998	10	0.3	$60
			Total	**$651**

Table 8. Specialty-specific equipment costs - Ophthalmology

Ophthalmology				
Equipment Type	**Cost**	**Amortization (Years)**	**Quantity**	**Annual Cost**
IOL Master Optical Biometer	$ 70,000	10	1	$ 7,000
OCT Scanner	$ 100,000	10	1	$ 10,000
Visual Field Analyzer	$ 50,000	10	1	$ 5,000
Examining lanes ($80K each, 3 rooms total)	$ 240,000	10	1	$ 24,000
			Total	**$ 46,000**

CMPA Classification Methodology

CMPA dues paid by physicians, when grouped by specialties, can be used to derive Practice Risk clusters. Most specialties had defined CMPA dues that could be applied accordingly. However, Obstetrics / Gynaecology, General Practitioner's and Emergency Medicine had to be further subdivided based on the percentage of services provided sub-categories.

Figure 2: Breakdown of CMPA Allocation by Specialty

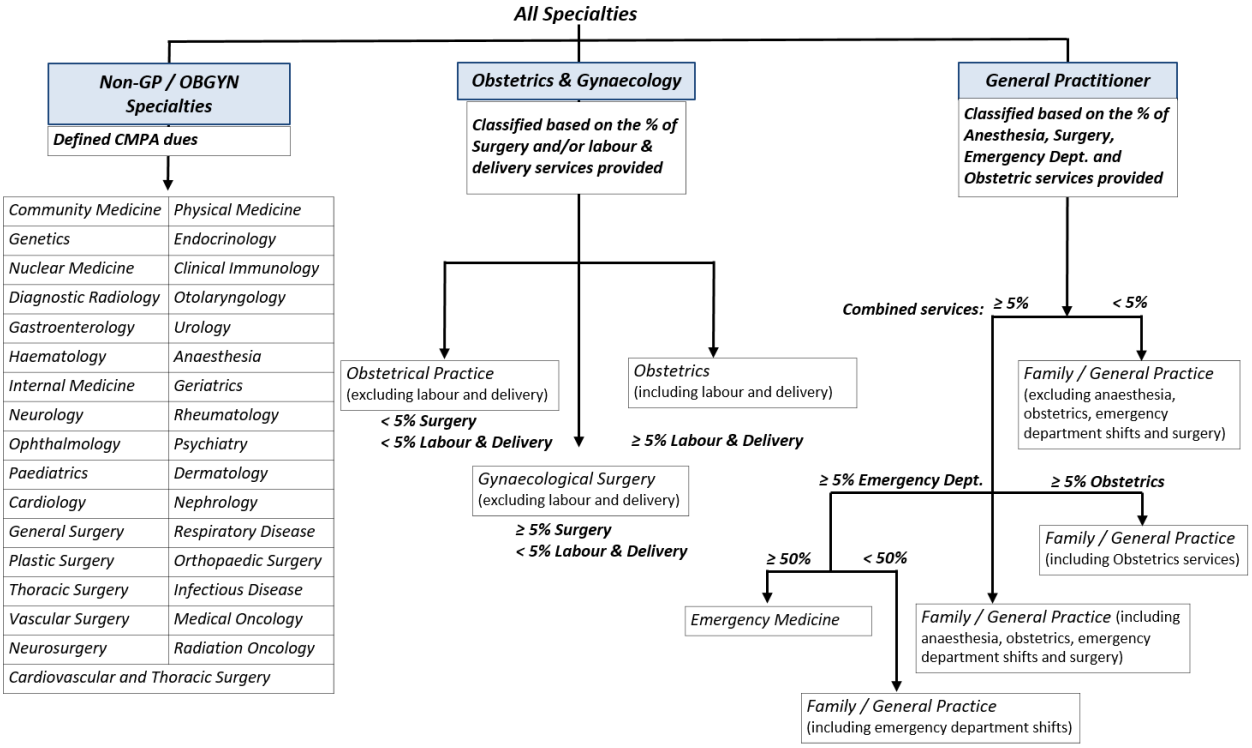


Table 9. Specialty CMPA Base rate[18]

Specialty	Base Rate
Anaesthesia	$7,210
Cardiology	$2,205
Cardiovascular and Thoracic Surgery	$7,210
Clinical Immunology	$1,325
Dermatology	$1,325
Diagnostic Radiology	$1,325
Emergency Medicine	$2,205
Endocrinology	$1,325
Family Practice and Practice in General (excluding anaesthesia, obstetrics, emergency department shifts and surgery)	$1,025
Family Practice and Practice in General (including emergency department shifts)	$1,025
Family Practice and Practice in General (including anaesthesia, obstetrics, emergency department shifts and surgery)	$1,765
Family Practice and Practice in General (including Obstetrics services)	$1,765
Gastroenterology	$1,325
General Surgery	$5,150
Geriatrics	$725
Haematology	$1,325
Infectious Disease	$1,325
Internal Medicine	$1,325
Medical Oncology	$1,325
Nephrology	$1,325
Neurology	$1,325
Neurosurgery	$7,210
Nuclear Medicine	$1,325
Obstetrical Practice (excluding labour and delivery)	$1,325
Gynaecological Surgery (excluding labour and delivery)	$5,150
Obstetrics	$7,210
Ophthalmology	$1,325
Orthopaedic Surgery	$7,210
Otolaryngology	$2,205
Paediatrics	$1,325
Physical Medicine	$725
Plastic Surgery	$5,150
Psychiatry	$1,025
Radiation Oncology	$1,325
Respiratory Disease	$1,325
Rheumatology	$1,325
Urology	$5,150
Vascular Surgery	$5,150

[18] CMPA Fee Schedule 2023