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

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

(the "Ministry")

- and –

THE ONTARIO MEDICAL ASSOCIATION

("the OMA")

BEFORE THE BOARD OF ARBITRATION:

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

June 5 and 6, 2024

REPLY BRIEF OF THE MINISTRY OF HEALTH

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EXECUTIVE SUMMARY

As a starting point of context for our reply submissions, the Ministry wishes to again note that it recognizes and values the vital services that physicians provide to the residents of Ontario. All of our reply submissions and rebuttal arguments are advanced herein with the objective of promoting greater access to care for Ontario patients and reasonably compensating Ontario's physicians within a high quality, patient-centered sustainable publicly funded health care system.

The Ministry's reply submissions reflect and take into consideration the recent record investments that have been made to Ontario's publicly funded health care system that directly and indirectly benefit the physicians of Ontario. The following investment highlights, for example, have enabled the province to achieve significant progress towards building a more connected and convenient health care system:

- By launching the largest medical school expansion in 15 years, adding hundreds of undergraduate and medical seats across the province, with 60% of seats specifically for family medicine and building 2 new medical schools[1], while breaking down barriers for internationally and interprovincially educated healthcare workers to work in Ontario.
- Announcing an investment of $110 million in 2024/25 to support new and expanded interprofessional primary care teams. In the 2024 Budget, the Government built on this investment, and outlined a total investment of $546 million to primary care teams 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[2].

[1] See Ministry submissions at Page 48 and 49 of this Brief

[2] Further detailed information and references contained in the Ministry's May 1 2024 submissions at paragraphs 288 to 292

- Registering a record number of new nurses two years in a row, adding 32,000 new nurses to the system; with another 30,000 in the process of studying nursing at one of Ontario's Colleges or Universities.[3]
- Further investments over the next four years in the expansion of nursing education in universities and colleges by increasing enrolment by 2,000 registered nurse, 1,000 registered practical nurse, and 150 nurse practitioner seats. With these investments, 8,000 additional nurses will join the healthcare workforce by 2028.[4]

These investments are set against the governments' proposal for the Arbitration Board to award a Year 1 compensation increase equal to 3% - an investment of just under one half of a billion dollars, for the normative increase to physicians from April 1, 2024 to March 31, 2025, in what will ultimately be a four year agreement.

The MOH addresses below the broad themes and arguments of the OMA's brief.

Retention and Recruitment

The OMA brief asserts, particularly at Part 7, that there are problems pertaining to the retention and recruitment of physicians.

The facts show a different picture than the sorts of problems that the OMA brief asserts. For example:

1. Ontario has invested significantly in physician services, such that the number of physicians in Ontario has increased since 2005 at an annual rate which is approximately double the rate of the increase in population (page 46 of this brief).

[3] https://news.ontario.ca/en/release/1003760/ontario-expanding-role-of-registered-nurses-to-prescribe-and-administer-more-medications; https://news.ontario.ca/en/statement/1004535/ontario-celebrates-nurses-during-national-nursing-week
[4] https://www.ontario.ca/page/your-health#section-6

- Since 2005 the number of physicians in Ontario has increased by 57.8%.
- Since 2005 the population in Ontario has increased by 25.9%.
- The Compounded Annual Growth Rate (CAGR) - number of physicians is 2.6%.
- The Compounded Annual Growth Rate (CAGR) - population is 1.3%.

2. As a result of this significant investment in the numbers of physician above population growth, the relative position of Ontario to the rest of Canada on a physicians per 100,000 population has improved significantly since 2005 (page 105 of this brief).

3. The facts demonstrate that Ontario has been able to consistently and substantially recruit top tiered talent into Ontario medical schools. The Ontario Government continues to open up more student placements and to grow the residency program (both by increasing the number of medical students and enabling more foreign trained students into Ontario placements). It is anticipated that with these additional investments, the number of physicians (net of attrition) will continue to outpace the increases in population. As a result, the ratio of physicians per 100,000 population will continue to improve. Accordingly, the Ministry submits that recruitment should not be a factor that motivates an above normative increase. This was laid out in detail in the MOH May 1, 2024 submissions at Section 6.

4. Retention and Recruitment was a major factor in the HLDAA decisions for Hospital RNs in Ontario in the consecutive and recent awards of Arbitrator Stout, Gedalof and Kaplan. However, the growth in the number of RNs up to 2021 (at the point of those awards) stands in sharp contrast to the higher growth in the number of physicians over the same time frame. We note parenthetically that since 2018, the Ontario government has actively invested in RN recruitment. The number of Direct Care RN’s (which does not include the totality of the RN

workforce) increased by 3,279 from 2018 to 2021[5]. In addition, there were approximately 15,000 newly registered RNs in Ontario in 2022, and 17,000 newly registered in 2023[6].

The MOH has reviewed the changes in the respective complement of these health professionals up to 2021, data points which were inherent in the evidence before the Hospital RN HLDAA arbitrators (review starts at page 126 of this brief).

- Between 2012 and 2021 the RN workforce **increased 7.3%** across Ontario. The major employer of those RNs were Hospitals.
- Over that same timeframe the number of physicians across Ontario **increased by 27.7%.**

This difference becomes more evident when the number of RNs per 100,000 population is measured. Between 2012 and 2021:

- the number of RN's per 100,000 population **decreased 2.6%.**
- the number of physicians (all specialities) per 100,000 population **increased 15.5% a**nd the number of family physicians per 100,000 population **increased 15.2%**

This stark contrast, within the same Ontario Health care system (up to the period of the three Hospital HLDAA awards), speaks volumes to fundamental difference in retention and recruitment between the two health care professions <u>at that time</u>. Through strategic investments and action of Government the trend of decreasing RNs registered to work that would have

[5] Workforce of regulated nurses, by type of professional and jurisdiction, provinces/territories with available data, 2012 to 2021. CIHI. Nursing in Canada, 2021 — Data Tables. Ottawa, ON: CIHI; 2022.
[6] https://news.ontario.ca/en/release/1003760/ontario-expanding-role-of-registered-nurses-to-prescribe-and-administer-more-medications; https://news.ontario.ca/en/statement/1004535/ontario-celebrates-nurses-during-national-nursing-week

informed those HLDAA decisions has reversed. So, not only do the physician head count data stand in stark contrast to that observed in the RN space, it is also reasonable to infer that the investments and actions taken by the Ministry to increase the number of medical school seats and residency positions will continue to have an demonstrable impact on Ontarians' ability to access physician services.

5. To further distinguish the issue of retention and recruitment as between RNs and Physicians at the time of these awards, the Ministry submits the following facts:

    - RNs are employees who are paid for worked time which is set out in their collective agreement. For a full-time RN in the Hospital sector it is 37.5 hours per week[7].
    - Physicians are by and large contractors who determine their own hours of work, areas of practice and location of practice.
    - The typical weekly hours of work for an RN **remained unchanged since 2005.**
    - The number of patient encounters per physician **has reduced by 22.0% since 2005. The Compounded Annual Reduction Rate (CARR) in physician encounters equals 1.4% per year over that 18 year period.** (reviewed at page 52 of this brief)

6. While the OMA argues that the complexity of patients has grown, and thus the workload of physicians have grown, the Ministry concludes that the age factor contributes about 0.5% per year to annual costs.

[7] Article 13.01(a) of the ONA Hospitals Central Agreement; https://www.ona.org/wp-content/uploads/20250331_hospitalcentralagreementenglish.pdf

The age factor is more than offset by the 1.4% reduction in average patient encounters per physician per year observed in the data (reviewed at page 66 of this Brief).

7. This leaves a 0.9% annual reduction (1.4% minus 0.5%). Perhaps that can be explained by a laudable desire/individual choice regarding work life balance. While the contractor status/contractual arrangements with physicians make it possible to exercise personal choice, that choice can not and ought not to be used to form the basis of an above normative compensatory increase.

8. Over the last PSA, the average physician's income increased approximately 1% per year above any negotiated/awarded price increase. Further, the average compensation increased when there have been fewer patient visits per year. The Ministry submits that this is due to the implementation of the price increases using the RAANI CANDI relativity model. Pursuant to that model, different sections are allocated different price increases such that the weighted average equals the overall negotiated/awarded price increases. Those sections (for example ophthalmology) who are allocated a lower portion of the price increase have traditionally still been able to significantly increase their compensation. This occurrence could be explained, in part, by the ability of these specialties to deliver services much more quickly and efficiently due to technologies, etc. Given that some sections like ophthalmology receive a lower price increase, other sections can receive a greater price increase than the negotiated/award price increase. In other words, some sections receive a greater compensation increase than the negotiated/awarded price increase because of the greater number of services performed. Others receive a greater compensation increase than the negotiated/awarded price because they receive a higher price increase through allocation. This is why price alone should not be equated to wage increases in other sectors. We suggest the average physician compensation increase is the more appropriate measure.

9. The Ministry further submits that since physicians are contractors, this enables a disproportionate number of physicians to locate in certain areas of the province. This is another distinction from the employment model (e.g. RNs) where employment levels are determined by the number of jobs available in a given area.

   As noted above, the Ministry's submissions on this point are supported by statistical evidence and its review of CIHI data, Ontario's population and the numbers of physicians by HCCSS's (formerly LHINs) for Family Physicians.

   The corresponding analyses illustrates that there are regions in Ontario that have significantly more physicians per 100,000 population than others. Where contractor physicians chose to practice is an issue. If only headcount was utilized to determine sufficiency, then Ontario has a sufficient number of comprehensive longitudinal family physicians.

   In the current system, the awarded price increase cannot be utilized to incent relocation of physicians to regions of greater need. The Ministry's rebuttal submissions explain why price increases and the inherent rules of the RAANI/CANDI fee distribution model are neither capable of nor able to address this problem. This is yet another reason why any increase beyond a normative increase as proposed, is not warranted and in fact will only exacerbate any existing distribution problem. A detailed explanation is provided later in the Ministry' rebuttal submissions.

   Simply put, to the extent that there may be geography based supply challenges in a particular area, such challenges are not symptomatic of a systemic macro recruitment and retention issue. Put another way, a shortage of physicians in one area or in one particular practice, if any, should not be attributed to an issue of retention and recruitment and does not fit within any reasonable comparison to

the systemic issue of nurse supply as it existed at the time of the Stout, Gedalof and Kaplan awards.

To summarize:

Ontario enjoys one of the most attractive and sought-after medical school experiences and there are students waiting to get in. There are no recruitment issues in filling Ontario's medical school spots, and in fact, Ontario has opened up two new medical schools, one of which is dedicated to primary care.

The facts and data do not show retention problems for physicians, in contrast to that which was found in the HLDAA awards. The number of physicians (net of attrition) has been growing every year and, given the investments and actions under the Your Health Plan, it is anticipated that this will continue.

Catch Up

In response to the OMA's arguments for catch up, particularly Section 8B of the OMA's brief, the Ministry respectful submits that there is no basis for catch up given the following facts:

1. The 2021 Settlement was a freely negotiated agreement where both parties took a calculated risk on the Year 3 result. There was no limit on the maximum increase that could have resulted from the 3rd year formula.

2. The period prior to the 2021 Settlement (the 2018 PSA) was determined by Interest Arbitration where the issue of catch-up and prior history of increases were extensively canvassed, reviewed, litigated, and, most importantly, decided upon.

3. The 2021 Settlement was not governed by Bill 124, however strenuously the OMA may wish to argue that it was nor was it merely a post-COVID catch up agreement. It contemplated the possibility for increases in Year 3 depending on overall utilization and was an agreement that the OMA itself conservatively estimated would yield a price increase of up to 3.4%.

4. Both parties were represented by experienced, competent and knowledgeable counsel and the settlement was fully ratified.

5. Ultimately, the increase in the average physician's income (including both price and utilization) was competitive with the OPS Arbitration results and the Bill 124 reopener results (the latter including sectors with discernably different retention and recruitment issues).

The Normative Price Increase for Year 1

The Ministry respectfully submits that its proposed increase of 3% for price reflects a "Normal" price increase for the one year term of April 1, 2024 to March 31, 2025, particularly when one consider the additional 1% + of income growth that typically accompanies a price increase (as well as any other non-insured services a physician can bill).

1. Settlement trends in the OPS and BPS for 2024 are 3%.

2. The data distinguishes physician supply in Ontario from the issues that were observed in RN supply at the time of the Hospital HLDAA awards.

3. The 1%+ extra increase above price for utilization significantly mitigates any extra overhead expenses, although the OMA did not quantify overhead costs in their brief.

4. The important issue of burnout is not an issue that can be resolved through price increases. Rather, innovative solutions to address such areas as Administrative Burden could allow greater time for work-life balance and by extension have a tangible impact on burnout.

5. Administrative burden should not be solved by a price increase. Such an approach could have unintended consequences such as incenting administrative work over clinical care. While any small business inherently requires its owners to innovate and modernize to address issues such as administrative burden, the Ministry is also dedicated to problem solving these issues to enable a win-win for the physician (work life balance) and the patient (more clinical care).

Furthermore, we ask the Board to take note that the Ministry has and will continue to invest significantly in measures to mitigate administrative burden while also improving patient safety.[8]

6. Workload through complexity (as measured either by the OMA submission (1%) or the Ministry of Health Submission (0.5%)) is entirely offset by the average fewer patient visits per physician. We again submit that fewer patient visits has not resulted in a decrease in the average physician compensation.

7. Specific areas of concern are not resolved through price increases but could be perhaps addressed through targeted investments (if appropriate) or negotiated, mediated or arbitrated over the remaining 3 years of this agreement term.

[8] The Ministry Brief of May 1, 2024 contains submissions regarding the Ministry's initiatives to address administrative burden at Section 10.2.

Targeted Investments

The Government has already made significant targeted investments in family medicine (including primary care), community supports, infrastructure[9] and significantly more Registered Nurses in the system as noted earlier in these submissions. The Ministry respectfully submits that this Board should not attempt to determine the merits of the numerous targeted investments proposals, listed and reviewed by the OMA at Section 9 of their Brief, for the following reasons:

1. The Implementation Agreement – a departure from the normal framework of negotiating and our mediation/arbitration - took the parties off of their normal path for negotiations in order to secure an early award for price increase and to create a pot of money to work with in respect of targeted investments.

2. The OMA has come to this arbitration with virtually all of their opening proposals which they may well wish to advance through the continuation of negotiations. However, it hasn't yet been put to the test of bargaining given the fact that the parties expedited the Year 1 price issue.

3. The OMA's list is long and exhaustive, even for a 4 year deal. As Weiler said in 1981 when reviewing the Interest Arbitration process:

> ***Indeed, the Union may be tempted as also the Employer which has its own diverse constituencies which it does not want to alienate, to carry all of these initial demands forward to the arbitration hearing, on the theory that it has nothing to lose by asking... Certainly it is essential to the integrity of arbitration that these latter assumptions not be reinforced.***

[9] The Ministry's May 1, 2024 submissions at Sections 10.2 and 14.1 contain, for example, the details regarding investments in a number of digital improvements such as ereferrals and AI scribe, new and expanded interprofessional care teams, increased primary care services such as the minor ailments program, Health 811.

4. The agreement between the parties clearly contemplates a two part process. As noted above, the parties have agreed that this expedited arbitration award will deal with the 1st year price increase and the size of the target envelope will be 30% of the price increase. Specifically, at paragraph 9(b) of the OMA and MOH 2021-204 PSA Year 3 Implementation and 2024-28 Procedural Agreement, the parties listed examples of potential targeted investments. However, the parties explicitly agreed that "*these 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*." The Ministry submits that, in agreeing to expedite a price change hearing for year one and in not identifying an exhaustive list, the parties realized that there was a significant amount of work that would need to be done, including prioritization, in reaching consensus with respect to targeted investments after the year 1 price change was awarded. This is evidenced by the fact that the parties agreed to move the originally scheduled December 2024 hearings dates for Years 2, 3 and 4 of the PSA to March 2025. The parties have set aside 19 dates, including 14 mediation dates, in advance of the March 2025 hearing dates. Thus, this Board is not charged with deciding the merits of any of the targeted proposals in order to make its decision on the first year price increase to be awarded. If the parties are unable to reach agreement on the allocation or costing with respect to targeted investments, the dispute will be referred to the Board of Arbitration as part of the conclusion of the Years 2-4 arbitration. The OMA had a desire to expedite the issue of the Year 1 price increase, and the Ministry agreed. In doing so, the OMA does not now gain the advantage (to the detriment of the Ministry) to ask the Board to decide how to deal with the areas of investment.

5. The Ministry had opening proposals and, during the course of negotiations, had ideas for targeted increases. The work required to explore these and the OMA's proposals follows the award of the year 1 price change. The parties will

negotiate the allocation of funds to the first year target pool after the arbitration result for the 1st year price is released.

6. Accordingly, the time to debate the merits of these issues is not at this particular stage of bargaining. It goes without saying, however, that the lack of argument on the merits should not be inferred to mean that the Ministry agrees with any given proposal. That work is the work that follows this Board's award. Even a proposal that has merit must be fully analyzed, costed and prioritized.

7. This is a four year agreement. The targeted investment for some meritorious issues may be included in the 2nd, 3rd or even 4th year of an overall result. The first test of these issues should be collective bargaining and mediation.

For all these reasons, the Ministry will not argue the merits or arbitrability of the long list of targeted issues from the OMA's opening proposals.

Format of Remaining MOH Brief:

To enable a further focused and specific review of the OMA submission, we first repeat in italics the specific paragraph from the OMA that is to be challenged and then provide the Ministry rebuttal comments.

The lack of a reference to any particular paragraph in the OMA brief is not an acknowledgement of its contextual accuracy or relevance, but rather reflects the Ministry's confidence that the same issue or argument is already specifically addressed in its original submission.

PARAGRAPH 5 OF THE OMA BRIEF:

5. Part Five provides an historical overview of OMA and Ministry of Health ("MOH" or the "Ministry") bargaining and resulting Physician Services Agreements ("PSA"), demonstrating the extent to which the Year 1 increase must include catchup and redress for past years. Since 2012, as a result of unilaterally imposed fee freezes and fee reductions, physician fee and compensation increases have fallen well behind both inflation and key comparators. Part Five also includes a discussion of the impact of the bargaining constraints and climate when the 2021 PSA was concluded, resulting in the the limited fee increases contained in the 2021-24 PSA. As this Board of Arbitration is well aware, Bill 124 substantially restricted compensation increases for employees across the health care and broader public sector (despite the impact of the pandemic and rising inflation). Although Bill 124 was subsequently struck down as being unconstitutional, physicians have yet to see any consequential increases that other groups in the health care sector and elsewhere have achieved, nor any protection against the inflationary increases that affected both the relative value of the fees and other payments they receive, but also the costs of practice they face. Redress for the very real impact of Bill 124 on the 2021-24 PSA is an important component of the Year 1 increase being sought by the OMA.

MINISTRY REBUTTAL

As set out in the Ministry's May 1, 2024 submission at paragraph 72, the OMA made extensive submissions regarding overhead, inflation and redress before the Arbitration Board for the 2017/18 to 2020/21 Physician Services Agreement. On February 18, 2019, the Arbitration Board issued their award considering the submissions of both the OMA and the Ministry, and as such definitively addressed these issues in its award.

PARAGRAPH 10 OF THE OMA BRIEF:

10. The first phase requires that the Board determine the overall price increase for Year 1 of the 2024-28 PSA. From the OMA's perspective, this will include consideration and determination of:

(a) the OMA's claim for redress or catch-up resulting from the relatively low level of price increases received by Ontario physicians dating back to 2012. and, more recently, the impact that restrictions imposed under the now unconstitutional Bill 124 had on price increases under the 2021-24 PSA, including price increases to reflect inflation and, in addition,

(b) the OMA's claim for a normative price increase for 2024-25. This includes both an appropriate general price as well as additional targeted funding to address a variety of critical areas, as outlined more fully below.

MINISTRY REBUTTAL

While the OMA argues the influence of Bill 124 on the 2021 to 2024 PSA, it is uncontroversial that it did not legally apply to the negotiations for the 2021 PSA.

In any event, the net increase in average physician income over this period of time is comparable to Bill 124 trends, inclusive of the reopeners.

As submitted by the Ministry in its May 1, 2024 submission, the average increase in income per physician from 2019-2020 to 2023-2024 was 10.0%.

Table 1: Average Increase in Income per Physician: 2019/20 to 2023/24

Fiscal Year	Income per Physician
2019-20	$ 426,382
2023-24 (F)	$ 469,144
% Awarded/Negotiated Price Adjustments from 2019-2020 to 2023-24	5.8%[10]
% Increase in income per physician from 2019-2020 to 2023-24	10.0%

[10] April 1, 2020 – 1% (awarded under previous PSA), April 1, 2021 – 1%, April 1, 2022 – 1%, April 1, 2023 – 2.8%

The average physician income over the period of time is comparable to the majority of voluntary settlements and interest arbitration awards of those OPS and BPS bargaining units previously covered by the PSPSFGA. The following tables set out the reopener or remedy increases (increases on top of the initial 1%) achieved to date through voluntary settlement or interest arbitration awards. Each of the tables are chronologically ordered by date of outcome and reflect the effective date of the increase.

The settlements are colour coded by sector as follows:

Sector Legend

	Long Term Care
	Hospitals
	Post-Secondary
	Energy
	Ontario Public Service
	LHINs

Table 2 - BILL 124 REOPENER INCREASES EFFECTIVE IN 2021

Date of Award/ MOS	Arbitrator/ Freely Negotiated	Employer	Union	Date of Increase	Increase above Initial 1%
2/15/2023	MOS	Craigholme	UNIFOR	11/1/2021	0.50%
2/17/2023	MOS	Belmont House	SEIU	9/16/2021	0.50%
3/6/2023	Parmar Award	Halton Health Services	OPSEU	4/1/2021	0.75%
3/13/2023	Stout Award	ONA Master (14 LTC Homes)	ONA	7/1/2021	0.75%
3/13/2023	MOS	Blue Water Rest Home	UNIFOR	11/1/2021	0.50%[11]
3/13/2023	MOS	Dom Lipa	SEIU	1/1/2021	0.50%
3/27/2023	MOS	St. Joseph's Brantford	SEIU	1/1/2021	0.50%
4/1/2023	Stout Award	OHA	ONA	4/1/2021	1.00%
4/5/2023	MOS	Parkwood Mennonite	USW	4/1/2021	0.50%
4/6/2023	MOS	Marianhill	CUPE	9/1/2021	1.00%
4/11/2023	Jesin Award	Kristus Darzs	CUPE	1/1/2021	0.50%
4/14/2023	MOS	Ivan Franko	SEIU	8/15/2021	0.50%
4/21/2023	MOS	Dundas Manor	CUPE	4/1/2021	1.50%
5/10/2023	MOS	Golden Dawn	UNIFOR	11/1/2021	0.50%[12]
5/10/2023	MOS	Heidehof	CLAC	4/1/2021	0.50%
5/25/2023	MOS	St. Clair O'Connor	SEIU	4/1/2021	0.50%
5/29/2023	MOS	North Renfrew	CUPE	4/1/2021	1.00%
6/2/2023	MOS	Shepherd Village	SEIU	9/22/2021	0.50%
6/7/2023	MOS	Ukrainian Canadian	IAMAW	11/1/2021	0.05%[13]
6/13/2023	Kaplan Award	OHA	CUPE	9/29/2021	3.75%
6/21/2023	Albertyn Award	Almonte General Hospital	CUPE	1/1/2021	2.50%
6/22/2023	MOS	Shepherd Village	ONA	7/1/2021	0.75%
6/27/2023	MOS	Trinity Village	UNIFOR	11/1/2021	0.50%[14]
7/4/2023	MOS	Shalom Manor	LIUNA	11/1/2021	0.50%
7/5/2023	Kaplan Award	OCAD	OCADFA	5/1/2021	1.00%
7/13/2023	MOS	Vision	UNIFOR	11/26/2021	0.50%[15]
7/20/2023	Jesin Award	Kensington	CUPE	6/1/2021	0.50%

[11] Total increase in 2021 of 2.5%, which includes 0.5% for each year of Bill 124, plus 1% equivalent for the third year of Bill 124

[12] Deferred for payment to the next year

[13] Deferred for payment to 5/1/2022 (along with other two 0.5% increases for each year of Bill 124)

[14] Deferred for payment to the next year

[15] Deferred for payment to 11/26/2022 (along with other two 0.5% increases for each year of Bill 124 + 3% increase for first year of renewal agreement)

Date of Award/ MOS	Arbitrator/ Freely Negotiated	Employer	Union	Date of Increase	Increase above Initial 1%
7/26/2023	Kugler Award	Victoria Village	CUPE	1/1/2021	0.50%[16]
7/27/2023	MOS	AR Goudie	UNIFOR	11/1/2021	0.50%[17]
8/11/2023	Consent to Alter	Ina Grafton Gage Home	ONA	4/1/2021	1.00%
8/15/2023	Kugler Award	Foyer des Pionniers	CUPE	1/1/2021	0.50%
8/15/2023	MOS	Ontario Public Colleges	OPSEU	10/1/2021	2.00%
8/17/2023	Jesin Award	Niagara Ina Grafton	CUPE	10/1/2021	0.50%[18]
8/18/2023	Chauvin Award	Yee Hong (4 LTC Homes)	SEIU	1/1/2021	0.50%
8/29/2023	MOS	Valley Manor	USW	8/23/2021	0.50%
9/11/2023	Consent to Alter	IOOF Seniors Home	ONA	4/1/2021	1.00%
9/13/2023	MOS	IOOF Seniors Home	CLAC	4/1/2021	0.50%
9/14/2023	Kaplan Award	Ontario Teaching Hospitals	PARO	7/1/2021	2.00%
10/2/2023	Kaplan Award	Pine Meadow	USW	5/1/2021	0.50%
10/5/2023	MOS	University of Ottawa	APUO	5/1/2021	1.25%
10/11/2023	Stout Award	Glen Hill (Strathaven)	CUPE	1/1/2021	0.50%
10/20/2023	Gedalof Award	Nisbet Lodge	CUPE	1/1/2021	0.50%
10/20/2023	MOS	College Employer Council (PT Support)	OPSEU	2/1/2021	2.00%
10/30/2023	Parmar Award	Bennett Village	CUPE	1/1/2021	1.00%[19]
11/2/2023	MOS	Knollcrest Lodge	UFCW	1/1/2021	0.50%
11/6/2023	Steinberg Award	Osgoode Care Centre (Service)	USW	6/13/2021	0.50%
11/6/2023	Steinberg Award	Osgoode Care Centre (RNs)	USW	6/13/2021	0.75%
11/7/2023	MOS	Marhkaven (RN Unit)	SEIU	4/9/2021	0.75%
12/4/2023	MOS	Blue Water Rest Home	ONA	4/1/2021	1.00%
12/6/2023	Award	University of Ottawa	APTPUO	9/1/2021	1.50%
12/7/2023	Johnston Award	Cama Woodlands	CUPE	4/1/2021	0.50%[20]
12/15/2023	Goodfellow Award	Toronto Finnish	CUPE	9/23/2021	0.50%

[16] Arbitrator also awarded additional increase of 1.5% effective 12/31/2021
[17] Deferred for payment to the next year
[18] Arbitrator also awarded additional increase of 2.0% effective 1/1/2022
[19] Arbitrator also awarded additional increase of 0.5% effective 10/1/2021
[20] Arbitrator also awarded additional increase of 1% effective 10/1/2021

Date of Award/ MOS	Arbitrator/ Freely Negotiated	Employer	Union	Date of Increase	Increase above Initial 1%
1/9/2024	MOS	Villa Marconi	CUPE	1/1/2021	0.50%
2/8/2024	Keller Award	Foyer Richelieu	CUPE	1/1/2021	0.50%
2/9/2024	Kaplan Award	School Boards	OSSTF	9/1/2021	2.75%[21]
2/9/2024	Kaplan Award	School Boards	ETFO	9/1/2021	2.75%[22]
				SIMPLE AVERAGE	**0.90%**

[21] Third year of moderation period; reopener increases for previous two years were 0.75%
[22] Third year of moderation period; reopener increases for previous two years were 0.75%

Table 3 - BILL 124 REOPENER INCREASES EFFECTIVE IN 2022

Date of Award/ MOS	Arbitrator/ Freely Negotiated	Employer	Union	Date of Increase	Increase above Initial 1%
2/15/2023	MOS	Craigholme	UNIFOR	11/1/2022	2.00%
3/6/2023	Parmar Award	Halton Health Services	OPSEU	4/1/2022	3.75%
3/8/2023	Stout Award	SEIU Master (9 LTC Homes)	SEIU	9/22/2022	2.00%
3/13/2023	Stout Award	ONA Master (14 LTC Homes)	ONA	7/1/2022	0.75%
3/13/2023	MOS	Dom Lipa	SEIU	1/1/2022	0.50%
4/5/2023	MOS	Parkwood Mennonite	USW	4/1/2022	0.50%
4/11/2023	MOS	Ontario Power Generation	PWU	4/1/2022	3.75%
4/25/2023	Gedalof Award	OHA	ONA	4/1/2022	2.00%
5/1/2023	Award	Ontario Power Generation	Society	1/1/2022	3.00%
5/10/2023	MOS	Golden Dawn	UNIFOR	11/1/2022	2.00%[23]
5/10/2023	MOS	Heidehof	CLAC	4/1/2022	0.50%
6/1/2023	Kaplan Award	OHA	OPSEU	4/1/2022	3.75%
6/13/2023	Kaplan Award	OHA	SEIU	1/1/2022	3.75%
6/13/2023	Kaplan Award	OHA	CUPE	9/29/2022	2.50%
6/21/2023	Albertyn Award	Almonte General Hospital	CUPE	1/1/2022	3.75%
6/27/2023	MOS	Trinity Village	UNIFOR	11/1/2022	2.00%[24]
7/4/2023	MOS	Maxville Manor	USW	3/1/2022	2.00%
7/5/2023	Kaplan Award	OCAD	OCADFA	1/1/2022 5/1/2022	1.00% 1.75%
7/10/2023	Award	Independent Electricity System Operator	SUP	1/1/2022	3.00%
7/27/2023	MOS	AR Goudie	UNIFOR	11/1/2022	2.00%[25]
8/11/2023	Consent to Alter	Ina Grafton Gage Home	ONA	4/1/2022	2.00%
8/15/2023	Kugler Award	Foyer des Pionniers	CUPE	1/1/2022	2.50%
8/15/2023	MOS	Ontario Public Colleges	OPSEU	10/1/2022	2.00%

[23] Plus additional 0.5% as deferred payment from previous year
[24] Plus additional 0.5% as deferred payment from previous year
[25] Plus additional 0.5% as deferred payment from previous year

Date of Award/ MOS	Arbitrator/ Freely Negotiated	Employer	Union	Date of Increase	Increase above Initial 1%
8/18/2023	Chauvin Award	Yee Hong (4 LTC Homes)	SEIU	1/1/2022	2.50%[26]
9/6/2023	Gedalof Award	University of Toronto	UTFA	7/1/2022	7.00%[27]
9/11/2023	Consent to Alter	IOOF Seniors Home	ONA	4/1/2022	2.00%
9/13/2023	MOS	IOOF Seniors Home	CLAC	4/1/2022	0.50%
9/14/2023	Kaplan Award	Ontario Teaching Hospitals	PARO	7/1/2022	3.75%
10/5/2023	MOS	University of Ottawa	APUO	5/1/2022	2.00%
10/20/2023	Gedalof Award	Nisbet Lodge	CUPE	1/1/2022	2.50%[28]
10/20/2023	MOS	College Employer Council (PT Support)	OPSEU	2/1/2022	2.00%
11/6/2023	Steinberg Award	Osgoode Care Centre (Service)	USW	6/13/2022	2.00%
11/6/2023	Steinberg Award	Osgoode Care Centre (RNs)	USW	6/13/2022	ONA Master Parity
11/7/2023	MOS	Marhkaven (RN Unit)	SEIU	4/9/2022	0.75%
11/17/2023	MOS	10 LHINs[29]	ONA	4/1/2022	2.00%
12/4/2023	MOS	Blue Water Rest Home	ONA	4/1/2022	2.00%
12/6/2023	Award	University of Ottawa	APTPUO	9/1/2022	2.00%
12/7/2023	Johnston Award	Cama Woodlands	CUPE	4/1/2022	2.50%
1/21/2024	Lee Award	OPS	OPSEU Unified	1/1/2022	2.00%
1/26/2024	Lee Award	OPS	AMAPCEO	4/1/2022	2.00%
				SIMPLE AVERAGE	**2.26%**

[26] Previous two years provided 0.5% reopener increases

[27] Incorporates remedy for all three years of moderation period (incl. two previous years) for an average of 2.33% per year on top of initial 1%

[28] Previous two years provided 0.5% reopener increases

[29] Not a reopener, but a settlement for a BU term that would have been covered by Bill 124

Table 4 - BILL 124 REOPENER INCREASES EFFECTIVE IN 2023

Date of Award/ MOS	Arbitrator/ Freely Negotiated	Employer	Union	Date of Increase	Increase above Initial 1%
3/8/2023	Stout Award	SEIU Master (9 LTC Homes)	SEIU	9/22/2023	2.00%
3/13/2023	Stout Award	ONA Master (14 LTC Homes)	ONA	7/1/2023	0.75%
4/11/2023	MOS	Ontario Power Generation	PWU	4/1/2023	2.50%
5/1/2023	Award	Ontario Power Generation	Society	1/1/2023	2.25%
5/10/2023	MOS	Golden Dawn	UNIFOR	11/1/2023	2.00%
6/1/2023	Kaplan Award	OHA	OPSEU	4/1/2023	2.50%
6/13/2023	Kaplan Award	OHA	SEIU	1/1/2023	2.50%
6/21/2023	Albertyn Award	Almonte General Hospital	CUPE	1/1/2023	2.50%
6/27/2023	MOS	Trinity Village	UNIFOR	11/1/2023	2.00%
7/4/2023	MOS	Maxville Manor	USW	3/1/2023	2.00%
7/5/2023	Kaplan Award	OCAD	OCADFA	6/30/2023	1.75%
7/10/2023	Award	Independent Electricity System Operator	SUP	1/1/2023	2.25%
7/27/2023	MOS	AR Goudie	UNIFOR	11/1/2023	2.00%
8/15/2023	Kugler Award	Foyer des Pionniers	CUPE	1/1/2023	2.50%
8/15/2023	MOS	Ontario Public Colleges	OPSEU	10/1/2023	2.50%
9/13/2023	MOS	IOOF Seniors Home	CLAC	4/1/2023	0.50%
10/5/2023	MOS	University of Ottawa	APUO	5/1/2023	2.25%
10/20/2023	MOS	College Employer Council (PT Support)	OPSEU	2/1/2023	2.50%
11/17/2023	MOS	10 LHINs[30]	ONA	4/1/2023	2.00%
12/6/2023	Award	University of Ottawa	APTPUO	9/1/2023	2.00%
1/21/2024	Lee Award	OPS	OPSEU Unified	1/1/2023	2.50%
1/26/2024	Lee Award	OPS	AMAPCEO	4/1/2023	2.50%
				SIMPLE AVERAGE	**2.10%**

[30] Not a reopener, but a settlement for a BU term that would have been covered by Bill 124

Table 5 - BILL 124 REOPENER INCREASES EFFECTIVE IN 2024

Date of Award/ MOS	Arbitrator/ Freely Negotiated	Employer	Union	Date of Increase	Increase above Initial 1%
6/1/2023	Kaplan Award	OHA	OPSEU	4/1/2024	2.00%
7/4/2023	MOS	Maxville Manor	USW	3/1/2024	TBD[31]
7/10/2023	Award	Independent Electricity System Operator	SUP	1/1/2024	1.75%[32]
1/21/2024	Lee Award	OPS	OPSEU Unified	1/1/2024	2.00%
1/26/2024	Lee Award	OPS	AMAPCEO	4/1/2024	2.00%
				SIMPLE AVERAGE	**1.94%**

[31] Difference between 1% and SEIU Master increase resulting from Year 1 of next round
[32] COLA escalator clause

Table 6: Overall Summary of OPS and BPS Bill 124 Reopeners (includes Sectors with Retention and Recruitment issues)

	Bill 124 1%	Reopener Average	Total Average	Physicians Price Only
2021	1%	0.90%	1.90%	1.0%
2022	1%	2.26%	3.26%	1.0%
2023	1%	2.10%	3.10%	2.8%
3 year total corresponding to the 3 years of the 2021 Physicians' Settlement		**(7.26%) 8.26%**		**4.8%** (not including typical 1% revenue increase)
2024	1%	1.94%	2.94%	**3.0%** (not including typical 1% revenue increase)

As a reminder, this data includes Bill 124 Reopeners only.

When comparing to physicians increases, it is important to note that for physicians, price increases are only a part of the compensation changes and certainly during the period of the 2021 settlement there were significant utilization increases on top of price as outlined in the MOH original brief. The MOH expects that to continue in 2024.

Please note that the Ministry will provide any award or settlement referenced above, if requested.

PARAGRAPH 12 OF THE OMA BRIEF:

12. The OMA is proposing a 22.9% increase for Year 1. This is comprised of the following elements:

(a) A 10.2% increase in respect of catch-up, based on the following factors:

(i) recognition and redress for the impact of inflation on the cost of living and physicians' cost of practice;
(ii) recognition and redress for the increases received by other groups including those in the Ontario health and broader public sectors for the period during which physician compensation was constrained by Bill 124; and
(iii) recognition and redress for the low price increases received by physicians since 2012 relative to the increases received by others in the Ontario health and broader public sector, and having regard to the increases to the costs of living and the cost of practice since 2012.

(b) A normative increase for year one of 12.7%, consisting of the following:

(i) 5% general price increase for 2024-25 (to be allocated to each section or physician grouping as the parties agree, or failing agreement, as this Board determines), and to be applied to the OHIP Schedule of Benefits (the "OHIP Schedule") and flow-through to other elements of physician compensation under the Binding Arbitration Framework ("BAF"); and
(ii) 7.7% to provide for additional targeted funding for 2024-25, reflecting the imperative to invest in various targeted physician-related health care system initiatives.

MINISTRY REBUTTAL

Compulsory interest arbitration is a substitute for the strike/lockout sanction. As such, the process must replicate what the parties might have achieved had they been required to strike/lockout, or faced the realistic prospect of one of those sanctions. It is not a forum where a Union is to be rewarded because it does not have the right to strike, nor can an Employer be rewarded because it need not sustain the inconvenience of a strike or, enforce a lockout.

Professor Weiler in his 1981 award between the 65 Participating Hospitals and CUPE, at page 27 clearly set out the role of an interest arbitrator as follows:

> *....the arbitration model does not inherently requires the parties to make these tough choices in their negotiating positions. .... In the arbitration context, the Union does not have to worry that if it asks for too many things at once, the result will be a painful work stoppage.* ***Indeed, the Union may be tempted as also the Employer which has its own diverse constituencies which it does not want to alienate, to carry all of these initial demands forward to the arbitration hearing, on the theory that it has nothing to lose by asking... Certainly it is essential to the integrity of arbitration that these latter assumptions not be reinforced.*** *(emphasis added)*

In this case, the OMA brought everything from its opening proposals to this arbitration, focused on price for Year 1, on the philosophy of "what is there to lose?". The Ministry submits that the OMA should not be reinforced in this assumption which undermines the integrity of this Year 1 arbitration process and devalues their proposals.

We ask the Board to make particular note that this is a four year agreement and Years 2, 3 and 4 are yet to be negotiated or mediated. The parties have set aside significant time to work on all issues, including those that the Ministry brought forward. The issues are complex and require significant study, review and prioritization.

PARAGRAPH 13 OF THE OMA BRIEF:

13. As of April 1, 2024, the OMA represents Ontario's 48,795 physicians, medical students, and retired physicians. Of these, 35,527 are actively practicing. Approximately 12.6% of OMA members are just starting their careers, 40.4% are established in their careers, and 19.9% are late career. 55.9% are men and 44.1% are women. The OMA's members can be found throughout all regions of the province including in urban, rural and Northern communities.

The OMA also references the issue of distribution of physicians at paragraph 66, 237 and 254.

MINISTRY REBUTTAL

The OMA states that "OMA's members can be found throughout all regions of the province including in urban, rural and Northern communities."

While this statement out of context is accurate, it should not be inferred that they are evenly distributed throughout the province. As per the Ministry's May 1, 2024 submissions at paragraph 31, the Government does not control the transfer of physicians to settings of greatest need.

The distribution of physicians is not even or equal at all. The unequal distribution is a very serious problem for the system.

The following analysis will illustrate that an above normative general price increase will not solve, and may in fact exacerbate this problem. This would be a Ministry priority in negotiations with the OMA regarding allocation of the awarded targeted increases in Year 1 of the PSA contemplated by the Ministry's proposal on price increases, and/or in negotiations for Year 2, 3 and 4 of this PSA.

Analysis:

On November 17, 2022, the Canadian Institute for Health Information (CIHI) released its report titled "Health Workforce in Canada, 2021: In Focus (including nurses and physicians)"[33]. This publication includes data that provide information on physicians, nurses, and other health care service providers in provinces and territories across Canada. The below table breaks down the number of family physicians per 100,000 population by LHIN in 2021, therefore showing the distribution of family physicians across Ontario. There were over 50% more family physicians per capita in Toronto than there are in 10 of the 13 other LHINs and over 100% more physicians than 3 others LHINs.

Table 7: Family Physician Distribution Across LHINs

Region (LHIN)	Family Medicine Physicians per 100,000 population	Percent More Family Medicine Physicians/100K Population in Toronto Central
Toronto Central	**196**	
North West	162	21%
Champlain	145	35%
South East	133	47%
North East	128	53%
South West	115	70%
North Simcoe Muskoka	113	73%
Mississauga Halton	106	85%
Hamilton Niagara Haldimand Brant	103	90%
Central	102	92%
Waterloo Wellington	100	96%
Erie St. Clair	95	106%
Central East	89	120%
Central West	77	155%
Ontario	***116***	***69%***

From these physician ratios the total family physician counts by LHIN can be estimated.

[33] Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2021 — Data Tables. Ottawa, ON: CIHI; 2022.

Table 8: Estimating Family Physician Counts by Region

Region (LHIN)	Family Medicine Physicians per 100,000 population	LHIN Population, April 1, 2022	Estimated Family Physician Headcount
Toronto Central	196	1,402,231	2,748
North West	162	223,134	361
Champlain	145	1,518,822	2,202
South East	133	542,215	721
North East	128	578,930	741
South West	115	1,089,828	1,253
North Simcoe Muskoka	113	541,510	612
Mississauga Halton	106	1,358,447	1,440
Hamilton Niagara Haldimand Brant	103	1,583,672	1,631
Central	102	2,085,524	2,127
Waterloo Wellington	100	898,254	898
Erie St. Clair	95	713,982	678
Central East	89	1,745,739	1,554
Central West	77	1,098,287	846
Ontario	***116***	***15,380,575***	***17,814***

However, we know that not all these physicians are practicing comprehensive longitudinal primary care. Family physicians are choosing to work in other areas of practice. A number of the family physicians practice in emergency medicine or in GP Focused practices (i.e. focusing on psychiatry or sports medicine) and thus would not have a standard patient roster for comprehensive care.

According to the OMA, approximately 65% of family medicine physicians are comprehensive longitudinal family physicians[34] that would operate a standard patient roster. The table below estimates the number of comprehensive longitudinal family physicians in each region.

[34] OMA May 1, 2024 Brief, Paragraph 507

Table 9: Estimating Comprehensive Longitudinal Family Physician Headcount

Region (LHIN)	Family Physician Headcount	Estimated Comprehensive Longitudinal Family Physician Headcount (65%)
Toronto Central	2,748	1,786
North West	361	235
Champlain	2,202	1,431
South East	721	469
North East	741	482
South West	1,253	815
North Simcoe Muskoka	612	398
Mississauga Halton	1,440	936
Hamilton Niagara Haldimand Brant	1,631	1,060
Central	2,127	1,383
Waterloo Wellington	898	584
Erie St. Clair	678	441
Central East	1,554	1,010
Central West	846	550
Ontario	***17,814***	***11,579***

Using an assumption of 1,300 patient roster size and targeting a 97% attachment rate, a number of comprehensive longitudinal family physicians can be estimated for each region.

If headcount alone determined whether there were sufficient family physicians to meet this attachment target, the table below demonstrates that there would be a sufficient number of comprehensive longitudinal physicians across the province:

Table 10: Calculating Physician Count Required for 97% attachment on 1,300 patient Rosters

Region (LHIN)	Comprehensive Longitudinal Family Physician Headcount	LHIN Population, April 1, 2022	Number of Comprehensive Longitudinal Family Physicians Required to Reach 97% Attachment	Distribution of Physician Headcount
Toronto Central	1,786	1,402,231	1,046	740
North West	235	223,134	166	68
Champlain	1,431	1,518,822	1,133	298
South East	469	542,215	405	64
North East	482	578,930	432	50
South West	815	1,089,828	813	1
North Simcoe Muskoka	398	541,510	404	-6
Mississauga Halton	936	1,358,447	1,014	-78
Hamilton Niagara Haldimand Brant	1,060	1,583,672	1,182	-121
Central	1,383	2,085,524	1,556	-173
Waterloo Wellington	584	898,254	670	-86
Erie St. Clair	441	713,982	533	-92
Central East	1,010	1,745,739	1,303	-293
Central West	550	1,098,287	819	-270
Ontario	***11,579***	***15,380,575***	**11,476**	103

The Ministry submits that the roster and attachment assumptions utilized are reasonable for illustrative purposes. A 1300 patient roster size aligns closely to the weighted average roster size of family physician (1274.8) based on the data presented in the OMA brief[35]. With respect to attachment, as will be further described below, 97% is a reasonable attachment assumption given the number of non-users of the health care system and the fact that some Ontarians are receiving care from NPs (i.e., the most responsible provider) who would otherwise be categorized as unattached. That notwithstanding only 9 more physicians would be required to hit a 98% attachment rate and 121 would be required for 99%, targets well within reach over the next few years of growth in physician numbers.

[35] Paragraph 282 of the OMA Brief presents data from the Ontario Ministry of Health: Corporate Provider Database, Registered Persons Database, Client Agency Program Enrolment, Ontario Health Insurance Plan. The calculated weighted average of the provided data is 1274.8.

We provide at Exhibit 1 the spreadsheet that is the foundation for these calculations. We have left the roster size and attachment rate as variables that can recalibrate the calculations if desired. For example, using the actual weighted roster size of 1274.8 and a 96% attachment rate, results in a sufficient headcount of comprehensive longitudinal family physicians if distribution across the regions were not an issue.

Thus, having a distribution of family physicians more evenly across the province would assist with regional issues with access to family doctors. An above normative wage increase is not going to assist with this issue. The parties have agreed that for Year 1 of the 2024-28 Physician Services Agreement, seventy percent (70%) of the price increase awarded in Year 1 will be allocated through the Physician Payment Committee process. The distribution 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 RAANI CANDI score. Under relativity, there is limited ability to apply a greater increase to primary care physicians outside of Toronto. Physicians compensated under the Family Health Organization model, for example, are in “Group 1 Family Physicians” and this group receives the relativity increase which they then apply (through PPC) to their compensation elements. As noted in the MOH original brief, the Group 1 allocation on RAANI CANDI is a smaller increase than both “Group 2” Family Physicians or “Group 3” Family Physicians. The Price increase, when allocated will provide Family Physicians in the preferred compensation model a lesser increase than the Fee for Service Family physicians who as in Group 3.

We provide below the primary care grouping under the RAANI CANDI relativity model, and the allocation of the general increasing in Year 1 and 2 of the PSA.

TABLE 11: 2021 PSA – Year 1 + Year 2 Allocation (2.01%) by Contract

		Allocation %
Group 1	Family Health Network (FHN)	1.7817%
	Family Health Organization (FHO)	1.7817%
Group 2	Blended Salary Model (BSM)	2.6186%
	Comprehensive Care Model (CCM)	2.6186%
	Family Health Group (FHG)	2.6186%
	Group Health Center (GHC)	2.6186%
	Rural & Northern Physician Group Agreement (RNPGA)	2.6186%
	St. Joseph's Health Centre (STJHC)	2.6186%
Group 3	Fee for Service (FFS)	3.3385%
	GP Focused Practice (GPFP)	3.3385%
	Aboriginal Family Health Team (AFHT)	3.3385%
	Interprofessional Primary Health Care Organization (IPHCO)	3.3385%
	Community Health Centres (CHC)	3.3385%
	GP Focus – Care of the Elderly (GPFCOE)	3.3385%
	GP Focus – Palliative Care (GPFPC)	3.3385%
	GP Focus – HIV (GPFHIV)	3.3385%
	Homeless Shelter Agreements (HSA)	3.3385%
	Sioux Lookout Regional Physician Services Agreement (SIOUX)	3.3385%
	Toronto Palliative Care Associates (TPCA)	3.3385%
	Weeneebayko Area Health Authority (WAHA)	3.3385%

Furthermore, under the relativity model, there is no way to give a greater increase to, for example, those doctors practicing in the Central West LHIN, as compared to Toronto. The compensation elements adjusted through PPC based on the increase awarded will apply to all family physicians including those in Toronto. Therefore, to the extent that distribution is an issue to be solved, it is through targeted increases that it can be addressed.

As we stated above, we know that family physicians in Ontario are not all practicing comprehensive primary care, or are practicing it part time, and take on a smaller patient roster. As noted above, the RAANI CANDI relativity formula allocates a greater increase

to the sole practitioner. Again, to the extent that family physicians are choosing these other areas of practice, the Ministry submits that it will not be an above normative compensation increase which stops this practice pattern and brings them back to solely providing comprehensive primary care. Many have not chosen these other areas of medicine for the compensation, but due to a greater interest in specialization.

Further, we know that there has been a changing practice pattern among family physicians and a greater regard for work-life balance. (See further submissions later in this presentation), and an above normative price adjustment will not incent these physicians to provide more hours in comprehensive care.

Finally, to the extent that such family physicians are undertaking “specialization work” in GP focused practice, an above normative increase will only exacerbate the earning differences. This is due to the fact that under the most current hybrid RAANI CANDI score, GP Focused Practices will receive a higher adjustment than other primary care groups such as the Family Health Organization.

Ontario does not have a recruitment and retention problem with physicians. It does have a distribution problem.

An above normative price increase allocated through the already agreed CANDI-RAANI relativity model is not a solution to the problem of patient access and may in fact be counterproductive.

PARAGRAPH 21 OF THE OMA BRIEF:

21. Delays and long-wait times can be found throughout the system. As of April 2024, as set out in the following chart based on Ontario Health data, wait lists for all surgeries have grown to well over 186,000. This backlog has more than doubled since the pre- pandemic period, and the problem is only getting worse. These delays "expose patients to higher risks of poorer health-related quality of life, progression of underlying conditions and worse surgical outcomes.

Service Area	Wait List	Wait List Over Target	# Wait list Over Target	Wait List over Target (Previous Week)		% Change Wait List Over Target vs. Previous Week	% Wait List Over Target (Pre-pandemic)
All Surgery	186,745	71,260	38%	72,389	↓	-1.6%	18%
General Surgery	20,458	6,972	34%	6,982	↓	-0.1%	11%
Gynaecologic Surgery	16,562	6.494	39%	6,579	↓	-1.3%	12%
Neurosurgery	1,758	939	53%	935	↑	0.4%	22%
Oncology Procedures	5,783	1,573	27%	1,680	↓	-6.4%	10%
Ophthalmic Surgery	45,653	15,169	33%	15,567	↓	-2.6%	17%
Oral and Maxillofacial Surgery and Dentistry	2,568	1,109	43%	1,139	↓	-2.6%	23%
Orthopedic Surgery	45,031	16,466	37%	16,726	↓	-1.6%	24%
Otolaryngic Surgery	10,819	4,861	45%	4,894	↓	-0.7%	20%
Plastic and Reconstructive Surgery	6,273	3,015	48%	3,078	↓	-2.0%	20%
Thoracic Surgery	507	216	43%	222	↓	-2.7%	17%
Urologic Surgery	9.217	3,296	26%	3,349	↓	-1.6%	11%
Vascular Surgery	2.145	1,116	52%	1,137	↓	-1.8%	27%

MINISTRY REBUTTAL

We address the issue of surgical backlog below. However, generally speaking, wait times are the result of multiple system issues that are ultimately about things such as the number of beds that are in and out of the system, including community longer term care, at home beds, supportive living environments, all of which are not related to physicians.

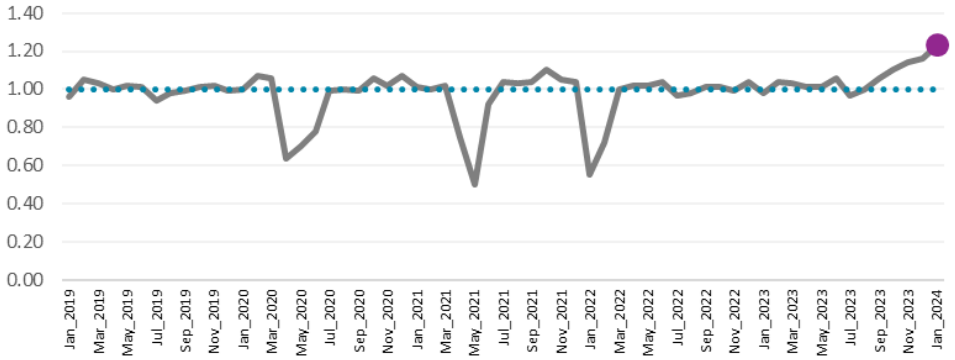
Surgical wait times are often due to a lack of operating room time or a lack of supporting staff such as nurses. Wait times for diagnostic imaging is not due to a shortage of radiologists but a shortage of technicians and limited hardware such as CT and MRI scanners. We therefore submit that an above normative compensation increase for physicians will not address the issue of wait times.

These are areas that the Ministry is addressing, successfully, with investments.

For example, more surgical procedures are being completed than added to the surgical waitlist, reducing the waitlist overall. This is due to the Government's expansion in the number of surgeries being done through community surgical and diagnostic centres. In 2023-24 there were approximately 31,000 cataract surgeries funded for patients in community surgical and diagnostic centres. This included four new centres in Windsor, Kitchener-Waterloo and Ottawa. We note that these investments have also translated to earning opportunities for physicians. Figure One below shows that more surgeries were completed than added in 2023, reducing the total wait list for surgeries[36]

[36] Ontario Wait Time Information System (WTIS), Ontario Health

Figure 1: All surgical Throughput (Adults & Paediatrics)



Notes:

- A monthly throughput ratio of 1 means that the cases added in the queue and cases completed are about equal for the month. A throughput ratio of more than 1 means that the cases completed in the queue is more than the cases added for the month. A throughput ratio of less than 1 means that the cases completed in the queue is less than the cases added for the month.
- Based on the graph, more surgeries have been completed than added during 2023. The ongoing increase in the number of surgeries completed vs. surgeries added reduces the total wait list for surgeries.

PARAGRAPH 28 OF THE OMA BRIEF:

28. The evidence of a crisis in the health care system is particularly stark in family medicine. At present, 2.3 million patients do not have a regular family physician in Ontario, an increase from 1.6 million in 2017 and a number which is expected to almost double by 2026. The lack of a family physician can have very serious health consequences for patients in obtaining initial diagnosis and follow-up care when ill and in receiving regular preventative care. This, in turn, results in increased pressures on physicians and the health care system generally.

MINISTRY REBUTTAL

The notion of an "unattached" patient requires careful scrutiny given the importance placed upon it by the OMA in their submissions.

With regards to the OMA assertions at paragraph 28 on the number of unattached patients, it appears the OMA is referring to the 2022 INSPIRE data[37]. The INSPIRE data suggests that 2,290,869 patients are uncertainly attached patients. The phrasing of "uncertainly attached" is not the same as "unattached". INSPIRES own definition is an express acknowledgement that such patients could have access to primary care (such as through walk in clinics, or a FFS doctor etc.)[38]. The INSPIRE data notes that of the 2.29 million uncertainly attached patients, 1,571,537 are non-health care users, tend to be younger (average age of 34.4 while the average age of patients seen by Ontario GPs is 51.7[39]) and have lower acuity and no chronic conditions. In other words, the uncertainly attached patients who have not accessed primary care services are on average nearly 20 years younger than patients accessing primary care services. More than 96% of non-users did not have any visit to an emergency department for CTAS IV and V conditions.

[37] https://www.ontariohealthprofiles.ca/loaddataON/OHT/allON_data/allON_data_Sept2022.xlsx
[38] https://www.ontariohealthprofiles.ca/loaddataON/OHT/summary/summary_OHT_2022.pdf
[39] OHIP Claims Data based on Fiscal Year 2022/2023

Moreover, given that INSPIRE's methodology excludes the following:

- NPs and other salaried models (excluding CHCs)
- Some patients that perceive FFS doctors as their regular provider will be classified as uncertainly attached (because some patients will not have seen their physician within the timeframe reviewed or because the method defines some doctors as walk-in clinic doctors).
- Patients of LTC home, nursing homes are not included or some Indigenous populations (without OHIP card).

The method inflates the number of unattached, as it is the case that some Ontarians are receiving care from practitioners who would not be included in the INSPIRE data.

This certainly brings into question the extent to which the INSPIRE data can be relied upon in reviewing the issue of access to primary care providers for Ontarians.

According to the Health Care Experience Survey (HCES) used by the Ministry of Health, 1.35 million Ontarians are unattached. Ontario also has the highest attachment rate of any province or territory in Canada with approximately 90% of Ontarians attached to a regular health care provider[40]. The Ministry's negotiation with the OMA for targeted investments, which will occur subsequent to the Year 1 price award, will focus on initiatives to increase attachment. The Ministry submits an above normative increase will not address the issue of patient attachment.

[40] https://www.cihi.ca/en/taking-the-pulse-a-snapshot-of-canadian-health-care-2023/88-of-canadians-have-a-regular-health

PARAGRAPHS 29 AND 30 OF THE OMA BRIEF:

29. As reflected by the large and growing number of unattached patients, and as set out in more detail under the discussion of recruitment and retention below, there is a severe shortage of family physicians in Ontario. With only one family physician per 1,000 people, Ontario has one of the lowest family physician to population ratios in the entire country.11 Compounding this shortage is the fact that the proportion of family physicians practicing comprehensive longitudinal family medicine is falling.12 The evidence is that this decline is happening across Canada and in Ontario, and not only for family physicians entering practice but across all career stages.13

30. The family physician shortage is further impacted by a growing population and an aging population. As well, increased patient care complexity and a higher prevalence of chronic health issues means that physicians must spend more time on each patient visit, further increasing the demands on an already overwhelmed system.

MINISTRY REBUTTAL

The OMA's submissions on physician shortages is a very complex issue that requires a careful review of all of the component parts of the issue (e.g. distribution, patient visits). While the Ministry does not intend to ignore the issue raised by the OMA, the Ministry submits it does not equate to a Recruitment and Retention issue, in contrast to that which was seen in recent nursing awards, and it is not an issue that an above normative price increase will address. The Ministry has already submitted at Section 6.2 of its May 1, 2024 brief data with respect to the Recruitment and Retention of Physicians. In reply, the Ministry reviews the following data with respect to the Retention and Recruitment of physicians:

a) Retention

There is no evidence of an issue with the retention of physicians. The fact that the number of physicians (net of attrition) increases year over year is evidence that there is not a retention problem. The evidence here is also in sharp contrast with the data and facts before this same chair for the Hospitals & ONA HLDAA decision for RNs.

In particular, with respect to family physicians, there is evidence to support that Ontario is able to maintaining physicians in the leading comprehensive care model – the FHO model. The number of signatory physicians to the FHO model have increased significantly over the course of the last PSA.

Total FHO Signatory Physicians[41]					
Fiscal	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
Total	**5415**	**5512**	**5660**	**6226**	**6392**

b) Recruitment

There is no evidence of an issue with the recruitment of individuals who want to become physicians.

The facts demonstrate that Ontario has been able to consistently and substantially recruit top tiered talent into Ontario medical schools. The Ontario Government continues to open up more student placements and to grow the residency programs. It is anticipated that with these additional investments, the number of physicians (net of attrition) will continue to outpace the increases in population.

As a result, the ratio of physicians per 100,000 population will continue to improve.

The comparison of ratios of Physicians to Population must be considered in the following context:

The ratio numbers of Physicians to Population has increased significantly over the past 18 years. This baseline data is set out in the MOH Brief and Exhibit 14, however it is pulled together and calculated as a ratio below.

[41] Based on a count of the number of physicians to signed FHO contracts as provided to the Primary HealthCare Branch

The ratios can not change overnight, but there can be no doubt that the Ontario situation continues to improve in the future, given the plans for more opportunities in the medical schools.

Fiscal Year	Total Active Physicians	Total Population	Ratio of Physicians per 1,000 Population	Year-over-Year % Change	Cumulative % Change
2005-06	22,944	12,587,149	1.82		
2006-07	23,334	12,703,327	1.84	1.10%	0.77%
2007-08	23,858	12,814,686	1.86	1.09%	2.14%
2008-09	24,451	12,932,742	1.89	1.61%	3.72%
2009-10	25,199	13,059,426	1.93	2.12%	5.86%
2010-11	26,063	13,199,081	1.97	2.07%	8.33%
2011-12	26,853	13,325,337	2.02	2.54%	10.55%
2012-13	27,678	13,446,276	2.06	1.98%	12.93%
2013-14	28,528	13,563,311	2.10	1.94%	15.39%
2014-15	29,411	13,657,423	2.15	2.38%	18.14%
2015-16	30,192	13,774,364	2.19	1.86%	20.25%
2016-17	30,916	13,975,516	2.21	0.91%	21.36%
2017-18	31,728	14,199,811	2.23	0.90%	22.58%
2018-19	32,567	14,449,986	2.25	0.90%	23.64%
2019-20	33,250	14,718,155	2.26	0.44%	23.94%
2020-21	33,548	14,772,726	2.27	0.44%	24.58%
2021-22	34,791	14,999,441	2.32	2.20%	27.25%
2022-23	35,324	15,378,179	2.30	-0.86%	26.02%
2023-24	36,204	15,848,654	2.28	-0.87%	25.32%

As a point of interest, the CAGR (Compounded Annual Growth Rate) for physician growth is 2.6% while the CAGR for population growth is 1.3%. Physician numbers have growth twice as quickly as population over this period.

Furthermore, credible studies indicated that the Ontario Family Physician to Population ratio is already at a reasonable level.

This is reviewed in the Lee study as referenced at paragraph 265 of the MOH Brief:

> **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).**

Accordingly, the Ministry submits that recruitment should not be a factor that motivates an above normative increase. This was laid out in detail in the MOH May 1, 2024 submissions at Section 6.

The Most Effective Means to Patient Access:

The most effective and immediate means to increase the number of patient visits and reduce wait times would be to free up physician time taken for administrative duties and enable the physicians to do more clinical work (i.e. patient visits)

Assuming a 40 hour work week, reducing physician administrative time by 5 hours per week would open up 12.5% more clinical hours (the equivalent of adding more than 4,000 physicians to the current workforce) or allow some of these hours to be utilized for work-life balance.

PARAGRAPH 31 OF THE OMA BRIEF:

31. The family medicine crisis is also only going to get worse due to the anticipated retirement of many family physicians. The retirement of a single doctor can leave thousands of patients without a family doctor. According to some estimates between 2019 and 2025, nearly 1.7 million Ontarians have and will need to find a new family doctor because their doctor has retired. Their new doctor, assuming one can be found, will encounter a patient who, themselves has grown older and whose patient complexity has increased.

MINISTRY REBUTTAL

To date, Ontario has been increasing the number of family physicians net of retirement year over year. This data was submitted at page 58 of the Ministry's May 1, 2024 Arbitration Brief:

Fiscal Year	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24 (Proj.)	Growth 2016 to 2023 (#)	Growth 2016 to 2023 (%)
GP Supply (Headcount)	14,449	14,772	15,110	15,392	15,541	16,134	16,265	16,505	2,056	14.2%

The number of family physicians in Ontario increased by 14.2% from 14,449 physicians in 2016/17 to 16,505 physicians projected in 2023/24.

Further, as previously submitted, in 2023 and 2024 Ontario has increased the number of family medicine residency positions, and filled all of them.

The Government's plan for the health care system includes training more family medicine physicians and thereby continuing to increase the number of family doctors. 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, 269 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.

As previously submitted, the distribution of physicians and fewer patient visits are a factor in patient access. Physicians are not employees, and Government does not control the transfer of physicians to settings of greatest need. This is another distinction from the employment model (e.g. RNs).

An above normative compensation increase will not address the issue of patient access. To the extent an investment should be made to address issues of patient access, it may be part of targeted investments from this year one award (and potentially years 2, 3 and 4 of this agreement).

PARAGRAPH 33 OF THE OMA BRIEF:

33. It has also been suggested that the clinical hours of work of family physicians are also declining due to demographic changes amongst physicians. For example, late career physicians have much larger rosters than early career physicians. Due to these changing demographics and patterns of practice, it is often the case that more than one family physician is needed to replace each retiring family physician, even before considering the increased demands on the system due to population aging and growth and increased patient complexity.

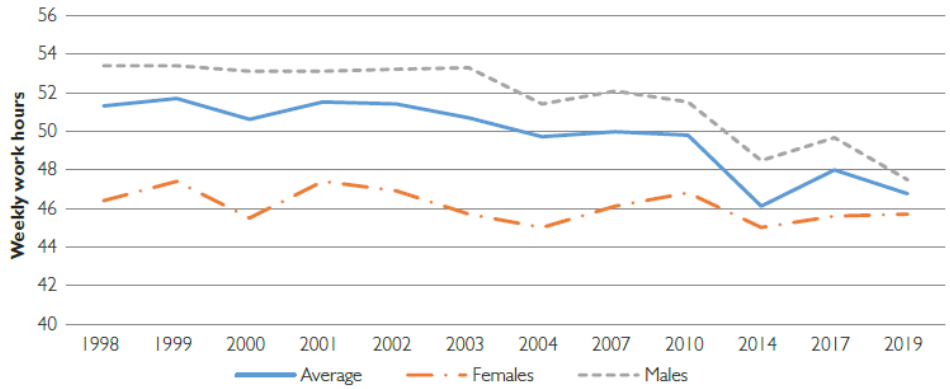
MINISTRY REBUTTAL

The OMA submits that it has been suggested that the practice patterns of family physicians are changing. It submits that one such change in the practice pattern is the decline in clinical hours of work of family physicians. The Ministry asks the Board to take note that the parties agree there is a decline in the clinical hours of work of family physicians.

While the parties can debate the reasons for the decreased productivity (if measured as a patient encounter per physician), we can be reasonably certain it is not gender based. The "Induced Productivity Decline Hypothesis: More Physicians, Higher Compensation and Fewer Services" study referenced at paragraph 266 (and Exhibit 16) of the MOH Brief confirms that the gender differences in physician productivity are very small. We excerpt below directly from the study:

> *"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



Further, the paper entitled “Long-Term Trends in the Work Hours of Physicians in Canada” (Exhibit 17 of MOH Brief) also identifies a similar trend when interpreting the data on the decreased hours of physicians:

> 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.**

Section 12.1 (page 113) of the Ministry’s May 1, 2024 Brief presents data that proves it is more than a mere suggestion. The Ministry brief presents data on the reduction in the total patient visits and number of distinct patients seen. The Ministry submits below further information which demonstrates that the number of patient encounters have been declining year over year for the last 18 years straight (absent an anomalous period of time in the middle of the pandemic).

On average, physicians today provide 1,000 (22%) fewer patient encounters per year than they did 18 years ago, **a compounded annual reduction of 1.4%.**

TABLE 12 – Cumulative Change in Patient Encounters Per Physician

Fiscal Year	Physician Supply	Total Patient Encounters	Average # of Patient Encounters per Physician	Cumulative Change in Patient Encounters per Physician
2005-06	22,944	105,384,533	4,593	-
2006-07	23,334	106,345,988	4,558	-0.8%
2007-08	23,858	106,799,737	4,476	-2.5%
2008-09	24,451	108,783,244	4,449	-3.1%
2009-10	25,199	111,269,484	4,416	-3.9%
2010-11	26,063	111,026,172	4,260	-7.3%
2011-12	26,853	112,890,178	4,204	-8.5%
2012-13	27,678	112,296,912	4,057	-11.7%
2013-14	28,528	113,572,017	3,981	-13.3%
2014-15	29,411	115,663,699	3,933	-14.4%
2015-16	30,192	118,209,316	3,915	-14.8%
2016-17	30,916	120,434,348	3,896	-15.2%
2017-18	31,728	122,034,392	3,846	-16.3%
2018-19	32,567	123,080,975	3,779	-17.7%
2019-20	33,250	123,766,693	3,722	-19.0%
2020-21	33,548	112,214,037	3,345	-27.2%
2021-22	34,791	124,306,232	3,574	-22.2%
2022-23	35,324	128,016,209	3,625	-21.1%
2023-24	36,204	129,762,576	3,584	-22.0%

In any event, with a pattern extending in the same direction for 20 years, it is difficult to dismiss that a desire for a better “Work Life Balance” is not among the many reasons for these changes. This is certainly what is suggested by the authors of the “Long-Term Trends in the Work Hours of Physicians in Canada”:

> 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.**

These are personal decisions that one can understand and appreciate. The only real question becomes whether the consequences of achieving a better work life balance should be the basis of an above normative fee increase. However, incenting greater clinical hours, and rewarding family physicians who currently provide greater clinical hours, is an interest of the Ministry that it will explore further in negotiating the implementation of targeted investments with the OMA.

PARAGRAPH 34 OF THE OMA BRIEF:

34. At the same time as more family physicians are retiring, fewer medical students are choosing to practice family medicine. Only 30.3% of students in Canada ranked family medicine as their top choice in 2023, down from 31.4% in 2021 and 38% in 2015. In Ontario, only 29.6% of Ontario students ranked family medicine as their top choice in 2023, down from 40.2% in 2015.

MINISTRY REBUTTAL

First, as presented previously, the total headcount of family physicians in Ontario has been increasing (not decreasing).

Further, the average age of a family medicine physician has remained unchanged since 2018, suggesting that a significant increase in retirements would not be expected, particularly within the terms of this PSA. We provide below the yearly average age of family medicine physicians:

Table 13: Yearly Average Age of Family Medicine Physicians

Average Age[42]	2018	2019	2020	2021	2022
Family Medicine	49.7	49.7	49.5	49.3	49.3

Ontario had an extremely successful match in filling residency positions, filling all 1,324 ministry funded positions. For a second year in a row, and after having added 136 positions, Ontario has filled 100% of its positions.

Ontario increased the number of family medicine positions in both the 2023 and 2024, filling 100% of offered family medicine positions.

[42] Source: Ontario's Physician Resource Data Centre, 2018 to 2022 Physicians in Ontario.

Ontario filled all 547 ministry funded Family Medicine positions in 2024. This was 24 more Family Medicine positions than in the 2023 match. This was the most Family Medicine positions ever filled by Ontario.

Ontario is making a historic investment in residency training by adding 449 new postgraduate positions, 60% of which will be dedicated to Family Medicine (an estimated 269 additional family medicine residency positions).

This will bring the total family medicine positions offered by Ontario to an estimated 777 by 2028, a 53% increase in the number of Family Medicine training positions offered by Ontario.

In addition, Ontario is supporting the planning for a new school of medicine at York University which would be focused on primary care training, the first school of its kind and representing an additional expansion in addition to the above.

PARAGRAPH 37 OF THE OMA BRIEF:

37. All of this in turn is leading to higher levels of burnout amongst family physicians. According to the Canadian Medical Association's 2021 National Physician Health Survey, "The prevalence of burnout is significantly higher among respondents in general practice/family medicine (57%) compared with physicians practicing in other/administration positions (40%*)." Similarly, according to the OMA's own survey, about 60% of physicians reported symptoms of burnout in 2022, with 10% of those reporting that they were "completely burned out and often wonder if [they] can go on."*

MINISTRY REBUTTAL

The important issue of burnout is not an issue that can be resolved through price increases. As per the below article authored by the president of the CPSO[43]:

> *Research has shown the many drivers of burnout fall into three major domains: efficiency of practice, a culture of wellness and personal resilience.* ***Most physician wellness initiatives focus primarily on improving personal resilience, which is, by far, the smallest contributor to burnout with only 20 percent of the drivers.*** *Mindfulness programs and yoga classes may be helpful in reducing stress, but they can't solve physician burnout.*
>
> *Indeed, if ever an issue has called out for our thoughtful attention, I believe it is physician burnout.*
>
> ***More than 80 percent of the drivers of burnout are related to organizational factors, including excessive workloads, inefficient work processes, clerical burdens, lack of input or control for physicians in issues affecting their work, and leadership culture****. We have all experienced electronic medical records that require multiple logins and passwords to obtain relevant patient information, excessive click counts, phone calls going directly to voicemail, email overload, lack of hospital beds and resources, and the list goes on. Effective solutions require organizations to align their efforts with these drivers.*
>
> *That message was key to Dr. Jillian Horton's recent presentation to Council. Dr. Horton, one of the physicians driving culture change in medicine, says the literature has overwhelmingly found that organizational factors are the primary causes of physician burnout. If we cast the issue as a personal problem, we do so at our peril, she said. Given that a recent Ontario Medical Association survey found 34 percent of physicians reported either persistent symptoms of burnout or feeling completely*

[43] https://dialogue.cpso.on.ca/2022/03/at-a-crisis-point/

burned out, it is essential health system organizations come together to focus on these issues.

Administrative burden should not be solved by a price increase. Such an approach could have unintended consequences such as incenting administrative work over clinical care. While any small business inherently requires its owners to innovate and modernize to address issues such as administrative burden, the Ministry is also dedicated to problem solving these issues to enable a win-win for the physician (work life balance) and the patient (more clinical care).

Furthermore, we ask the Board to take note that the Ministry has and will continue to invest significantly in measures to mitigate administrative burden while also improving patient safety. The Ministry has initiatives to address administrative burden, as set out in Section 10.2 of its May 1, 2024 submissions.

PARAGRAPH 38 OF THE OMA BRIEF:

38. Signs of crisis are also widespread in emergency medicine ("EM"). According to Ontario Health Quality reports, as of February 2024, patients spent an average of 20.5 hours in the emergency department ("ED") before being admitted and getting a bed. This far exceeds the provincial target of 8 hours. This in turn makes it harder to see new patients, slowing workflow for emergency physicians, including taking them longer to complete an assessment for a given patient, in turn increasing wait times. As well, emergency physicians end up being responsible for the care and management of a patient over an extended period of time leading increased stress and burnout in physicians. None of this is captured in bare Ministry statistics, devoid of this clinical on the ground reality.

MINISTRY REBUTTAL

As previously submitted, the important issue of ED wait times are the result of multiple system issues that are ultimately about things such as the number of beds that are in and out of the system, including community longer term care, at home beds, supportive living environments, all of which are not related to physician compensation.

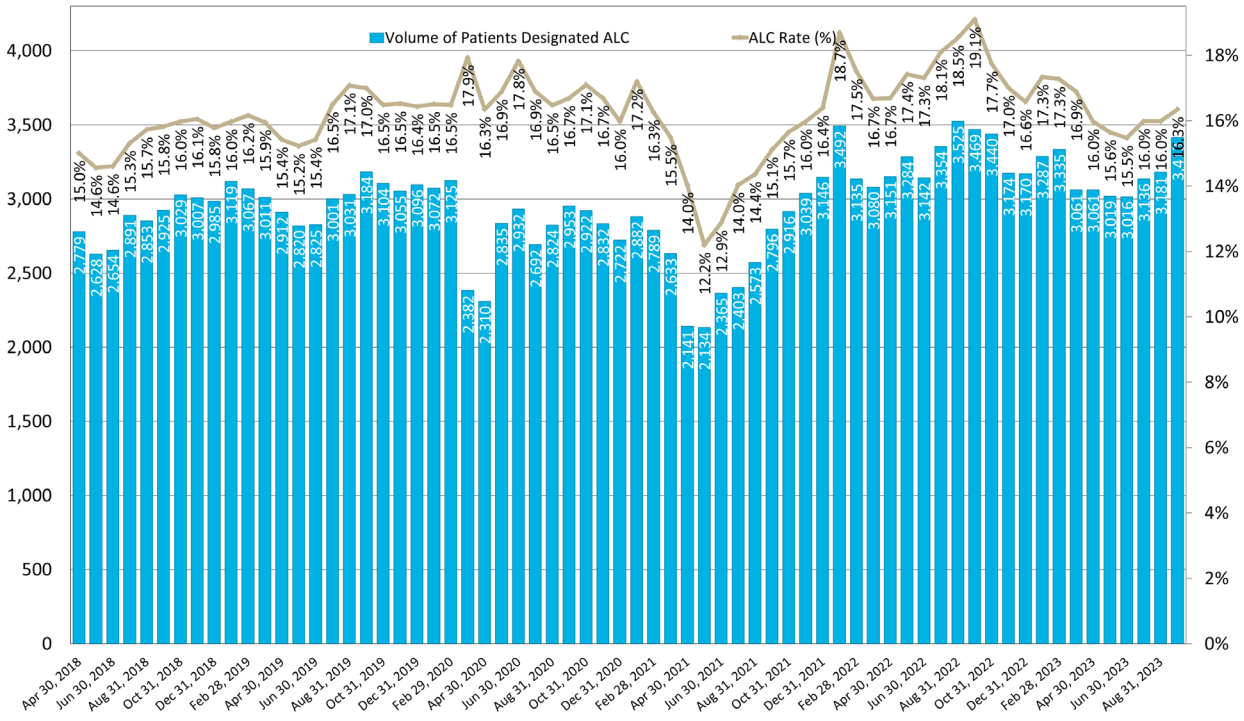
The Ministry provides the total number of Emergency Department visits from 2018/2019 to 2022/2023. This evidence demonstrates that the number of visits to Emergency Departments have not increased over this time period. It therefore suggests that it is not an increased volume of patients visiting Emergency Rooms, and thus a lack of physicians to care for an increased volume of patients, which results in higher wait times.

FY	ER Visits
2018/19	6,080,131
2019/20	6,023,517
2020/21	4,664,105
2021/22	5,522,049
2022/23	5,852,981

Instead, the facts support that a contributing factor to ED wait times is the unavailability of inpatient hospital beds, and those patients in hospital who are awaiting for an alternative level of care such as Long Term Care and Home Care. Alternative Level of Care or ALC patients, is a termed defined by the Canadian Institute for Health Information as a description used in hospitals to refer to patients who occupy a bed but do not require the intensity of services provided in that care setting

As can be seen in the below chart, the Provincial Alternative Level of Care has been increasing in recent years from a low in mid-2021.

Monthly Trend of Provincial ALC Rate and Volume of Patients Designated ALC on the Waitlist in Acute Care: April 2018 to September 2023



Data Source: Numerator: Wait Time Information System (WTIS); ALC Data cut on October 10, 2023; Denominator: Bed Census Summary (BCS) data as of October 10, 2023 cut

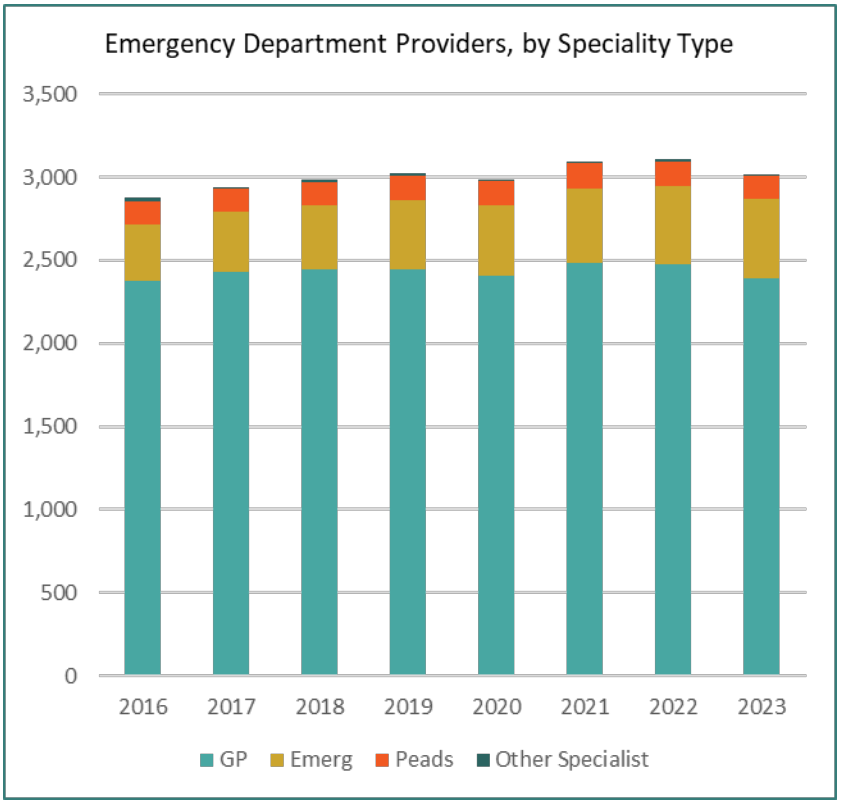
For fiscal year 2024/25, the Ministry will be investing a total of $134 million into the Emergency Department Pay for Results (ED P4R) program to address this issue[44]. The

[44] https://news.ontario.ca/en/release/1003300/ontario-reducing-wait-times-in-emergency-departments

funding will result in the implementation of innovative solutions to reduce ED wait times including hiring additional health care staff, accessing more transportation to help transfer medically stable patients out of emergency departments, and creating new beds.

Further, a large number of Emergency Room physicians are Family Physicians. Based on OHIP claims data analysis, approximately 3,000 physicians provided at least some emergency department services in FY2022. The large majority of these physicians are General Practice Physicians:

Emergency Department Provider Demographics[45]:

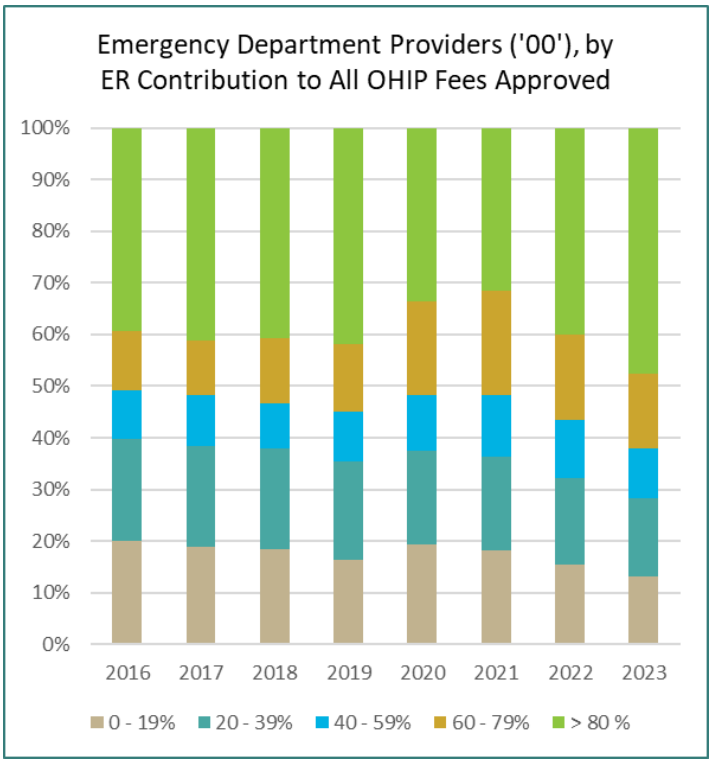


Of these GP's working in Emergency Departments, a number of them are also providing other primary care services. We have analysed the billing data of GP physicians who are working in emergency department. Taking an average from 2016, approximately 60% of

[45] OHIP Claims Data based on Fiscal Year 2022. Providers are included in this dataset if they were associated with 6 or more services dates in the respective Fiscal Year with any "H-prefix" ER service claim

family physicians receive less than 80% of their total approved fees from ER codes, suggesting there is a significant amount of primary care work also being undertaken by these physicians.

GP ('OO') Providers



As submitted above, it is not yet known that increasing the compensation for Emergency Room physicians will impact on the wait times in Emergency rooms (given ED wait times are due to factors other than physicians). However, it could have the unintended consequence of reducing the number of family physicians.

Finally, we note that Ontario made investments in EDAFA's as a result of the COVID19 pandemic that continue to date, despite observed decreases in patient volumes. ED AFA Funding is based, in part, on volume. Under a temporary agreement with the OMA dated July 22, 2020 (and it's subsequent extensions to date), the Ministry has agreed to hold the base year for EDAFA funding calculations at 2018-19 levels versus adjusted funding based on the 12-months preceding the funding year in question. For sites whose volume

fell below what was used to calculate base funding in 18/19, they continued to receive funding at the 2018-19 level. In contrast, if volume was greater than the defined baseline, it was agreed that additional funding would be provided.

To the extent that a compensation solution to address Emergency Department wait times is even possible, it will not be from a general price increase (given relativity adjustments as submitted above) but rather from targeted increases, if any (see Ministry submissions with respect to the POWER study below in reference to Paragraph 44 of the OMA brief).

PARAGRAPH 39 OF THE OMA BRIEF:

39. Shortages of emergency physicians manifest themselves in larger EDs as increases in waiting times to be seen by a doctor ("Physician Initial Assessment" or PIA time). In contrast, these shortages, in smaller hospitals result in closures of the emergency department entirely; these are increasing, with the Ontario Health Coalition reporting that there have been there have been 868 temporary emergency department closures, and 316 urgent care centre closures in smaller communities in 2023 alone.

MINISTRY REBUTTAL

The OMA submissions would lead one to believe that physician shortages are the reason for the emergency department closures. In fact, the top reason for emergency department closures is a lack of nursing staff, contributing to 90% of all closures last fiscal year. Closures due to physicians contributed to 3.7% of all closures[46].

Reason for Closure	1 April 2023 – 31 March 2024
Nursing Total	**173**
Physician Total	**7**
Other Total	**11**
TOTAL	**191**

[46] Source: Ontario Health, data on reasons for emergency department closures April 1, 2023 to March 31, 2024.

PARAGRAPH 44 OF THE OMA BRIEF:

44. Stated differently, higher complexity in ED visits requires that each visit today requires approximately 4 minutes longer on average than it did in 2009-10, or about 17% more time (from about 23 minutes per visit in 2009-10 to about 27 minutes per visit in 2022-23), an equivalent to at least 3 patient visits per day. This estimate is based on the Predictors of Workload in the Emergency Room ("POWER") study conducted nearly two decades ago and is most likely a significant underestimate of the impact of this increased complexity on physician's throughput. As a result, the indicated decrease is likely worse than 3 patients per shift. Under the 2021 PSA, a new POWER study is being conducted which will provide updated data.:

MINISTRY REBUTTAL

In the 2021 to 2024 PSA, the parties agreed at paragraph 4(c) that:

> 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.

This paragraph outlines the commitment of the parties to do the POWER study. When coming to the agreement for the 2021 PSA, the parties knew and accounted for the fact that the study would wait until conditions resulting from the pandemic allowed researchers to safely start and undertake the work. It has now started, and a study advisory group has

been established and has been meeting to discuss implementation of the study. The results of this time-based study are intended to inform the time on task assumptions that underly the current EDAFA funding formula. The Ministry submits that it would be premature to award anything in advance of study's completion and the parties negotiations of the outcome of that study.

Further, to the extent that Emergency Rooms are dealing with an increase in higher acuity issues, the Ministry notes that the EDAFA calculation for the workload model[47] uses time required for the site to operate based on acuity. This means that Emergency Room physicians under these agreements would receive payment based on the time spent with higher acuity patients as part of the funding formula. There are currently 65 emergency department sites in which the EDAFA workload model is the funding model.

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[47] For reference, EDAFA for the workload model operates in EDs in larger communities with annual OHIP insured patient visits greater than 30,000 a year.

PARAGRAPH 46 OF THE OMA BRIEF:

46. According to a recent study using the Canadian Institute for Health Information ("CIHI") Population Grouper, the prevalence of multiple chronic conditions in Ontario is growing, with 'minor' or 'moderate' conditions slightly declining while 'major' conditions increased. Overall, the age-sex standardized patient resource intensity has increased by about 0.5 percent each year from 2008-09 to 2017-18.

MINISTRY REBUTTAL

The Ministry also reviewed the OMA referenced paper ("Trends in prevalence of chronic disease and multimorbidity in Ontario, Canada") at Section 13.1 of its May 1, 2024 brief (and Exhibit 18). The Ministry submitted the finding from the paper which suggest that there was not a significant increase in chronic disease in recent years. In fact, we note that in the abstract for the article, the first line under interpretation states *"Evidence of an upward trend in the prevalence of chronic disease was mixed.*" The paper also states *"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%."* **The latter direct quote from the paper contradicts what OMA states.**

While the OMA argues that complexity of patients has grown, **the OMA does not provide any details on how they have arrived at the 0.5% increase age/sex standardized in resource intensity per patient per year.** The study finds that the share of the population with chronic conditions (and those with multiple conditions) is decreasing AFTER they adjust for age and sex.

Further, the Ministry submits that an analysis of claims data between 2009/10 and 2022/23 shows that the impact of aging contributes 0.48% per year to the growth in annual physician expenditures (see Table 14 which follows).

Table 14. Isolating the Impact of Aging on Patient-Level Expenditures[48]

Fiscal Year	Age/Sex Weighted Average Billings per Patient (Fee Rates and Utilization Held Constant at FY22 Levels to Isolate for Impact of Aging)
2009-10	$786.21
2022-23	$833.01
Growth (Total)	**$46.80 (5.95%)**
Growth (Annual)	**$3.60 (Simple Average = 0.46%, CAGR = 0.48%)**

Upon review of OMA paper and the Table above we posit:

1. Both a 0.48% increase in patient expenditure due to aging and a 0.5% increase in resource intensity due to complexity are expenditure measures.
2. While we have no basis to confirm the 0.5% increase in resource intensity, if we add the 0.48% increase in expenditure due to aging, and the 0.5% increase in resource intensity due to complexity, we would conclude that, to the extent that billings are a measure of complexity, patients become about 1% more complex per year over the time period studied. This increase in complexity (which is in the range of 0.48% to 0.98% per year growth) is more than offset by a decrease in visits per physician (1.4%).

Although this is a very difficult factor to measure and calculate, the Board has a range of possible results. Respectfully the upper range is not supported by any clear and convincing evidence. Our conclusion is consistent with the conclusion of the authors of the paper.

As stated in the OMA paper:

> *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*

[48] Methodology at Exhibit 2

for population health management and increased health system spending above that predicted by population aging.

PARAGRAPH 47 OF THE OMA BRIEF:

47. Individuals with complex health and social needs also require interprofessional team-based care as the level of support required for them may well be beyond the capacity of family medicine physicians working alone. One study has found that 6.1% of the population of Ontario—approximately 725,500 people—had high comorbidity, but that only 15% of these people were rostered to practices offering interprofessional team-based care. Similarly, data from the Commonwealth Fund suggests that people with high needs often do not have access to the services they need, such as care coordination, emotional counselling, and assistance with managing functional limitations; this is despite having a regular doctor or place of care. In the absence of sufficient support, this workload burden falls the family physician. Moreover, patients with unmet needs are likely to report difficulties in accessing care primary care and are therefore less likely to participate in preventative care and more likely to visit the emergency department.

MINISTRY REBUTTAL

The OMA states that “Individuals with complex health and social needs also require interprofessional team-based care as the level of support required for them may well be beyond the capacity of family medicine physicians working alone.”

This was a major theme in the Ministry’s Brief. Ontario’s plan includes utilizing the engagement of a broader team of care providers including Nurse Practitioners, Pharmacists and Social workers, to name a few. Ontario has skilled and qualified resources that have started and will continue to be utilized to support and care for Ontario’s patients. Physicians alone are not the only provider, and thus the only solution, to the provision of primary care in Ontario.

PARAGRAPH 49 OF THE OMA BRIEF:

49. Another challenge that physicians are experiencing is the unprecedented administrative burden that has been added to their already high workloads which, amongst other things, takes away from their ability to provide clinical care. The Ontario College of Family Physicians ("OCFP") found that family physicians spend 19.1 hours per week on administrative work.

MINISTRY REBUTTAL

The Ontario College of Family Physicians sent a survey to family physicians and provided a report in May of 2023. We were not provided with a copy of the survey, and do not know how it was framed to physicians filling out the survey. We do know that the survey asked such questions as "below is a list of opinions we have heard from physicians about the challenges they face as a family physician. Please indicate the extent to which you agree or disagree these statements reflect significant pain points for you/your practice." Challenges listed included "other parts of the health care system often place unnecessary and/or inappropriate burden back onto me/my practice" and "I am overwhelmed with administrative burden and paperwork related to the care requirements of my patients." Surveys and survey questions that encourage or guide the respondent towards a desired answer raise a question of credibility.

Further, the response rate to the survey was approximately 1343 respondents. It was conducted in 2023, and per the previously submitted Ministry data, there were approximately 16,265 family physicians in 2022/23. It therefore doesn't represent a large proportion of family physicians in Ontario[49].

The Ministry submits that there is best evidence data that this Board can consider based on hours actually billed by physicians instead of the self reported data. The BC experience to date is that 24% of a family physicians time is spent on indirect patient care/administrative work. We can be reasonably certain that the BC doctors are capturing

[49] https://ontariofamilyphysicians.ca/wp-content/uploads/2023/09/ocfp_member_survey_report_2023_05.pdf

all of their administrative time in this brand new model. Based on an assumption that the average Family Physicians perform 40 hours of work per week, this would produce a weekly average of 9.6 hours spent on administrative tasks.

PARAGRAPH 50 OF THE OMA BRIEF:

50. The OMA recognizes that there are some administrative tasks that add value to the health system and are best done by physicians (e.g., certain forms requiring medical expertise). At the same time, there are many that are redundant, needlessly complicated, not integrated with electronic health records ("EHRs"), and simply unnecessary. As a result, the considerable extra time and complexity added to an already overburdened physician workload could either be eliminated, reduced or better performed by other (currently unavailable) health professional or staff.

MINISTRY REBUTTAL

The Ministry made significant submissions with respect to administrative burden at Section 10, page 101 of it's brief. The administrative work within ones medical practice is not new, but the concept of an "administrative burden" advanced by the OMA is a new issue to bargaining in this round and ought to be addressed with system reform, with physician input, rather than through compensation that incents paying for administrative time over clinical time with patients.

It is too early in this issue's tenure, within the parties bargaining process, to make such a conclusion and issue an award in recognition of it, as it would have the dilatory effect of incentivising pay for non-clinical work. Instead, the matter should be addressed by solving the problem. The parties have started their efforts in this regard.

Additionally, the MOH and OMA will be engaged in extensive bargaining for the next three (3) years of this agreement. This will enable the parties to focus on this new issue relaying to administrative time and bilaterally explore ways to bring about change to reduce administrative burden which will result in more clinical care and income for physicians and positively impact their work life balance.

PARAGRAPH 53 OF THE OMA BRIEF:

53. In a survey focused on Nova Scotia, physicians identified spending 10.6 hours per week on administrative work and estimated that 38% of this work was either unnecessary or could be done by someone other than a physician.

MINISTRY REBUTTAL

The Nova Scotia Physician survey on administrative burden was filled out by 500 of approximately 2,624 physicians in Nova Scotia[50]. We note that these survey results do not align with the OCFP survey results in Ontario and are closer aligned with the time periods billed in British Columbia.

[50] https://doctorsns.com/sites/default/files/2020-11/admin-burden-survey-results.pdf?

PARAGRAPH 59 OF THE OMA BRIEF:

59. Burnout is primarily defined as a work-related syndrome characterized by three dimensions: "emotional exhaustion; depersonalization, or feelings of detachment and cynicism toward people and work; and a reduced sense of personal accomplishment." At the personal level, physician burnout has "been associated with increased depression, suicidal ideation, substance use and motor vehicle crashes."

MINISTRY REBUTTAL

As submitted previously, a compensation increase will not solve the important issue of burnout.

PARAGRAPH 66 OF THE OMA BRIEF:

66. In addition to the challenges outlined above, Ontario is also now in the midst of a growing physician human resources crisis, affecting many specialties and geographic areas. Some regions such as the North and rural and remote areas endure chronic undersupply issues that have never been effectively addressed. Various specialties are increasingly having difficulty recruiting and retaining new physicians. As well, the Ontario population is increasing, aging, and experiencing a higher volume and complexity of health issues. Indeed, the COVID pandemic exposed the many cracks in an unintegrated, fragmented system which does not effectively support its health care workforce or optimize patient access to high-quality health care close to home. The OMA refers the Board to Part Seven of the brief for more information about the scope and breadth of this problem.

MINISTRY REBUTTAL

As previously submitted, the distribution of physicians and fewer patient visits are a factor in patient access. An above normative compensation increase will not address the issue of patient access.

PARAGRAPH 76 OF THE OMA BRIEF:

76. The Arbitration Board can address what is or is not to be included in the Physician Services Budget (PSB) and how the PSB is to be calculated. In the first arbitration award for the 2017-2021, the Board rejected the government's proposal to put a hard cap under the PSB on physician billings.

MINISTRY REBUTTAL

The government's proposal for a hard cap was rejected by the Arbitration Board for the 2017/2018 to 2020/2021 PSA. However, the Ministry submits that the following OMA proposals were also rejected:

- While the Board awarded redress for across-the-board payment discounts applied to both the fee for service and the non-fee for service payments, they did not order the reversal or amelioration of any of the earlier targeted reductions direct to certain fees and schedules, as sought by the OMA.
- The Board did not award any of the OMA (or Ministry) primary care proposals
- The Board did not award the OMA's NOSM and AHSC proposals in respect of rightsizing and repair (instead directing continued discussions)
- The Board did not award the OMA's additional technical fees proposal (instead directing continued discussions)

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PARAGRAPH 97 OF THE OMA BRIEF:

97. Although not covered by the provisions of Bill 124, the OMA recognized, during the last round of bargaining, that it was very unlikely to receive greater increases than the imposed 1% if it had proceeded to arbitration before the constitutionality of Bill 124 had been determined. The OMA did not have a formal reopener provision in the 2021-2024 PSA and, accordingly, is now seeking increases for Year 1 of the 2024 PSA which will remedy and provide catchup for the amounts that should and could have been negotiated but for the very real practical restraints imposed by the existence of Bill 124 at the time their last PSA was concluded. Ontario's doctors must now receive the price increases that would have been and should have been negotiated and awarded during the 2021-24 PSA, and bearing in mind what we now know about inflation over that time period. They cannot be deprived of the appropriate, just and necessary remedy for unconstitutional legislation that was made available and received by many others in the broader public sector and by all of their colleagues in the health care sector.

MINISTRY REBUTTAL

As submitted earlier, the average physician income over the period of time is competitive with the majority of voluntary settlements and interest arbitration awards of those OPS and BPS bargaining units previously covered by the PSPSFGA. We have filed the complete Bill 124 table with all awards/settlements.

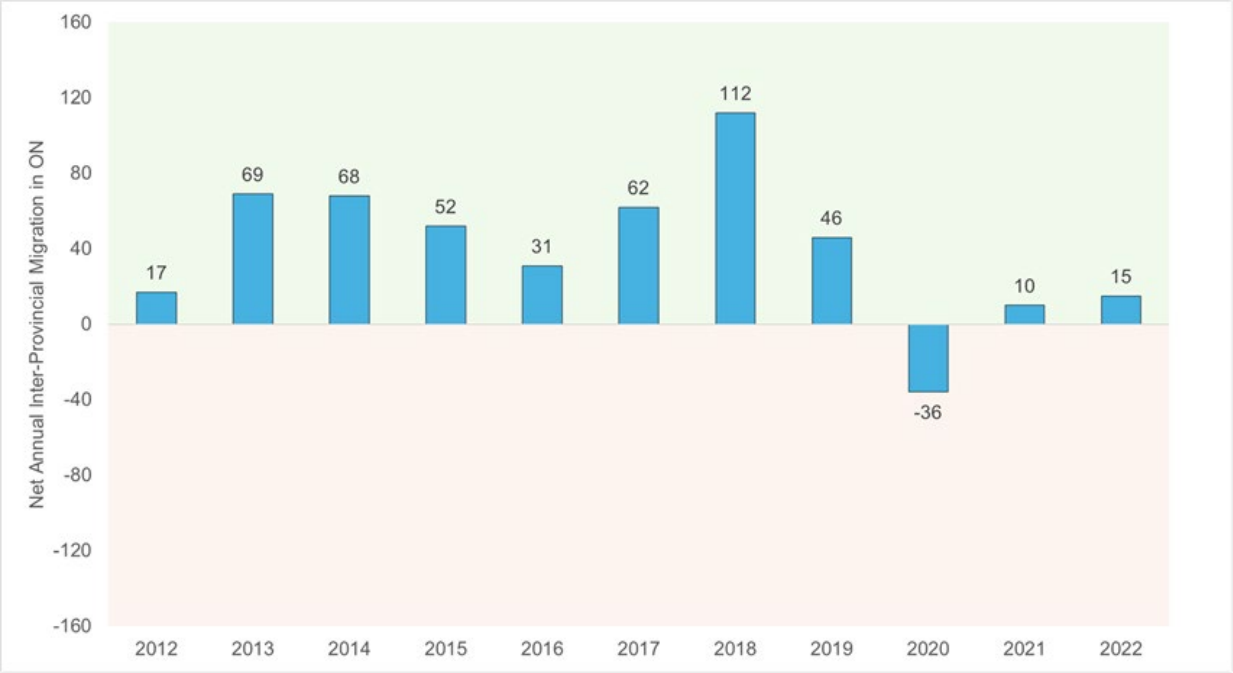
Further, we note that the OMA submits it did not have a "reopener provision" in the 2021-2024 PSA. The Ministry submits that the freely negotiated settlement did not include a reopener provision. It would have been open to the parties to negotiate such a provision if they had deemed it appropriate.

PARAGRAPH 122 OF THE OMA BRIEF:

122. The negotiations for the subsequent 2008-2012 PSA were largely driven by the jointly recognized need to continue to improve access to family medicine physicians for Ontarians and to address the doctor shortage. At that time, the province had suffered a net loss of physicians for two consecutive years, resulting in a shortage of 2,500 physicians and leaving more than 850,000 patients with no family physician.

MINISTRY REBUTTAL

The Ministry submits that from 2012 forward, with the exception of one year, there has been a net inflow of family physicians to Ontario. The figure below shows the net number of family physicians migrating into Ontario. For example, +15 physicians in 2022 means that the number of family physicians who moved to Ontario (from another province) exceeded the number of family physicians who left Ontario (to another province) by 15. The year 2020 was the only year where there was a net outflow of family physicians from Ontario[51].



[51] Physician workforce, by jurisdiction, Canada, 1971 to 2022. CIHI Supply, Distribution and Migration of Physicians in Canada, 2022 — Historical Data. Ottawa, ON: CIHI; 2023

PARAGRAPH 123 OF THE OMA BRIEF:

123. Against this backdrop, the parties entered into the 2008-2012 PSA in September 2008, with a term from April 1, 2008 to March 31, 2012 (the "2008 Agreement"), which was formally ratified by the OMA membership in October 2008. The 2008 PSA provided for a 3% lump sum payment on OHIP billings for the year beginning October 1, 2008, a 5% increase to OHIP fees effective October 1, 2009, a further 3% increase October 1, 2010, and a final 4.25% effective September 1, 2011.

PARAGRAPH 128 TO 157 OF THE OMA BRIEF:

B. 2012 UNILATERAL ACTIONS AND SUBSEQUENT NEGOTIATIONS

C. FAILED NEGOTIATIONS IN 2014

D. GOVERNMENT UNILATERAL ACTION IN 2015

MINISTRY REBUTTAL

First, the OMA's submissions on compensation restraint during the 2012 period were fully taken into account by the Arbitration Board for the 2017 to 2021 PSA, and resulted in certain fee adjustments in recognition of this. However, it did not find a case for the further adjustments submitted by the OMA, stating:

> "While we have concluded there should be redress, as set out above, for the across-the-board payments discounts applied to both the fee for services and the non-fee for service payments, we have decided no to order the reversal or amelioration of any of the earlier targeted cuts directed to certain fees and schedules."
> …
>
> "**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**."

Second, the Ministry reminds the Board that during the period 2004 to 2012, the OMA settlements were significantly above the average for the Ontario public sector settlement trends. Beginning in 2009, compensation restraint had been applied to the

Ontario public sector, and restraint only began for physicians in 2012. This is evidenced by the significant price increases physicians received in the 2008-2012 agreement at a time where others were negotiating zero percent increases. Given this, a period of rebalancing and restrain was absolutely necessary and appropriate starting in 2012 for Ontario Physicians. Information about compensation restraint and settlements during that period of time is set on the following pages.

Prior to 2012 and during 2012, many major Health Care collective agreements reflected wage freezes. We review these agreements below in the next few pages:

HEALTH CARE SECTORS

1. HOME CARE (Wage Freezes, lump sum payments, no other improvements)

SEIU and Red Cross (April 1, 2011 to March 31, 2013) – 30 Units; 3,500 PSWs

- SEIU and Red Cross bargained covering most regions of the Province.
- **a wage freeze over the two year term of the agreement.**
- Annual lump sum payments equal to 15¢/hour
- There were no other compensation improvements.

2. LONG TERM CARE

ONA MASTER (185 Participating Nursing Homes – 2011 to 2014)

- Registered Nurse bargaining units across the Province
- **a wage freeze over the first two years of the agreement.**
- Annual lump sum payments for freeze years of 1%
- 3nd year increase of 2.75%
- Very modest compensation improvements and cost containment

SEIU MASTER (98 Participating Nursing Homes – 2012 to 2015)

- Service Worker bargaining units across the Province
- **a wage freeze over the first two years of the agreement.**
- Annual lump sum payments for freeze years of 15¢/hour
- 3nd year reopener increase of 1.5%
- No catch-up adjustments for any homes with lower wage rates
- Net 0 changes in benefits

3. HOSPITALS

ONA and the Participating Hospitals (2011 - 2014)

- Registered Nurse bargaining units across the Province
- **a wage freeze over the first two years of the agreement.**
- Annual lump sum payments for freeze years of 1%
- 3nd year increase of 2.75%
- Very modest compensation improvements and cost containment

OPSEU and the Participating Hospitals (2011 – 2014)

- Registered Technologists bargaining units across the Province
- **a wage freeze over the first two years of the agreement.**
- Annual lump sum payments for freeze years of 1%
- 3nd year increase of 2.75%
- compensation improvement and cost containment (net 0 impact)

CUPE and the Participating Hospitals (2013 – 2017)

- Service Worker bargaining units across the Province
- **0.7% wage increase for each of 4 years.**
- Annual lump sum payments 0.7% for each year
- Negligible compensation improvements (4/100th of 1%)

SEIU and the Participating Hospitals (2013 – 2017)

- Service Worker bargaining units across the Province
- **0.7% wage increase for each of 4 years.**
- Annual lump sum payments 0.7% for each year
- Compensation improvement trade for extra 3 months term – no wage increase

4. CCAC SECTOR

LHINs (FORMERLY CCACs) & ONA (April 1, 2011 - March 31, 2014)

- 10 bargaining units across the Province
- **a wage freeze over the first two years of the agreement.**
- Annual lump sum payments for freeze years as per hospitals.
- 3nd year increase of 2.75%
- Very modest compensation improvements

- Modest catch-up for two CCACs which were materially behind

LHINs (FORMERLY CCACs) & CUPE (April 1, 2011 - March 31, 2014)

- 8 bargaining units across the Province
- **a wage freeze over the first two years of the agreement.**
- Annual lump sum payments for freeze years of 1.2%
- 3nd year increase of 2.75%
- Very modest compensation improvements

LHINs (FORMERLY CCACs) & OPSEU (2011 - 2014)

- 5 bargaining units across the Province
- **a wage freeze over the first two years of the agreement.**
- Annual lump sum payments for freeze years of 1.2%
- 3nd year increase of 2.75%
- Very modest compensation improvements

ONTARIO PUBLIC SERVICE

In late 2011 the challenging economic and fiscal context manifested itself in the 2012 OPS negotiations where OPSEU, AMAPCEO and all other OPS employees experienced wage freezes and significant benefit reductions in their settlements.

We have summarized the major monetary provisions of these settlements on the next few pages below.

1. AMAPCEO (April 1, 2012 to March 31, 2014)

- No wage increases for the duration of the collective agreement term.
- Merit progression funded through cost savings in the settlement.
- Starting April 1, 2013 satisfactory performance merit reduced from 3.5% to 3%.
- Elimination of annual lump sum for employees at the maximum of the salary range effective April 1, 2013.
- Elimination of 6 Compensation Option Credits for both 2013 and 2014.
- For regular employees, a reduction of days from COC, vacation and/or Compensating Time (Overtime) credits to 3.5 days effective January 1, 2013.
- Effective April 1, 2013: Pay for any absence over and above six and subsequent days of illness reduced from 75% pay to 66 2/3% pay. Employees suffering from a catastrophic illness or injury continue to receive 75% pay.

<u>Job Evaluation System</u>

- Implemented effective October 1, 2013.
- Eight new classification levels and salary ranges replacing all the existing classifications and salary ranges.
- post implementation of the JE Plan the Employer reassumes the right to classify employees in positions, and to manage and maintain the job classification and evaluation system on an on-going basis.

Net Total Compensation Increase (Exhibit 3)

Year 1 - 3.8% (2.2% of which was the COC Freeze)

Year 2 - 0.3%

Total - 4.19% (2.2% of which was the COC Freeze)

OPSEU Central and Unified (January 1, 2013 to December 31, 2014

- No wage increases for the duration of the collective agreement.
- Merit progression funded through cost savings in the settlement.
- Employees to be hired at a start rate 3% below the current first step of the existing wage grid.
- Pay for any absence over and above six and subsequent days of illness reduced from 75% pay to 66 2/3% pay. Employees unable to attend work due to severe or serious chronic illness or injury continue to receive 75% pay.
- Eliminated termination payments upon retirement for employees hired after January 1, 2013.

Net Total Compensation Increase (Exhibit 4)

Year 1 - 1.3%

Year 2 - 0.12%

Total - 1.42%

OPSEU Correctional Bargaining Unit (January 1, 2013 to December 31, 2014)

- No wage increases for the duration of the collective agreement.
- Merit progression funded through cost savings in the settlement.
- Employees to be hired at a start rate 3% below the current first step of the existing wage grid.
- Pay for any absence over and above six and subsequent days of illness reduced from 75% pay to 66 2/3% pay. Employees unable to attend work due to severe or serious chronic illness or injury continue to receive 75% pay.
- Eliminated termination payments upon retirement for employees hired after January 1, 2013.
- Elimination of weekend shift premium with savings used to fund an increase of $0.85 per step in all classifications that receive weekend shift premium.

Net Total Compensation Increase

The OPSEU Correction costing is part of the overall OPSEU costing above

ELEMENTARY AND SECONDARY EDUCATION

The Ministry of Education's Memoranda of Understanding with the Teachers also shows the severity of Ontario's fiscal challenges at this time. We illustrate with a comprehensive review of the OECTA settlement, noting that the same pattern applied to all teachers in the Elementary and Secondary panel. The CUPE agreement is representative of the non-education settlements in School Boards covering this period. These settlements provided for wage freezes, plus unpaid days and sick leave benefit cost rollbacks, and as such had a significantly negative total compensation change.

Two pattern settlements are described on the following pages:

Ontario English Catholic Teachers' Association (OECTA) and Ministry of Education (September 1, 2012 to August 31, 2014)

Salary

- 0% in 2012-13
- 0% in 2013-14

Movement on the Grid

- No movement on the salary grid until 97th school day.

Unpaid Leave Days

- one-time savings in the 2nd year - three specific unpaid leave days.

Benefits after Retirement (Early retirement to age 65)

- Previously, the contracts provided for retirement benefits.

There were two major changes in this area:

1. Effective September 1, 2013, the retiree benefits are segregated from the active employees and the new segregated pool will establish new (self-funded) premiums for new retirees.
2. Effective September 1, 2013, any premiums paid by Boards on behalf of new retirees will cease.

This change had significant actuarial savings for the Boards.

CUPE & Ministry of Education (September 1, 2012 – August 31, 2014)

Wages

- 0% in 2012-13
- 0% in 2013-14

Retirement Gratuities

- Eliminated after August 31, 2012 (vested up to that point)
- Consistent with other education settlement.
- If agreement has service requirement greater than 10 years it will be changed to 10 years before vested.
- If ineligible for Gratuity – Gratuity Wind-up payment of 10% of wages if losing 200 days, 30 years of service (prorate lesser amount if service and days are less)

Non-Vested Sick Days

- Eliminated

Sick Leave (including Short-Term Disability Plan

- The complete change to the same system negotiated with the teachers except in allows for 11 days versus 10 days. This change will amend the other education settlements as well**.**

Movement on the Grid

- No movement on the salary grid for 6 months.

PARAGRAPH 140 OF THE OMA BRIEF:

140. Faced with the government's intransigence, the OMA commenced the non-binding Facilitation - Conciliation process referenced above. The OMA and Ministry participated in this process between September and December 2014, resulting in a confidential non-binding Facilitation Report from Dr. David Naylor and a non-binding Conciliator Report in December 2014 from former Chief Justice Warren Winkler, covering the three-year period from 2014 to 2017.

MINISTRY REBUTTAL

We review some particularly relevant comments from the Winkler Conciliation Report[52] below:

At page 5 the Honorable Warren K. Winkler stated:

> *iv) Targeted Savings*
>
> ***...***
>
> *Ultimately, after what I would describe as **many days of very hard bargaining, the Parties agreed, contingent on an overall settlement, on targeted savings of $650 million** (of which the Ministry costed at $580 million to the PSA while finding a further $70 million outside the PSA). This was to be achieved by the end of the second year of the 2014 PSA.*

At page 6 the Honorable Warren K. Winkler stated:

> v) Collaborative Framework
>
> ...
>
> *The Parties had a window of opportunity in these negotiations to create a process whereby the present structure could be studied with a view to reform. A study of this nature requires time for research and reflection and input from a number of stakeholders. **These sort of systemic issues cannot be effectively addressed in a set of PSA negotiations.***
>
> *Accordingly, I introduced two initiatives which were intended to be separate from the PSA: The Task Force on the Future of Physician Services in Ontario (the "Task Force") and the Minister's Roundtable on Health System Transformation (the "Minister's Roundtable"). **The Parties***

[52] Conciliation Report contained at Exhibit 5

embraced both of these suggestions.

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

PARAGRAPH 162 OF THE OMA BRIEF:

162. The parties proceeded to arbitration before a board of arbitration chaired by William Kaplan in 2018, ending in early 2019. The Board's decision was released on February 18, 2019. In its reasons, the Board rejected the Ministry's hard cap proposal, finding that it would be "intrinsic[ally] unfair", and that "the Ministry is responsible for the PSB including growth." With respect to redress, the board partially accepted the case for redress, finding that doctors "uniquely were the only group to have their compensation cut, and these cuts continue" and that it was "not wage restraint normally given expression in a freeze" but "confiscatory." Accordingly, the Board ordered, as a partial redress, that the 2.65% for non-fee for service and 3.95% for fee-for service 2015 payment discounts be removed as of April 1, 2019. However, all of the other targeted cuts remained in place.

MINISTRY REBUTTAL

Respectfully, it is inconceivable to argue that the 2018 Board of Arbitration did not take these factors into account when rendering their award on redress, leaving those reductions in place that were appropriate. The Ministry has already submitted the relevant sections of the award which demonstrate that redress was considered and no reversal or amelioration was awarded for these earlier targeted cuts directed to certain fees and schedules.

PARAGRAPH 167 OF THE OMA BRIEF:

167. While Bill 124 did not strictly apply to physicians and the PSA, it did apply to virtually all other health sector workers. Bargaining for the 2021-2024 PSA was, thus, conducted under the constraints and cloud of Bill 124, which significantly impacted and restricted the negotiations. The OMA recognized and accepted that, at a time when, as a result of Bill 124, and in the midst of the pandemic, nurses and other health care workers would not receive increases of more than 1%, there was no prospect of physicians being awarded increases in excess of 1%.

MINISTRY REBUTTAL

This was not the case.

Year 3 was not 1%.

Given the parties agreement on the methodology for further Year 3 payments, the number in Year 3 could have been significantly higher – as there was no upper cap. By the OMA's own admissions, they anticipated a price increase of 2.1% to 3.6% in Year 3.

In any event, the average increase in physician income over the 3 year period of the PSA is very competitive with the reopener results for all bargaining units covered by Bill 124.

Respectfully, the OMA’s Bill 124 arguments are a red herring.

PARAGRAPH 170 OF THE OMA BRIEF:

170. In addition, the 2021-2024 PSA included the following changes:

- *A permanent framework for virtual care by telephone and video, when appropriate. Both patients and physicians had found virtual care to be effective, efficient and convenient during the pandemic;*
- *Modest easing of "managed entry" restrictions thereby enabling more family doctors to join Family Health Organizations;*
- *Additional changes in family medicine and, in particular, to Family Health Organizations such as complexity, mandatory group size, and acuity modifiers;*
- *Improved parental leave benefits, which will allow early and mid-career physicians to spend more time with their families and help address both work- life balance and physician burnout;*
- *The repair of specific underfunded APPs;*
- *Implementation of a process to develop and implement additional APPs including APPs for Laboratory Physicians, Genetics and Infectious Diseases;*
- *Continuation of funding for CMPA until the renewal of the next PSA; and*
- *A modified Appropriateness Working Group process.*

MINISTRY REBUTTAL

Many of these changes, particularly the changes to virtual care, reflected a significant improvement over the previous agreement.

All of the virtual care codes (which were a significant convenience to physicians) were non existent and could not be billed under the prior agreement.

The 2021 PSA resulted in 19.8% (forecasted) increase over 2019-20 expenditures (which includes the 5.8% of price increases over that period of time).

PARAGRAPH 176 OF THE OMA BRIEF:

176. Moreover, while the Kaplan Award for the 2017-21 PSA provided some limited redress for some of the historic losses experienced by physician over the 2012-2017 period (reversing only the across the board fee cuts), it did not provide anything near full redress; rather, it focussed on a categorical rejection of the Ministry's attempt to impose a hard cap on physician service expenditures, a total dismissal of its attempt to impose further fee cuts on certain specialties. In that context, it is not surprising that the 2017-21 PSA Award, provided for very modest price increases, out of step with those negotiated or awarded by other comparator groups. All of this must be taken into account in respect of the OMA's overall request for a 10.2% Year 1 catch-up component

MINISTRY REBUTTAL

As previously submitted, the Ministry disagrees entirely with the OMA's misleading characterization that the Arbitration Board did not consider and reject the OMA's claims for further redress.

Further, the Ministry disagrees entirely that, having already been considered and rejected, that the OMA's claim regarding compensation for these prior years should now form part of a compensation increase in Year 1 of this PSA. The question before this Board is what is the NORMATIVE increase for Year 1 of this PSA.

PARAGRAPH 182 TO 219 OF THE OMA BRIEF:

A. ONTARIO'S ECONOMY IS STABLE AND CONTINUING TO GROW

MINISTRY REBUTTAL

To reinforce that there continues to be economic uncertainty, the Ministry provides the below recent and relevant data on real GDP per person.

Between 2000 and 2023, Canada had the second highest GDP growth in the G7, however it had one of the lowest growth rates when measuring GDP per person.[53] The differences are predominantly due to varying rates of population growth rather than productivity growth, which is the principal factor driving higher incomes and improved living standards.

Since 1985, the three periods of the most severe decline measured by real GDP per person were:

- Q2 1989 to Q3 1994 (21 quarters)
- Q3 2008 to Q4 2011 (13 quarters)
- **Q2 2019 to Q4 2023 (18 quarters)**

Canada is still recovering from the decline that followed Q2 2022, with most recent GDP data available as of Q4 of 2023. The period from Q2 2019 to Q4 2023 is a period of ongoing decline with respect to number of quarters from high-point to recovery quarter. This same period from Q2 2019 to Q4 2023 also saw a **-3%** in real GDP per person, from high-point to low-point quarter, third to the declines seen between Q3 2008 to Q2 2009 (-5.2%) and Q2 1989 to Q2 1992 (-5.3%).

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[53] Eisen, Ben, Milagros Palacios, and Lawrence Schembri (2024). *GDP Growth Unadjusted for Population Change—a Misleading Measure of Canada's Economic Progress.* <https://www.fraserinstitute.org/sites/default/files/GDP-growth-unadjusted-for-population-change.pdf>,

If per capita GDP does not recover in 2024, the current period can be the longest and largest decline in per-person GDP in the last 40 years. We provide the following supporting quotes:

" While there are a number of factors to consider when comparing economic performance, particularly those factors within the control of governments (that is, policy) and those beyond the control of governments, it is fairly clear from the data presented that the economic performance of Canada was weakest during the period from 2016 to 2019 compared to the previous pre-recession periods."[54]

"Whereas the above article highlights the period leading up to and including 2019 as having the worst economic performance since 1985, we (the authors) find that the experience since Q2 2019 is unlike any since 1985. As of Q4 2023, real GDP per person is below the level it was in Q2"

[54] Clemens, Jason, Milagros Palacios, and Niels Veldhuis (2021). *Comparing Economic Performance in Five Pre- Recession Periods*. Fraser Institute. <https://www.fraserinstitute.org/sites/default/files/comparing-economic-performance-in-five-pre-recession-periods.pdf>,

PARAGRAPH 227 OF THE OMA BRIEF:

227. It should also be noted that federal funding for health care is also expanding. The Canada Health Transfer is expected to be $19.242 billion in 2023-24 increasing to $20.289 billion in 2024-25, the first year of the 2024-2028 PSA. Some of this new funding is to be targeted at the following shared priorities: family health services, health workers and backlogs, mental health and addiction, and a modernized health system,161 many of which are priorities that overlap with some of the OMA's targeted proposals discussed below. Notably, Canada Health Transfers to Ontario have increased 55% since 2015-2016, and 21.4% since 2021-22, the first year of the last PSA. Unfortunately, very little of those increases have been directed to physicians by the MOH.

MINISTRY REBUTTAL

The Canada Health Transfer (CHT) provides long-term funding for provincial health care services to support the principles of the Canada Health Act (CHA). The CHA requires provinces to provide funding for medically necessary physician and hospital services, as well as dental services that must be performed in a hospital. CHT funding accounts for approximately 25% of the cost of Ontario's total health care expenditures. Federal health funding originally announced in February 2023 includes a one-time additional health care payment, time-limited funding for shared priorities and an enhancement of the CHT. Despite additional federal health funding that is expected to provide Ontario with $4.4 billion over three years (beginning in 2023-24), the province's incremental health care investments in the 2023 Budget totaled $15.3 billion over three years. Therefore, even considering increased federal transfers, it is not anticipated that the additional funding will meaningfully increase the portion of provincial health care costs covered by the federal government. For example, the Canada-Ontario Agreement to Work Together to Improve Health Care for Canadians does not include annual funding growth over the 10-year term, which means this stream of federal funding will decline over time compared to the annual growth of the provincial health care budget. As part of the Work Together to Improve Health Care for Canadians agreement, $34.25 million was specifically allocated to expanding interprofessional teams ($30 million) and Indigenous family health services ($4.25 million), which builds upon significant investments in primary care made through Your Health: A Plan for Connected and Convenient Care.

PARAGRAPH 237 OF THE OMA BRIEF:

237. This crisis is particularly acute in certain regions of the province, such as the North, and specific practice areas, including family medicine, emergency department coverage, internal and occupational medicine, pediatrics, psychiatry, cardiac paediatric surgery, and anesthesiology, amongst others. However, concerns about physician recruitment and retention are found in all regions and specialties.

MINISTRY REBUTTAL

As previously submitted, distribution issues will not be resolved through an above normative compensation adjustment.

PARAGRAPH 239 OF THE OMA BRIEF:

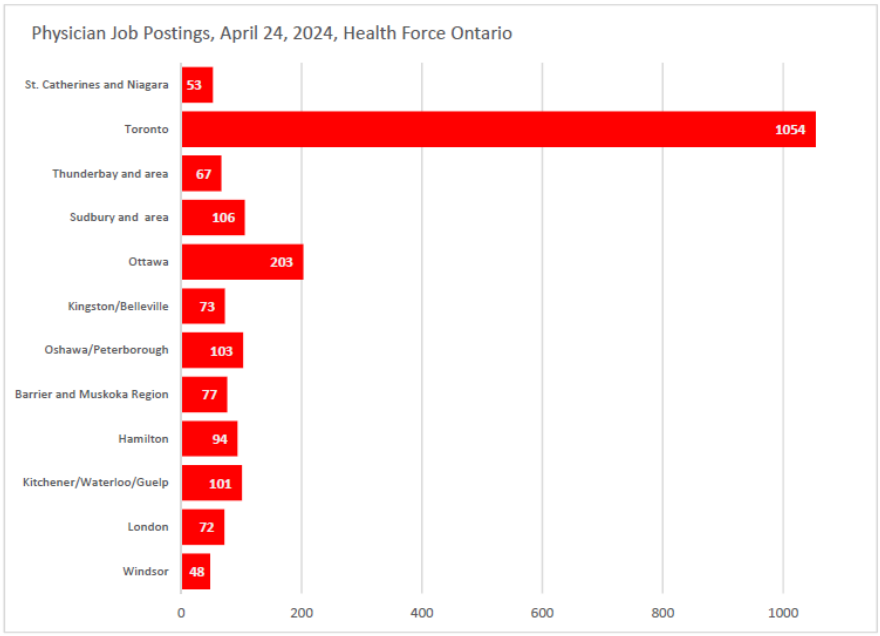
239. While increased compensation is not the sole solution to recruitment and retention problems, it is a vital and essential part of it. As reflected in the arbitral case law, "there is no question that compensation is a key driver in attracting and retaining ...employees."

MINISTRY REBUTTAL

As the Ministry submitted at Section 1.3 of its Brief, physicians are not employees. The same rules of supply and demand, retention and recruitment do not apply here.

PARAGRAPH 248 AND 249 OF THE OMA BRIEF:

248. According to data from Health Force Ontario for 2024, there are vacancies for more than 3,000 full-time, part-time and locum physicians across the province, as set out below: 176



249. As well, as set out in the following chart, when one compares the physician job opportunities advertised through the Health Force Ontario, the marketing and recruitment branch of Ontario Health, from before the pandemic to post-pandemic, the shortage of physicians is proportionately higher than it was in the pre-pandemic era by about 1% of total physician workforce.

Physician Job Opportunities, 2019 to 2023, Ontario (% of total physicians)

Source: Canadian Medical Association. Physician Opportunities in Canada. As of December of each year. Excludes locums and part-time.

Year	Family	Specialists	All
2019	520	468	988
2020	578	375	953
2021	745	592	1,337
2022	773	607	1,380
2023	669	707	1,376

MINISTRY REBUTTAL

The Ministry submits that the purpose of the HFOJobs platform is to provide a venue for communities, health care and educational institutions to advertise job opportunities, educational and community information to physicians, nurses and other health care professionals. The aggregate quantitative data housed within HFOJobs is not representative for the following reasons:

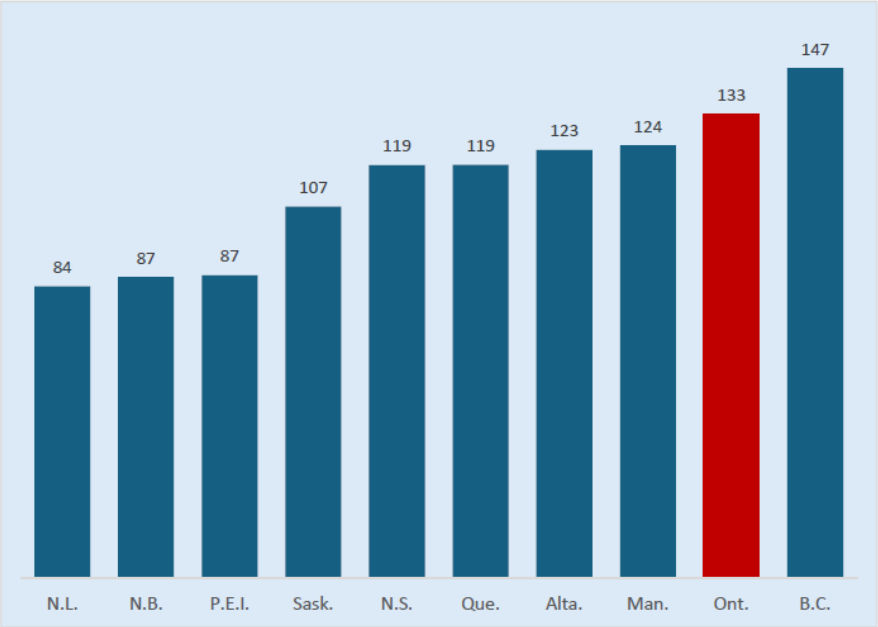
(1) There are a large number of duplicate postings;
(2) Recruiters post the same posting in different ways to try and track diverse candidates;
(3) Postings for medical office space, which are reposted for a variety of community specialists and family medicine physicians, are unrelated to a physician vacancy;
(4) Individual postings are not vetted for accuracy, legality, or the employer's ability to offer the employment opportunities advertised; and
(5) Postings are not taken down after successful recruitment

As such, given that this voluntary platform is used by a variety of employers across the provincial health care system, aggregate quantitative data from the HFOJobs website cannot reliably be used as a means of understanding patient need, or to accurately identify shortages of certain types of health care professionals.

PARAGRAPHS 250 THROUGH 253 OF THE OMA BRIEF:

250. In general, the supply of physicians in Ontario relative to other provinces has been dropping in recent decades. In 1971, the first year for which the data is available, Ontario had the second highest physician to population ratio in Canada, as depicted in the following chart:

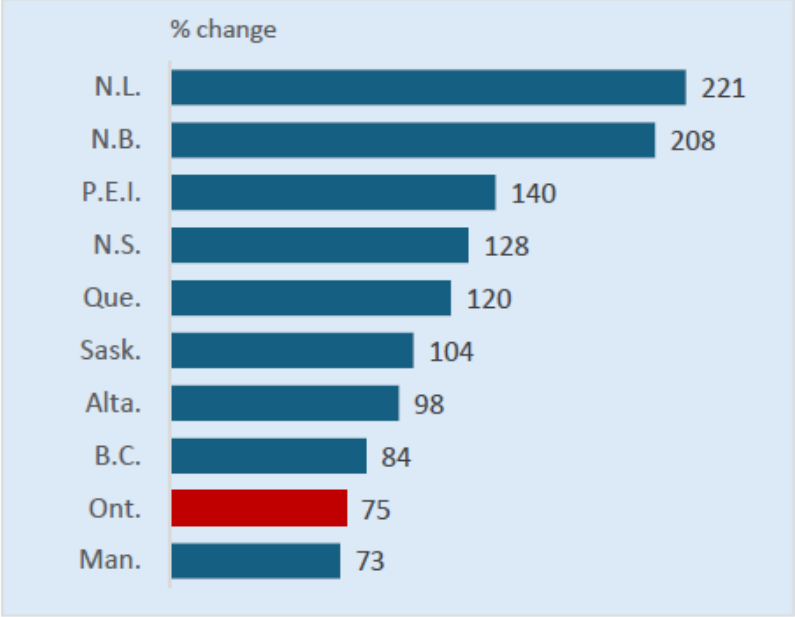
Number of total physicians per 100,000 population, by jurisdiction, Canada, 1971



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

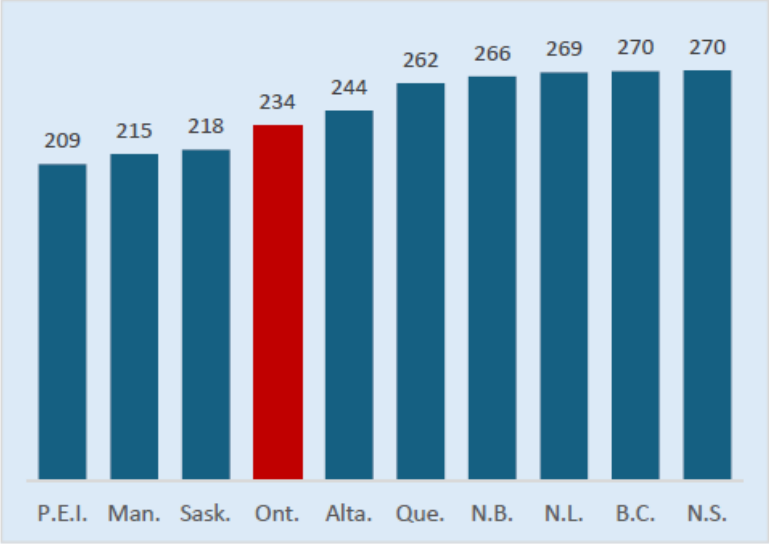
251. Since then, Ontario has had the second lowest growth in the number of physicians per population:

Percentage Change in the number of physicians per 100,000 population, by jurisdiction, Canada. 1971 to 2022



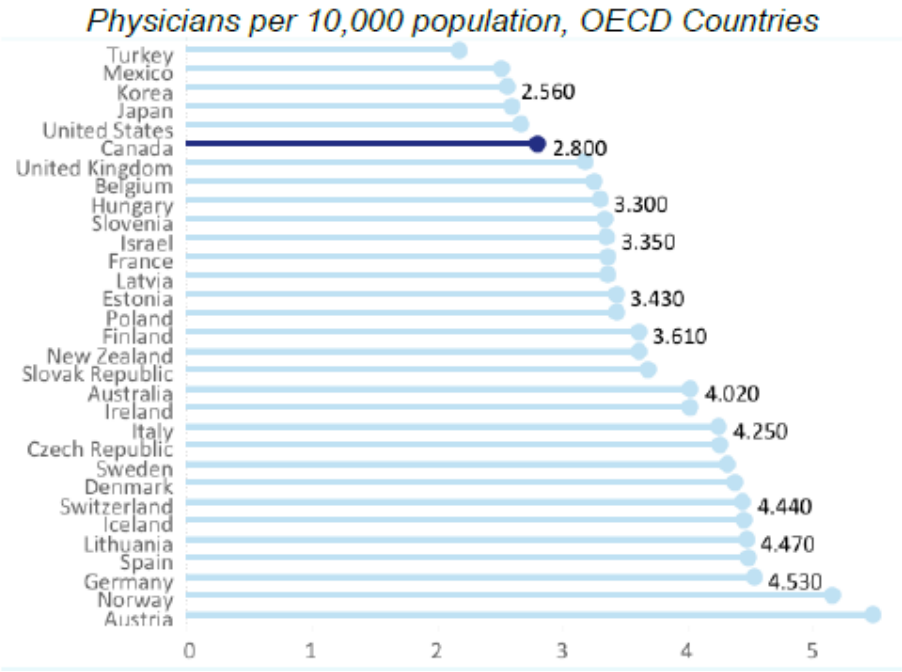
252. As a result, Ontario has gone from one of the provinces with the highest physician to population ratios in the country to one of the lowest, as seen in the following chart:

Number of total physicians per 100,000 population, by jurisdiction, Canada, 2022



Source: Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2022 — Data Tables. Ottawa, ON: CIHI; 2023. Table 23.0.

253. In turn, Canada has one of the lowest physician to population ratios among OECD countries:



MINISTRY REBUTTAL

The Ministry submits below the total physicians per 100,000 population year over year from 2005 to 2022 in Ontario. As can be seen from the below table, Ontario has significantly increased the total number of physicians per 100,000 population since 2005. Ontario's relative position to the Canadian average increases and decreases over time, depending on the other provinces rate of increase in physicians per 100,000.

The Ministry has highlighted in purple the years of 2004 to 2011. We note that in these years, the price increases were among the highest of the 18 year period reviewed in this table. Despite this, it was during this period that Ontario was furthest behind the Canadian average (lagging by 14.1% in 2008).

The Ministry has highlighted in yellow those years of 2012 to 2018 where fee for service and other physician compensation elements were reduced (and for which the OMA sought redress)[55]. During this time period, the total physicians per population was at its highest (236.7 in 2018).

The table on the next page demonstrates that compensation is not correlated with physician supply or how Ontario compares with the Canadian average.

[55] The award for the 2017 to 2021 PSA was not released until February 18, 2019.

TABLE 15 - Total Number of Physicians per 100,000 Population (All Specialties) in Ontario versus Canadian Average (excluding Ontario) by Calendar Year

	Total Number of Physicians per 100,000 Population (All Specialties) in Ontario versus Canadian Average (excluding Ontario) by Calendar Year (2005 – 2022)		
Calendar Year	Ontario	Canadian Average (excluding Ontario)	% that Ontario is over/ under Canadian Average
2005	177.5	199.8	-11.2%
2006	174.9	201.7	-13.3%
2007	177.0	204.2	-13.3%
2008	178.9	208.2	-14.1%
2009	188.6	211.3	-10.7%
2010	190.7	214.0	-10.9%
2011	197.3	220.0	-10.3%
2012	203.9	224.4	-9.1%
2013	210.4	228.3	-7.9%
2014	215.7	231.6	-6.9%
2015	222.5	235.1	-5.4%
2016	223.5	238.6	-6.3%
2017	227.8	242.9	-6.2%
2018	236.7	245.6	-3.6%
2019	234.4	248.4	-5.7%
2020	229.7	250.6	-8.3%
2021	235.4	253.1	-7.0%
2022	233.8	254.8	-8.3%

PARAGRAPH 254 OF THE OMA BRIEF:

254. Within Ontario, there is also significant variation in the number of physicians per 1000 population. Whereas there are 4.7 physicians per 1,000 people in Toronto, there are only 1.8 to 2.2 physicians per 1,000 people in other Ontario health regions as of 2021.

MINISTRY REBUTTAL

As previously submitted, distribution issues will not be resolved through an above normative compensation adjustment.

PARAGRAPH 257 THROUGH 259 OF THE OMA BRIEF:

257. Similarly, as can been seen in the following chart, early career physicians (forty years of age or less) conduct fewer annual visits than mid (40 to 60 years of age) or late (65+ years of age) career physicians.

Number of Annual Visits per Physician, by Career Stage, 2022, Ontario

Source: Ontario Health Insurance Plan ("OHIP") Claims Database. Fiscal year 2022-23.

258. Due to all these demographic changes, the number of visits per average physician has decreased since 2010 by about 4%, also contributing to the overall shortage of physicians in the province.

259. Thus, there is clear and compelling evidence of generalized physician shortages throughout the province and as well as specific shortages in many practice areas.

MINISTRY REBUTTAL

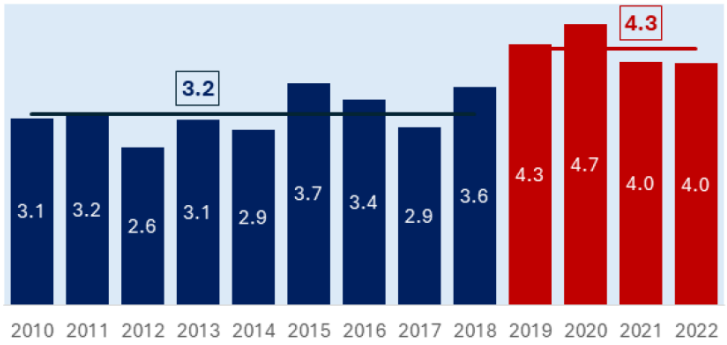
With respect to the OMA's submissions at 257, this would align with the Ministry submissions at Section 12.1 (page 113) of the Ministry Brief, where it presented data on the reduction in the total patient visits and number of distinct patients seen by physicians. However, the Ministry disagrees with the OMA's submissions at paragraph 258 which greatly underestimates the decline in physician visits. As presented earlier in these

submissions, on average, physicians today provide 1,000 (22%) fewer patient encounters per year than they did 18 years ago, a compounded annual reduction of 1.4%.

PARAGRAPH 270 OF THE OMA BRIEF:

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

Percent Physicians Exiting from Active Practice, Ontario, 2010 to 2022



Source: Ontario Physician Reporting Centre, Physicians in Ontario Longitudinal Dataset (2009-2022) - Hamilton, ON: OPRC; 2024

MINISTRY REBUTTAL

With respect to the OMA's assertions regarding attrition of Ontario physicians, the Ministry resubmits the below tabled provided in the Ministry's May 1, 2024 submissions (Exhibit 15) which demonstrate that Ontario's Supply of Physicians has continued to increase year over year.

Fiscal Year	Physician Supply	Physician Supply Increase (Cumulative)
2005-06	22,944	-
2006-07	23,334	1.7%
2007-08	23,858	4.0%
2008-09	24,451	6.6%
2009-10	25,199	9.8%
2010-11	26,063	13.6%
2011-12	26,853	17.0%
2012-13	27,678	20.6%
2013-14	28,528	24.3%
2014-15	29,411	28.2%
2015-16	30,192	31.6%
2016-17	30,916	34.7%
2017-18	31,728	38.3%
2018-19	32,567	41.9%
2019-20	33,250	44.9%
2020-21	33,548	46.2%
2021-22	34,791	51.6%
2022-23	35,324	54.0%
2023-24	36,204	57.8%

PARAGRAPH 274 OF THE OMA BRIEF:

274. Alarmingly, in 2024 the number of vacant family medicine spots after the first round of residency matching in Ontario was higher than in previous years. According to CaRMS data, there were "108 unfilled family medicine spots out of a total of 560 in Ontario following the first round of this year's match, up from 103 unclaimed spots last year." This is an increase from 100 in 2023, 61 in 2022, 52 in 2021 and 30 in 2020. As well, consistent with a decline that has been seen for many years, only 30% of graduates ranked family medicine as their first choice for their specialty training, down from 38% in 2015.

MINISTRY REBUTTAL

As previously submitted, Ontario increased the number of Family Medicine residency position in both 2023 and 2024.

Despite the increase, Ontario filled 100% all family medicine positions offered. In 2024 this was 547 ministry funded family medicine positions, the most ever filled by Ontario.

PARAGRAPH 296 OF THE OMA BRIEF STATES:

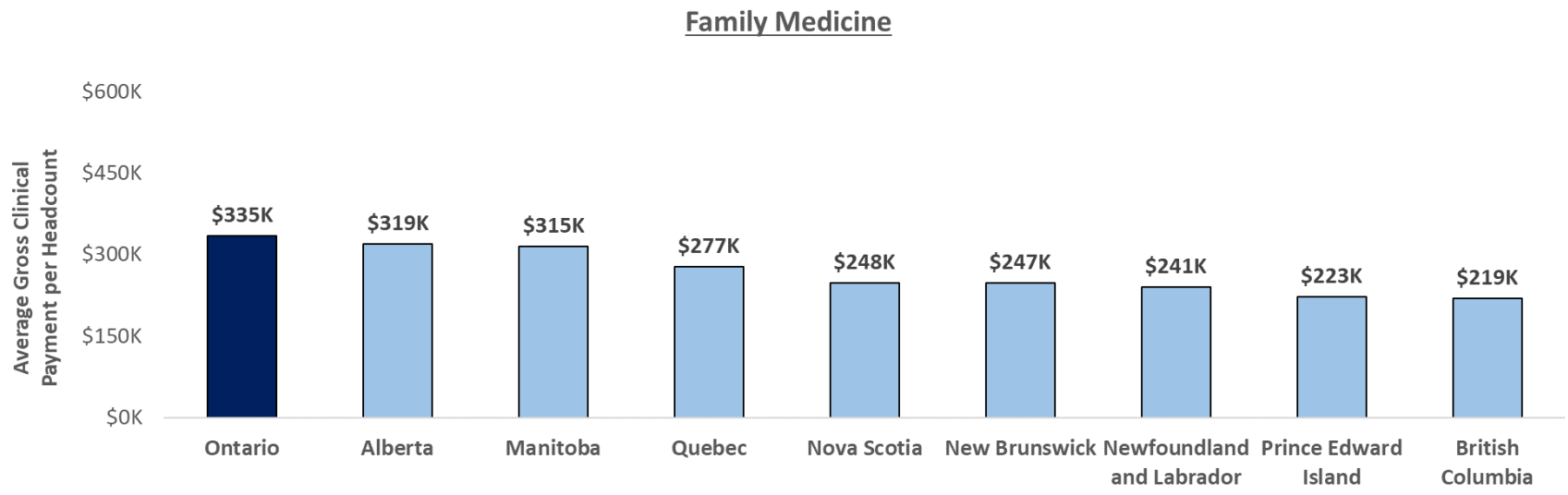
296. In the specific context of physicians, research has also confirmed that decisions around early retirement and feelings of dissatisfaction with the profession are tied to compensation. For example, "compensation that has not kept pace with inflation" has been identified as a specific factor driving the shortage of family physicians by the OCFP. Similarly, Flood et al. have confirmed that the shortage of family physicians is explained in part by the higher earning potential of other specialities.

MINISTRY REBUTTAL

Firstly, as submitted previously, a general price increase that is allocated through the RAANI-CANDI model will not significantly close the gap between the income of family physicians and other, higher earning specialties. It is open to these parties in the subsequent years of this PSA to revisit the allocation method of general price increases.

Second, the Ministry submits that Ontario's family physicians are the highest paid among all the provinces for primary care. Most importantly, and in recognition of their value to Ontario's healthcare system, the fact is that family physicians in the FHO model are the mostly highly paid in relation to other provinces. The Ministry refers to the submissions at Section 8.6 of the Ministry's May 1, 2024 brief which compare the FHO to other provinces. However, even if the CIHI data is utilized for comparison purposes (which the OMA relies on in paragraphs 418 to 423 of their brief), in 2021/2022 Family Medicine is ranked first among all provinces compared on the basis of average income per headcount (see chart below):

Family Medicine – Provincial Comparison of Average Gross Clinical Payment per Physician Headcount (2021/22)



Notes:

1) Comparisons shown below are based on data available in CIHI National Physician Database (NPDB) for fiscal year 2021/22
2) Data for Saskatchewan is not available in the 2021/22 CIHI NDPB data release

PARAGRAPHS 304 THROUGH 306 OF THE OMA BRIEF:

304. The OMA submits that its claim for catch-up is justified and necessary in light of the recent high rates of inflation and the resulting need to address the erosion of physician compensation, the impact of which is further compounded by increases to overhead and the costs of practice due to inflation.

305. The OMA's proposal is also consistent with replication, comparability, and the principle of "catch up". The concept of catch up is well recognized in the arbitral jurisprudence. As explained by Arbitrator Gedalof in UTFA v. University of Toronto, "catch up" is essential to the legitimacy of the interest arbitration process. Historical benchmark comparisons become artificial if the need for catch up is not accounted for...[W]here the parties have long-since adopted the usual replication model for interest arbitration, the availability of catch up in appropriate circumstances is...fundamental to the comparative exercise and ought to be non-controversial.

306. Applying the concept of catch-up, Arbitrator Gedalof awarded an 8% across the board increase for 2022 (in addition to the 2% that had earlier been agreed for the first two years of the Bill 124 moderation period restrictions), in order to make up for losses in relation to CPI and to other comparators experienced over the previous two years.

MINISTRY REBUTTAL

First, the University of Toronto Award has little, if any, application to this proceeding. We have included this award in our analysis of Bill 124 Reopeners (starting at page 21), but note that it is a single decision among the 67 settlements or awards that speak to the Bill 124 Reopener period.

The January 25, 2022 MOS set out the parties' agreement on all salary and benefit matters for the first 2 years of their 3-year moderation period. More specifically, the University of Toronto and UTFA agreed on the following salary and benefit increases:

> July 1, 2020 – June 30, 2021 (Year 1) – 1% salary increase and benefit improvements equal to the residual of 1% of total compensation
>
> July 1, 2021 – June 30, 2022 (Year 2) – 1% salary increase and benefit improvements equal to the residual of 1% of total compensation

In addition, the University of Toronto and UTFA agreed that all unresolved matters regarding salary, benefits and workload for July 1, 2022 – June 30, 2023 (Year 3) would be subject to final and binding interest arbitration before Arbitrator Gedalof.

Arbitrator Gedalof's decision to award an 8% salary increase for the period July 1, 2022 to June 30, 2023 (Year 3) cannot be viewed in isolation. In this same award, Arbitrator Gedalof left the parties' prior agreement to 1% increases in both Year 1 and Year 2 undisturbed. He determined that these sub-normative increases, which had been affected by unconstitutional bargaining constraints, supported his decision to award a far higher salary increase for Year 3. Arbitrator Gedalof viewed the monetary consequences of his award in a holistic manner, over the course of the entire 3-year moderation period. At paragraph 121 of the U of T Faculty Award, Arbitrator Gedalof described the impact of his monetary award as:

> a total increase of 10% over the three-year term of the parties' agreement, with the bulk of that increase in the final year, [which] reasonably reflects the freely bargained outcome that these parties would have reached had they been able to reach an agreement.

Finally, as with almost all interest arbitration proceedings, Arbitrator Gedalof anchored his analysis in the replication principle. At the outset of his analysis, Arbitrator Gedalof emphasized that:

> The overarching guiding principle in interest arbitration is the principle of replication. The parties, in [the Memorandum of Agreement], have expressly adopted this principle in paragraph 16 of Article 6. Article 6 sets the terms for negotiation and interest arbitration, and paragraph 16 directs the Dispute Resolution Panel (in this case the sole interest arbitrator) to issue a report (in this case an award) "which shall attempt to reflect the agreement the parties would have reached if they had been able to agree."[6]

As noted above, the present proceeding is a product of the unique language agreed to by the parties in the Letter of Understanding which was expressly incorporated into the MOA. In this proceeding, traditional interest arbitration principles, including the replication

principle, must be adjusted in a way that recognizes the overriding impact of the language that these parties negotiated.

Since the replication principle calls for a determination of the agreement that the parties would have reached had they been able to do so, prior collective bargaining outcomes achieved by these same parties are especially relevant. In the U of T Faculty Award, Arbitrator Gedalof found incontrovertible evidence of a clear and longstanding connection between increases in the Consumer Price Index (the "CPI"), and salary increases for the University of Toronto's faculty members and librarians.

In reviewing prior Article 6 interest arbitration decisions between the University of Toronto and UTFA, Arbitrator Gedalof found that the annual increase in the CPI was consistently treated as an important factor in determining the appropriate salary increase to be awarded for the subsequent year. His analysis ended with an excerpt from an earlier Article 6 decision of Arbitrator Martin Teplitsky, which is reproduced below:

> *In my opinion, based on the approach in prior rounds of bargaining, the CPI is considered retrospectively. In other words, for 2009-2010 and 2010-2011, the relevant CPI increases are 2008-2009 and 2009-2010. UTFA submitted that these were approximately 2% in each year. In fact, the total increase in the CPI, whether one looks at June 2008-June 2010 or July 2008-July 2010, is approximately a total of 2%. The Faculty's position in the past has been that CPI protection is the minimum that ATB increases should generate. In fact, over the past 30 years, total increases in the ATB have coincided almost exactly with the increases in the CPI for the same period. In any bargaining round, the ATB increase has been higher or lower than the CPI increase. For example, in the settlement for 2007-2008 and 2008-2009, the ATB increase exceeded the CPI for those years. Although increases in CPI are not determinative, the fact of a 30-year coincidence between the total ATB increase and the increases in CPI, and the obvious role of CPI in the ATB increase given a. compensation structure which includes PTR, CPI is a very relevant factor.[8]*

To underscore the close connection between annual CPI increases and related salary increases for faculty members and librarians at the University of Toronto, Arbitrator Gedalof reproduced a chart from UTFA's submissions, which, in his view, demonstrated

how “salaries for faculty and librarians [at the University of Toronto] have, with occasional corrections as discussed above, kept pace with inflation over the past 20 years.” This chart used by Arbitrator Gedalof as support for this proposition is reproduced below:

Year	Canada	Ontario	Canada	Ontario	UTFA ATB	Notes
1993-1994	85.68	84.79	1.50%	1.40%	0%	
1994-1995	86.03	85.14	0.40%	0.40%	0%	
1995-1996	87.87	87.13	2.10%	2.30%	0%	
1996-1997	89.39	88.67	1.70%	1.80%	0%	
1997-1998	90.60	90.04	1.4%	1.6%	0.50%	
1998-1999	91.44	90.84	0.9%	0.9%	1.50%	
1999-2000	93.46	93.08	2.2%	2.5%	1.50%	
2000-2001	96.03	95.91	2.7%	3.0%	2.00%	
2001-2002	98.16	98.38	2.2%	2.6%	1.50%	
2002-2003	101.09	100.98	3.0%	2.6%	3.00%	
2003-2004	102.98	102.95	1.9%	1.9%	3.00%	2.25%+0.75%
2004-2005	105.21	105.11	2.2%	2.1%	3.37%	2.7%+0.615%
2005-2006	107.60	107.52	2.3%	2.3%	3.00%	
2006-2007	109.61	109.12	1.9%	1.5%	3.25%	
2007-2008	111.94	111.17	2.1%	1.9%	3.00%	3.0% +$585 in Jan 2008
2008-2009	114.44	113.71	2.2%	2.3%	3.00%	3.0%+$605 in Jan 2009
2009-2010	114.89	114.18	0.4%	0.4%	2.50%	
2010-2011	117.22	117.33	2.0%	2.8%	2.50%	1.25% July 2009, 1.25% Jan 2010 + flat dollar
2011-2012	120.55	120.79	2.8%	3.0%	1.70%	1.0% + $1000
2012-2013	121.95	122.03	1.2%	1.0%	2.00%	1.0% + $1520
2013-2014	123.24	123.51	1.1%	1.2%	2.25%	1.0% + $1815
2014-2015	125.49	126.34	1.8%	2.3%	1.90%	1.0% in July 2014 and 0.9% in Jan 2015
2015-2016	127.05	127.94	1.2%	1.3%	1.90%	1.0% in July 2015 and 0.9% in Jan 2016
2016-2017	128.98	130.38	1.5%	1.9%	1.75%	

2017-2018	131.09	132.57	1.6%	1.7%	1.75%	1.0% + $1150
2018-2019	133.92	135.50	2.2%	2.2%	1.90%	
2019-2020	136.59	138.03	2.0%	1.9%	2.00%	1.0% + $1520
Compounded Average			**1.80%**	**1.87%**	**1.84%**	

The extent to which Arbitrator Gedalof relied on this longstanding and well-established connection between annual CPI increases and accompanying salary increases for faculty members and librarians employed by the University of Toronto is highlighted in paragraph 89 of the U of T Faculty Award:

> Considering the 1% Bill 124 compliant increases already awarded, wages over the term of the parties' agreement were estimated to have eroded by 12.75% as compared to the CPI. Using the prior year CPI comparison, the number is 8.6%. The questions are therefore which approach is correct, and how significant a factor ought inflation to be? In answer, and having regard to the bargaining history between these parties, I find that the prior year approach to accounting for CPI best replicates how these parties' have bargained historically, and best replicates a freely bargained outcome here. What also becomes clear when one examines the bargaining history between these parties, is that maintaining salaries in relation to inflation has been a preoccupation and a highly significant factor for these parties for a very long time.

The MOH submits that Arbitrator Gedalof's decision to award an 8% wage increase to the faculty and librarians employed by the University of Toronto for the period July 1, 2022 to June 30, 2023, which includes the 1% salary increase he had previously ordered must not only be considered alongside his decision not to award any monetary compensation to this same group of employees beyond the 1% increases mandated by Bill 124 in Year 1 and Year 2, but it must also be considered in the context of the decades-long trend whereby the salaries of the University of Toronto's faculty members and librarians have tracked very closely to the CPI increases in the prior year.

As is outlined below, the current proceeding is not informed by this same longstanding historical connection between increases in CPI and across-the-board salary increases, and therefore the outcome of the U of T Faculty Award is of little to no relevance.

PARAGRAPH 310 OF THE OMA BRIEF:

310. There can be no doubt that inflation in the last three years has been extraordinary. At the same time as Ontario's economy rebounded rapidly from the pandemic with exceptional GDP gains in 2021 and 2022 and the Ontario government saw large budget surpluses, the 2021-24 period was also marked by the highest inflation rates been in the past forty years. For physicians, unlike for employees, inflation has also had a doubly negative impact as it has both eroded the value of any PSA compensation rate increases they have received and, at the same time, significantly increased their costs to practice as overhead expenses have gone up.

MINISTRY REBUTTAL

The MOH notes the following:

1. The impact of inflation on wage trends is already baked into the Bill 124 Re-opener settlements and awards and the recent Lee Awards in the OPS for OPSEU and AMAPCEO.
2. The Ministry disagrees that the GDP growth has been remarkable, and suggest that much of the growth can be attributed to an increasing population.
3. The OMA reference to expense growth is not quantified nor is it supported by any persuasive evidence. In any event, as reflected in the MOH original submission, a 1% growth in average revenue for physician mitigates a substantial increase in their overhead.

PARAGRAPH 314 AND 315 OF THE OMA BRIEF:

314. The eroding price rate relative to inflation is also seen in in the table below. Since 2012, increases to the rate of physician fees have significantly trailed inflation, which cumulatively has had a significant impact on physician compensation. While inflation was 32.8% over the 2012-23 period, the overall level of physician fees increases/decreases (including the reductions caused by the targeted cuts prior to 2017) over that same period is zero, and only 8.8% even excluding the targeted cuts. The OMA submits that its catch-up proposal will at least go some way to restoring the historic pattern of fee increases matching inflation from pre-2012:

Year	OMA Physician Fee Increases April 1*	Average Annual Inflation Ontario
2012	-3.80%	1.4%
2013	-1.40%	1.0%
2014	-0.80%	2.4%
2015	-1.00%	1.2%
2016	-1.80%	1.8%
2017	0.75%	1.7%
2018	1.25%	2.4%
2019	1.00%	1.9%
2020	1.00%	0.7%
2021	1.00%	3.3%
2022	1.00%	6.9%
2023	2.80%	4.2%

**does not include the 3.5% unilateral cut in 2016 that was returned in 2019*

315. When one looks forward to the first year of the 2024-2028 PSA, inflation is expected to be between 2.5-3%. Thus, looking just at inflation since 2021, a Year 1 increase of approximately 13% is needed just to ensure that increases to the level of physician fees is not eroded due to inflation since the start of the 2021-24 PSA.

MINISTRY REBUTTAL

The Ministry has been unable to verify the OMA's submitted physician fee increase table. Further, the Ministry disagrees that there was a historic pattern of fee increases matching inflation pre-2012.

In any event, and as previously submitted, there is no basis for catch up.

1. The period prior to the 2021 Settlement (the 2018 PSA) was determined by Interest Arbitration where the issue of catch-up and inflation were argued and decided upon.
2. The 2021 Settlement was a freely negotiated agreement. The 2021 Settlement was not governed by Bill 124. There was no limit on the maximum increase that could have resulted from the 3rd year formula.
3. The increase in the average physician's income (including both price and utilization) was competitive with the OPS Arbitration results and the Bill 124 reopener results (the latter including sectors with discernably different retention and recruitment issues)

PARAGRAPH 316 OF THE OMA BRIEF:

316. Moreover, as noted above, the impact of inflation on physicians since 2011 is further compounded by the fact that inflation results in increases to physician costs of practice. As a result, the net real physician compensation rate has deteriorated even more than is captured just by comparing the differences between inflation and physician price increases. Thus, the actual impact of inflation on physician expenses of practice, and in particular the compounding effect of increasing costs of practice on a given level of physician compensation, must be taken into account when determining appropriate price increases.

MINISTRY REBUTTAL

In the OMA submissions, they have not identified specific changes to overhead costs. The Ministry made extensive submissions at Section 9 (page 93) of its May 1, 2024 brief regarding the high degree of variability in the levels of overhead, analysis on the average overhead of physicians and submissions on how businesses have addressed overhead.

PARAGRAPH 318 OF THE OMA BRIEF:

318. As noted, replication is the central guiding principle for interest arbitration and requires consideration of comparators. Because of the impact of Bill 124 on the 2021-24 PSA, as well as the prior sub-normative fee increases for physicians in the period 2012 to 2020, the OMA submits that the OMA's claim for catch-up must include an examination of key relevant settlements and interest arbitration awards over various time periods, including 2012-2023 (a time period that includes fee freezes together with various unilateral cuts to physician fees that remain in effect), 2017-2023 (the period since the BAF commenced), and 2021-2023 (the period covering the last PSA which was seriously constrained by the presence of Bill 124.

MINISTRY REBUTTAL

For all the reasons set out previously, there is no basis for catch up based on the 2021 to 2024 period. We disagree and the data supports a proposition that there is no basis for catch up in that period.

Further, retention and recruitment was a major factor in the HLDAA decisions for Hospital RNs in Ontario in the consecutive and recent awards of Arbitrator Stout, Gedalof and Kaplan. However, the growth in the number of RNs up to the point of those awards stands in sharp contrast to the higher growth in the number of physicians over the same time frame. As submitted previously, Ontario does not have a recruitment and retention problem for physicians, in contrast to that which was seen in the recent hospital sector awards. The Ministry also refers to Section 6.1 of their May 1, 2024 submissions regarding the recruitment and retention issues present in the recent hospital sector awards.

PARAGRAPHS 319 TO 340 OF THE OMA BRIEF:

A. HOSPITAL SECTOR INCREASES

MINISTRY REBUTTAL

It is clear that the Arbitrators for the Hospital Sector awards were influenced significantly by the retention and recruitment of nurses in Ontario's Hospitals.

First, the trends in the total number of RNs (providing Direct Care), in comparison with the total number of Physicians in Ontario is reviewed

Table 16. Trends in Total Registered Nurse (RN) Workforce in Direct Care vs. Total Number of Physicians in Ontario (2012 – 2021)

	Total Registered Nurse Workforce in Direct Care in Ontario by Calendar Year (2012 – 2021)		Total Number of Physicians (All Specialties) in Ontario by Calendar Year (2012 – 2021)	
Calendar Year	Total RN Workforce in Direct Care	% Change in RN Workforce in Direct Care Over Previous Year	Total Number of Physicians	% Change in Total Number of Physicians Over Previous Year
2012	83,794	-	27,300	-
2013	85,294	1.8%	28,422	4.1%
2014	86,488	1.4%	29,368	3.3%
2015	86,757	0.3%	30,494	3.8%
2016	86,666	-0.1%	31,017	1.7%
2017	86,246	-0.5%	32,055	3.3%
2018	86,636	0.5%	33,872	5.7%
2019	88,380	2.0%	34,091	0.6%
2020	88,752	0.4%	33,830	-0.8%
2021	89,915	1.3%	34,860	3.0%

Sources:

1. *Workforce of regulated nurses, by type of professional and jurisdiction, provinces/territories with available data, 2012 to 2021. CIHI. Nursing in Canada, 2021 — Data Tables. Ottawa, ON: CIHI; 2022.*
2. *Physician workforce, by jurisdiction, Canada, 1971 to 2022. CIHI Supply, Distribution and Migration of Physicians in Canada, 2022 — Historical Data. Ottawa, ON: CIHI; 2023.*

Table 17. Trends in Total Registered Nurse (RN) Workforce in Direct Care vs. Total Number of Family Medicine Physicians in Ontario (2012 – 2021)

	Total Registered Nurse Workforce in Direct Care in Ontario by Calendar Year (2012 – 2021)		Total Number of Family Medicine Physicians in Ontario by Calendar Year (2012 – 2021)	
Calendar Year	Total RN Workforce in Direct Care	% Change in RN Workforce in Direct Care Over Previous Year	Total Number of Family Medicine Physicians	% Change in Total Number of Family Medicine Physicians Over Previous Year
2012	83,794	-	13,513	-
2013	85,294	1.8%	13,973	3.4%
2014	86,488	1.4%	14,695	5.2%
2015	86,757	0.3%	15,077	2.6%
2016	86,666	-0.1%	15,417	2.3%
2017	86,246	-0.5%	16,088	4.4%
2018	86,636	0.5%	16,814	4.5%
2019	88,380	2.0%	16,863	0.3%
2020	88,752	0.4%	16,990	0.8%
2021	89,915	1.3%	17,220	1.4%

Sources:

1. *Workforce of regulated nurses, by type of professional and jurisdiction, provinces/territories with available data, 2012 to 2021. CIHI. Nursing in Canada, 2021 — Data Tables. Ottawa, ON: CIHI; 2022.*
2. *Physician workforce, by jurisdiction, Canada, 1971 to 2022. CIHI Supply, Distribution and Migration of Physicians in Canada, 2022 — Historical Data. Ottawa, ON: CIHI; 2023.*

The Ministry submits that the above tables illustrate that while the number of nurses have grown year over year from 2018, the total number of physicians (all specialities) and the total number of family physicians have grown at a greater rate.

The below tables then illustrate that while the number of nurses per 100,000 population had been decreasing, the number of physicians per 100,000 had increased significantly. The difference is dramatic.

Table 18. Trends in Total Registered Nurse (RN) Workforce Employed in Direct Care per capita vs. Total Number of Physicians per capita in Ontario (2012 – 2021)

	Total Registered Nurse Workforce Employed in Direct Care per 100,000 Population in Ontario by Calendar Year (2012 – 2021)			Total Number of Physicians per 100,000 Population (All Specialties) in Ontario by Calendar Year (2012 – 2021)		
Calendar Year	Total RN Workforce Employed in Direct Care per 100,000 Population	% Change in RN Workforce Employed in Direct Care per 100,000 Population Over Previous Year	Cumulative % Change in RN Workforce Employed in Direct Care per 100,000 Population Since 2012	Total Number of Physicians per 100,000 Population	% Change in Total Physicians per 100,000 Population Over Previous Year	Cumulative % Change in Total Physicians per 100,000 Population Since 2012
2012	625.8	-	-	203.9	-	-
2013	631.3	0.9%	0.9%	210.4	3.2%	3.2%
2014	635.1	0.6%	1.5%	215.7	2.5%	5.8%
2015	632.9	-0.3%	1.1%	222.5	3.2%	9.1%
2016	624.6	-1.3%	-0.2%	223.5	0.5%	9.6%
2017	613.0	-1.9%	-2.0%	227.8	1.9%	11.7%
2018	605.5	-1.2%	-3.2%	236.7	3.9%	16.1%
2019	607.6	0.4%	-2.9%	234.4	-1.0%	15.0%
2020	601.9	-0.9%	-3.8%	229.7	-2.0%	12.7%
2021	609.8	1.3%	-2.6%	235.4	2.5%	15.5%

Sources:

3. *Workforce of regulated nurses, by type of professional and jurisdiction, provinces/territories with available data, 2012 to 2021. CIHI. Nursing in Canada, 2021 — Data Tables. Ottawa, ON: CIHI; 2022.*
4. *Physician workforce, by jurisdiction, Canada, 1971 to 2022. CIHI Supply, Distribution and Migration of Physicians in Canada, 2022 — Historical Data. Ottawa, ON: CIHI; 2023.*

Table 19. Trends in Total Registered Nurse (RN) Workforce Employed in Direct Care per capita vs. Total Number of Family Medicine Physicians per capita in Ontario (2012 – 2021)

	Total Registered Nurse Workforce Employed in Direct Care per 100,000 Population in Ontario by Calendar Year (2012 – 2021)			Total Number of Family Medicine (FM) Physicians per 100,000 Population in Ontario by Calendar Year (2012 – 2021)		
Calendar Year	Total RN Workforce Employed in Direct Care per 100,000 Population	% Change in RN Workforce Employed in Direct Care per 100,000 Population Over Previous Year	Cumulative % Change in RN Workforce Employed in Direct Care per 100,000 Population Since 2012	Total Number of Family Medicine Physicians per 100,000 Population	% Change in FM Physicians per 100,000 Population Over Previous Year	Cumulative % Change in FM Physicians per 100,000 Population Since 2012
2012	625.8	-	-	100.9	-	-
2013	631.3	0.9%	0.9%	103.4	2.5%	2.5%
2014	635.1	0.6%	1.5%	107.9	4.3%	6.9%
2015	632.9	-0.3%	1.1%	110.0	1.9%	9.0%
2016	624.6	-1.3%	-0.2%	111.1	1.0%	10.1%
2017	613.0	-1.9%	-2.0%	114.3	2.9%	13.3%
2018	605.5	-1.2%	-3.2%	117.5	2.8%	16.4%
2019	607.6	0.4%	-2.9%	115.9	-1.3%	14.9%
2020	601.9	-0.9%	-3.8%	115.4	-0.5%	14.3%
2021	609.8	1.3%	-2.6%	116.3	0.8%	15.2%

Sources:

1. *Workforce of regulated nurses, by type of professional and jurisdiction, provinces/territories with available data, 2012 to 2021. CIHI. Nursing in Canada, 2021 — Data Tables. Ottawa, ON: CIHI; 2022.*
2. *Physician workforce, by jurisdiction, Canada, 1971 to 2022. CIHI Supply, Distribution and Migration of Physicians in Canada, 2022 — Historical Data. Ottawa, ON: CIHI; 2023.*

This stark contrast, within the same Ontario Health care system (up to the period of the three Hospital HLDAA awards), speaks volumes to fundamental difference in retention and recruitment between the two health care professions at that time. Through strategic investments and action of Government, the trend of decreasing RNs registered to work that would have informed those HLDAA decisions has reversed. So, not only do the physician head count data stand in stark contrast to that observed in the RN space, it is also reasonable to infer that the investments and actions taken by the

Ministry to increase the number of medical school seats and residency positions will continue to have an demonstrable impact on Ontarians' ability to access physician services.

PARAGRAPHS 350 AND 351 OF THE OMA BRIEF:

350. The following table sets out increases paid to the two largest OPS groups, OPSEU Central and AMAPCEO, from 2012 to present, compared to the OMA:

YEAR	OMA*	OPSEU	AMAPCEO
2012	-3.80%	2%	0%
2013	-1.40%	0%	0%
2014	-0.80%	0%	0%
2015	-1.00%	0%	0%
2016	-1.80%	0% (plus a 1.4% lump sum)	1.4%
2017	0.75%	1.4% 1.5%	1.4% 1.5%
2018	1.25%	0%	0%
2019	1.00%	1.0% 1.0%	1.0% 1.0%
2020	1.00%	1.0% 1.0%	1.0% 1.0%
2021	1.00%	1.0% 1.0%	1.0% 1.0%
2022	1.00%	3.0%	3.0%
2023	2.80%	3.5%	3.5%
2024	TBD	3.0%	3.0%
Cumulative Uncompounded Increases 2012-2023	0%	17.30%	16.80%
Cumulative Uncompounded Increases over moderation period	4.80%	9.50%	9.50%

351. Thus, the OPS numbers do further illustrate how out of line physician increases are with all other groups.

MINISTRY REBUTTAL

The Ministry also compared the increases in Average Physician compensation to AMAPCEO and OPSEU.

The Ministry reviewed the prior settlements and subsequent Bill 124 Reopener awards, tracking the same years to reflect the actions and results of those parties following the high inflation periods. Using the average expenditure per physician as an equivalent to physician income, the average physician over this time period exceeded significant Ontario public sector settlements and awards.

Table 19 - Wage Increases for Major Public Sector Unions vs Physician Avg. Increases:

DATE	OPSEU	AMAPCEO	TEACHERS	PHYSICIANS (Avg)
Jan. 1/20	1%			10.0% as per para 169
Apr. 1/20		1%		
Jul. 1/20	1%			
Sep. 1/20			1.75%	
Oct. 1/20		1%		
Jan. 1/21	1%			
Apr. 1/21		1%		
Jul. 1/21	1%			
Sep. 1/21			3.75%	
Oct. 1/21		1%		
Jan. 1/22	3%			
Apr. 1/22		3%		
Jul. 1/22				
Sep. 1/22			TBD	
Jan. 1/23	3.5%			
Apr. 1/23		3.5%		
Jul. 1/23				
Sep. 1/23			TBD	
Jan. 1/24	3%			

DATE	OPSEU	AMAPCEO	TEACHERS	PHYSICIANS (Avg)
Apr. 1/24		3%		3%** (minimum 4% if historical utilization added)
Jul. 1/24				
Sep. 1/24			TBD	
TOTAL*	13.50%	13.50%	5.5%	13% (minimum 14% if historical utilization added)
# of Years	5	5	2	5
Avg./Year	2.7%	2.7%	2.75%	2.6% (minimum 2.8 if historical utilization added)

**We note that the totals are not compounded

**Ministry Position (plus minimum 1% utilization if historical utilization added)

PARAGRAPHS 352 TO 355 OF THE OMA BRIEF:

352. As well, the recent reopener awards for these groups include some additional compensation adjustments not reflected in the ATBs. Both the Ontario Public Service Employees Union ("OPSEU") Unified223 award and the Association of Management, Administrative and Professional Crown Employees of Ontario ("AMAPCEO")224 awards are consent awards that arise in the context of Bill 124 reopeners. As noted, these awards provide for increases of 3% in 2022, 3.5% in 2023, and 3% in 2024, inclusive of the 1% already provided in those years.

353. The OPSEU Consent Award also includes wage adjustments for certain classifications in addition to the ATBs. The scale and size of these increases only become apparent when the wage grids in the current collective agreement225 are compared to those in the Consent Award. In some cases, these additional increases were over 20% (see for example the 21.2% increase for the Ambulance Communications Officer 1 and the 9.79 % increase for Resource Technician 2 (G29 Salary Note).

354. As well, OPSEU has agreed to a new dispute resolution process to address wage disparities in other job classifications,226 which is not found in the Consent Award but set out in a side agreement.227 Pursuant to this process and agreement, other classifications will be reviewed and may receive further compensation increases where there are compensation-related recruitment and retention issues. In other words, the OPSEU Consent Award is not the complete agreement between the parties with respect to compensation, since there is a binding dispute resolution process applicable to an unknown number of OPSEU classifications and employees who may be receiving further compensation increases.

355. In addition, the OPSEU Corrections Award, 228 which has a term of January 1, 2022 to December 31, 2024, provides for increases of 3% in 2022, 3.5% in 2023, and 3% in 2024, but also contains a further 1% special adjustment in 2022 for Correctional Officers, Youth Workers, Probation Officers/Probation and Parole Officers (i.e. the vast majority of the bargaining unit), as well as even larger increases and a new wage grid for nurses.

MINISTRY REBUTTAL

With respect to OPSEU Unified, the weighted average for the special adjustments (excluding Nurses, which are still being determined and Summer Law Students) is 6.22%, impacting 7.15% of the Unified bargaining unit. This represents a 0.4% total compensation increase. See Exhibit 6.

With respect to AMAPCEO, the weighted average for the special adjustments is 3.74%, impacting 0.05% of the bargaining unit. See Exhibit 7.

Therefore, the special adjustments awarded for certain classifications were of a slight cost given the application to a limited percentage of the bargaining unit. Further, all of the special adjustments were based on market comparison, and not awarded on the basis of supply and demand.

PARAGRAPHS 363 OF THE OMA BRIEF:

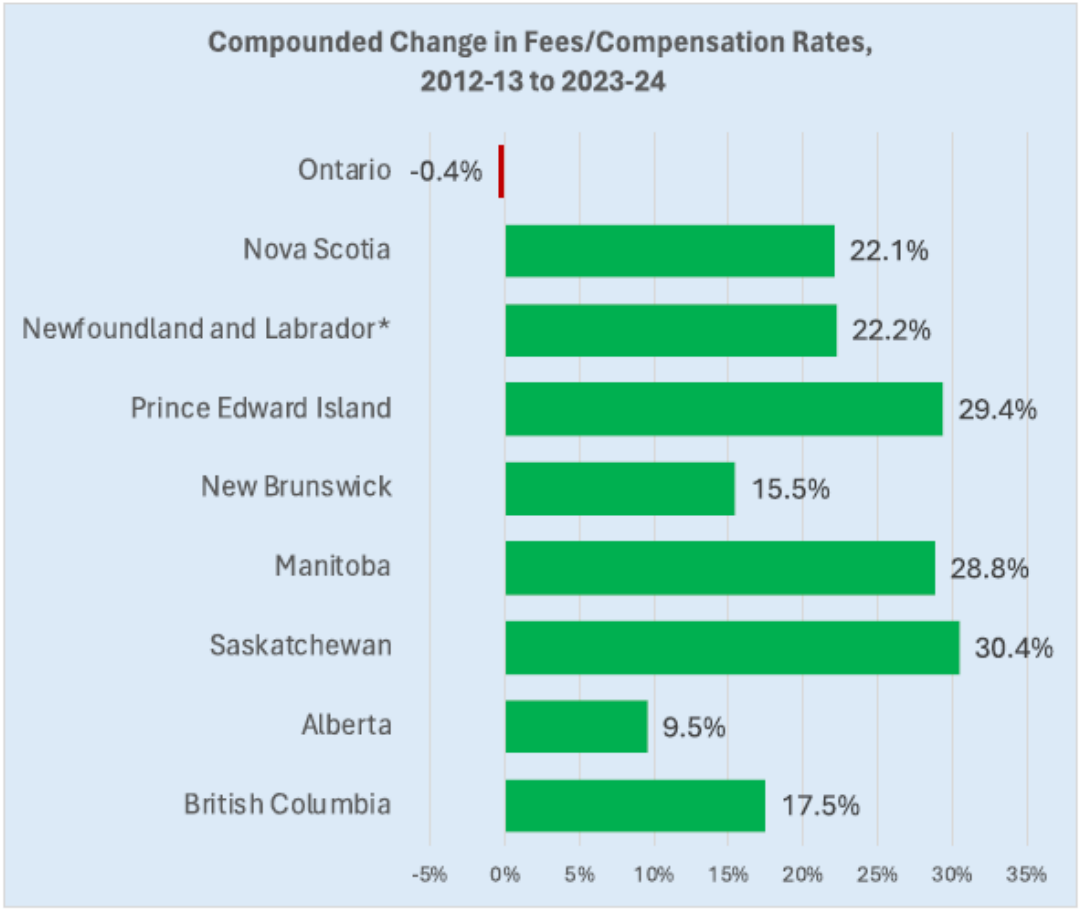
363. Thus, the OMA submits that, while the energy and federal public sectors are not necessarily the most relevant comparator, the awards and settlements from these sectors have been relied upon as the results of free collective bargaining in inflationary circumstances, and therefore provide further evidence that the increases received by physicians in the 2021-2024 period are well below normative and catch up is required.

MINISTRY REBUTTAL

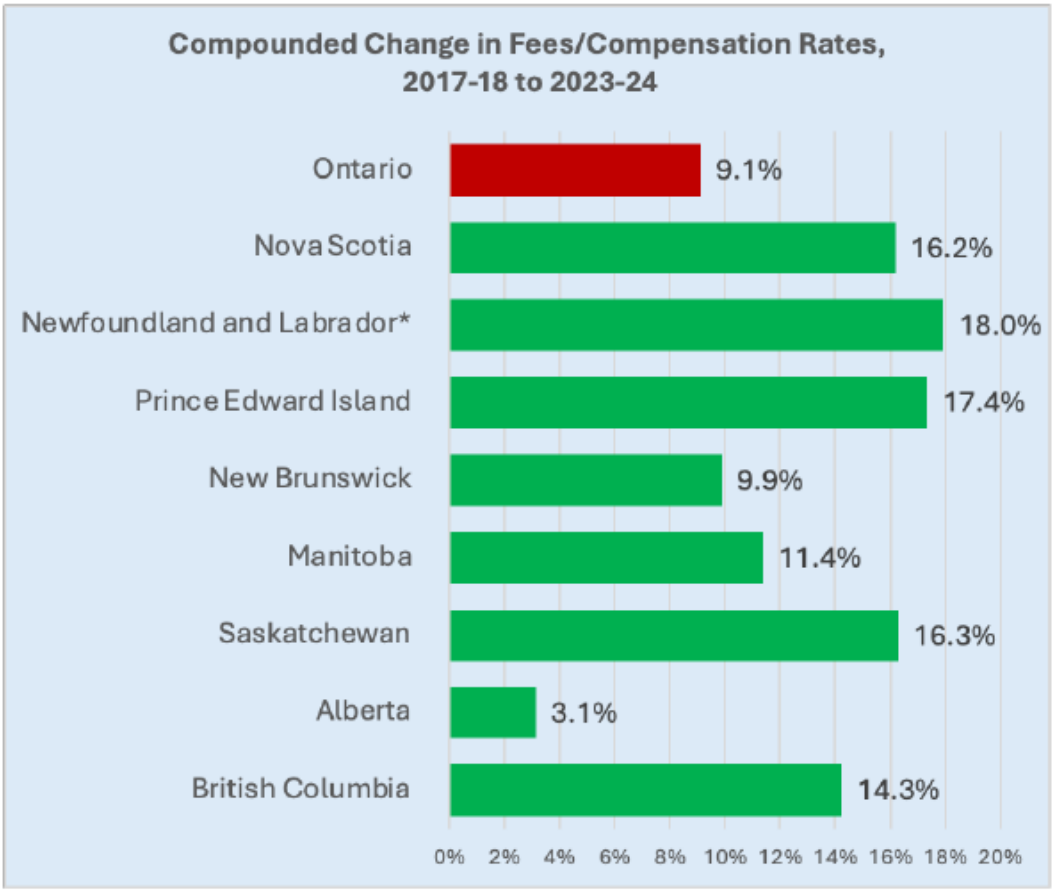
The settlements the OMA references in this paragraph did not influence the arbitration awards of Gerry Lee in OPSEU or AMAPCEO. These settlements were in place long before these OPS awards.

PARAGRAPH 374 TO 417 OF THE OMA BRIEF:

374. Since 2012, the point in time at which Ontario physicians began experiencing cuts to their income, physicians in other provinces have received regular normative compensation increases to fees and alternative payment plans, that have resulted in fee /compensation increases anywhere between 10-30% higher than Ontario. This fact is reflected in the following table:

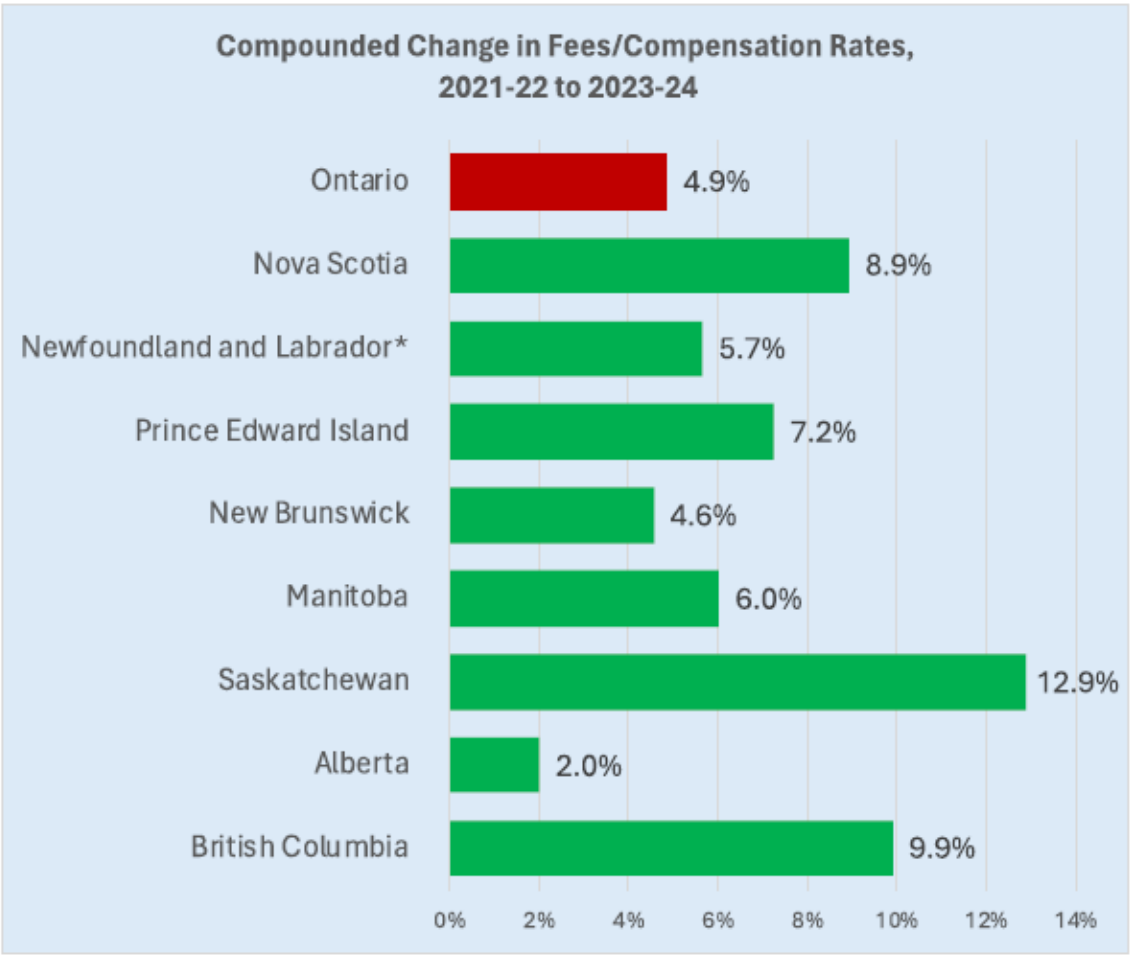


375. Even if one looks over a shorter time period in terms of fee/compensation increases, Ontario does not compare favourably. Looking back to 2017, the start date of the PSA that was last determined at arbitration, there is, for example, an up to 9% difference in the compounded change in fees/compensation rates between Ontario and Newfoundland, even before the not yet known 2023 increase for Newfoundland is included. As well, Ontario trails PEI by approximately 8%, Saskatchewan and Nova Scotia by approximately 7%, and British Columbia by approximately 5%.



376. For the most recent PSA period of 2021-2024, physicians in a number of other provinces have also continued to fare better than physicians in Ontario. For example, physicians in Saskatchewan have received compounded fee/compensation increases in their agreement that have been 8% higher than Ontario over the same time period.

Similarly, physicians in British Columbia and Nova Scotia have seen increases that are 5% and 4% higher respectively. Indeed, in every province except Alberta and New Brunswick, increases to physicians have exceed those paid in Ontario in the 2021-2024 period, as reflected in the following table:



377. As well, many of the physician agreements with different provinces include additional compensation increases not captured by just a comparison of the global increases. As a result, it is helpful to also look in more detail at the agreements in each province.

PARAGRAPH 378 TO 417 OF THE OMA BRIEF HAS THE FOLLOWING SECTIONS:

i) *NEW BRUNSWICK*
ii) *NOVA SCOTIA*
iii) *PRINCE EDWARD ISLAND*
iv) *NEWFOUNDLAND AND LABRADOR*
v) *MANITOBA*
vi) *SASKATCHEWAN*
vii) *ALBERTA*
viii) *BRITISH COLUMBIA*

MINISTRY REBUTTAL

The Ministry submits that little relevance should be given to the quantum of increases in physician fees or compensation in other provinces. Interprovincial comparisons, and where Ontario physicians stand in their compensation relative to other provinces, is more appropriately reflective of the comparisons the parties would themselves consider. We have provided these submissions starting at page 152.

To the extent that such submissions are considered by the Board of Arbitration, the MOH submits that the OMA comparisons are flawed and should be given little weight.

The MOH has attempted to review and replicate the data presented at paragraph 376 with respect to the provincial comparisons in changes in fees/compensation rates from 2021/2022 to 2023/24.

First, the OMA has assumed attribution of increases where they themselves recognize they had no source to do so. For example, the OMA notes in Tab 117 of the Book of Documents that they were unable to find fee rate increases for Newfoundland and Labrador and yet they assign a rate without knowing what a significant portion of the billings would represent as an increase.

Further, the source of the chart at paragraph 376, Tab 117 in the book of documents, makes references in the notes to “slides” that are not contained in the document. Further, information was not provided for MOH to investigate the asterisk associated with Newfoundland and Labrador.

Second, the OMA’s data and explanation on the provincial agreements also contain errors. We review these in the following paragraphs.

PARAGRAPHS 383 AND 385 OF THE OMA BRIEF:

(b) Nova Scotia

383. For the 2019-2023 period, physicians in Nova Scotia received increases of 2% a year.
…

385. The agreement provides for the following fee increases:
April 1, 2023 – March 31, 2027
Year 1: 3%, Year 2: 3%, Year 3: 2%, Year 4: 2%
Overall increase physician compensation over 4-year term expected to be 20% on a compounded basis (approximately 4.7% a year)

MINISTRY REBUTTAL

Based on this data the compounded change from 2021-22 to 2023-24 would be as follows:

- 2021/22 – 2%
- 2022/23 – 2%
- 2023/24 – 3%

Which equals 7.2% compounded, not 8.9% as reflected in the OMA chart at Paragraph 376. It appears that the OMA is using 4.7% for 2023/24 as this is what was calculated as the estimated total compensation increase including targeted investments. The comparison the OMA has presented is for the change in fees/compensation rates not including all targeted investments.

7.2% is the appropriate representation for fee increases.

PARAGRAPHS 399 AND 401 OF THE OMA BRIEF:

(F) Saskatchewan

399. The 2017-2022 agreement included increases of 1%, 2% and 2% in 2019-20, 2020-21 and 2021-22 respectively.

…

401. Other specific details of the 2022-2026 agreements include the following elements:

- *Overall fee increases*
  - *Year 1 – 5.5% (3% + 2.5% additional adjustment)*
  - *Year 2 – 3%*
  - *Year 3 – 2%*
  - *Year 4 – 2%*
- *$50M investment in a new primary care payment model for family physicians that unifies existing volume-based pay with a new capitation payment (based on patient contacts and panel size);*
- *An innovation fund of up to $10 million annually over the duration of the agreement, that will increase the amount of team-based care in primary health care settings;*
- *Funding to address gender pay inequity in physician fee codes, as well as new funding to support physician training and awareness related to equity, diversity, racism, and truth and reconciliation;*
- *A new Rural and Northern Practice Recognition Premium that recognizes the unique nature and critical importance of rural medicine;*
- *Introduction of permanent virtual care codes to increase efficient access to health services for patients and reduce unnecessary travel for appropriate services; and*
- *Increased funding to support long term retention, parental leave and*
- *continuing medical education.*

MINISTRY REBUTTAL

Based on this data the compounded change from 2021-22 to 2023-24 would be as follows:

- 2021/22 – 2%
- 2022/23 – 5.5%
- 2023/24 – 3%

Which equals 10.9% compounded, not the 12.9% as reflected in the OMA chart at paragraph 376.

Further, The OMA Book of Documents Tab 117 lists the 2023/24 increase as 4.9% which is not reflected in the source it relies on, Tab 135 of the Book of Documents.

PARAGRAPHS 413 AND 414 OF THE OMA BRIEF:

(H) British Columbia

413. The 2019 Physician Master Agreement included fee increases of 1.7% in 2019-20 and 0.8% in 2020-21 and 2.4% in 2021-22.

…

414. Specifically, the 2022 PMA provides as follows:

- *Total compensation increases:*
  - *Year 1: 4.0%;*
  - *Year 2: 6.5% - up to 7.5% with COLA; and*
  - *Year 3: 2.7% - up to 3.7% with COLA*

- *Fee increases (40% of total funds):*
  - *3.0% April 1, 2022;*
  - *2.0% April 1, 2023; and*
  - *1.0% April 1, 2024.*

MINISTRY REBUTTAL

Based on this data the compounded change from 2021-22 to 2023-24 would be as follows:

2021/22 – 2.4%

2022/23 – 3.0%

2023/24 – 2.0%

Which equals 7.6% compounded, not 9.9% as reflected in the OMA chart at Paragraph 376. The OMA methodology uses 3.6% for 2022/23 and 2023/24 which is not reflected in the OMA's source document Tab 145 of the Book of Documents.

Aside from the OMA's errors, the Ministry submits compensation comparisons are of greater relevance than general increase comparisons. Ontario stands competitively in physician compensation in comparison to other provinces, particularly with respect to Primary Care. As the Ministry submitted in its Brief at Section 8.6, looking at compensation in 2023 for the largest populated primary care compensation model (the FHO model), this Ministry has provided data to prove that Ontario is at least 22% above the closest province when compared across Canada, even with BC's most recent agreement taken into account.

To the extent that general rate increases across provinces are relevant (which the Ministry submits they are not), then the relevant time period to review interprovincial general rate increases would be the more recent years of 2022/23 and 2023/24. When this time period is reviewed, the general rate increase for Ontario physician payments are comparatively normative, with higher general increases than Manitoba, Alberta and New Brunswick.

	General Rate Increase Awarded in Fiscal Year			
Province	**2022/23**	**2023/24**	**2-year Compounded General Increase**	**2-year Increase Difference: Ontario vs. Province**
Ontario	1.00%	2.80%	**3.83%**	-
Manitoba[1,2]	1.00%	0.91%[A,B]	**1.92%**	-1.90%
Alberta[3]	1.00%	1.00%	**2.01%**	-1.82%
New Brunswick[4]	1.50%	1.50%	**3.02%**	-0.81%
Prince Edward Island[5]	2.36%	2.36%	**4.78%**	0.95%
Nova Scotia[6,7]	2.00%	3.00%	**5.06%**	1.23%
British Columbia[8]	3.00%	2.00%	**5.06%**	1.23%
Saskatchewan[9]	5.50%	2.50%	**8.14%**	4.31%

Notes:

A. Manitoba's general rate increase in 2023/24 is derived based $8,834,116.50 FFS market adjustments awarded and applied on October 1, 2023 (as per Manitoba's 2023-2027 Physician Services Agreement) and $966,593,000 actual FFS expenditures in 2022/23 (as per Part A: Expenditure Summary by Appropriation, Manitoba Health Annual Report for the year ended March 31, 2023; https://www.gov.mb.ca/health/annualreports/docs/manitoba-health-annual-report-22-23.pdf).

B. Manitoba's 2023-2027 Physician Services Agreement awarded a 2% increase to alternate funding agreement/payment rates that were applied on October 1, 2023.

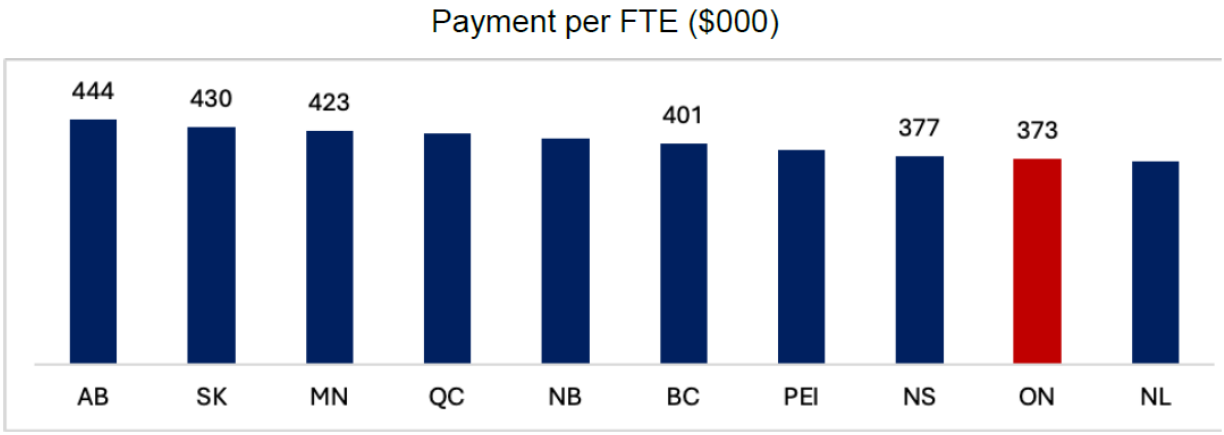
Sources:

1. Froese, I. (2019, July 19). *Manitoba reaches new tentative contract with 3,000 doctors*. CBC. https://www.cbc.ca/news/canada/manitoba/manitoba-contract-extension-doctors-manitoba-wage-freeze-bill-1.5214477.
2. Article 3:01 Fee For Service, page 6, 2023-2027 Physician Services Agreement between Manitoba and Doctors Manitoba.
3. Schedule 3, 2022-2026 Alberta Medical Association Agreement between Alberta Health and AMA (effective April 1, 2022).
4. Genera Economic Increase (GEI). 2020-21 to 2024-25 Tentative Physician Services Master Agreement Summary, New Brunswick Medical Society. https://www.nbms.nb.ca/wp-content/uploads/2021/10/Tentative-Physician-Services-Master-Agreement.pdf.
5. Annual Report 2019-2020, Medical Society of Prince Edward Island. https://www.mspei.org/wp-content/uploads/2021/04/MSPEI-2020-AnnualReport.pdf.
6. Article 4.1(b)(i). Rate Increases, 2019-2023 Physician Services Master Agreement between NS Department of Health and Wellness and Doctors Nova Scotia. https://doctorsns.com/sites/default/files/2019-12/MA-Execution-Copy-SIGNED-Dec_9_2019.pdf.
7. Article 4(b)(i). Rates and Rate Increases, 2023-2027 Physician Services Master Agreement between NS Department of Health and Wellness and Doctors Nova Scotia. https://doctorsns.com/sites/default/files/2023-2027_PhysicianAgreement.pdf .
8. Government of Saskatchewan. (2024, February 5). *Saskatchewan Doctors Ratify New Four-Year Contract*. News Release. https://www.saskatchewan.ca/government/news-and-media/2024/february/05/saskatchewan-doctors-ratify-new-four-year-contract.

Appendix F, 1.1(a)(i) Compensation Changes in 2022/23 and 1.2(a)(i) Compensation Changes in 2023/24, 2022 Physician Master Agreement between BC Government and Association of Doctors of BC and Medical Services Commission. https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/health/consolidated_physician_master_agreement.pdf

PARAGRAPH 418 TO 423 OF THE OMA BRIEF:

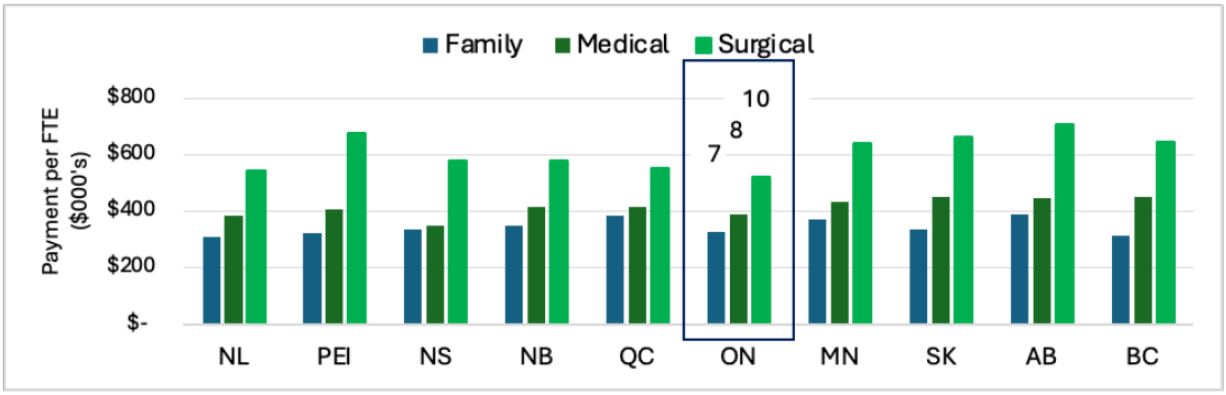
418. Separate and apart from the details of each provincial agreement, it is important to compare physician compensation across provinces by looking at changes in average gross clinical payments. From a comparative perspective, in relative terms, average gross clinical payment per full-time equivalent physician in Ontario is among the lowest in the country, as seen in the following chart. It is about 12.8% lower than the weighted average of its main competitor provinces (Alberta, B.C., Manitoba, and Saskatchewan).



Source: Canadian Institute for Health Information. National Physician Database — Payments Data, 2021–2022. Ottawa, ON: CIHI; 2023.

419. When gross clinical payment per full-time equivalent physician in Ontario is looked at by specialty, Ontario ranks 10th in the country for payments to surgical specialties, 8th in the country for payments to medical specialties and 7th in terms of overall payments to family physicians

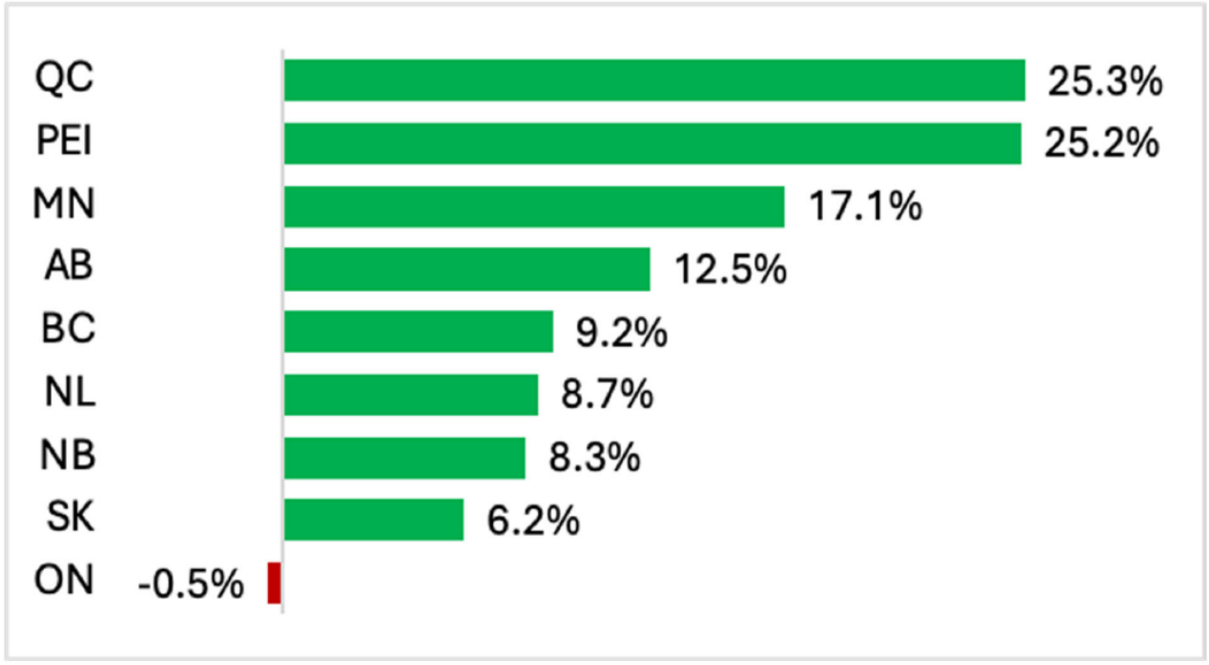
Payment per FTE ($000), by Specialty Group



Source: Canadian Institute for Health Information. National Physician Database — Payments Data, 2021–2022. Ottawa, ON: CIHI; 2023.

420. The fact that gross clinical payments per full-time equivalent ("FTE") physician is relatively low compared to other provinces is in large part because Ontario has experienced the lowest growth in payment per physician in the country since 2011-12. As seen in the following chart, a comparison of average gross clinical payments per physician in 2011-12 to 2021-22 by province reveals that the payments to Ontario doctors have declined while payments in all other provinces have increased, in some cases significantly so (i.e. by up to 25%):

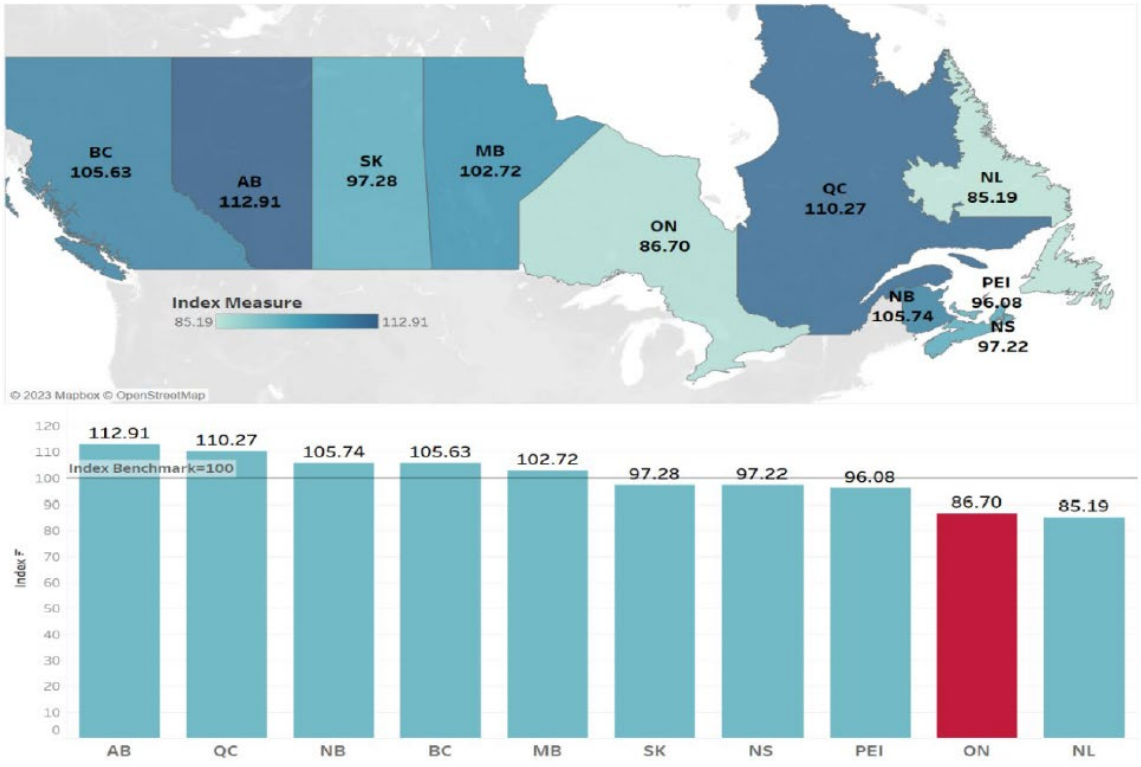
Percent Change in Gross Clinical Payment per Physician, by jurisdiction, Canada, 2021-22 vs. 2011-12



Source: Canadian Institute for Health Information. National Physician Database — Payments Data, 2021–2022. Ottawa, ON: CIHI; 2023.

421. As well, physician fees in Ontario are also among the lowest in the country. The average fees in Ontario are about 23.7% lower than the MD-weighted average of its main competitor provinces (Alberta, B.C., Manitoba, and Saskatchewan

Average Fee for Service, by jurisdiction, Canada, 2021-22



Source: Canadian Institute for Health Information. Physician Services Benefit Rates, 2021–2022. Ottawa, ON: CIHI; 2023.

422. This interprovincial comparison in all likelihood understates the true deterioration of relative economic position of physicians in Ontario, given that it does not yet incorporate fee increases in physician agreements in other provinces for fiscal years 2022-23 and 2023-24.

423. In conclusion, a comparison of fee/compensation increases to physicians across the country since 2012, together with a comparison of average gross clinical payments for all physicians both now and historically as well as a comparison of average fees for services all reveal that Ontario trails almost all other provincial comparators. The OMA's proposed Year 1 increase is thus supported by the higher increases negotiated by physicians in other provinces, including since 2012, and by the fact that the average gross clinical payment and average fees are lower in Ontario.

MINISTRY REBUTTAL

The OMA has relied entirely on average income per FTE in their comparisons to other provinces using the CIHI data. The average income per FTE metric reported by CIHI can not be used for any inter-provincial comparisons on physician income for a few reasons:

1. The FTE (i.e. denominator in the income per FTE metric) is a number that is developed in-house by CIHI using its own methodology and is not a number that is submitted by the provinces.
2. FTEs calculated by CIHI are not based on true measures of physician workload (e.g., hours or days worked, patient encounter volumes, etc.), and are instead statistically computed using only payment data.
3. CIHI uses an in-house built price index to normalize each physician's total payments (FFS and non-FFS) in an attempt to adjust for payment rate differences between provinces, when computing the average FTE for each physician. This price index, however, is based on FFS data only, and is therefore not a viable approach for provinces like Ontario that have significant payments in capitation and other non-FFS payments. CIHI acknowledges limitations around its use and states that "*this has an unquantifiable and skewing effect on the FTE count and on the "comprehensive" average payment per FTE values*."[56]

The impact of these adjustments is that they significantly skew Ontario FTE data. CIHI's average Ontario physician FTE is overstated and its average Ontario physician income per FTE is significantly understated.

These skewing effects are best exemplified in the FTE results for Family Medicine physicians in Ontario. In 2021/22, CIHI assigned Family Medicine physicians in Ontario

[56] As per *Appendix B: Measurement of a full-time equivalent physician*, National Physician Database Data Release, 2021–2022 — Methodology Notes. Ottawa, ON: CIHI; 2023

an average of 1.02 FTE per physician.[57] Family Medicine physicians in the rest of Canada were assigned an average of 0.73 FTE per physician.[58]

We can use recent FTE definitions developed by British Columbia and Nova Scotia for family physicians to calculate the average FTE of Ontario family physicians, based on actual patient workload. British Columbia's new Longitudinal Family Practice (LFP) Model explicitly defines a 1.0 FTE as physicians that provide 5,000 patient interactions per year.[59] Nova Scotia's Longitudinal Family Medicine (LFM) Model similarly defines a 1.0 FTE as 5,152 patient encounters per year.[60]

Ontario claims data shows that Family Physicians in Ontario held an average of 3,702 patient encounters per physician in 2021/22. This equates to 0.72 – 0.74 FTE per Ontario family physician based on the expectation that a full time equivalent is between 5,000 – 5,152 patient interactions (as defined in BC and Nova Scotia). This 0.72-0.74 FTE per family physician estimate is in stark contrast to CIHI's estimate of 1.02 FTE per family physician.

Taken together, this suggests that CIHI FTE results for Ontario are unfavorably skewed, that comparisons of average physician income per FTE using CIHI data are inaccurate and misleading, and that they do not inform true provincial differences in physician income normalized for actual workload.

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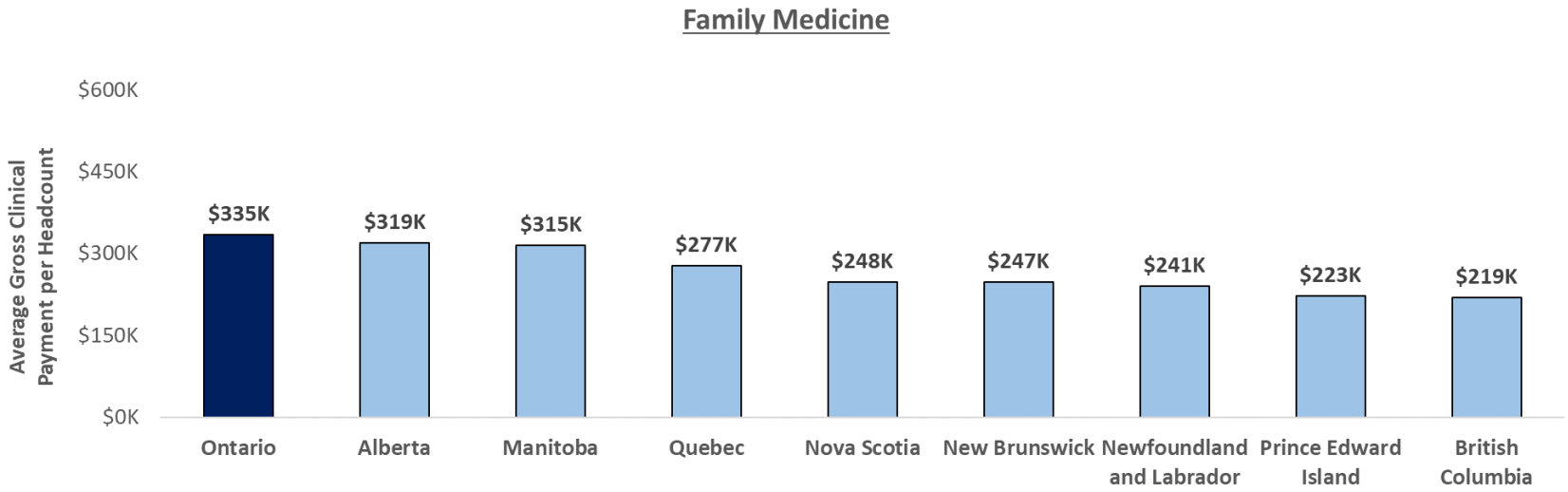
[57] Table A.3.3 Gross clinical payment per physician, by specialty, 2021–2022, National Physician Database — Payments Data, 2021–2022. Ottawa, ON: CIHI; 2023.
[58] Ibid.
[59] Appendix B – Background and Principles of the LFP Payment Model, Section 2. LFP Payment Model Components, British Columbia Ministry of Health, Medical Services Commission, Longitudinal Family Physician Payment Schedule, March 11, 2024. https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/longitudinal-family-physician/lfp-payment-schedule-mar-2024.pdf
[60] Longitudinal Family Medicine (LFM), Frequently Asked Questions – Sept. 25, 2023. https://msi.medavie.bluecross.ca/wp-content/uploads/sites/3/2023/09/LFM-FAQ-Sept-25-2023.pdf

To the extent that the CIHI data can be relied upon, the Ministry submits that the more appropriate comparison is on the basis of headcount. When this data is analysed, the average income earned by Ontario's physician specialty groups are among the highest compared to other provinces in Canada. We analyse the data in the below tables:

In 2021/22, average income per headcount earned by Ontario's Family Medicine physicians ranked 1st among all provinces compared.

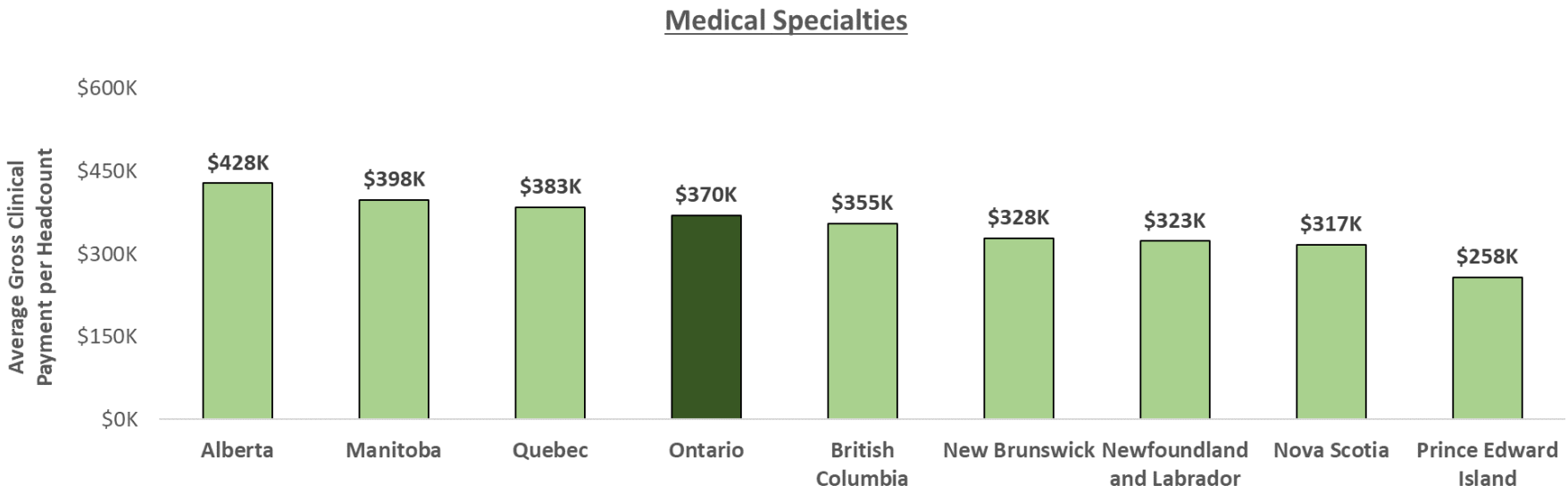
Figure 2. Family Medicine – Provincial Comparison of Average Gross Clinical Payment per Physician Headcount (2021/22)



Notes (1) Comparisons are based on data available in CIHI National Physician Database (NPDB) for fiscal year 2021/22
(2) Data for Saskatchewan is not available in the 2021/22 CIHI NDPB data release

In 2021/22, average income per headcount earned by Ontario's Medical Specialists ranked 4th among all provinces compared

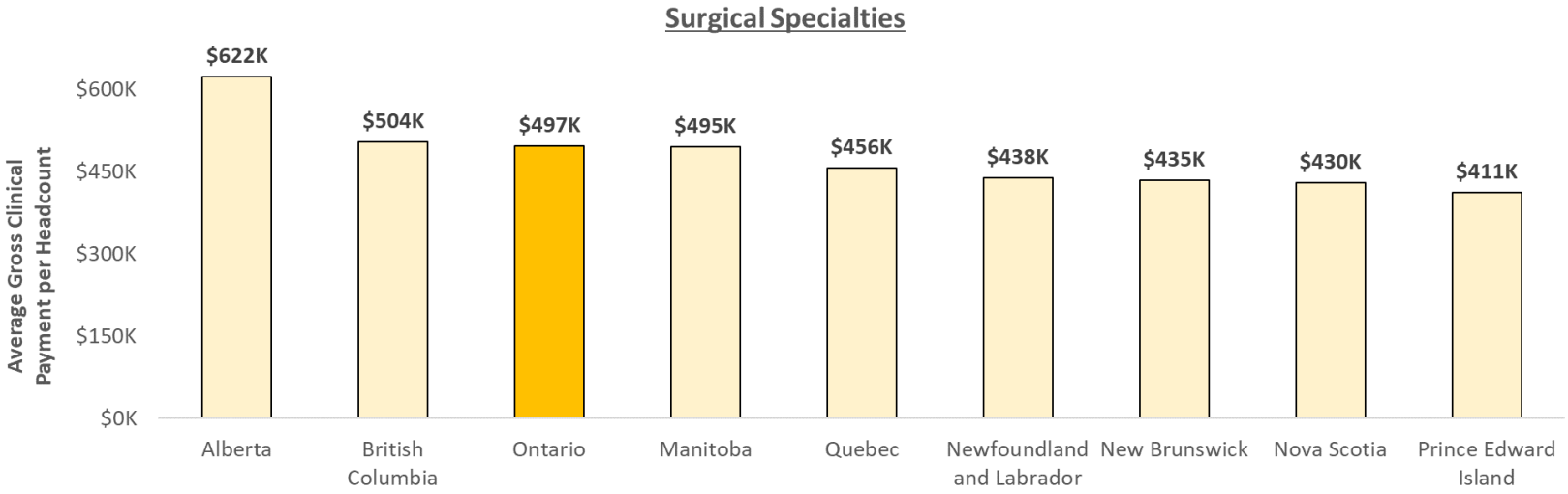
Figure 3. Medical Specialists – Provincial Comparison of Average Gross Clinical Payment per Physician Headcount (2021/22)



Notes (1) Comparisons are based on data available in CIHI National Physician Database (NPDB) for fiscal year 2021/22
(2) Data for Saskatchewan is not available in the 2021/22 CIHI NDPB data release

In 2021/22, average income per headcount earned by Ontario's Surgical specialists ranked 3rd among all provinces compared.

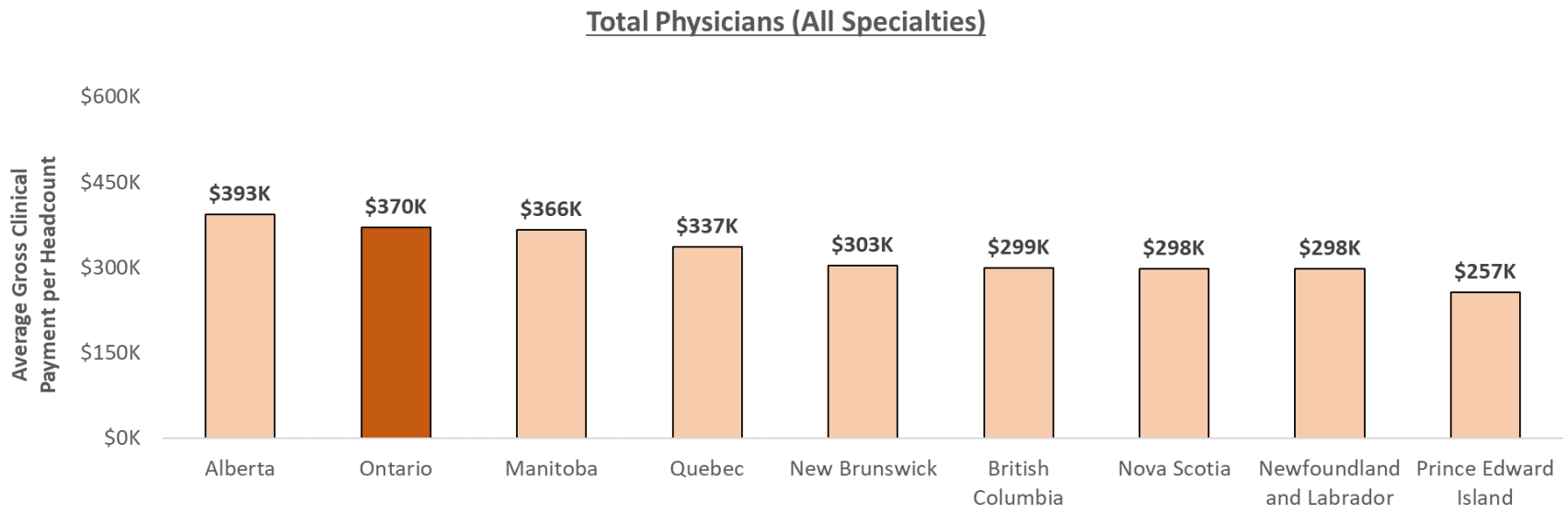
Figure 4. Surgical Specialists – Provincial Comparison of Average Gross Clinical Payment per Physician Headcount (2021/22)



Notes (1) Comparisons are based on data available in CIHI National Physician Database (NPDB) for fiscal year 2021/22
(2) Data for Saskatchewan is not available in the 2021/22 CIHI NDPB data release

Overall, in 2021/22, average income per headcount earned by all Ontario Physicians (All Specialities) ranked 2nd among all provinces compared.

Figure 5. Total Physicians (All Specialties) – Provincial Comparison of Average Gross Clinical Payment per Physician Headcount (2021/22)

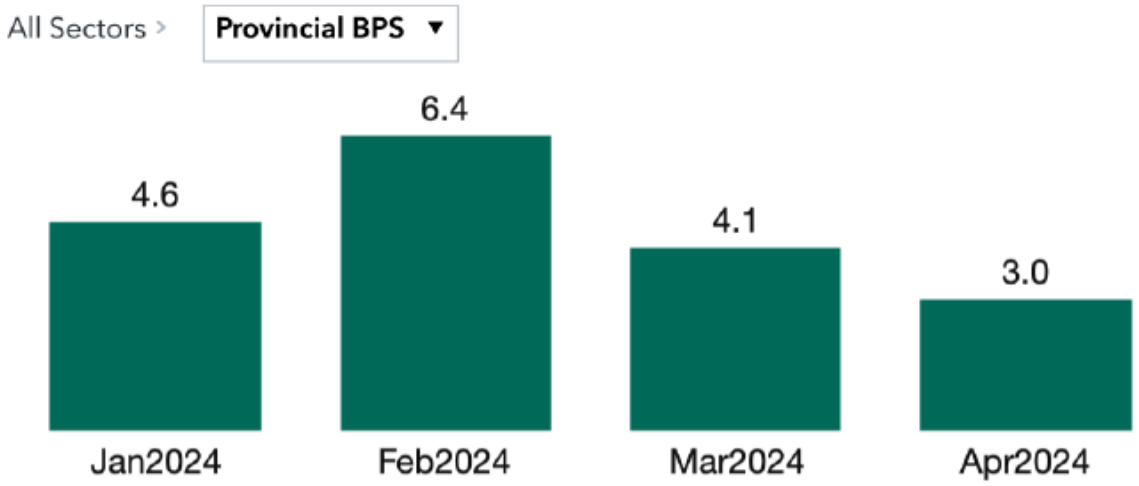


Notes (1) Comparisons are based on data available in CIHI National Physician Database (NPDB) for fiscal year 2021/22
(2) Data for Saskatchewan is not available in the 2021/22 CIHI NDPB data release

PARAGRAPH 427 AND 428 OF THE OMA BRIEF:

427. The proposed 5% increase is also consistent with recent and current general bargaining trends. According to data from the Ministry of Labour's Collective Bargaining Ontario site, the bargaining trend for average annual increases in the provincial broader public sector ("BPS") was 4.6% in January 2024, 6.4% in February 2024, 4.1% in March 2024. These agreements from the first quarter cover 16,000 BPS employees.274

428. The following table and chart, breaks the average annual increases down by the month in which the agreements were ratified:275



	Number of Settlements	Number of Employees	Avg. Annual Increase (%)	
Provincial BPS	79	56,719	3.7%	
Jan2024	3	787	4.6%	
Feb2024	6	9,549	6.4%	
Mar2024	5	5,905	4.1%	
Apr2024	65	40,478	3.0%	

MINISTRY REBUTTAL

The Ministry submits that the above data shows the predominant settlement trend is in the Broader Public Service is 3%, consistent with the Ministry's proposed increase. The January, February and March 2024 average annual increase is based on very few settlements (3, 6 and 5 respectively). In comparison, the April 2024 average annual increase is based on 65 settlements and shows an average annual increase of 3%.

Further, the Ministry submits below that the average annual increase for the public service shows increases averaging from 2.7% to 3.3%[61]:

Ratification Month and Year	Increase (%)	Sector	Number of Collective Agreements	Number of Employees
Jan2024	3.2	Public	8	232
Feb2024	3.3	Public	9	514
Mar2024	2.7	Public	10	819
Apr2024	3.2	Public	1	3

[61] https://www.lrs.labour.gov.on.ca/VAViewer/VisualAnalyticsViewer_guest.jsp?reportSBIP=SBIP%3A%2F%2FMETASERVER%2FShared%20Data%2FSAS%20Visual%20Analytics%2FPublic%2FLASR%2FCollective%20Bargaining%20Wage%20Trends(Report)&page=vi906260

PARAGRAPH 519 OF THE OMA BRIEF:

519. In this respect, many provinces have recognized the indirect physician clinical time being spent, and are compensating for it through such mechanisms as providing hourly rates for indirect clinical work, overhead funding and EMR funding.

PARAGRAPHS 520 TO 553 OF THE OMA BRIEF THEN HAS THE FOLLOWING SECTIONS:

A) BRITISH COLUMBIA (LFP)
B) MANITOBA (FM+)
C) NOVA SCOTIA (LFM)
D) NEWFOUNDLAND AND LABRADOR (BLENDED CAPITATION)
E) SASKATCHEWAN (TPM)
F) ALBERTA

MINISTRY REBUTTAL

The OMA submissions focus on a description of the listed models of other provinces.

The Ministry has provided the Board in its May 1 submission at Section 8.6 (page 84) a factual and analytical review of the contracts in other provinces. It revealed that the compensation resulting from the Primary care contracts in those provinces remain substantially behind Ontario's most lucrative Team Based contract, that being the Family Health Organization (FHO) contract.

CONCLUSION

The Ministry thanks the Board for the time and consideration that it will devote to this extremely important matter.

If further information or analysis relevant to this arbitration is required we are pleased to provide it to the Board, if it is available.

As per the past practice in such matters, if there are material post hearing settlements or awards, we will file such documents with the Board and provide the OMA with a copy.

All of which is respectfully submitted.