In the Matter of an Arbitration

BETWEEN:

ONTARIO MEDICAL ASSOCIATION

(the "OMA")

- AND -

MINISTRY OF HEALTH

(the "MOH")

(together, "the PARTIES")

BOOK OF DOCUMENTS OF THE
ONTARIO MEDICAL ASSOCIATION
VOLUME 2 of 8

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

Howard Goldblatt
hgoldblatt@goldblattpartners.com

Steven Barrett
sbarrett@goldblattpartners.com

Colleen Bauman
cbauman@goldblattpartners.com

Counsel for OMA

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

Michael Wright
mwright@wrighthenry.ca

Kevin Smith
kevin.smith@uhn.ca

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

Craig Rix
craig-rix@hicksmorley.com

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

Bob Bass
bbass@bassassociates.com

Michele White
mwhite@bassassociates.com

Counsel for MOH

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21. Ontario Health Coalition. Unprecedented and Worsening: Ontario’s Local Hospital Closures 2023. (December 4, 2023)

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

23. Jopling S, Wodchis WP, Rayner J, et al “Who gets access to an interprofessional team-based primary care programme for patients with complex health and social needs? A cross-sectional analysis” BMJ Open 2022;12:e065362. doi: 10.1136/bmjopen-2022-065362

24. Jamie Ryan et al., “How High-Need Patients Experience Health Care in the United States’ Commonwealth Fund”

25. Cynthia Mulligan, “Paperwork burden driving Ontario family doctor to quit, amid critical GP shortage” City News Toronto (February 14, 2024)

26. Fan-Wah Mang, as told to Anthony Milton, “I’ve been a family doctor for more than 20 years. Now, I have no choice but to close my practice,” *Toronto Life,* (April 18, 2024)

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29. Canadian Foundation for Pharmacy, “Post-pandemic boom in billable services”

30. OMA, “Healing the Healers: System-Level Solutions to Physician Burnout,” (August 18, 2021)

31. CPSO, “Physician Burnout and COVID-19,” *Dialogue,* (June 12, 2020)

32. Canadian Medical Association, “CMA National Physician Health Survey: a national snapshot,” (October 2018)

33. Kane L., “Death by 1000 Cuts”: Medscape National Physician Burnout & Suicide Report. 2021

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

35. Martha Hostetter and Sarah Klein, “Responding to Burnout and Moral Injury Among Clinicians,” *Commonwealth Fund* (August 17, 2023)

36. Rosen, A., Cahill, J.M. & Dugdale, L.S. “Moral Injury in Health Care: Identification and Repair in the COVID-19 Era,” J GEN INTERN MED 37, 3739–3743 (2022)

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41. News Release "McGuinty government and Ontario's doctors achieve ground-breaking deal" (March 30, 2005)

42. OMA, Media Release "79% of Ontario's Doctors Vote in support of New Agreement with Province" (October 18, 2008)

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47. Institute for Clinical Evaluative Sciences, "Payments to Physicians from the Ministry of Health and Long-Term Care Sources 1992/3 to 2009/10" (February 2012)

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54. OMA, Executive Summary, "Tentative 2012 Physician Services Agreement Executive Summary"

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57. January 9, 2015 MOH Final Offer to the OMA

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59. January 14 Amendment to January 9, 2015 Ministry Offer

60. O. Reg. 15/15: GENERAL, filed January 29, 2015 under Health Insurance Act, R.S.O. 1990, c. H.6

61. Implementation Plan Update for the OMA, January 29, 2015

62. Health Services Branch, INFOBulletin 2105, "Implementation of the 2.65% Payment Discount", February 12, 2015

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64. Primary Health Care Branch, Ministry of Health and Long-Term Care, INFOBulletin 11125, "Changes to Primary Health Care Physician Payments" (February 12, 2015)

65. Negotiations Branch, INFOBulletin 4647, "Continuing Medical Education Reimbursement Program for Course/Product Expenses Discontinued," February 12, 2015

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67. Ontario Hospital Association, "OHA Analysis of Ministry of Health and Long-Term Care's Additional Reductions to Funding for Physician Services"

68. Health Services Branch, Ministry of Health and Long-Term Care, INFOBulletin 4648, "Payment Discount – Non-Fee-For-Service Physician Payment Programs," (February 17, 2015)

69. Brittany Harrison and Merry Guo, "2015 Ontario Health Cut Backs: Overview and Specific Impact on Primary Care" University of Ottawa Journal of Medicine, Vol. 5 No. 1 (2015)

70. O. Reg. 283/15

71. Health Services Branch, INFOBulletin 4657, "REVISED – Payment Reduction on Fee-for-Service Professional Fee Payments of $1 Million or more, Payment Discount of 1.3%, and Amendments to the Schedule of Benefits for Physician Services," September 14, 2015

72. Fee Changes and Fee Code Deletions – Effective October 1, 2015

73. Canadian Association of Radiologists, "Statement – Ontario Fee Cuts will Result in Limited Access to Timely, Quality Patient Care" (October 1, 2015)

74. Ontario Medical Association v Ontario (Minister of Health and Long-Term Care) and Lieutenant Governor in Council of Ontario, Notice of Application, Court File CV-15539424, October 29, 2015

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99. Rabiul Islam, Boris Kralj and Arthur Sweetman, “Physician workforce planning in Canada: the importance of accounting for population aging and changing physician hours of work” CMAJ March 06, 2023 195 (9) E335-E340

100. OMA, *Prescription for Ontario: Doctors’ 5-Point Plan for Better Health Care* (October 26, 2021)

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102. Kelly Grant, “Almost 20 per cent of Toronto doctors are considering closing their practice in the next five years,” Globe and Mail (November 14, 2022)

103. Kelly Grant, “More than three million Ontarians could be without a family doctor by 2025,” Globe and Mail (September 13, 2022)

104. Statistics Canada, Consumer Price Index, monthly, not seasonally adjusted, (Table: 18-10-0004-01)

105. ONA, “Frequently Asked Questions – and Answers for Ontario Nurses’ Association (ONA) Hospital Members” (August 2023)

106. O. Reg. 247/94: *Salaries and Benefits of Justices of the Peace* under *Justices of the Peace Act*, R.S.O. 1990, c. J.4

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112. Public Service Alliance of Canada, “Breaking down the gains in PSAC’s Treasury Board settlement”, May 6, 2023

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114. PIPSC, IT Tentative Agreement Update (October 27, 2023)

115. OPSEU, CAAT-A Bargaining Bulletin August 2023

116. Amy Judd, “B.C. tops the list of the most expensive provinces in Canada: study,” Global News (November 6, 2023)

117. Data Table showing Compounded Growth for Fee/ Compensation Rate Changes for All Provinces 2012-2023

118. Government of New Brunswick, “New Release: Province and New Brunswick Medical Society ratify a new four-year agreement”

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120. Physician Services Master Agreement Between the Province of Nova Scotia and Doctors Nova Scotia Dated 9th September, 2016

121. Government of Nova Scotia, “Investing in Family Doctors” (April 2018)

122. Doctors Nova Scotia, “Nova Scotia’s doctors ratify new four-year contracts” Press Release (November 27, 2019)

123. Nova Scotia Government, “Province, Doctors Nova Scotia Reach New Four-Year Agreements” Press Release (July 20, 2023)

124. Doctors Nova Scotia, “Doctors accept new four-year contracts” Press Release (July 20, 2023)

125. Master Agreement between the Medical Society of Prince Edward Island and the Government of Prince Edward Island and Health PEI (April 1, 2015 to March 31, 2019)

126. Newfoundland and Labrador Medical Association, “President’s Letter: 2013-2017 MOA Update,” (November 8, 2017)

127. Memorandum of Agreement between Newfoundland and Labrador Medical Association & Government of Newfoundland and Labrador, dated December 6, 2017

128. Manitoba, “News Release: Doctors Ratify New Four-Year Agreement with Manitoba Government” (October 7, 2011)

129. Government Employed Doctors Collective Agreement (Doctors Manitoba), April 1, 2011 to March 31, 2015

130. Larry Kusch, “Just what the Doctors Ordered: Deal Aims to Keep Province Competitive” Winnipeg Free Press, (October 14, 2011)

131. Master Agreement Between Province of Manitoba and Doctors Manitoba (February 12, 2015)

132. Doctors Manitoba, Board of Directors Annual Reports 2014-2015

133. Government of Manitoba, “Manitoba Government and Doctors Manitoba Reach Landmark Tentative Agreement” Press Release (July 20, 2023)

134. Saskatchewan Medical Association, “Summary of a tentative agreement between the Saskatchewan Medical Association and Ministry of Health, 2013-14 to 2016-17

135. Saskatchewan Medical Association, “Ministry of Health news release: Saskatchewan Doctors Ratify New Four-Year Contract” (February 5, 2024)

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136. Alberta Medical Association Agreement Between Alberta and the Alberta Medical Association, Effective April 1, 2011 (as amended by the 2016 Amending Agreement and the 2018 Amending Agreement)

137. Alberta Medical Association, “Overview: Tentative Agreement Package 2018-2020”

138. Alberta Medical Association, Context & Highlights: Tentative Agreement Package of Proposed Amendments to AMA/AH/AHS Agreements

139. Alberta Medical Association, “Questions and Answers About the Tentative Package,” Updated May 10, 2018

140. Alberta Ministry of Health and Alberta Medical Association Agreement, April 1, 2022

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147. Canadian Institute for Health Information. “Approaches for Calculating Average Clinical Payments per Physician Using Detailed Alternative Payment Data. Ottawa,” ON: CIHI; 2015

148. Unifor, “Unifor members ratify collective agreement with Ford Motor Company,” (September 24, 2023)

149. CBC, WestJet pilots deal grants 24% pay raise over four years (May 26, 2023)

150. Theurl E, Winner H. The male-female gap in physician earnings: evidence from a public health insurance system. Health Econ. 2011

151. Magnusson, C. (2016). The gender wage gap in highly prestigious occupations: a case study of Swedish medical doctors. Work, Employment and Society, 30(1), 40-58

152. Dumontet M, Le Vaillant M, Franc C. What determines the income gap between French male and female

GPs—the role of medical practices. BMC Fam Pract. 2012

153. Buys YM, Canizares M, Felfeli T, Jin Y. Influence of age, sex, and generation on physician payments and clinical activity in Ontario, Canada: an age-period-cohort analysis. Am J Ophthalmol. 2019

154. Cohen M, Kiran T. Closing the gender pay gap in Canadian medicine. CMAJ. 2020;192(35):E1011-E1017. doi:10.1503/cmaj.200375

155. Dossa F, Simpson AN, Sutradhar R, et al. Sex-based disparities in the hourly earnings of surgeons in the fee-for-service system in Ontario, Canada. JAMA Surg. 2019

156. Kralj B, O'Toole D, Vanstone M, Sweetman A. The gender earnings gap in medicine: Evidence from Canada. Health Policy. 2022 Oct;126(10):1002-1009. doi: 10.1016/j.healthpol.2022.08.007. Epub 2022 Aug 17. PMID: 35995639

157. Chami N, Weir S, Shaikh SA, et al. Referring and Specialist Physician Gender and Specialist Billing. *JAMA Netw Open.* 2023;6(8):e2328347. doi:10.1001/jamanetworkopen.2023.28347

158. Sarsons H. Interpreting Signals in the Labor Market: Evidence from Medical Referrals [Job Market Paper]. Working Paper

159. Hedden L, Barer ML, Cardiff K, et al. The implications of the feminization of the primary care physician workforce on service supply: a systematic review. Hum Resour Health 2014;12:32

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

161. Dee Mangin et al., “Brief on Primary Care Part 2: Factors Affecting Primary Care Capacity in Ontario for Pandemic Response and Recovery,” Ontario COVID-19 Science Advisory Table

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163. Ruth Lavergne et al., “Examining Factors That Shape Changing Workloads in Primary Care Groups,” Healthcare Policy Vol.19 No.1, 2023 [123]

164. Porter J, Boyd C, Skandari MR, Laiteerapong N. “Revisiting the Time Needed to Provide Adult Primary Care”. J Gen Intern Med. 2023

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166. Kamila Premji, Michael E Green, Richard H Glazier, Shahriar Khan, Susan E Schultz, Maria Mathews, Steve Nastos, Eliot Frymire, Bridget L Ryan, “Trends in patient attachment to an aging primary care workforce: a population-based serial cross-sectional study in Ontario, Canada”

167. Kelly Grant, “Medical schools raise alarm over declining interest in family medicine” *Globe and Mail,* (April 23, 2024)

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168. Premji K, Green ME, Glazier RH, Khan S, Schultz SE, Mathews M, Nastos S, Frymire E, Ryan BL. (2023), INSPIRE-PHC Data Charts, October 2023

169. Starfield, B., Shi, L. and Macinko, J. (2005), Contribution of Primary Care to Health Systems and Health. The Milbank Quarterly, 83: 457-502

170. Government of Ontario, “Ontario Population Projections,” Accessed April 18, 2024

171. Doctors of BC, ”Longitudinal Family Physician Payment Model,“

172. CBC News, “B.C. launches new payment model for family doctors” (February 1, 2023)

173. Government of British Columbia, Ministry of Health Medical Services Commission Longitudinal Family Physician Payment Schedule, March 11, 2024

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198. Alberta Medical Association, “Panel Management Support Program,” (April 5, 2024)

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200. Bayoumi I, Glazier RH, Jaakkimainen L, Premji K, Kiran T, Frymire E, Khan S, Green ME. “Trends in attachment to a primary care provider in Ontario, 2008-2018: an interrupted time-series analysis,” CMAJ Open. 2023

201. Richard H. Glazier, Michael E. Green et. Al, “Do Incentive Payments Reward The Wrong Providers? A Study Of Primary Care Reform In Ontario, Canada,” Health Affairs 38, NO. 4 (2019)

202. Shaikh S., Weir S., Alam N., Matthew S., Sibley L., and Kantarevic J*. Primary Care Use with Outside Providers: Multilevel Analysis of Family Health Organizations in Ontario, Canada*. 2024

203. Åke Blomqvist, Boris Kralj and Jasmin Kantarevic, “Accountability and Access to Medical Care: Lessons from the Use of Capitation Payments in Ontario.” CD Howe Institute Essential Policy Intelligence E-Brief (November 19, 2013)

204. Memo from Dr. David Kaplan dated November 22, 2023, re Launch of the 2024/25 Quality Improvement Plan program cycle

205. Office of the Auditor General of Ontario, “Value for Money Audit: Emergency Departments” (December 2023)

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208. CTV: Critical shortage of ER doctors in North Bay (Sep 30, 2023)

209. Inside the Village: The doctor is out: Why one small town was forced to shut down its emergency room (May 25, 2023**)**

210. Bay Today: Doctor shortage: Now the emergency ward in Blind River is closing (May 31, 2023)

211. Belleville Intelligencer: Expect ER delays due to doctor shortage: Quinte Health (June 29, 2023**)**

212. Ministry of Health, Temporary Locum Program (TLP), Frequently Asked Questions, Spring 2024

213. Ministry of Health, Temporary Locum Program (TLP) Program Guide, Spring 2024

214. Drummond A, Chochinov A, Johnson K, Kapur A, Lim R, Ovens H. CAEP position statement on violence in the emergency department. CJEM. 2021 Nov;23(6):758-761. doi: 10.1007/s43678-021-00182-z. Epub 2021 Aug 5. PMID: 34351599

215. Canadian Federation of Nurses Unions (CFNU) “Enough is Enough: Putting a Stop to Violence in the Health Care Sector”, 2017

216. Catherine Varner, “Emergency departments are in crisis now and for the foreseeable future,” CMAJ June 19, 2023 195 (24) E851-E852

217. Liam Casey, Canadian Press, “Other programs can help uninsured, Ontario health minister says as coverage to end | Globalnews.ca” (March 27, 2023)

218. Cancer Care Ontario, *Recommendations for Radiation Peer Review*, (May 2021)

219. OMA Radiation and Oncology Section, “Call for New Data for Purpose of Relativity Calculation in the CANDI Model,” (November 30, 2018), Survey Results, and Appendix G, Survey Questions and Appendix E, Survey Results Data

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223. Technical Fee Working Group Report, “Cost of Selected Technical Fee Codes: Pilot Study” and “Cost of Selected Technical Fee Codes: Scalable Approach”

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Where Have All the Family Doctors Gone?

A Discussion Document

Contact:

Ms. M. Janet Kasperski, RN, MHSc, CHE
Executive Director
THE ONTARIO COLLEGE OF FAMILY PHYSICIANS
357 Bay Street, Mezzanine Level, Toronto, Ontario M5H 2T7
Phone: (416) 867-9646 ❖ *Fax*: (416) 867-9990
Email: ocfp@cfpc.ca ❖ *Website*: www.cfpc.ca/ocfp

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EXECUTIVE SUMMARY

With 2001 fast approaching, Family Medicine is still operating in an atmosphere of uncertainty and crisis management. Family Doctors are the public's most important interface with the healthcare system. In addition to delivering necessary care, they play a key role in determining the level of confidence that the public has in the system. With patients across the province finding it increasingly difficult to find a trusted physician delivering comprehensive continuity care, access to services has become compromised and confidence in the system is at an all time low.

Ontario citizens are convinced that the need is urgent and the time to implement solutions is *now* in the era of unheralded prosperity. Taxpayers, patients, and physicians alike are looking for an end to uncertainty and seeking solutions from the Ministry of Health & Long Term Care.

The Ontario College of Family Physicians (OCFP) has sounded alarms on behalf of patients and the Family Physicians of this province. We have fully documented the critical shortages of care, the lack of continuity of care and the gaps in the system across the province that are widening into unbridgeable crevices. We have described the downward spiral of overwork and burnout that has resulted in fewer Family Physicians providing comprehensive care and unhealthy workloads for the remaining doctors. Our concern at this point is that the crisis is in fact becoming the status quo. It is for this reason that many of Ontario's Family Physicians are withdrawing services, planning early retirements, refusing to set up practice or simply moving away. The practice of Family Medicine has become untenable and the effect on physician morale is corrosive. Each week that this vicious cycle continues endangers the health of Ontario citizens.

However, the OCFP believes that adherence to models of practice rooted in the 1950s is not an option. Five years into the crisis, we are convinced that the Government of Ontario is at *a historic turning point and can lead the nation in creating a healthcare system for the new millenium*. Family Medicine is the fulcrum. Indeed, it must be so because *only Family Physicians have the mandate and the flexibility to deliver comprehensive primary healthcare to every citizen in the province. As the only discipline that can coordinate care throughout this increasingly complex healthcare system, Family Medicine is the key to an integrated healthcare system.*

The Ontario College of Family Physicians offers the following twenty recommendations in the certainty that implementing them is vital. These ideas are updates to our previous papers and reflect broad consultation. They demonstrate how to:

- Address urgent supply needs, now and for the future
- Attract Family Physicians to the locations that need them the most
- Retain those physicians in practice
- Provide access to "24/7" care for every citizen in the province

The key proposal is the establishment of Family Health Networks, anchored by Family Physicians. Solutions to issues such as urgent care around the clock, workload, cost-effective use of healthcare professionals, continuity of care across the system, flow from this practical, workable, cost-effective and empowering vision.

We are confident that the solutions for Family Medicine are at hand. The time to implement the Family Medicine model for the future can never be better than it is right now. All the pieces are in place and we look forward to working with the Ministry of Health & Long Term Care to build the future together.

• Recommendations

The Ontario College of Family Physicians (OCFP) recognizes that the Ministry of Health & Long Term Care has laid important groundwork toward the goal of ensuring optimal, cost-effective primary care to all Ontario citizens. The OCFP respectfully advises that in moving toward that end, the Ministry will carefully consider the following as necessary policy commitments and next steps:

1. **Develop strategies to provide every citizen with access to their own Family Physician.**
   - To utilize national and international research and consensus regarding the fundamental importance of Family Physicians as the cornerstone of our health system.

2. **Move quickly to support the development of Family Health Networks offering alternative funding models.**
   - To counter the increasing number of patients that are having difficulty finding Family Physicians to provide the care they need.
   - To counter the negative impact of uncertainty surrounding "Primary Care Reform" across Ontario

3. **Implement the Patient Choice Registration System as soon as possible.**
   - To introduce the only method that can accurately determine the number of Family Physicians needed to deliver primary care across the province.

4. **Conduct a community-based physician human resources planning exercise in each community, for cumulative use in province-wide planning.**
   - To replace current ineffective, inaccurate, and obsolete methods of human resource planning.

5. **Factor manageable workloads and on-call schedules into the Professional Human Resource planning process.**
   - To recognize that without realistic workload and on-call estimates, the decline Family Physicians will continue across Ontario.

6. **Establish a permanent Healthcare Human Resource authority to oversee the ongoing process of evaluating and planning Professional Human Resources.**
   - To review the changing demographics, patterns of practice, databases, and tabulations that must be taken into account to ensure that the future supply of Family Physicians is equal to the need for Family Physicians.

7. **Review the need for an increased number of Family Doctors.**
   - To reflect increased workload with shift from hospital to community.

8. **Immediately increase the number of medical school placements to 1992 levels, as a necessary minimum.**
   - To meet the impact of demographic, technological, and system changes that will require an increased number of physicians in virtually all medical disciplines.

9 **To establish a sixth medical school whose mission would be to train physicians for northern and rural practice, and that would place a special emphasis on recruiting from northern, aboriginal, remote and rural communities.**

- To rectify the long-standing and serious deficits in both recruiting and retaining Family Physicians to serve rural, northern and aboriginal communities.

10. **Increase the number of Family Medicine Residency positions, to ensure at a minimum that the number of new licences issued each year to Family Physicians is equal to the number granted to the 1992 graduates in the combined Family Medicine and Rotating Internship Programs (945 Family Medicine Residency positions)**

- To address the decline in medical students training for Family Medicine.

11. **Develop strategies to restore the optimal policy ratio of Family Medicine to Specialist Medicine, and review the policy in light of evidence supporting the strengths of Family Medicine.**

- To address the fact that the Ministry's own policy of a 55/45 ration of Family Medicine to Specialists has not been adhered to in recent years (i.e., currently 47/53 in favour of Specialists, or 38/62 using the Full-time Equivalent (FTE) Non-Specialist method).

12. **Increase both the number of General Specialists in training and the number of third-year residency positions in advanced Family Medicine skills (Family Physician anaesthesia, obstetrics, care for the elderly, mental health, surgical procedures, palliative care and emergency medicine, etc.).**

- To address shortfalls in supply of General Internist, General Surgeons, Anaesthesiologists, Pediatricians, and Psychiatrists, which are compromising care in most communities across Ontario.

13. **Create 120 post-graduate slots for every 100 medical student placements, thereby allowing for re-entry and career change, as well as providing opportunities for Family Medicine Residents, International Medical Graduates, and practicing physicians to expand their skill base.**

- To offer an alternative to the common first-year internship model, which would add expense without value.

14. **Provide medical students with practical experiences in each practice setting (remote, rural, suburban, urban, inner-city) in Ontario, reflecting the actual diversity of practice in Ontario.**

- To implement a key recruiting strategy for our most seriously under-serviced areas of the province – on-site, realistic experience and exposure to Family Medicine.

15. **Make medical school tuition affordable.**

- To ensure that medical school tuition is not a barrier to recruitment for some socioeconomic groups across the province, including rural, aboriginal, and inner-city students – i.e., the very students who are most likely to choose these practice settings upon graduation.

16. **Set the goal of self-reliance in training sufficient Physicians in Canada, rather than actively recruit Healthcare Professionals form foreign countries.**
    - To cease the morally questionable practice of recruiting Healthcare Professionals from the disadvantaged countries that invested in their training and need their services.
    - To provice qualified Canadian youth with access to the professional training of their choice

17. **Streamline the assessment process for International Medical Graduates, with an assessment protocol designed to maintain Canada's high standards of training and practice.**
    - To clarify a current situation that does a disservice both to current Ontario residents who are qualified International Medical Graduates, and to our communities urgently in need of Family Physicians.

18. **Empower Family Physicians to enter into collaborative Family Health Networks with health professionals such as nurses, nurse practitioners, social workers, dietitians, pharmacists, physiotherapists, and others.**
    - To give Family Physicians in communities across Ontario the resources and power to meet the actual needs of their local patient population.

19. **Develop Shared Care Programs and Managed Waiting Lists to ease access to all major specialty and subspecialty services, and strengthen community-based systems.**
    - To address the compromised access to care in hospitals and communities across the province.
    - To build on the success of Cardiac Care Network and Shared Care as models for maximizing access.
    - To reflect technological changes allowing for effective delivery of care in the home or community (non in-patient setting).

20. **Including the Ontario College of Family Physicians in future planning of changes that impact upon the education of our members and the practice of Family Medicine.**
    - To utilize the expertise of the Ontario College of Family Physicians in all matters relating to the training and practice of Family Medicine – including accreditation of Family Medicine residency programs, maintenance of certification and continuous medical education of Family Physicians, and recruitment, retention and repatriation strategies for Family Medicine.
    - To acknowledge the Ontario College of Family Physicians as the voice of more than 6,000 Family Physicians in Ontario.

• Fact Sheet

1.0 1.1 Family Medicine is the cornerstone of our Canadian Healthcare System and Family Physicians are the major providers of primary care. According to Dr. Barbara Starfield,[5, 7] "a wealth of evidence documents the benefits of characteristics associated with primary care performance." Of the seven countries (including Canada) with the top average ranking for sixteen health indicators, five have strong primary care infrastructures. Although better access to care is widely considered to be the solution, there is evidence that the major benefit of better access to care accrues only when it facilitates receipt of primary care.[11] (see *Appendix A*) Planning needs to ensure that every person in the province has their own Family Doctor providing comprehensive services and continuity of care.

1.2 In any given month, less than 0.1% of the people of Ontario require services in a tertiary care setting where Family Physicians provide few services. In the remainder of medical care settings (private offices, community hospitals, long-term care facilities and patient homes), the majority of the required care is provided by Family Doctors. Due to the current shortage and increased workload, more Family Doctors are needed.

2.0 Current databases are unreliable as planning tools and should be replaced by a Patient Choice registration process and a community-based planning exercise that can be used cumulatively for provincial planning of medical resources. (see *Appendix C*)

2.1 The estimates of Medical Human Resources requirements vary considerably from organization to organization. It is clear that we do not know how many practicing physicians there are in Ontario and have failed to properly plan for future needs.

Estimate of Number of MDs Needed in Ontario

Dr. R. McKendy's Report	1,000 MDs needed
Canadian Medical Association	700 MDs needed
Ministry of Health & Long Term Care	570 MDs needed

2.2 The lack of a single reliable database and methodology has hampered planning activities. Each database produces different head counts.

Number of GPs / FPs in Ontario (1995) [7]

9,433	Full-Time Equivalent
9,869	Ontario Database (OPHROC)
9,903	CIHI
10,926	MOH Method

2.3 The appropriate physician-to-population ratio is unknown; however, Canada's ratio is lower than the rest of developed countries and Ontario's ratio is even lower.

Physicians per 100,000 Population

Ontario	178
Canada	186
US	230
OECD *	260

* Organization for Economic Co-operation & Development

2.4 The full-time equivalent (FTE) Non-Specialist method is the preferred method for identifying the number of practicing Family Physicians in the province since it has the potential for identifying physicians who are delivering comprehensive Family Medicine services. Head count methods include non Royal College certified specialists and Family Medicine specialists. These physicians perform valuable services but are not practicing comprehensive Family Medicine.

General / Family Practice Physician Head Count 1997 / 98

Area	Raw	Active	FTE	Non-specialized Active	Non-specialized FTE	% FTEs Specialized
Toronto	2,843	2,472	2,692	2,001	2,210	18%
Kingston	177	136	123	109	101	18%
London	377	328	325	269	276	15%
Ottawa	528	406	371	313	291	22%
Sault Ste. Marie	71	49	49	33	36	26%
Sudbury	129	116	135	87	105	22%
Windsor	157	137	170	116	149	12%
Rest of Ontario*	6,106	5,189	5,580	4,329	4,734	15%
All Ontario	10,386	8,811	9,445	7,257	7,903	16%

* Rest of Ontario = all of Ontario minus the above named communities

(Taken from *Primary Medical Care in Toronto, Strengthening the Foundation, Building the System*, Toronto District Health Council, June 2000, Page 7.)

2.5 A simple head count physician / population measure fails to take into account factors such as use of resources of people from outside the catchment area. Formulas using population statistics fail to account a further 13.7% population who use Toronto's Family Doctors but reside elsewhere.

Population per Family Physician Ratio 1997 / 98

Area	Raw	Active	FTE	Non-specialized Active	Non-specialized FTE
Toronto	880	1,012	929	1,250	1,132
Kingston	837	1,089	1,202	1,359	1,460
London	902	1,043	1,047	1,264	1,231
Ottawa	689	892	977	1,157	1,245
Sault Ste. Marie	864	1,252	1,248	1,860	1,692
Sudbury	1,416	1,568	1,352	2,091	1,735
Windsor	1,402	1,606	1,296	1,897	1,477
Rest of Ontario	1,136	1,342	1,243	1,603	1,466
All Ontario	1,035	1,220	1,139	1,482	1,361
Toronto + 13.7	1,301	1,151	1,057	1,422	1,287

(Taken from *Primary Medical Care in Toronto: Strengthening the Foundation, Building the System*, Toronto District Health Council, June 2000, Page 8.)

None of the methodologies identify physician needs related to complexity of care for the target population or variation in the provision of secondary and tertiary care by Family Physicians in communities throughout Ontario.

3.0 A Significant Shortage of Family Doctors in Ontario

Since 1995, Family Medicine has seen a decrease in numbers of Physicians per 100,000 population. The number of Specialists in the province has increased.

3.1 Family Medicine has experienced a decrease in absolute numbers (4.1%) and in the Family Physicians / population ratio (8.6%). Ontario and Northwest Territories recorded the greatest declines in the number of Family Physicians per 100,000 population between 1995 to 1999. Only Prince Edward Island and the Northwest Territories have lower Family Physicians per 100,000 population rates than Ontario.

Number of Physicians by Physician Type and Province / Territory, Canada (1995 – 1999)

	Family Medicine						Specialists						Total Physicians					
	1995	1996	1997	1998	1999	% change (95–99)	1995	1996	1997	1998	1999	% change (95–99)	1995	1996	1997	1998	1999	% change (95–99)
NHS	506	549	580	580	551	(7.9)	334	359	363	368	389	16.5	840	908	932	926	927	(1.4)
PEI	100	99	98	100	100	0.0	76	71	70	75	77	1.3	176	170	168	175	176	2.3
NS	931	924	924	947	955	2.7	842	822	842	883	915	14.1	1,773	1,746	1,766	1,830	1,870	9.0
NB	660	652	657	673	692	4.9	448	460	470	477	477	6.5	1,108	1,112	1,127	1,150	1,164	5.1
Que	7,829	7,561	7,553	7,695	7,755	2.0	7,533	7,687	7,755	7,795	7,809	2.7	15,159	15,248	15,316	15,491	15,564	2.6
Ont	10,230	9,969	9,773	9,802	9,811	(4.1)	10,287	10,313	10,429	10,667	10,974	6.8	20,447	20,216	20,102	20,469	20,785	1.6
Man	1,012	992	1,004	1,042	1,047	3.5	971	981	1,009	1,017	1,006	3.6	1,983	1,973	2,013	2,059	2,055	3.6
Sask	992	979	988	996	947	1.6	535	539	603	634	605	5.0	1,527	1,475	1,474	1,530	1,537	2.9
Alta	2,459	2,390	2,375	2,536	2,627	7.1	2,082	2,073	2,135	2,206	2,244	15.4	4,485	4,472	4,510	4,762	4,871	30.8
BC	4,090	4,144	4,193	4,263	4,266	4.6	3,281	3,269	3,479	3,489	3,559	9.1	7,341	7,535	7,672	7,752	7,825	6.6
YT	78	40	43	46	38	(7.7)	5	7	7	6	8	200	83	87	50	46	42	(9.6)
NWT	46	49	52	47	45	(6.5)	13	12	14	15	19	26.7	59	61	66	62	64	8.6
Canada	29,629	28,221	28,193	28,542	28,638	9.6	28,387	28,239	27,135	27,564	28,332	6.7	58,016	54,960	55,243	56,709	56,990	3.5

Notes: Excludes interns and residents.
Data as of December 31 of given year.
Includes physicians in clinical and/or non-clinical practice.

(Taken from *Southam Medical Database: Supply, Distribution and Migration of Canadian Physicians, 1999*. Canadian Institute for Health Information, 2000, Page 16.)

Physicians per 100,000 Population by Physician Type and Province / Territory, Canada (1995 – 1999)

	Family Medicine						Specialists						Total Physicians					
	1995	1996	1997	1998	1999	% change (95–99)	1995	1996	1997	1998	1999	% change (95–99)	1995	1996	1997	1998	1999	% change (95–99)
NHS	107	102	100	103	103	(3.7)	69	64	68	67	68	15.3	167	166	160	170	171	2.4
PEI	74	73	69	73	74	0.0	58	52	51	55	55	(1.8)	130	125	121	127	130	0.0
NS	100	99	99	101	101	1.0	86	88	90	94	97	12.8	186	187	189	195	199	7.0
NB	88	88	87	90	91	3.4	60	61	62	63	63	5.0	147	149	149	153	154	4.8
Que	104	101	100	102	102	1.0	100	102	103	103	103	1.0	200	203	203	214	212	1.4
Ont	93	89	86	86	85	(8.6)	98	92	92	93	94	1.1	185	181	178	179	179	(3.2)
Man	89	87	88	89	91	2.2	85	86	89	89	88	2.3	174	174	177	177	179	2.3
Sask	92	86	86	87	82	0.0	58	56	59	62	61	3.4	150	145	144	149	153	2.0
Alta	89	86	83	86	83	(11.1)	74	74	76	77	79	6.8	161	159	157	162	167	2.6
BC	106	106	105	106	105	(0.9)	85	86	90	87	88	3.5	191	191	191	193	194	1.6
YT	124	125	105	130	119	(4.0)	16	22	22	19	25	25.0	140	146	127	149	138	(1.4)
NWT	72	73	77	69	61	(9.7)	23	18	21	22	27	22.7	94	90	98	91	82	(2.1)
Canada	97	95	93	94	94	(3.1)	89	90	89	91	92	3.4	186	184	183	185	186	0.0

Notes: Physician per 100,000 ratios for 1999 are revised from previous years' figures due to updated population estimates. Therefore figures may differ from past publications.
Excludes interns and residents.
Data as of December 31 of given year.
Includes physicians in clinical and/or non-clinical practice.

(Taken from *Southam Medical Database: Supply, Distribution and Migration of Canadian Physicians, 1999*, Canadian Institute for Health Information, 2000, Page 11.)

3.2 A significant factor in this decrease is due to the loss of Rotating Interns who became General Practitioners after graduation.

Field of Training of Canadian Medical Graduates at Exit from Canadian Postgraduate Programs (1990 – 1998)

Year of Exit	Rotating Internship	Family Medicine	Total (rotating internship & family medicine) N (%)	Specialties N (%)	Total N
1990	383	537	920 (51%)	878 (49%)	1,798
1991	399	539	938 (53%)	828 (47%)	1,766
1992	348	597	945 (54%)	805 (46%)	1,750
1993	284	606	890 (51%)	872 (49%)	1,762
1994	28	622	650 (45%)	781 (55%)	1,431
1995	—	654	654 (45%)	784 (55%)	1,438
1996	—	692	692 (47%)	789 (53%)	1,481
1997	—	682	682 (43%)	901 (57%)	1,583
1998	—	694	694 (44%)	886 (56%)	1,580

(Taken from Thurber & Busing, "Decreasing the Supply of Family Physicians & General Practitioners; Serious Implication for the Future")[3]

3.3 Most countries are moving towards a higher ratio of Family Doctors to Specialists (70/30 or 60/40 compared with Canada's traditional 50/50 split). Ontario has reversed the trend and the Family Doctor-to-Specialist ratio has been reduced to 47/53. With an emphasis on Primary Care and Community-based Care, this reversal from previous policy needs to be addressed.

CIHI Number of Physicians by Type

	Family Medicine			Specialists			Total Physicians		
	1995	1999	% Change	1995	1999	% Change	1995	1999	% Change
Ontario	10,230	9,811	(4.1%)	10,217	10,914	6.8%	20,447	20,725	1.4%
Canada	28,619	28,838	0.8%	26,387	28,152	6.7%	55,006	56,990	3.6%

Current Ratio	
47 / 53	ratio in Ontario
51 / 49	ratio in Canada

Ratio according to Policy	
55 / 45	in Ontario
50 / 50	in Canada

If the FTE Non-Specialist method is used, the Ontario ratio for eligible Family Physicians available to deliver comprehensive care is 38/62. Thousands of people in Ontario are without a Family Doctor because of this trend which needs to be reversed.

4.0 Other Facts

4.1 None of the planning for Medical Human Resources took into account the increased workload for Family Doctors produced by Healthcare restructuring which is moving resources from hospitals to the community and from Specialists to Family Doctors.

4.2 None of the planning for Medical Human Resources took into account the growth and aging of the population or changes in the practice patterns of Family Physicians (early retirements, reduced hours of work, locums and walk-in clinics rather than Family Medicine practices). The average age of Family Physicians in Ontario is significantly higher than the Canada-wide average (46.7 vs. 45.8). The average age for Specialists is comparable (48.9 vs. 48.8). The early retirement of Canada's Family Physicians will hit Ontario first

4.3 Primary Care Reform models that propose replacing Family Physicians with Nurse Practitioners to save money are misguided. The narrow scope of Nurse Practitioner practice requires the backup of Family Physicians. This fragmented approach to care disrupts the patient-physician relationship which is at the heart of Family Medicine and the strength of Primary Care systems. Nurse Practitioners need to be in collaborative practice with Family Doctors and should be viewed as an added cost to the system; however, given the improvements in care and potential downstream savings, it is money well spent (see *Appendix E*).

4.4 The Primary Healthcare Team needs to reflect the needs of the practice population. Planning for Professional Human Resources has not taken into account the need for each Group Practice Network to gather demographic information regarding the population to be served and based on that data, make decisions regarding the best staffing complement. As an example, an aboriginal community may need a diabetes educator and an inner-city population may need mental health workers and social workers. The composition of the team needs to be flexible and based on patient needs.

4.5 Policies requiring International Medical Graduates to serve a short period of time in an underserviced area in exchange for a licence to practice have not worked in the past. For example, of the 25 International Medical Graduates recruited to provide psychiatric services in Northern Ontario, 24 were practicing in Toronto within two years. Rural medicine requires a higher level of expertise than Family Medicine practiced in communities with easy access to specialists. Rural communities require stable group practices committed to long-term service to the community. Planning based on short-term obligations to practice in underserviced areas fail to address the need for committed rural experts in Family Medicine. Recruiting of International Medical Graduates is morally unacceptable.

4.6 The maldistribution of specialists is of grave concern. Of particular concern is the maldistribution of Psychiatrists:

Ratio of Psychiatrists to Population

Ottawa:	1 Psychiatrist per 3,000 people
Northeastern Ontario:	1 Psychiatrist per 20,000

Other specialists are always inappropriately distributed but not to the same degree.

4.7 The vast majority of communities cannot support subspecialists. The number of General Surgeons, General Internists, community-based Paediatricians, Psychiatrists and Anaesthesiologists residency position needs to be increased to meet community needs.

1.0 Introduction

Until recently, Canadian healthcare planners held fast to the assumption that healthcare costs could be contained by restricting the number of physicians allowed to practice in Canada. Physicians were considered to be a cost centre and the physician's pen was described as the most expensive piece of equipment in healthcare. The assumption biased the planning of medical human resources and prevented the necessary analysis of medical databases. Because inadequate planning tools focus only on head counts and physician / population ratios, future resource requirements were significantly underestimated. A strong message was sent to government to reduce the number of doctors in the country. Government was only happy to comply with these recommendations. The number of placements for medical students and international medical graduates were reduced and the rotating internship was eliminated. While rural and northern communities have experienced shortages of doctors for many years, many communities large and small began to have had problems recruiting and retaining physicians in the last five years.

In May of 1999, the Ontario College of Family Physicians issued our first paper in a series of papers entitled "*Where Have All the Family Doctors Gone.*" [1, 2, 3, 4] These papers reflect the concerns of the public and our findings, as we conducted a thorough consultation amongst our 6,000 members, General Practitioners, and the major healthcare organizations in Ontario. The public described the effects that the shortage that was having on them. Family Physicians and General Practitioners described their overloaded working conditions resulting from the shortage of Family Physicians and healthcare restructuring. The draft paper "*Family Medicine in the 21st Century. A Prescription for Excellent Healthcare*" [5] called for the provision of a broad scope of services outlined in the Provincial Coordinating Committee on Community and Academic Health Service Relationships' Report on Primary Care (PCCCAR Report). Physicians stated quite clearly that there needed to be an adequate number of Family Physicians added to the system in order to deliver the level of care that people in Ontario want and need.

Prior to the release of our paper in June of 1999, the Ministry of Health & Long Term Care claimed that distribution – not supply, was the problem. It was felt that there are too many physicians in urban settings and not enough willing to go where needed. The Ontario College of Family Physicians demonstrated that Family Medicine was in crisis throughout the province. There were simply not enough Family Physicians available to deliver comprehensive services and continuity of care for the people of Ontario. The media coverage of our concerns and our recommendations was extensive. The Minister of Health and Long Term Care, the Honourable Elizabeth Witmer responded by appointing a Commissioner, Dr. Robert McKendry to investigate and provide recommendations. The Ontario College of Family Physicians was pleased that the Expert Panel on Professional Human Resources that was struck in response to Dr. McKendry's report. We would like to contribute to their work by providing further information and recommendations.

2.0 Family Medicine is in Crisis

2.1 Overview

Family Medicine is in crisis. There are too few Family Physicians available to deliver comprehensive continuing care for each person in this province. As Professor Rebecca

Coulter, Associate Dean of Education at the University of Western Ontario in London recently noted, "We have been and will continue to be, remarkably bad predictors of labour market needs."[11] This statement has been confirmed by this country's inability to anticipate professional resource needs in both medicine and nursing in the last thirty years."[15]

Historically, isolated communities, mainly in the far north, have had chronic difficulty attracting and retaining Family Physicians. Within the last five years, this problem is no longer unique to remote practice environments. Communities throughout the province of *all sizes* are desperately seeking Family Physicians to provide care for their growing and aging populations.

In any given month, less than 0.1% of the people of Ontario require services in a tertiary care setting where Family Physicians provide few services. In the remainder of medical care settings, from private offices to community hospitals, long-term care facilities and patient homes, the majority of care is provided by Family Physicians. But in most communities in Ontario, many patients cannot find a Family Physician to provide care, forcing these individuals to rely on episodic care in walk-in clinics and Emergency Departments. These practice settings provide one-time-care for a particular problem but lack the comprehensive care, including preventive healthcare and continuity of care, that is the hallmark of Family Medicine. The cost of care in communities that are highly dependent upon walk-in clinics and Emergency Departments is much higher than communities with better integrated systems. The annual average cost per patient seen by Family Physicians in Toronto is $190.51 compared to a province-wide cost of $135.00. East Muskoka – Parry Sound, as an example, has a cost of $101.68 per patient.

Throughout the province, comprehensive care provided by Family Physicians is now in jeopardy. Ironically, this particular aspect of healthcare has been recognized by other countries as one of the most valued aspects of the Canadian Healthcare System. The provision of quality Family Medicine services to a population is seen as the most affordable means for governments to meet the health requirements of their citizens. The high cost of care in the United States is often justified by claims that their healthcare is the best in the world. Dr. Barbara Starfield [6,7] disputes this fact and notes that the United States ranks an average of second from the bottom when sixteen available health indicators are averaged, whereas Canada ranks third. She believes that the historical failure of the United States to build a strong primary care infrastructure plays a role in this failing. "A wealth of evidence documents the benefits of characteristics associated with primary care performance. Of the seven countries in the top of the average healthcare ranking, five have strong primary care infrastructures. Although better access to care is widely considered to be the solution, there is evidence that the major benefit of access accrues only when it facilitates receipt of primary care."

In Ontario, instead of proceeding with system enhancements that build upon the strong foundation of Family Medicine, we have allowed the healthcare system to erode. During the past five years, as hospital restructuring in Ontario downsized some hospitals and closed others, there was a shift of patient care from hospitals to the community and from specialist care to Family Doctor. The downsizing of the hospital

sector, unfortunately, preceded changes to community health services and the resources to deal with the extra workload were not available. Shortened hospital stay for illness means that the number of office visits, both before and after hospital discharge, has increased and early discharge means that the complexity of the medical care needed to be provided by the Family Doctor is greater. Poor communication between the hospital sector and community Family Physicians complicates patient management. In addition, home care services through Community Care Access Centres (CCAC) are markedly overloaded and therefore, even more responsibility falls on the community Family Physician.

Canadian Institute for Health Information (CIHI) confirms that the number of Family Physicians in the province actually declined by 4% during the last five years. In the same space of time, the general population has increased, and the population most in need of care (i.e. the aged) has increased significantly. The downsizing of hospital sector has increased the volume and complexity of community care and limited access to specialty support due to lack of hospital beds for critically ill patients and lack of operating room time. Community resources have been overloaded and compromised by the shortage of community nurses and inadequate resources.

It is not surprising the Family Physicians all over the province are showing signs of burn out. They are expected to look after more complex cases, both in the acute care setting, as well as in long-term care facilities and the community. The uncertainty around Primary Care Reform initiatives and the impending growth of the population as the baby-boomers age and require more health services merely adds to their burden. The Ministry of Health & Long Term Care needs to move forward with Primary Care Renewal, and the capacity to train sufficient number of Family Physicians needs to be increased to address current and future demands.

2.2 Symptoms of the Family Medicine Crisis

Throughout the province, less than 27% of Family Physicians are accepting new patients. Most doctors have closed practices to new patients because they simply cannot work any more hours and are already struggling on a daily basis to provide quality care to their present practice population.

Surveys of Family Physicians reflect their growing frustration with the workload as many plan changes to their practice environment within the next few years. We are already seeing the effects of burn out in the style of practice in many communities in Ontario where Family Physicians are giving up providing the comprehensive care they have been trained to deliver. Less than 25% of Family Physicians continue to provide obstetrical services. Some hospitals are having great difficulty staffing hospital Emergency Departments.

Many Family Physicians are giving up hospital privileges entirely, leaving patients requiring hospital admission to be cared for by someone else. At one time Family Physicians would participate in a rota to care for unattached patients requiring admission to hospital so that everyone had a physician. With this new population of patients *with* a Family Doctor who does not provide hospital care, the volume of in-patients requiring care becomes totally unmanageable for the remaining physicians. A

snowball effect occurs and in many cases there are no longer enough Family Physicians providing hospital care in the community. This forces hospitals to hire "hospitalists" to care for in-patients.

Of even greater concern is the refusal of many Family Physicians to care for patients in long-term care facilities. There are many reasons for this phenomenon but once again the root of this problem stems from the ever more unmanageable workload of most community Family Physicians. There are some communities in which no physician can be found to care for nursing home patients. Residents have to be transferred to the hospital emergency ward by ambulance for even minor medical care including routine prescription renewals.

The morale of Family Physicians is very low and surveys reveal that many now plan early retirement or at least a further reduction in the range of services they are willing to provide. It is important to realize that retiring doctors in the last two years usually had no physician available to take over their practice and consequently, their retirement left an additional group of patients to join the increasing pool of "orphan" patients. Many more who are over seventy would like to retire but feel obligated to their patients to remain on the job until a physician takes over the practice, unfortunately, none are in sight.

New medical school graduates are well aware of the current problems in Family Medicine. Less than 30% of last years graduating class choose Family Medicine as their choice of specialty (the lowest number since the 1960's). Many of the new graduates are refusing to set up practice, choosing to do locums or move to the United States instead. Those who move to the United States admit that their move was not based on better financial remuneration but rather on improved lifestyle in the American system.. Further concern is being expressed by recent medical students that heavy debt load due to tuition increases will result in future decisions on medical discipline or practice patterns based on remuneration.

Also a much higher proportion of Family Physicians are now women, especially the population of new graduates. These physicians will spend much of their practice life working part-time in order to accommodate child rearing into their busy schedules.

The Ontario College of Family Physicians firmly supports moving forward with Primary Care Renewal and so do our members; however, they are extremely concerned about the added workload. While an effective infrastructure including Nurse Practitioners, telephone triage and information system will enhance quality and efficiency, we still need sufficient numbers of Family Physicians. The addition of Nurse Practitioners and such improvements as information technology will not substitute for adequate number of physicians. The price for further deterioration in working conditions will be high as morale falls further and physician burning out results in earlier retirements and continued withdrawal from comprehensive care.

- In so far as the effectiveness of Family Medicine is well recognized nationally and internationally, the important role that Family Physicians play in communities throughout Ontario needs to be recognized by strategies ***to provide every citizen with access to their own Family Physician***.

- In so far as uncertainty surrounding Primary Care Reform is negatively impacting upon Family Medicine in Ontario, ***Ministry of Health & Long Term Care needs to move quickly to support the development of Family Health Networks offering alternative funding models.***

- In so far as Patient Choice (Registration and Rostering) is the only method that can accurately predict the number of Family Physicians needed to serve the primary care needs of the public, ***Ministry of Health & Long Term Care needs to move quickly to implement the Patient Choice system.***

3.0 Medical Human Resources Planning in Crisis

After a year of debate regarding the physician shortage, the province still doesn't know how many doctors we have nor how many we need in the future. Dr. McKendry has stated that we are short 1,000 MDs; the Canadian Medical Association puts the number at 700 and the Ministry of Health & Long Term Care says that we are short 570. The variety of answers is just one concrete example of the problems facing the Expert Panel in developing recommendations for the Minister of Health and Long Term Care. We do not know how many physicians we have and it is, therefore, difficult to project how many we need.

The planning for Medical Human Resources has been hampered by the available planning tools. Each of the databases relies on a head count methodology and even when heads are counted, the numbers differ.

Number of GPs / FPs in Ontario (1995) [8]

9,433	Full-Time Equivalent
9,869	Ontario Database (OPHROC)
9,903	CIHI
10,926	MOH Method

The head count method fails to take into account the services provided by each Family Physician and assumes that a doctor is a doctor; however, physicians work differently and have different areas of specialization. Young physicians and many of our women doctors want more balance in their lives and wish to work fewer hours. Senior physicians use to work well into their seventies but today, those in their forties and fifties are cutting back and planning early retirements. Like many people in Ontario, freedom fifty-five seems to be a theme. Physician to population ratios fail to take into account these changes in the work habits of physicians and also fail to address changing workload demands.

A study commissioned by the Toronto District Health Council[9] attempted to overcome some of the problems with the head count methodology. The preferred methodology recognized that some physicians work full-time and others work part-time. The full-time equivalent (FTE) methodology demonstrates that many more physicians are working more than a full-time equivalent than those working part-time. This method indicates that if each physician worked an average number of hours, there would be 9,445 FTEs rather than 8,811 doctors who actively bill OHIP.

In completing the study, individuals who work as Specialists or quasi specialists but bill as General Practitioners were separated from the General Practitioners / Family Physicians pool. 16% of Ontario's General Practitioners function as non Royal College certified Specialists or as Family Physician Specialists in Psychology, Palliative Care, Sports Medicine and the like. In Sault Ste. Marie as an example, 26% of the Generalists function as Specialists. The head count method seriously overestimates the number of functioning Family Physicians in the province (10,386 – 7,903 = 2,483, i.e. 23.9% fewer practicing Family Physicians than the head count method would indicate).

General / Family Practice Physician Head Count 1997 / 98

Area	Raw	Active	FTE	Non-specialized Active	Non-specialized FTE	% FTEs Specialized
Toronto	2,843	2,472	2,692	2,001	2,210	18%
Kingston	177	136	123	109	101	18%
London	377	326	325	269	276	15%
Ottawa	526	406	371	313	291	22%
Sault Ste. Marie	71	49	49	33	36	26%
Sudbury	129	116	135	87	105	22%
Windsor	157	137	170	116	149	12%
Rest of Ontario*	6,106	5,169	5,560	4,329	4,734	15%
All Ontario	10,386	8,811	9,445	7,257	7,903	16%

* Rest of Ontario = all of Ontario minus the above named communities

(Taken from *Primary Medical Care in Toronto: Strengthening the Foundation, Building the System*, Toronto District Health Council, June 2000, Page 7.)

Physician / Population ratios fail to take into account population differences that may require additional physician resources. In Toronto, as an example, people from outside the city receive care in Toronto. As well, Toronto's residents receive care in other communities. A net influx of 13.7% was recorded. Using a single head count method, Toronto has a population per physician ratio of 880 compared to the Ontario ratio of 1,035. Taking into account the influx into Toronto and using the non-specialist FTE method the Toronto ratio increases dramatically to 1,287. Ontario's ratio increases to 1,361. The Non-Specialized FTE methodology is an improvement over previous planning tools but fails to take complexity of care into account and other factors influencing future workload.

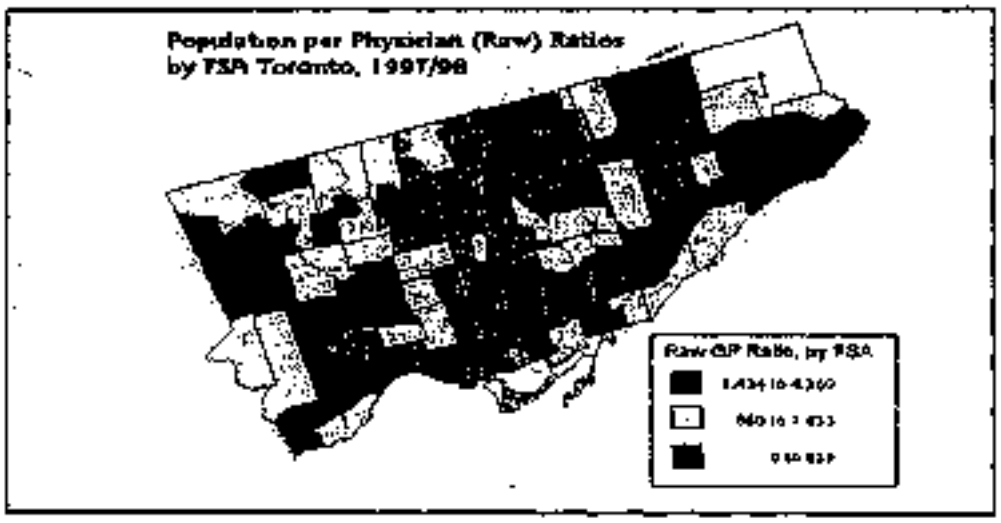
Population per Family Physician Ratio 1997 / 98

Area	Raw	Active	FTE	Non-specialized Active	Non-specialized FTE
Toronto	880	1,012	929	1,250	1,132
Kingston	837	1,089	1,202	1,359	1,460
London	902	1,043	1,047	1,264	1,231
Ottawa	689	892	977	1,157	1,245
Sault Ste. Marie	864	1,252	1,248	1,860	1,692
Sudbury	1,410	1,568	1,352	2,091	1,735
Windsor	1,402	1,606	1,296	1,897	1,477
Rest of Ontario	1,136	1,342	1,243	1,603	1,466
All Ontario	1,035	1,220	1,139	1,482	1,361
Toronto + 13.7	1,001	1,151	1,057	1,422	1,287

(Taken from *Primary Medical Care in Toronto: Strengthening the Foundation, Building the System*, Toronto District Health Council, June 2000, Page 8.)

Using the Ministry of Health & Long Term Care formula, Toronto is shown to be a series of underserviced and overserviced neighbours rather than one large overserviced area. Yet, the whole of Toronto is considered to be overserviced. The graph speaks to the need of local planning rather than province-wide reliance on data that is clearly inadequate to deal with the problems facing Family Medicine in this province. It is only through local planning that the age, gender, socio-economic factors affecting health and practice differences can be taken into account. Current methods fail to recognize the difference in roles of Family Physicians in the provision of primary, secondary and tertiary care. Methods to accurately determine the number of Family Doctors needed in a community have been developed and are in use in many communities, such as Sioux Lookout.

Distribution of GPs by Forward Sortation Area (FSA)



(Taken from *Primary Medical Care in Toronto: Strengthening the Foundation, Building the System*, Toronto District Health Council, June 2000, Page 9.)

- In so far as current methods of medical human resource planning have proven to be ineffective and Family Physicians deliver much more than primary care, ***a community-based physician human resources planning exercise needs to be conducted in each community in Ontario and used in a cumulative manner as the basis for province-wide planning*** (see *Appendix C*).

- In so far as Family Doctors deserve an improvement in professional working conditions as the key strategy for recruitment, retention and repatriation of Family Doctors in Ontario, ***manageable workloads and on-call schedules need to be factored into the Professional Human Resource Planning processes.***

- In so far as the factors that influence the appropriate number and mix of healthcare providers change over time, ***Ministry of Health & Long Term Care needs to establish a permanent Healthcare Human Resource authority to oversee the ongoing process of evaluating and planning Professional Human Resources including the tabulation of demographic and patterns of practice changes that impact upon the required number of healthcare professionals, including physicians, that will be needed to meet future demands.***

4.0 The Downsizing of Family Medicine

Canada has a ratio of 186 doctors per 100,000 population. This is well below the US ratio of 230 and the Organization for Economic Co-operation & Development (OECD) average of 260. Many of these countries are moving towards a split in the Specialist / Family Physician ratio that favours Family Medicine. The vital role of Primary Care is being recognized by decisions to move to a 60/40 or 70/30 split in favour of Family Medicine. Canada has traditionally aimed at 50/50 split. Ontario[16] policy to preserve a 55/45 ratio was set in the 1970s. The latest CIHI data indicates an 8.6% drop in the number of Family Physicians per 100,000 in Ontario and 1.1% increase in the number of Specialists. The ratio in Ontario is now 47/53 in favour of Specialists. If the FPE Non-Specialists method is used, the ratio drops to 38/62. This trend and the reasons for this shift need to be addressed by the Ministry of Health & Long Term Care.

CIHI Physicians per 100,000 Population

	Family Medicine			Specialists			Total Physicians		
	1995	1999	% Change	1995	1999	% Change	1995	1999	% Change
Ontario	93	85	(8.6%)	93	94	1.1%	185	179	(3.2%)
Canada	97	94	(3.1%)	89	92	3.4%	186	186	0.0%

Canada
94 Family Physicians per 100,000
92 Specialists per 100,000
Ontario
85 Family Physicians per 100,000
93 Specialists per 100,000
International Comparison
Ontario 179 doctors per 100,000
Canada 186 doctors per 100,000
US 230 doctors per 100,000
OECD * 260 doctors per 100,000

* Organization for Economic Co-operation & Development

CIHI Number of Physicians by Type

	Family Medicine			Specialists			Total Physicians		
	1995	1999	% Change	1995	1999	% Change	1995	1999	% Change
Ontario	10,230	9,811	(4.1%)	10,217	10,914	6.8%	20,447	20,725	1.4%
Canada	28,619	28,838	0.8%)	26,387	28,152	6.7%	55,006	56,990	3.6%

Current Ratio	
47 / 53	ratio in Ontario
51 / 49	ratio in Canada

Ratio according to Policy	
55 / 45	in Ontario
50 / 50	in Canada

In addition to the reduction in International Medical Graduates and Family Medicine Resident positions, Ontario has lost a significant number of physicians entering into the system as General Practitioners through the elimination of the rotating internship. In essence, we are now graduating 192 more Specialists each year than Family Physicians. In 1992, 54% of the total number of graduates in Canada were enrolled in Family Medicine or a Rotating Internship. By 1998 this number was reduced to 44%. The ratio of Family Medicine to Specialist residency positions needs to be changed to restore the 55/45 ratio.

Field of Training of Canadian Medical Graduates at Exit from Canadian Postgraduate Programs (1990 – 1998)

Year of Exit	Rotating Internship	Family Medicine	Total – N (%) (rotating internship & family medicine)	Specialties N (%)	Total N
1990	383	537	920 (51%)	878 (49%)	1,798
1991	399	539	938 (53%)	828 (47%)	1,766
1992	348	597	945 (54%)	805 (46%)	1,750
1993	284	606	890 (51%)	872 (49%)	1,762
1994	28	622	650 (45%)	781 (55%)	1,431
1995	—	654	654 (45%)	784 (55%)	1,438
1996	—	692	692 (47%)	789 (53%)	1,481
1997	—	682	682 (43%)	901 (57%)	1,583
1998	—	694	694 (44%)	886 (56%)	1,580

(Taken from Thurber & Busing, "Decreasing the Supply of Family Physicians & General Practitioners: Serious Implication for the Future".)[13] (see *Appendix F*)

- In so far as changing practice patterns, Healthcare Reform and Primary Care Renewal (PCR) are affecting the ability of Family Doctors to meet patient requirements, ***the number of Family Doctors must be increased from historic levels to reflect increased need for care by Family Physicians.***

- In so far as the impact of demographic, technological, system changes will required an increased number of physicians in all disciplines within medicine in the near future, ***as a minimum, the number of medical school placements should return to 1992 level.***

5.0 Future Planning for Family Physicians

To ensure adequate planning for Medical Human Resources needs in the future, the following consideration must be taken into account:

1. Workload is changed

   The aging of the population, technological changes and healthcare restructuring means that we need more Family Physicians, not less.

2. Workforce is changing

   44% of Family Physicians are female compared with 23% of the Specialist workforce. All Family Physicians regardless of age are wanting more balance in their life.[6] Early retirements are becoming the norm amongst physicians. Currently, planning has not taken these factors into consideration.

3. Ontario's needs are not being met

   While the number of Specialists has increased, the mix of specialists and subspecialists is not meeting Ontario's needs. Smaller cities and towns cannot support subspecialties; yet, general internists, general surgeons, community-based paediatricians and psychiatrists and anaesthesiologists have not been trained in sufficient numbers. The maldistribution of specialists is of grave concern. The ratio of psychiatrists to population is 1 for 3,000 in Ottawa compared to 1 for 20,000 in Northeastern Ontario.

4. Current planning system is inadequate

   Patient Choice (registration and rostering) and local community-based planning need to be used in a cumulative manner as the basis for province-wide Medical Human Resource Planning. (*see Appendix B*)

5. Primary Care Renewal will have an impact

   Workload under Primary Care Renewal[10] will increase and require more Family Physicians, not less. Nurse Practitioners, telephone triage and information system will enable enhanced care to be delivered. These investments in quality primary care are necessary adjuncts to the current Family Medicine system and are well worth the additional costs. Unlike multi-skilled workers who were added to nursing units to replace nurses, improvements in Primary Healthcare need to focus on quality of care rather than cost-constraint. Nurse Practitioners should assume their rightful place in Primary Care [11, 12] but it must be remembered that "It is the Family Physician who bears

responsibility for seeing to the totality of primary care. Other personnel may assume responsibility for certain aspects of primary care, but it is the physician who must oversee all of the aspects of care." – Barbara Starfield, *Primary Care – Balancing Health Needs, Services and Technology* [1] (see *Appendix D*).

6. Canada needs to be self-sufficient

International Medical Graduates have a role to play and entry to practice should be streamlined in a manner that maintains Canada's high standards of practice; however, active recruiting of International Medical Graduates must stop, given the devastating effects of importing physicians or other healthcare providers from those countries that are tremendously more underserviced than Canada.[13] International Medical Graduates are not the answer to Canada's problems. Of the 25 International Medical Graduate psychiatrists recruited for the north, 24 were practicing in Toronto within two years (see *Appendix D*).

7. Retention and repatriation needs to replace recruitment

Ontario needs to develop systems that promote positive professional working relationships.[3, 5, 7] Environments that are hostile to Family Medicine need to be changed so that we retain our physicians and can repatriate Canadian doctors who have emigrated to other countries.

8. System changes are needed

Shared Care models with Specialists,[11] and managed wait-lists such as the Cardiac Care Network needs to replace the current "hunt and seek" systems that find Family Physicians calling all over the province for assistance for their patients with emergent and urgent conditions. Community resources need to be dramatically increased in anticipation of technological changes that will allow monitoring in the home.

9. Decentralizing the medical education system

Training in tertiary referral hospitals (0.1% of care) needs to be replaced with community-based training in settings that expose medical students to remote, rural, suburban, urban and inner-city practice sites. Strategies to recruit students from underserviced areas especially in the north and to provide clinical training close to home should be supported. Tuition needs to be affordable to ensure that we maintain diversity (northern students and those from lower socio-economic and multi-cultural families) and to prevent young graduates making practice decisions influenced by their debt load.

10. Physicians viewed as resource, not a cost centre

Physicians are viewed with respect by the public they serve. The public views Family Physicians as a valued healthcare professional. Planning should reflect this view of Family Medicine by ensuring easy access for each person in this province to have their own Family Doctor

- In so far as remote, rural, northern and aboriginal communities continue to experience recruitment problems, ***a sixth medical school whose mission would be train physicians***

for these communities should be considered. Active recruiting from these communities should be encouraged.

- In so far as Family Medicine is in decline in this province, ***the number of Family Medicine Residency positions needs to be increased, as a minimum, to ensure that the number of new licences issued each year to Family Physician is equal to the number granted to the 1992 graduates in the combined Family Medicine and Rotating Internship Programs.***

- In so far as the Ministry of Health & Long Term Care's policy of a 55/45 ratio favouring Family Medicine over Specialists has not been adhered to in recent years (currently 47/53 in favour on Specialists and 38/62 using the Full-time Equivalent (FTE) Non-Specialist method) and in light of the fact that other countries are moving towards a 60/40 or 70/30 ratio, ***the Ministry of Health & Long Term Care needs to develop strategies to restore the policy ratio and to review the policy in light of evidence supporting the strengths of Family Medicine.***

- In so far as a serious shortage of General Internists, General Surgeons, Anaesthesiologists and community-based Paediatricians and Psychiatrists is compromising care in most communities in Ontario, ***an increase in the training of general specialists is needed as well as an increase in third year residency positions to educate Family Physicians in advanced skills for special needs (Family Physician anaesthesia, obstetrics, care for the elderly, mental health, surgical procedures, emergency medicine, palliative care, etc.).***

- In so far as the establishment of a common first year rotating internship will add expense without value, ***post-graduate resources should be directed at creating 120 post-graduate slots for every 100 medical student placements, thereby, allowing for re-entry, career change, opportunities for added skills for Family Medicine Residents, International Medical Graduates and practicing physicians.***

- In so far as recruiting of physicians to underserviced areas remains a major problem, ***medical students and residents need to receive practical experiences in each practice setting in Ontario (remote, rural, suburban, urban and inner-city) reflecting the diversity of practice in Ontario and as a recruiting strategy for our most seriously underserviced areas of the province.***

- In so far as medical school tuition may be a barrier to recruitment for some socioeconomic groups and may force physicians to choose a medical discipline or a practice pattern based on remuneration, ***tuition needs to be affordable.***

- In so far as it is morally questionable to actively recruit Healthcare Professionals from poorer countries, and Canadian youth are being denied access to the profession of their choice, ***the ultimate goal should be self-reliance by training sufficient Canadians to meet requirements*** (see *Appendix D*).

- In so far as a number of International Medical Graduates are already in Ontario, and since lowering of standards is unacceptable, ***access to medical licences through a streamlined assessment process designed to maintain Canada's high standards of practice should be supported.***

- In so far as Family Health Networks need to include nurses, nurse practitioners and other healthcare professionals such as social workers, dietitians, pharmacists, physio and occupation therapists, etc., ***Family Physicians should be provided with the process and resources to enter into collaborative practice reflecting the needs of the patient population*** (see *Appendix E*).

- In so far as access to care for patients is compromised in hospitals and the community, ***system changes such as Managed Waiting Lists such as the Cardiac Care Network, and Shared Care should be developed to ease assess to all major specialty and subspecialty services. Community capacity needs to be built to reflect technological changes allowing for effective delivery of care in non in-patient setting***.

- In so far as the Ontario College of Family Physicians is the professional organization overseeing the accreditation of Family Physician residency programs, the certification of Family Medicine residents and the maintenance of certification of Family Physicians and in so far as the Ontario College of Family Physicians is the voice of Family Physicians in this province, ***the Ministry of Health & Long Term Care should recognize the role of the Ontario College of Family Physicians in future planning of changes that impact upon Family Medicine and the education of our members***.

REFERENCES

1. Ontario College of Family Physicians. May 1999. "Where Have All the Family Doctors Gone #1 – A Brief History of the Family Physician Shortage in Ontario."

2. Ontario College of Family Physicians. June 1999. "Where Have All the Family Doctors Gone #2 – Reversing the Trend."

3. Ontario College of Family Physicians. August 1999. "Where Have All the Family Doctors Gone #3 – Hospitals Without Family Physicians."

4. Ontario College of Family Physicians. September 1999. "Where Have All the Family Doctors Gone #4 – The Future is Now."

5. Ontario College of Family Physicians. November 1999. "Family Medicine in the 21st Century: A Prescription for Excellent Healthcare."

6. Starfield, Barbara. "Is US Health Really the Best in the World?" in *JAMA*, July 26, 2000, Vol. 284, No. 4, pp 483–5.

7. Starfield, Barbara. 1998. *Primary Care Balancing Health Needs Services & Technology*. Oxford University Press.

8. Ontario College of Family Physicians. July 2000. "Implementation Strategies: Too Many Hours, Too Much Stress, Too Little Respect."

9. Toronto District Health Council. "Primary Medical Care in Toronto, Strengthen the Foundation, Building the System."

10. Ontario College of Family Physicians. April 1999. "Family Medicine in the 21st Century: Implementation Strategies."

11. Ontario College of Family Physicians. June 2000. "Implementation Strategies: Protecting Trust in the Patient-Physician Relationship"

12. Ontario College of Family Physicians. May 2000. "Implementation Strategies: Collaboration in Primary Care – Family Doctors & Nurse Practitioners Delivering Shared Care."

13. Thurber, Audrey Dianne & Nicholas Busing. "Decreasing the Supply of Family Physicians and General Practitioners: Serious Implication for the Future" in *Canadian Family Physician*, September 1999, Vol. 45, pp 2084–9.

14. Bundred, Peter E. & Cheryl Levitt. "Medical Migration: Who are the Real Losers" in *Lancet*, July 2000:356(9225), pp 245–6.

15. Hennen, Brian K. E. "Fixing the Doctor Shortage: Working Together to Achieve Success" in *Canadian Family Physician*, September 1999, Vol. 45, pp 2017–9.

16. Task Force on Medical Manpower, Ontario Council of Health. February 1983. *Medical Manpower for Ontario: A Policy Perspective*.

TAB 46

ONTARIO'S Physician Workforce

Building Ontario's Capacity to Plan, Educate, Recruit and Retain Physicians to Meet Health Needs

REPORT OF THE EXPERT PANEL ON HEALTH PROFESSIONAL HUMAN RESOURCES

DEAR MINISTER:

We are pleased to provide you with the final report and recommendations of the Expert Panel on Health Professional Human Resources: *"Shaping Ontario's Physician Workforce"*.

Building on the work undertaken in 1999 by Dr. Robert McHendry, the Physician Fact Finder, the Expert Panel was asked to develop medium and long-term strategies to ensure Ontario has sufficient physician resources to meet future health needs. Over the past year we have spent considerable time reviewing and analyzing the evidence, and debating the options.

While we reviewed a wealth of relevant material, including some 30 submissions made to the Panel, the focal point for our work was the Report of the Physician Fact Finder. We used Dr. McHendry's recommendations as the basis for some of our analysis and as a reference guide as we developed our strategy.

Early in our mandate, the Panel identified the need for better data for physician resources planning and a needs-based model for forecasting requirements to inform our recommendations. As a result, the Panel has developed a new, robust master physician database and has used this database to develop an access modelling approach to determine physician resource requirements now and in the future.

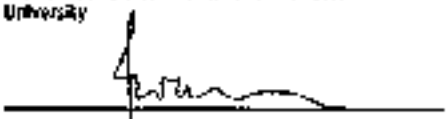
Based on the results of this work, we have concluded that there is indeed a problem with the effective supply of physician resources in Ontario. This problem, together with a maldistribution of physician resources, will continue to grow unless Ontario immediately takes comprehensive steps to plan and manage the physician workforce, and to make more effective use of other health providers and resources.

The Expert Panel has considered a variety of strategies and initiatives, and now offers recommendations that, taken together, represent a comprehensive, systems-level approach to ensuring the right number, mix and distribution of physician resources. The recommendations include measures that will address the effective supply of physician resources in the short, medium and long-term.

The underlying theme of our report centres on building capacity. To provide our growing and aging population with the right number and mix of skilled health professionals to deliver high quality services, we must begin now to build and shape our resources. In particular, the Panel felt that there exists a great need, and a unique opportunity, to build the capacity for: integrated health human resources planning; larger and more effective education and training programs, including decentralized education and training; and flexible, effective recruitment and retention initiatives. This capacity-building will require significant investment in resources such as universities, hospitals, and information technology. However, the return on this investment will be measured in improved quality of care, better access to care and a sustainable health care system that can meet health needs in the future.

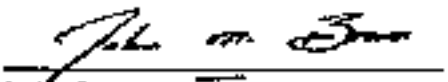
The members of the Expert Panel have developed a comprehensive plan of action that provides clear direction to the Government for shaping the future physician workforce. The success of this strategy will depend on implementation of all of the recommendations together with continuous monitoring and evaluation to make adjustments as required. The opportunity to shape a physician workforce that will meet the needs of the population in the new millenium is now. We urge you to seize this opportunity for the benefit of all Ontarians.

Dr. Peter George
Chair, Expert Panel on Health
Professional Human Resources
President and Vice-Chancellor of McMaster
University



Dr Peter Walker
Vice-Chair, Expert Panel on
Health Professional Human Resources
Dean of Medicine, University of Ottawa
Chair of the Council of Ontario
Faculties of Medicine

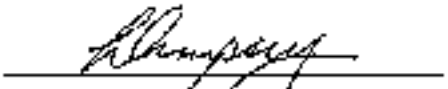
Dr Gail Beck
Psychiatrist
Ottawa, Ontario



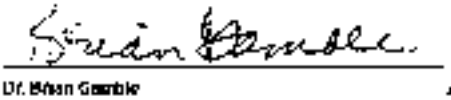
Dr. John Bonn
Registrar, College of Physicians and Surgeons of
Ontario

Dr. Ben Chan
Senior Scientist, Institute for Clinical Evaluative
Sciences

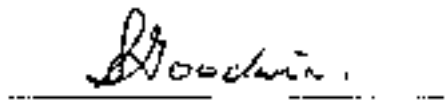
Joe deBora
President and CEO
Kingston General Hospital
(formerly CEO of the Sudbury Regional Hospital)



Dr. Laurel Dempsey
Family Physician, Primary Care Network
Verona, Ontario

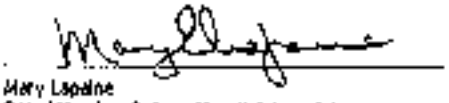


Dr. Brian Gamble
Family Physician, Primary Care Network
Chatham, Ontario

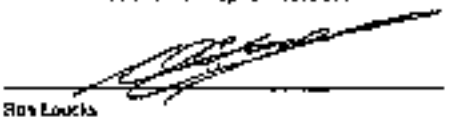


Sharon Goodwin
Chair of the Nurse Practitioner
Association of Ontario
Director of Operations, Clinidata

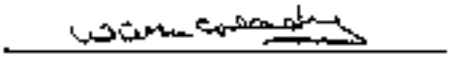
Dr. Michael Howcroft
Ophthalmologist, St. Michael's Hospital



Mary Lapaine
Board Member, Ontario Hospital Association

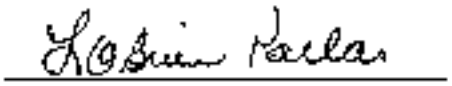


Ron Loucks
Executive VP - BCE Emergis Assure Health Division



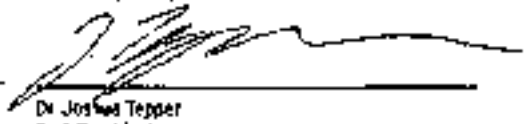
Dr. William McCready
Nephrologist
Chair of Northwestern Ontario Medical Program

Neera Mehta
Employment Counsellor, Kitchener-Waterloo
Multicultural Centre

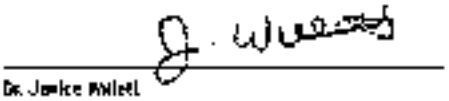


Dr. Linda Lee O'Brien-Pallas
Co-principal Investigator
Nursing Effectiveness, Utilization and Outcomes
Research Unit

Dr. Jeff Remington
Chair, Niagara Physician Planning Task Force
Family Physician, Port Colborne



Dr. Joshua Tepper
Past-President,
Professional Association of Interns and Residents of
Ontario



Dr. Janice Willett
Obstetrician, Sault Ste Marie
Ontario Medical Association

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Colin Andersen
Assistant Deputy Minister, Integrated Policy and Planning Division

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Executive Director, Integrated Policy and Planning Division

Helga Lorchet
Manager, Provincial Health Services Planning Unit

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Caroline Abrahams
Project Manager, Expert Panel on Health Professional Human Resources

Jean Bacon
Writer

Paul Donoghue
Assistant VP, Health Sciences
McMaster University

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Gabrielle Martin

Over the next 10 years, Ontario's population is expected to increase by about 12%, and age significantly. As the population grows and ages, its need for health services will also grow. Government has made a commitment to meet those needs. In the Communiqué on Health issued in September 2000, Canada's First Ministers agreed to: "ensure that each government or jurisdiction has the people with the skills needed to provide appropriate levels of care and health services." In Ontario's April 1999 "Blueprint" and the Ontario 2000 Budget, the government underlined its commitment to ensure all communities across the province have access to physician services.

Yet these are signs – physician shortages in some parts of the province, nursing shortages, waiting lists – that Ontario's health care system (like those in other provinces) may not have the number and mix of human resources to meet health needs. Recent reports from Dr. Robert McKendry (the Fact Finder on Physician Resources in Ontario appointed by the government and the Ontario Medical Association in 1999), the Canadian Medical Forum and the Institute for Clinical Evaluative Sciences – all released late in 1999 – specifically identified problems with the supply, mix and distribution of Ontario's physician services. These problems are occurring at a time when the province has made significant commitments to increase certain priority health services to meet the needs of an aging population, such as cardiac care and cancer care – commitments that will increase the need for health professionals, including physicians.

To address these needs and ensure Ontario has the right supply, mix and distribution of physician services in the future, the Minister of Health and Long-Term Care established the Expert Panel on Health Professional Human Resources. The 18-member panel, chaired by Dr. Peter George, President and Vice-Chancellor of McMaster University, brought together a wide range of expertise and perspectives, including urban areas, rural communities and the North.

Having reviewed Dr. McKendry's work and other relevant research, the Expert Panel proposes that Ontario take a strategic, systems-wide approach to health workforce planning. The problems cannot be solved by simply adjusting the number of students going into the system. They require a more comprehensive approach, one that will address all the factors – including education, incentives, demographics, public expectations and health policies – that affect where and how health professionals practice and the type of services they provide.

To shape the physician workforce to meet health needs, the Expert Panel suggests Ontario take four steps to build its capacity to plan for, educate, recruit, and retain physicians.

I. PLAN PHYSICIAN SERVICES TO MEET NEEDS

Although human resources are only one component of a complex health care system,[2] they are the most difficult part to plan and manage. This is due to the length of training (nine to 12 years for physicians, five years for nurse practitioners), the fierce competition for mobile Ontario-trained health professionals, the explosions in new knowledge, changing demographics (the growing number of female physicians who may practise differently and who tend to work fewer hours than male physicians early in their careers when they have family responsibilities), changing practice patterns (many physicians no longer provide the full range of services in their specialty) and changing attitudes towards workload (most physicians want to lead more balanced lives).

To plan effectively, the system must identify and understand health needs, and then use its resources to meet those needs. Ontario's past efforts to plan and manage physician services have been hampered by the lack of accurate consistent data on physician supply and on the population's health needs. They have also suffered from the lack of ongoing monitoring, and the inability to adjust plans and targets to reflect changes in needs, practice, knowledge or technology.

In the course of its work, the Expert Panel, with the Ministry of Health and Long-Term Care (MOHLTC), the Institute for Clinical Evaluative Sciences (ICES) and the Ontario Physician Human Resources Data Centre (OPHRDC) developed a new, more robust master physician database, called the Ontario Physician Workforce Database. The Panel also developed a data-driven modelling approach to estimate Ontario's future physician requirements. But these are only the first steps towards effective workforce planning, and they must be continuously monitored and evaluated to ensure they are accurate and achieve their goals. To develop the capacity for ongoing, effective, needs-based, evidence-driven health human resource planning, the Expert Panel recommends that:

#1 **MOHLTC establish the Health Human Resources Advisory Panel (HHRAP), a permanent, expert advisory body responsible for continually monitoring and anticipating the health needs of Ontarians and making recommendations on the appropriate supply, mix and distribution of health human resources to meet health needs. HHRAP should develop the capacity for integrated health human resources planning, beginning with building the capacity for physician services planning. MOHLTC should review HHRAP after its first three years of operation to ensure its efficacy.**

#2 **HHRAP, with the financial support of the MOHLTC, continue to refine and use the Ontario Physician Workforce Database as the basis for physician workforce planning, and work with the other professions to develop comparable high quality workforce databases.**

2 The health care system is a complex mix of policies, programs, funding, people, technology, buildings, equipment, and services.

1. PROVIDE APPROPRIATE EDUCATION

One of the main causes of inequities in Ontario's health care system is the maldistribution of health resources – including the physician workforce. While Ontario has physician shortages throughout the system, the shortages are particularly acute in rural and remote areas. Because of this, the Expert Panel has focused its attention primarily on the health care needs of Ontario's rural and remote populations.

Experience in other jurisdictions indicates that rural physicians do not just happen, they have to be nurtured and developed. For example, physicians are more likely to choose to practice in rural, remote or underserviced areas when they come from rural areas, receive a significant portion of their training in rural or remote areas, and participate in a dedicated rural training stream.

To create more rural physicians, Ontario must change the way it educates its physician workforce, and the training infrastructure now in place. It must develop the capacity – in all regions of the province – to provide education that prepares physicians to work where they are needed, and to encourage a multidisciplinary approach to education and practice.

DECENTRALIZE AND STREAM MEDICAL EDUCATION

The Expert Panel carefully reviewed proposals for ways to restructure medical education, including a proposal for a new medical school in northern Ontario and a proposal to develop a regional medical program, based in Windsor. The Expert Panel supports the goals and intent of the submissions. At issue is the most cost-effective and sustainable way for Ontario to achieve those goals. In the Panel's view, it will take time for the different regions of the province to develop the capacity to provide medical education independently, and the existing academic health science centres (AHSCs) should be key resources in that process. Once the capacity for rural medical education is developed, the system will have the potential to develop free-standing rural medical schools, if required.

To develop the capacity to provide appropriate education, the Expert Panel recommends that:

R3 Ontario's medical schools build on existing relationships and infrastructure to create in Thunder Bay, Sudbury and Windsor university-based clinical education campuses (CECs) that have the capacity to deliver decentralized medical education.

R4 The Ontario Government, in collaboration with the federal government, provide:

- the funding to support the capital development and operating cost of three CECs, including the university and hospital/training site costs to provide decentralized medical education
- the initial investment to develop the information technology infrastructure required to support decentralized medical education, including broad-band video-conferencing and telemedicine, with particular emphasis on rural and northern sites
- the funding to develop, within the CECs, the capacity for research in health services and population health.

#5 The Directors of the CECs immediately become members of the Council of Ontario Faculties of Medicine (COFM), and COFM be responsible for co-ordinating the development of an integrated plan for rural, northern and underserviced medical education in Ontario.

#6 MOHLTC and the AHSCs take steps to address the issue of funding, support and incentives for clinical teachers in CECs and AHSCs.

#7 The CECs work with their training sites, communities and the sponsoring universities to develop rural and/or northern medical education streams, including a separate or enhanced admission process based on factors that are most likely to identify students who will choose rural or northern practice.

#8 Ontario's medical schools and CECs work with other health disciplines to identify underserved populations for which they have a responsibility, and develop multidisciplinary streamed training programs designed to meet their health service needs.

#9 Ontario's medical schools and CECs assess the potential for a training stream for clinical scholars, based in rural and northern environments.

#10 MHRAP evaluate the effectiveness of the CECs and sponsoring universities in implementing targeted training streams, and advise MOHLTC on future investments in training for rural and northern medicine, underserviced populations and clinical scholars.

ENSURE QUALITY

In addition to restructuring the education system, the health system must increase its capacity to provide high quality education designed to ensure that all health professionals provide appropriate care targeted to the population's health needs. Education and ongoing professional development programs should focus on helping health professionals continuously develop and update their skills. To ensure the quality of medical education and provide training that reflects the needs of a decentralized streamed system, the Expert Panel recommends that:

#11 MOHLTC provide the funding to support 20 medical education specialists, distributed among the AHSCs and CECs, responsible for:

- conducting research in education and professional development
- developing educational resources for students and preceptors
- improving the quality of medical education in the province.

#12 Government increase its investment in continuing medical education, and provide funding to support the development of:

- common educational resources
- the digital health library
- evaluation tools that can be used to assess the quality/appropriateness of care and guide medical education.

III. PRODUCE THE RIGHT SUPPLY AND MIX OF PHYSICIAN SERVICES

Decentralizing and streaming medical education has the potential to improve physician distribution, but it does not on its own address the supply and mix of physician services. How many physicians does Ontario need? What skills should they have?

To answer those questions, the province will need increasingly sophisticated planning models that can take into account the complex factors that affect the need for services as well as the physician workforce. The Expert Panel has taken the first steps in developing a needs-based, access modelling approach to planning/forecasting physician services.

Using the model, the Expert Panel was able to look at the impact of a variety of scenarios for physician supply and mix, across a range of critical specialties. For purposes of its recommendations, the Panel made a series of assumptions about the demand for health services, population increases, changes in workload, retirements and migration. It also assumed that, in addition to increasing physician supply, Ontario would institute a number of policies designed to manage both health care services and the demand for care.

To produce the right supply and mix of physician services, the Expert Panel proposes that the health system increase its capacity to

- produce physicians
- manage the mix of physician skills
- make more effective use of existing resources
- manage the demand for physician services.

PRODUCE PHYSICIANS

Using its data model, which takes into account the growth and aging of the population, changing health needs, the productivity of the current workforce, the current capacity of the medical education system, retirements, migration, changing physician workload, the contribution of other health providers, and other factors that affect the supply of physician services, the Expert Panel was able to project health needs to 2010 and the potential shortfall in physician services. Based on those figures, the Panel estimates that, by 2010, even with focused efforts to manage demand, encourage comprehensive practice and make more effective use of other health care providers, Ontario will need over 1300 new physicians. To meet future health needs, the Expert Panel recommends that:

R13 HHRAP continue to develop and refine sophisticated data models and planning tools that can be used to measure both health needs and the capacity of the system to meet those needs.

R14 MOHLTC and the AHSCs increase undergraduate medical school enrolment by a total of 160 positions (including the 40 positions already added in the fall of 2000). These increases should:

- be phased in over four years (40 in 2000, 80 in 2001, 20 in 2002 and 20 in 2003) to allow the training system to develop the necessary resources and capacity
- allocate a minimum of 60 of the new positions to northern/rural training, and contract with the sponsoring medical schools and the CECs to provide that education
- allocate a proportion of the new positions to training streams for underserviced populations (based on the recommendations of HHRAP) and contracting with the appropriate AHSC/CEC to provide that education.

R15 MOHLTC increase the province's capacity to provide postgraduate medical training by:

- increasing the number of funded entry level postgraduate training positions by 160 when required to match the increase in undergraduate enrolment
- providing funding for salary support and benefits for the additional postgraduate trainees.

R16 MOHLTC provide additional funding to enable hospitals and other clinical training sites across the province to fulfil their role in undergraduate and postgraduate medical education.

MANAGE THE MIX OF PHYSICIAN SKILLS

Simply increasing enrolment will not necessarily provide the mix of physician services Ontario needs. The specialties that physicians choose and the skills they develop depend on the pool of postgraduate training positions. Every effort must be made to manage that pool and to ensure it produces the "right" mix of specialists to meet the population's health needs. This is particularly important given the increasing subspecialization among internists and surgeons. Although subspecialization may help physicians cope with the increasing complexity of medical care, it reduces the number of "general" specialists available to meet health needs.

#17 HHRAP, in consultation with COFM, take immediate steps to review and provide advice on the current and future mix of specialty training positions, giving particular attention to:

- specialties identified as being in short supply or having severe problems with distribution, such as anesthesiology, general surgery, obstetrics, ophthalmology, orthopedics, and psychiatry
- priority health programs, such as cardiac surgery, oncology and geriatrics
- public health.

#18 MOHLTC provide funding, beginning in 2001, for up to 25 postgraduate positions annually to give postgraduate trainees more opportunity and flexibility to transfer between residency positions. To ensure these positions help meet health care needs, they should be limited to specialties identified in short supply and to specialties required to meet the needs of priority health programs.

#19 MOHLTC provide funding in 2001 for an additional 25 third year residency positions (PGY3) for enhanced Rural Family Medicine targeted to the needs of rural and northern communities.

#20 MOHLTC fund up to 25 of the 160 new entry level postgraduate training positions in 2002 and 2003, with all these positions to be located in the CECs and targeted to the general specialties in short supply.

#21 HHRAP, beginning in 2001, continually monitor and annually evaluate the impact of increases in undergraduate enrolment and the mix of postgraduate positions, and advise on adjustments required to meet health needs.

MAKE MORE EFFECTIVE USE OF EXISTING RESOURCES

The Expert Panel's recommendations on physician supply – combined with the earlier increases made after Dr. McKendry's Fact Finder report – will add a total of about 662 doctors to the physician workforce by 2000 and a total of about 1,700 by 2015, when the full impact of the increases will work their way into the system. Based on the initial data and modelling analysis, this may not meet all the population's need for physician services over the next 15 years – without other changes in the health care system. However, the Expert Panel cautions that its forecasts of the need for physician services and physician supply must be revisited regularly to ensure they reflect both changes in the health care system and improvements in forecasting methods.

To close the gap between need and supply, Ontario will have to make more effective use of other resources in the health care system now and in the future. The Expert Panel has identified five groups that could play a valuable role in improving the supply, mix and distribution of physician services: new graduates, international medical graduates (IMGs), physicians already in practice, nurse practitioners and midwives.

To ensure that Ontario's health resources are used effectively, the Expert Panel recommends that:

#22 MOHLTC provide funding for three years to support the PARO Resident Placement Program to assist trainees who are ready to enter the workforce. To determine the long-term potential of this program, HHRAP should:

- evaluate the success of the program in matching new physicians to communities in need
- assess its impact on the supply, mix and distribution of physicians in Ontario
- make recommendations, based on the evaluation, about ongoing long-term funding.

#23 MOHLTC fund, on a four-year pilot basis, the COFM/CPSO proposal to license up to 25 fully qualified IMGs annually. Funding should be provided to screen potential candidates, and to allow each successful candidate to undergo up to six months of assessment and, if necessary, up to two years of postgraduate training. The program will be limited to specialties or communities in short supply. HHRAP should evaluate the impact of the program on the supply, mix and distribution of physician services in Ontario, and advise on the future of this program.

#24 HHRAP assess and provide advice on incentives to encourage existing specialists and family physicians to provide more of the services that are in short supply, such as psychiatry and obstetrical care. HHRAP also assess the impact that the cost of liability insurance has on access to certain health services and provide advice on how to address this issue.

#25 MOHLTC take steps to remove the barriers to collaborative physician/nurse practitioner primary care practice, and provide the funding to integrate a minimum of 75 nurse practitioners a year for the next five years into collaborative physician/NP practice, starting first in settings where collaboration has been successful.

#26 HHRAP assess the potential to double the number of nurse practitioners entering the workforce each year, beginning no later than 2006. The assessment should include the ability to recruit, train and place nurse practitioners, as well as the impact that doubling production of nurse practitioners will have on nursing supply in the province.

#27 MOHLTC work with hospitals to remove any artificial barriers that may prevent midwives from functioning appropriately within their scope of practice, thereby increasing the proportion of unassisted low-risk deliveries that midwives are able to perform each year.

MANAGE DEMAND

While all these initiatives to increase or maximize supply will help, the Expert Panel believes that not all Ontario's efforts to manage the system should focus on supply. Some attention should also be given to managing demand and ensuring that people use health services appropriately. The Expert Panel recommends that:

#28 MOHLTC develop initiatives designed to reduce inappropriate use of health services by educating the public about when to see a physician or other health care provider.

IV. ATTRACT AND RETAIN PHYSICIANS WHERE THEY ARE NEEDED

As of December 2000, 107 Ontario communities (33 in the North and 74 in the South) were designated as undersupplied for family physician services and were looking for a total of 456 family physicians. In addition, 12 communities in the North were designated as undersupplied for specialist services and were looking for a total of 123 different specialists.[1]

These figures highlight the need for physicians in underserviced areas. They also indicate how crucial it is for Ontario to keep the physicians who are already working in rural, northern and underserviced communities. Although Ontario has developed a number of successful initiatives to recruit physicians to underserviced areas, it has few incentives to retain them.

Decentralized, streamed training programs have the potential to attract a significant number of physicians to underserviced areas, but physicians will only stay if they have collegial support (the critical mass of physicians and other health care providers to meet needs and share on-call), appropriate facilities, adequate compensation, and access to continuing medical education. For physicians in rural practice, compensation, lifestyle and opportunities for family members are extremely important. To make rural practice more attractive for the physicians there now and those who will enter the workforce in the future, Ontario must act now. The Expert Panel recommends that:

#29 HHRAP develop an equitable, workable rurality index for specialty and family practice that can be used to quantify the degree of rurality and remoteness of physician practice in different communities across Ontario, and form the basis for compensation and incentive programs.

#30 MOHLTC, in consultation with HHRAP and the Physician Human Resources Subcommittee of the OMA/MOHLTC Physician Services Committee:

- establish a menu of incentives/initiatives for physicians based on their degree of rurality
- make an initial allocation of at least $10,000,000 in 2001 (over and above any existing contracts) to fund those incentives
- determine the future funding requirement for incentives.

1 Specialists are also in short supply in parts of southern Ontario, but there are programs to meet the need for specialized services in the south.

CONCLUSION

The Expert Panel's recommendations represent a comprehensive, strategic, system-wide approach to physician workforce planning. Taken together, they offer Ontario the opportunity to plan and manage physician services effectively. Implemented selectively, they will fail to have the desired impact and could have serious negative effects on the health care system.

Panel members caution the Ministry of Health and Long-Term Care about the risk of implementing certain recommendations, and ignoring others. For example, if the ministry makes the recommended increase in physician supply, without making fundamental changes to the education and training system, the inequities (i.e., distribution problems) in the system will become more acute. If it implements the proposed increase in supply, but does not develop other supportive health policies (i.e., efforts to manage demand for services, policies to encourage more comprehensive practice and greater collaboration between physicians and nurse practitioners), then the province will continue to struggle with a shortfall in physician services. To achieve its goals, the ministry must use all the available levers and tools, including planning, undergraduate education, postgraduate training, continuing medical education, incentives and other health policies that can shape physician practice.

The Expert Panel recognizes that its recommendations will have significant cost implications for medical schools, hospitals and other training sites, and incentive programs. Based on a rough, preliminary estimate, the costs would be about $45 million in the first year and about $190 million a year in 10 years time when all programs are implemented. Although the costs may seem high, the Expert Panel notes that they amount to less than 1% of Ontario's current health care budget, and stresses that they are an investment in the future.

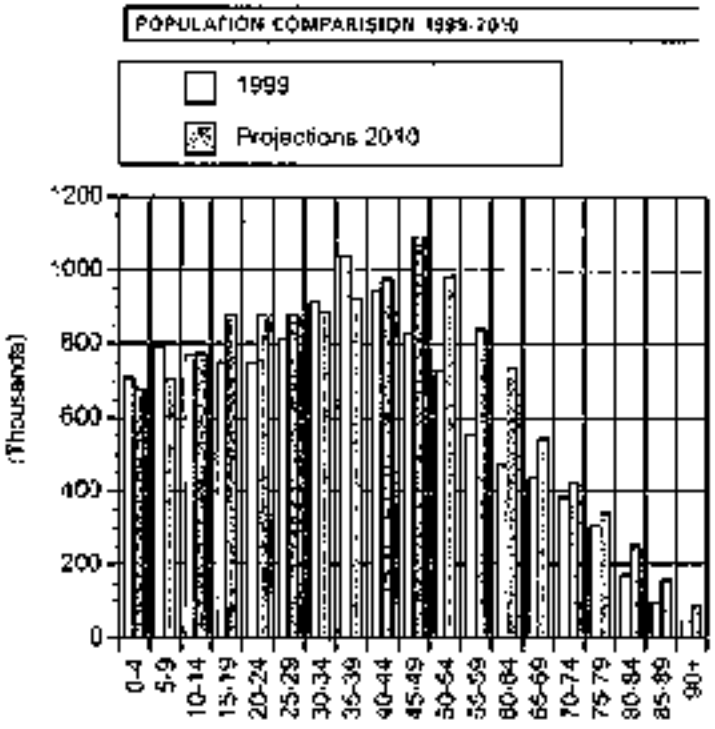
In the early 1990s, when health care spending was constrained, this plan would not have been possible. However, with the current fiscal climate, Ontario has a unique opportunity to establish the ongoing capacity to plan physician services, to reshape the way physicians are trained, to improve the mix and distribution of physician skills, and to confront inequities in health care. It also has the opportunity to lay the groundwork for integrated health workforce planning, which will be vital for the future of the health care system.

At this point in the evolution of Ontario's health care system, Ontario should make every effort to capitalize on these opportunities. The return on the investment – measured in improved quality and equity of care, greater patient and provider satisfaction, and the sustainability of the health care system – will be substantial. Without this investment, the quality of health care in Ontario will decline, and Ontario's "Blueprint" for a stronger health care system will be at risk. To safeguard the future, Ontario must invest today.

Introduction

The 11.7 million people who call Ontario home expect to have the health services they need, when they need them: now and in the future.

Over the next 10 years, Ontario's population is expected to increase by 12%, and the population will also age significantly.



As the population increases and ages, its need for health services will grow.

The Ontario Ministry of Health and Long-Term Care (MOHLTC) is committed to providing the services people need as close to home as possible. On September 11, 2000, Canada's First Ministers issued a Communiqué on Health, stating that

> ... the key goals of the health system in Canada are to: preserve, protect and improve the health of Canadians; ensure that Canadians have reasonably timely access to an appropriate, integrated and effective range of health services anywhere in Canada, based on their needs, not their ability to pay; and ensure its sustainability so that health care services are available when needed by Canadians in future years.[3]

In Ontario's "Blueprint" the government's policy platform for a stronger health care system and the recent Ontario Budget, the government underlines its commitment to ensure that all communities across the province have access to physician services. Yet there are signs that Ontario's health care system (like those in other provinces) may not have the number and mix of human resources to meet health needs or to provide equitable access to health services. As of the fall of 2000:

- 107 communities (33 in the north and 74 in the south) – up 9% from October 1999 – were designated as undersupplied for family physician services and were looking for a total of 456 family physicians
- 12 communities in the north were designated as undersupplied for specialist services and were looking for a total of 123 different specialists[4]
- Ontario was struggling to deal with a nursing shortage and, by the year 2007, is anticipating a cumulative loss of between 17,000 and 18,000 experienced working nurses due to retirements alone[5]
- 1,642 of 3,186 family physicians surveyed were not taking new patients; in 14 of 26 selected counties, over 75% of family physicians surveyed were not taking new patients; and 78 of 228 communities (34%) with a population of <10,000 had no open practices[6]

3 *First Ministers' Meeting Communiqué on Health, Canadian Intergovernmental Conference Secretariat, Ottawa, Ontario, September 11, 2000*

4 *Specialists are also in short supply in parts of southern Ontario, but there is no program to track the need for specialized services in the south.*

5 *O'Brien-Pallas L., Baumann A. Towards evidence based policy decisions: A case study of nursing health human resources in Ontario, Canada. Nursing Leading. (3)4:245-257, 2000.*

6 *Family Medicine Practitioners Taking New Patients in Selected Counties in Ontario. Ontario Physician Human Resources Data Centre, November 2000.*

- patients referred to a medical specialist were waiting between 5.5 and almost 12 weeks for a first consultation; patients referred to a surgical specialist were waiting between three weeks and 16 weeks for a first consultation[7]
- non-urgent patients referred to a cardiac specialist were waiting about eight weeks for a first appointment in most parts of the province except the northeast and the northwest, where the waiting times were over 16 and 24 weeks respectively[7]
- 1,889[8] breast and prostate cancer patients had been re-referred from their home treatment centre to treatment centres in the north or in the United States because of a shortage of cancer care providers in southern, central and eastern Ontario.

COMMITMENT TO HEALTH HUMAN RESOURCES

In the Communiqué on Health, the First Ministers specifically addressed the issue of health human resources, and agreed to: "ensure that each government or jurisdiction has the people with the skills needed to provide appropriate levels of care and health services. Their governments will coordinate efforts on the supply of doctors, nurses and other health care personnel so that Canadians, wherever they live, enjoy reasonably timely access to appropriate health care services. Their governments will also work together to identify approaches to improve education, training, recruitment and retention of our future health workforce."

How will Ontario fulfill this commitment? What can the province do to develop and shape its health human resources to meet health needs?

The work is already underway. In February 2000, Elizabeth Wilmer, the Minister of Health and Long-Term Care established the Expert Panel on Health Professional Human Resources, chaired by Dr. Peter George, President and Vice Chancellor, McMaster University. The Panel's task was to:

> Provide advice on the most effective ways to ensure an adequate supply of physician services and appropriate use of other health professionals over the medium to long-term in Ontario.

7 *Ontario Physician Human Resource Data Centre, 2000*

8 *Since January 1999, when the computerized program started.*

ABOUT THE EXPERT PANEL

TASKS

The Expert Panel on Health Professional Human Resources was charged with five tasks:

- Provide advice on strategies to ensure an adequate supply of physician services, including changes in medical school enrolment and the recruitment of International Medical Graduates (IMGs)
- Examine the appropriate use of other health professionals
- Identify strategies to ensure more effective distribution of physician services
- Provide advice on changes to the medical education system to ensure an appropriate mix of physician services
- Develop a framework to assess physician human resource requirements.

PRINCIPLES

The Expert Panel based its work on the following principles:

Rights and Responsibilities

1. All Ontario residents should have timely access to health care from a suitably qualified health care professional.
2. Recognizing that health care professionals exist to serve the public, strategies to improve physician supply and distribution should balance the needs of the individual with the needs of the individual health care provider.
3. Health professionals should provide appropriate services. Consumers should be educated and encouraged to use health services responsibly.

Overall Planning

4. A sustainable supply of physician services should exist within an affordable health care system.
5. Planning for physician services should be aimed at ensuring that Ontario is self-sufficient in the supply of health care professionals.
6. Planning for physician services should be needs-based, evidence-driven and continually monitored to anticipate and respond quickly to required changes in needs.
7. Planning for physician services should be flexible and reflect differences in health needs and models of care among various communities and regions throughout the province.
8. Medical education and postgraduate training in Ontario should be based on a provincial planning framework for physicians.

9. Regional physician workforce plans should be developed within a provincial framework and closely co-ordinated with provincial and national workforce initiatives.

10. The needed supply and mix of physicians will be affected by the number and mix of other health care providers.

11. The supply and mix of physicians is influenced by the degree of access to appropriate infrastructure and facilities such as ambulatory care centres, operating rooms and intensive care units.

12. Strategies to improve the distribution of health care professionals should be designed to attract and encourage them to practice in areas of need rather than penalizing them for not doing so.

APPROACH

Focus

Because of the key role that physicians play in the health care system, the current shortage of physician services, the long lead-time required to train physicians, and the mandate it was given, the Panel decided to focus primarily on issues related to physician services, taking into account other health professionals that provide those services.

Structure

To analyze and address the key issues, the Expert Panel established three working groups: the Working Group on Data and Modelling, chaired by Dr. Ben Chan; the Working Group on Supply, chaired by Dr. Michael Howcroft; and the Working Group on Distribution, chaired by Dr. William McCready.

The working groups, which were made up of Expert Panel members as well as others with knowledge and expertise in these areas (see Appendix 1), gathered information and developed recommendations, which were presented to the Expert Panel for discussion and decision.

Activities

The Expert Panel's work over the past 10 months focused primarily on two activities:

1. Improving physician workforce data and developing more sophisticated data modelling and forecasting tools (primary research).

2. Reviewing the extensive work that has already been done on managing physician resources in Ontario, Canada and other jurisdictions, and assessing the feasibility, effectiveness, cost and potential impact of various strategies (secondary research).

In the course of their work, members of the Expert Panel reviewed

- the recent major reports on health human resources in Ontario and other jurisdictions

- submissions from the north and from southwestern Ontario, proposing strategies to educate physicians for practice in northern, rural and underserviced settings
- papers and recommendations prepared by different medical specialty groups and other provider groups. (For a list of submissions and presentations to the Expert Panel, see Appendix 2.)

In addition, the Panel monitored health human resource strategies in other provinces and jurisdictions facing the same issues.

In an attempt to develop new data modeling tools, the Expert Panel worked with data modelling experts from the Institute for Clinical Evaluative Sciences (ICES), the Ontario Physician Human Resource Data Centre (OPHRDC), the Canadian Medical Association (CMA) and the Nursing Effectiveness, Utilization and Outcomes Research Unit. In addition, the working group applied the Physician Resource Evaluation Template (PRET) model developed by the CMA. It also gathered data on education and retention strategies that have proven effective in meeting the needs of underserviced areas, on the collaborative practice of primary care physicians and nurse practitioners (NPs), and on services provided by midwives.

Strategic Approach: System-wide, Needs-based, Evidence-driven

The Panel used state-of-the-art conceptual and evidence-driven approaches to health workforce planning. Its recommendations about physician numbers are based on an attempt to measure the population's service needs, identify the right number and mix of physicians and other professionals to provide that level of service, and then shape services to meet needs. Its recommendations for physician recruitment, education and retention are based on evidence that similar approaches have worked well in Ontario or in other jurisdictions and can be adapted to Ontario.

In developing its recommendations, the Panel adopted a strategic, system-wide approach designed to address all factors that affect physicians' practice and the type of services they provide, including how physician services are planned, where and how physicians are educated, other providers who can contribute to the supply of physician services and physicians' working conditions and incentives.

ABOUT THE REPORT

In this report, the Expert Panel on Health Professional Human Resources lays out four key steps that Ontario can take to develop the ongoing capacity to shape health human resources to meet health needs, beginning with physician services.

1. Plan services to meet needs
2. Provide appropriate education
3. Produce the right supply and mix of physician services
4. Attract and retain physicians where they are needed.

Background

CHALLENGES OF HEALTH HUMAN RESOURCES PLANNING

Although human resources are only one component of a complex health care system,* they are the most difficult part to plan and manage. This is due to:

- the time required to produce skilled health professionals – nine to 12 years to train a physician, up to four years to train a registered nurse, and another year beyond a BScN to prepare a nurse practitioner
- the competition for mobile Ontario-trained health professionals – in Canada and in other parts of the world
- the explosion in new knowledge and treatments – which makes it difficult for training programs and health professionals to keep current with new developments and, at the same time, affects practice patterns
- the impact of broad health policies, such as primary care reform, mental health reform, health services restructuring, and the restructuring of long-term care services – which can create uncertainty in the workplace and affect attitudes and morale
- changing demographics – the increasing number of female physicians, who tend to practice differently and work fewer hours than male physicians, particularly when their children are young; and the large cohort of physicians who are reaching retirement age – which will affect the total number of physicians required to deliver the same level of service
- changing practice patterns – the growing number of physicians reluctant to maintain an onerous workload and seeking more balance between their professional and personal pursuits, which will affect the total number of physicians required to deliver the current level of service
- the pressure and demands of the current health care system, and their impact on morale and on the willingness of people to enter and stay in health-related careers.

Efforts to plan and manage Ontario's physician human resources planning are also complicated by the fact that physicians have traditionally been viewed as a national resource. Ontario is committed to a national strategy for physician resources, and must be sensitive to the impact that any of its health human resource policies and decisions may have on the other provinces.

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9 The health care system is a complex mix of policies, programs, facilities, people, knowledge, buildings, equipment, and products

PAST EFFORTS AT PHYSICIAN RESOURCE PLANNING

Past efforts at physician resource planning have been hampered by the inability to identify and forecast needs or supply accurately, the inflexibility of the medical education system, the inability to assess the impact of training, working conditions and other factors on physician practice, and the tendency to invest in short-term solutions, rather than developing the capacity for ongoing, long-term planning. Past decisions have also often been based more on financial imperatives, than on population health needs. In fact, past efforts to manage physician resources have often created serious problems. For example:

- The recommendations of the Hall Commission Report (1964) dramatically increased Canada's capacity to produce physicians and to attract foreign trained physicians (i.e., international medical graduates or IMGs). However, the projected population growth on which the Commission's recommendations were based did not materialize. For a number of years after, Canada continued to have a physician oversupply – even after moving (in 1975) to limit opportunities for international medical graduates.

- Faced with growing deficits and pressure to contain health care costs, federal, provincial and territorial governments adopted some recommendations of the Barer Stoddart report (1991), cutting undergraduate medical school enrolment by 10% and reducing post-graduate positions (effective 1993). However, the governments did not act on the report's other interdependent recommendations about payment methods and models of care, which were designed to influence how the smaller number of physicians would work as well as the services they would provide.

- Financial pressures also led to policies, such as claw backs, proposed billing number restrictions and new entrant discounts, that had an adverse effect on physician morale and led to an increase in physician migration from Ontario.

As a result of a combination of actions and decisions, Ontario – like most other provinces in Canada – is now faced with a physician supply problem that will only be exacerbated by the full impact of the 1993 reductions (which will affect the graduating class of physicians beginning in 2000) and by the significant proportion of older physicians who are expected to retire in the next 10 to 20 years.

According to the Canadian Institute for Health Information (CIHI), Ontario's physician to population ratio dropped 3.2% between 1995 and 1999. In 1999, Ontario had 179 physicians per 100,000 population compared to a national average of 186 physicians per 100,000 population. Based on that 1999 data, Ontario is tied for fourth with Manitoba in the number of physicians to the size of the population, trailing Quebec, B.C. and Nova Scotia.

CURRENT EFFORTS TO MANAGE PHYSICIAN SUPPLY

In the spring of 1999, the joint MOHLTC/Ontario Medical Association (OMA) Physician Services Committee expressed concern that, given the province's increasing and aging population, the smaller number of new physicians being produced and the aging of the physician workforce, Ontario might not have enough doctors to meet current and future needs. In response, the Minister of Health and Long-Term Care, Elizabeth Witmer:

- appointed, in July 1999, a Fact Finding Commissioner, Dr. Robert McKendry to help understand the problem. His task was to assess the scope and nature of Ontario's physician supply, mix and distribution problems, and to recommend some short-term solutions
- announced in December 1999, the Expert Panel on Health Professional Human Resources, chaired by Dr. Peter George, to begin the process of long-term planning for health human resources, starting with physician resources, and to recommend medium to long-term solutions. The Panel began its work in February 2000.

RECOMMENDATIONS OF THE FACT FINDER

In his December 1999 report[9], Dr. McKendry confirmed that, based on the research he conducted across the province, Ontario has a growing, pervasive problem with the "effective supply"[10], mix and distribution of physician services. In his view, the pressures on the system are coming from the increasing population, the growing number of female physicians who, in the early years of their career, work fewer hours than their male colleagues, the desire of all physicians to lead more balanced lives, the current level of physician migration, the aging of the physician pool, and the drop in the number of new graduates. According to McKendry, the province's current tight physician supply is exacerbating the province's long-standing problem of physician distribution.

He recommended that Ontario use a number of strategies to increase total physician supply by about 5% or about 1000 physicians overall, including increasing medical school enrolment by about 20% and, at the same time, addressing the province's long-standing problems with distribution. He suggested that Ontario focus first on implementing short-term solutions to attract already trained physicians, and then on developing long-term opportunities to provide more training and experience in rural medicine, which will attract and prepare physicians who will choose rural and remote practice. In addressing the problem of distribution, he suggested that the province assess the feasibility of establishing a new medical school, located in northern Ontario, with a mission to prepare physicians for northern and rural practice.

He also recommended that Ontario take steps to improve its ability to assess population health needs, plan and manage physician services, recruit and retain physicians where they are needed, and make more effective use of other health professionals, particularly nurse practitioners.

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9 McKendry R. *Physicians for Ontario: Too Many? Too Few? For 2000 and Beyond. Report of the Fact Finder on Physician Resources in Ontario.* Ontario Ministry of Health and Long-Term Care. December 1999

10 *Effective supply is the overall amount and type of physician services available to meet medical health care needs. It is a measure of physician productivity, determined by analyzing the collective total billings of individual physicians (how much do they bill? What kind of services do they provide?). Effective supply takes into account the volume of the services provided and overall productivity of the workforce.* Source: McKendry RM. *Physicians for Ontario: Too Many? Too Few? For 2000 and Beyond. Report of the Fact Finder on Physician Resources in Ontario.* December 1999.

OTHER VIEWS

About the same time Dr. McKendry's report was released, the Canadian Medical Forum[12] Task Force on Physician Supply in Canada produced a major report on physician services in Canada. It concluded that, to avoid a serious physician shortage and decline in quality of care, Canada will need about 2500 new physicians each year (an increase of about 4% per year), and recommended increasing enrolment in Canadian medical schools to 2000 by the year 2000 (an increase of about 27% over 1998 levels).

Around the same time, the Institute for Clinical Evaluative Sciences issued an Atlas Report, *Supply of Physicians' Services in Ontario*, prepared by Dr. Ben Chan. That report identified some key issues in physician practice patterns, in particular:

- increasing subspecialization among internists and surgeons, which may help physicians cope with the increasing complexity of medical care but also reduces the number of "general" specialists available to serve rural areas and may contribute to the maldistribution problem.
- the decreasing number of family physicians who provide "comprehensive" care, such as providing services in hospital inpatient wards, nursing homes and emergency rooms, or providing anesthesia or obstetrical services.

As Ontario's health care system has traditionally relied on family physicians to provide a range of services outside their offices, and on general specialists and specialty trained family physicians to provide specialized services, particularly in smaller communities, these trends have serious implications for the effective supply of physician services. Dr. Chan suggests that simply adding more physicians to the system won't be enough to solve the physician supply problem. There must be other incentives to encourage physicians to go where they are needed and to provide the full breadth of services required.

THE IMPACT OF NEW/EXPANDED PROGRAMS AND HEALTH SYSTEM REFORM

Over the next 10 to 20 years, Ontario expects to see a significant increase in demand for a number of services associated with aging, such as cardiac care, cancer care, joint (hip and knee) replacements, dialysis, and specialized geriatric services.

MOHLTC has taken steps to increase the system's capacity to meet these priority health needs. For example, it recently announced funding for three new tertiary cardiac centres[13], five new cancer centres[14], a 30% increase in funding for dialysis services, 20,000 long-term care beds (scheduled to come on stream by 2004), an increased number of hip and knee replacements, and new funding for nurse practitioners to work in underserviced areas, primary care reform projects, long-term care facilities and aboriginal communities. While these service expansions will help meet population health needs, they also increase the demand for skilled health professionals in these fields in different parts of the province.

MOHLTC has also identified a serious shortfall in the field of public health. The province's 37 health units currently have 15 vacancies: seven for Medical Officers of Health (MOHs) and eight for Associate MOHs. Over half the positions for community medicine specialists in the City of Toronto have been vacant for over two years. The

12 *The Canadian Medical Forum is made up of 11 different organizations, including the Canadian Medical Association, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, the Canadian Nursing Association, the Association of Canadian Medical Colleges, the Association of Canadian Teaching Hospitals, the Canadian Association of Interns and Residents, the Canadian Federation of Medical Students, and the Consumers' Association of Canada.*

13 In Mississauga, Kitchener-Waterloo and Newmarket

14 In Oshawa, Mississauga, St. Catharines, Kitchener and Sault Ste. Marie

recent health issues related to water quality and safety have highlighted the critical importance of adequate, high quality public health services and the vital role the MOH plays in the community. Ontario must have the skilled professionals to respond to public health needs[15].

Changes are also occurring within the primary care system that may affect physician services. Over the next four years, MOHLTC and the OMA have agreed to shift 80% of family physicians from fee-for-service practices to group practices, based on alternative payment plans. This could have a significant impact on the way physicians practice, the opportunities for interdisciplinary care teams, and the availability of physician services.

Any effort to plan and manage health human resources must take into account these health care priorities and changes.

PROGRESS IN 2000

I. More Postgraduate Training and Placement Support: Implementing McKendry Recommendations

During 2000, MOHLTC quickly implemented a number of Dr. McKendry's recommendations, including:

- providing up to two years of postgraduate training to repatriate up to 15 Canadian physicians (annually) who took their postgraduate training in the United States
- increasing from 24 to 36 the number of positions in the training program for international medical graduates (IMGs) at the University of Toronto
- increasing from 24 to 30 the number of entry level residency positions in the northern family medicine programs in Sudbury and Thunder Bay
- increasing from four to 10 the number of third year family medicine positions in Sudbury and Thunder Bay, which offer family physicians additional training in obstetrics, emergency medicine, anesthesiology, care of the elderly and psychiatry
- expanding from 25 to 40 positions the existing re-entry/return-of-service program (MOHLTC is currently reviewing the program to identify ways to attract more applicants)
- increasing from three to six the number of Community Development Officers to help small and rural communities recruit health care professionals.

The McKendry recommendations that were implemented resulted in an increase of 33 new postgraduate training positions, as well as providing opportunities for 21 existing physicians to take additional training.

Later in the year, as part of the 2000 Budget, the government announced an expansion of the Telehealth program established in northern Ontario in 1999 to southern Ontario (which had also been recommended by Dr. McKendry), and will recruit a total of 144 nurses to staff the province-wide service. This health information service has the potential to reduce inappropriate visits to emergency departments and physicians' offices.

15 *According to section 64 of the Health Protection and Promotion Act (HPPA) and Regulation 561, a Medical Officer of Health must be a physician in good standing with the College of Physicians and Surgeons of Ontario and have either:*
- *a certificate in community medicine from the Royal College of Physicians and Surgeons of Canada; or*
- *a certificate, diploma or degree from a university in Canada, granted after not less than one academic year of full-time postgraduate studies or its equivalent in public health. These studies must include epidemiology, quantitative methods, management and administration, and disease prevention and health promotion.*

2. Better Data and More Undergraduate Positions: Implementing Expert Panel Interim Recommendations

The ministry referred the remaining recommendations in the McKendry report to the Expert Panel on Health Professional Human Resources for further study.

In the early days of its work, the Expert Panel identified two key issues that should be addressed before the end of its mandate:

- the need to develop a more robust physician database to support its work and provide a sound basis for future planning
- the need to make some immediate, preliminary increases in medical school enrolment for the 2000/01 school year, as recommended by Dr. McKendry. (Several other provinces, including Alberta, Quebec and New Brunswick, had already announced increases in enrolment. The Expert Panel was concerned that, by waiting to determine the exact number of new physicians required, Ontario would "lose" a year.)

To deal with these issues, the Expert Panel recommended that MOHLTC:

Facilitate and finalize the necessary agreements to allow the Institute for Clinical Evaluative Sciences (ICES) and the Ontario Physician Human Resources Data Centre (OPHRDC) to develop a more robust, reliable physician database for Ontario which will allow for development of a workload measure and provide a more accurate assessment of effective physician supply.

Provide funding for an interim increase in undergraduate and postgraduate positions, beginning in September 2000, for the 2000/01 school year.

The ministry acted on both recommendations. It provided resources to facilitate enhancement of the ICES and OPHRDC databases, and to develop more robust baseline data on physicians in Ontario. These data formed the basis for the Panel's data modelling and analysis.

The ministry also increased medical school enrolment by adding a total of 40 undergraduate positions (an increase of 7.6%) in the fall of 2000. The new undergraduate positions were allocated among the Ontario's five medical schools as follows:

Medical School	# of new positions
University of Western Ontario	7
McMaster University	8
University of Toronto	13
Queen's University	5
University of Ottawa	7
Total	**40**

WHERE WE ARE NOW

These increases in physician numbers are only the first step. To be able to provide the right services in the right places, Ontario must take a more systemic approach – one that tries to manage all the factors that affect the supply of physician services, including how services are planned, how physicians are selected and trained, the number required, the available practice opportunities, the incentives provided, and the ongoing support for physicians and other health care providers.

The Expert Panel cautions that, to achieve the desired result – the equitable distribution of physician services to meet health needs – Ontario must adopt a comprehensive approach. It is not enough simply to train more physicians. The province must also develop the ongoing capacity to identify current and future needs, to select and prepare physicians who will have the right skills, to manage all its health resources effectively, and to provide appropriate incentives for physicians and other health professionals.

I. Plan Services to Meet Needs

To plan effectively, the system must understand health needs, and how to shape and use all parts of the system to meet needs. But planning health services is no simple task.

How many health services will we need? Will those needs change over the next five to 10 years? How many hospitals, operating rooms, magnetic resonance imaging machines (MRIs) and other facilities will be required to meet needs? How many doctors, nurses and other health professionals will Ontario need? What training and skills will those health professionals have to have? How can Ontario ensure that health services and health professionals are distributed equitably across the province?

Ontario's past efforts to plan and manage its health human resources have been hampered by the lack of accurate consistent data on the supply of physician services and on the population's health needs. Different provincial and national databases report different numbers of physicians, and none has been able to provide comprehensive, consistent information on the exact services physicians provide or their workload. There is also no reliable method to identify or measure health needs, or determine the services required to meet needs. Past efforts at physician workforce planning have also suffered from the lack of ongoing monitoring, and the inability to make adjustments to reflect any changes in needs or the environment.

The 10 months that the Expert Panel has spent assessing the issues has only confirmed the conviction that health human resources planning is not a short-term, time-limited process. The Expert Panel believes that Ontario must start now to develop the capacity for ongoing, effective, needs-based, evidence-driven integrated health human resource planning. In particular, Ontario needs:

- the ability to assess needs, determine the capacity of the system, develop plans, anticipate changes and adjust its plans to reflect changing needs, policies, practices and technology
- more accurate workforce data to understand the issues and guide planning decisions.

DEVELOP THE CAPACITY TO PLAN

In his report, Dr. McKendry recommended that Ontario establish a permanent independent structure responsible for health workforce planning. The Expert Panel agrees with Dr. McKendry's recommendation, and recommends that:

#1 MOHLTC establish the Health Human Resources Advisory Panel (HHRAP), a permanent, expert advisory body responsible for continually monitoring and anticipating the health needs of Ontarians and making recommendations on the appropriate supply, mix and distribution of health human resources to meet health needs. HHRAP should develop the capacity for integrated health human resources planning, beginning with building the capacity for physician services planning. MOHLTC should review HHRAP after its first three years of operation to ensure its efficacy.

OBJECTIVES

HHRAP's key objectives are to:

- Continuously monitor and identify future requirements for physicians and other health professionals based on key indicators of health needs (e.g., demographics, health status, disease incidence), referral patterns, health provider demographics, workload trends, labour market analyses and changes in the health care delivery system
- Recommend planning targets and policy initiatives for a specific planning cycle (e.g., three years)
- Provide for ongoing consultation with regional health agencies, such as district health councils, to identify needs and system changes at a regional or district level
- Liaise with other provincial and national planning bodies, such as the Joint Provincial Nursing Committee (JPNC), the Physician Services Committee (PSC), the Cardiac Care Network (CCN), and Cancer Care Ontario (CCO), as well as research organizations, such as the Institute for Clinical Evaluative Sciences (ICES), the Centre for Health Economics and Policy (CHEPA), the Centre for Rural and Northern Health Research (CRaNHR), and the Nursing Effectiveness, Utilization and Outcomes Research Unit, to assist in addressing specific issues or questions related to health human resource policy and planning objectives
- Evaluate and monitor the impact of policy initiatives and planning targets and recommend changes as required.

STRUCTURE

The Expert Panel proposes a six to eight-member advisory panel, whose members will be chosen based on their broad background, experience and knowledge in health human resource planning in Ontario and other jurisdictions. Members will serve two to three year terms, with the option of renewing for one term. The chair will be appointed by and report directly to the Minister of Health and Long-Term Care.

The panel will be supported by a small dedicated secretariat, with an executive director accountable to the chair. HHRAP would form working groups and ad hoc committees as necessary to address specific technical issues that may be related to a particular profession (e.g., physicians, nurses), a particular sector of health care (e.g., cardiac, cancer, long-term care), or a particular aspect of health human resources (health human resources data, modelling approaches, education, migration, regulation). Working groups and subcommittees would include representation from key stakeholders where appropriate.

HHRAP will meet approximately once every two months to set priorities, review reports from working groups/ad hoc committees, and develop advice for the Minister. It will provide reports/recommendations to the Minister as required as well as an annual report to the Minister and stakeholders.

IMPROVE THE DATA

To plan effectively, Ontario must know how its physician workforce works. In September 2000, on the recommendation of the Expert Panel, MOHLTC worked with the two organizations that maintain key physician databases in the province – the Ontario Physician Human Resources Data Centre (OPHRDC) and the Institute for Clinical Evaluative Sciences (ICES) – to integrate the existing databases and develop a more comprehensive database on all physicians in active practice in Ontario, called the Ontario Physician Workforce Database. With this database, Ontario is now able to:

- accurately count and track the number of physicians in practice, by age and gender
- determine their workload or level of activity (i.e., part-time, full-time, or more than full-time)
- identify their functional specialty (i.e., identify the services they actually provide, as opposed to assuming that they are providing a comprehensive range of services in their specialty of certification). This is important because it eliminates the problem of over-estimating the effective services available to meet health needs. For example, a significant proportion of ophthalmologists may devote a large part of their time to non-Ontario Health Insurance Plan (OHIP) or privately funded activities, such as refractive surgery and cosmetic procedures, and may not be available to meet the population's need for routine, publicly funded ophthalmological services; a significant proportion of obstetrician/gynecologists may not deliver babies; and a proportion of active physicians attached to the academic health science centres (AHSCs) may spend a significant amount of their time in clinical teaching and research rather than in providing care.

The Ontario Physician Workforce Database – which formed the basis for the Expert Panel modelling exercises – can now be used with some confidence to assess the effective supply of physician services available to the public. It will give Ontario the ongoing capacity to determine the effective supply of physician services available to the population, and to assess the impact of any change in factors that can affect supply now and in the future (e.g., retirements, the increase in the number of female physicians, and changes in the comprehensiveness of physician practice patterns).

However, to be an effective tool, the Ontario Physician Workforce Database must be continually maintained and refined, and comparable high quality data must also be available for nurses and other health professionals. The Expert Panel recommends that:

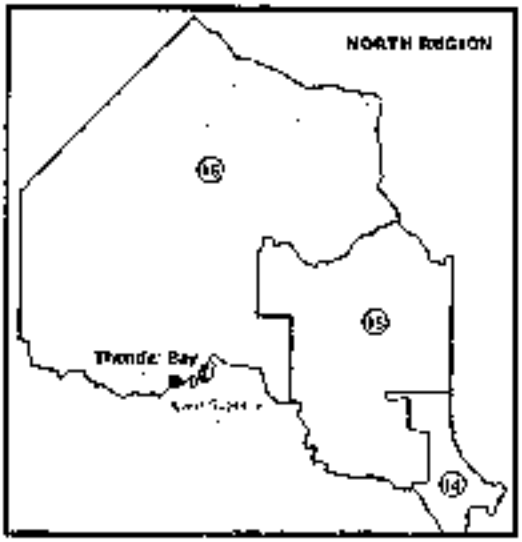
R2 **HHRAP, with the financial support of the MOHLTC, continue to refine and use the Ontario Physician Workforce Database as the basis for physician workforce planning, and work with the other professions to develop comparable high quality workforce databases.**

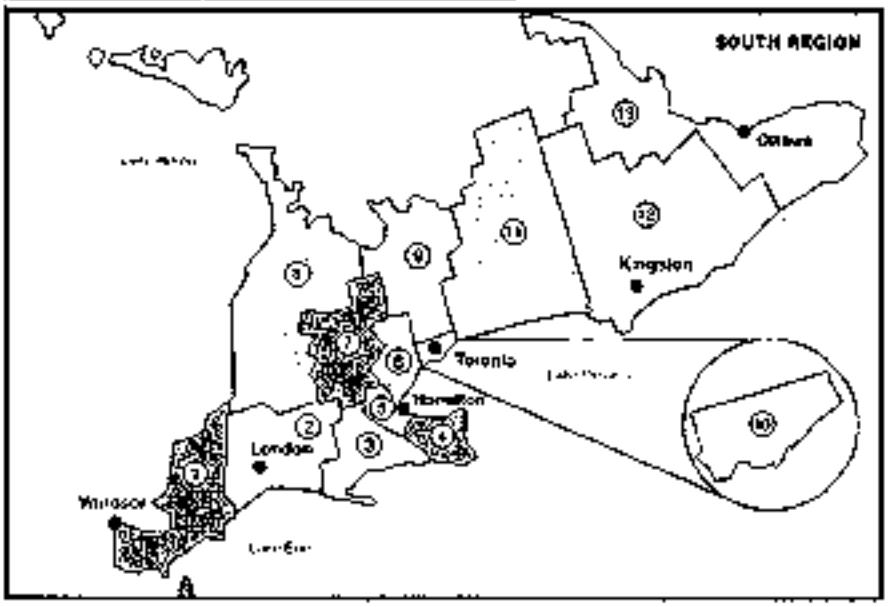
II. Provide Appropriate Education

Simply counting physicians or producing more of them will not solve Ontario's physician supply problems. As noted by Barer-Stoddart, McKendry, and Chan, the main cause of inequities in Ontario's health care system is the maldistribution of health resources - including the physician workforce. A tight physician supply only aggravates the long-standing challenge of providing health care services in chronically underserved areas, and allows the problem to creep into urban communities that, when doctors were more plentiful, had enough physician services.

The following maps, prepared by ICES, highlight the parts of the province that are undersupplied for physician services

AREAS UNDERSUPPLIED FOR PHYSICIAN SERVICES





ONTARIO DISTRICT HEALTH COUNCILS

1. Essex, Kent and Lambton
2. Thames Valley
3. Grand River
4. Niagara Region
5. Hamilton-Wentworth
6. Halton-Peel
7. Waterloo Region + Wellington – Dufferin
8. Grey, Bruce, Huron, Perth
9. Simcoe-York
10. Toronto
11. Durham, Haliburton, Kawartha and Pine Ridge
12. Quinte, Kingston, Rideau
13. Champlain
14. Muskoka, Nipissing, Parry Sound and Temiskaming
15. Algoma, Cochrane, Manitoulin and Sudbury
16. Northwestern Ontario

DATA SOURCE: National Physician Database for fee-for-service physicians, Ministry of Health, Canada Institute for Health Information and Association of Ontario Health Centres for non-fee-for-service physicians

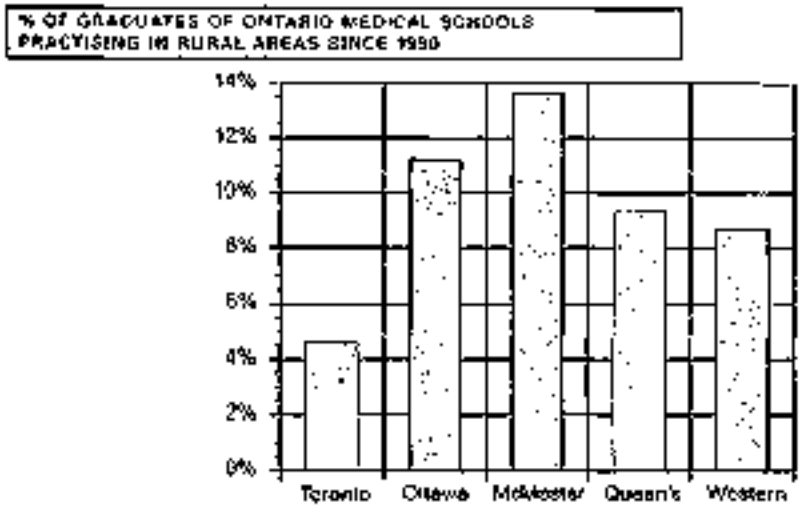
GENERAL & FAMILY PRACTITIONER SUPPLY PER 10,000 POPULATION

- GREATER THAN 8.5 (5)
- 8.0 TO 8.49 (4)
- 7.5 TO 7.99 (4)
- 7.0 TO 7.49 (3)

Value in brackets is the number of DHCs in each category

Source of maps: Chan B. Atlas Report: Use of Health Services, Report #1: Supply of Physicians Services in Ontario. Institute for Clinical Evaluative Sciences. November 1998.

The problem is that not enough physicians choose to work in rural or remote communities. The following chart illustrates the proportion of graduates from Ontario medical schools between 1990 and 1999 who chose rural or remote practice[16].



Why is the proportion so small?

THE ARGUMENT FOR DECENTRALIZING AND STREAMING MEDICAL EDUCATION

Based on a literature review and experience in other jurisdictions, the Expert Panel learned that rural physicians do not just happen, they have to be nurtured and developed. Physicians are more likely to choose to practice in rural, remote or underserviced areas when they[17]:

- grow up/complete high school in a small or rural community
- receive frequent, early exposure to rural, remote or underserviced practice in their undergraduate training
- have access to streamed medical education programs that ensure they develop the skills required for rural, remote or underserviced practice
- receive a significant portion of their postgraduate training in rural, remote or underserviced areas
- have rewarding practice opportunities/careers in rural settings
- have the support to lead a balanced life (e.g., critical mass of physicians and other health providers, working conditions, opportunities for continuing education).

How can Ontario use this knowledge to shape physician services to meet these needs? How can it develop physicians with the attitudes/skills required to work in rural, remote and underserviced areas?

16 McKendry R. *Physicians for Ontario, Too Many? Too Few? For 2000 and Beyond. Report of the Fact Finder on Physician Resources in Ontario.* December 1999. Source for the data: Canadian Medical Association.

17 McKendry R. *Ontario Physician Resources. Medical Education and Rural/Remote Practice Location. Abstracts of International Experience. Prepared for the Expert Panel on Health Professional Human Resources.* April 4, 2000.

The strategy of recruiting medical students to a rural stream and providing education in a rural setting has been used successfully in a number of other jurisdictions, including the United States, Australia, New Zealand, Norway and Japan. Ontario's preliminary efforts at providing a rural education stream – the postgraduate family medicine and generalist specialist programs organized through the University of Ottawa and McMaster University, and provided in Sudbury and Thunder Bay – have also been extremely effective. A recent study[18] indicated that 70% of graduates of the Family Medicine North program and the Northeastern Ontario Family Medicine program continue to practice in rural and remote settings.

In an attempt to build on this success and develop streamed training programs that will help shape rural physicians, the McKendry report recommended that the existing medical schools develop rural streams. At the same time, the Fact Finder also recommended that the ministry assess the feasibility of establishing a northern medical school that would not only provide a northern/rural stream but recruit students from rural settings and provide education in a northern/rural setting – thereby ensuring at least four of the critical success factors for producing rural physicians.

During its deliberations, the Expert Panel reviewed submissions for different options for providing rural medical education, including one for a northern medical school and one for a regional medical program based in Windsor. While the submissions advocated different strategies, they all made it clear that physicians in practice in underserved areas – the northeast, northwest and southwest – are ready and willing to take a more active role in preparing physicians and other health care providers for rural and remote practice. As the ones who have chosen rural practice and who are dealing day-to-day with the shortage and inequity of physician services, they believe they can be an important part of solving the problem.

Driven by the imperative to distribute services more equitably, the Expert Panel believes that Ontario must change the way it selects medical students and educates physicians. The Expert Panel supports the need for training in rural settings and for rural training streams that can help shape physician services to meet needs. It believes the province must develop the capacity – in all regions of the province – to provide multidisciplinary education that prepares health professionals to work where they are needed. At issue is the most cost-effective and sustainable way for Ontario to achieve that goal.

A PLAN FOR INTEGRATED RURAL, NORTHERN AND UNDERSERVICED MEDICAL EDUCATION

The Expert Panel proposes a plan for an integrated, province-wide approach to rural, northern and underserviced medical education. The plan, which will require fundamental changes to the way medical education is delivered and organized, will involve:

- providing more opportunities for decentralized medical education at all stages of training in rural, northern and underserviced areas
- developing appropriate training streams and recruitment strategies
- ensuring quality

18 *Pong R et al. Medical Training and Practice Locations: A Tale of Two Provinces. Centre for Rural and Northern Health Research, Laurentian University; Northeastern Ontario Family Medicine Program; August 2000*

DECENTRALIZE MEDICAL EDUCATION

Health needs can differ markedly from one community to another and, as noted earlier, can be influenced by socio-economic status, culture and geography. The health needs of a remote northern community will be different from the health needs of a small town in southwestern Ontario, which will be different from the health needs of a large, multicultural urban centre. At a more specific level, the needs of underserviced urban populations are distinct from those of underserviced rural populations. And the needs of an aboriginal community will be different from the needs of francophone or other cultural communities.

As McKendry stressed, Ontario's health care system must not just address geographic inequities, it must also address the inequities and unmet needs of certain populations, such as the urban poor and aboriginal people. It must be able to produce health professionals who are prepared to work in different settings, with different populations.

RURAL TRAINING INITIATIVES IN ONTARIO NOW

The Northeastern Ontario Family Medicine (NOFM) program and the Northeastern Elective Program (NEP) program at Laurentian University in Sudbury, linked with the University of Ottawa.

The Northwestern Ontario Medical Program (NOMP) and Family Medicine North program at Lakehead University, linked with McMaster University.

The Northern Academic Health Science Network (NAHSN), based out of Sudbury and Thunder Bay (established in May 1999).

The South Western Ontario Rural Medicine (SWORM) program, based in Goderich and linked with the University of Western Ontario.

Rural Ontario Medical Program (ROMP), based out of Collingwood, and linked with McMaster University.

Location of training is clearly a key factor in determining both the mix and distribution of physician services, and one that has not been used to its full potential in Ontario. At the current time, most of Ontario's medical education is provided at the province's five AHSCs, and focuses mainly on the type of care that can be provided in large urban tertiary care centres. While some of the medical schools have made an effort to provide some rural training opportunities (see box), only a relatively small number of medical students receive any significant exposure to rural practice in their six to 10 years of medical school – and most of that occurs late in the students' training. (Even fewer have any exposure to the health needs of underserviced populations, such as aboriginal people, the urban poor, or people with mental health and/or addictions problems.) This significantly reduces the chance that physicians will choose a career in rural medicine or underserviced areas. It also means that many may not be prepared – or may not have the confidence – to practice in communities that lack the resources of a tertiary care teaching hospital.

The Expert Panel believes that this must change. More education must occur in and with underserviced communities and populations, and physicians must be given the skills, opportunity and encouragement to pursue careers in those fields. Training programs must be developed in partnership with the communities and populations that need care.

Ontario is beginning to develop the critical mass of human resources and services to be able to offer high quality medical education in settings outside the five AHSCs. It has also started to invest in the technology to support decentralized training. However, it will take time for centres outside the AHSCs to develop the capacity to provide decentralized programs, and the process will require the support of the existing AHSCs.

STRUCTURE

For these reasons, the Expert Panel proposes a staged approach to decentralizing medical education, beginning with the establishment of three clinical education campuses (CECs) in universities in geographically underserviced parts of the province: Thunder Bay, Sudbury and Windsor.

The goal of the clinical education campuses is to develop the capacity to deliver the full spectrum of medical education, from pre-clerkship through postgraduate training.

Initially, the CECs will be affiliated with an existing medical school, but will develop their own administrative structure. The head of each CEC will hold a dual appointment: director of the CEC in the local university and associate dean of rural or northern medicine at the sponsoring AHSC. Administratively, the director/associate dean will be responsible to his/her local university, academically he or she will be accountable to the Dean of Medicine/Health Sciences at the sponsoring AHSC. The responsibilities of all the partners (i.e., the local university, the sponsoring AHSC and the CEC), the nature of the affiliation, and the accountability required will be spelled out in an affiliation agreement.

To develop the capacity to provide comprehensive decentralized medical education, the CECs will have to recruit department heads and program heads, and develop effective working relationships with local health providers and facilities. These new academic opportunities at CECs will help attract skilled clinicians to underserviced areas of the province, which will not only increase the capacity to provide medical education in these regions, but increase the capacity to provide clinical services and to recruit local clinicians to act as preceptors.

Using this model, the CECs will be able to evolve beyond a branch office of the sponsoring medical school. Eventually, they will develop, on site, the capacity to plan, manage and deliver their own programs. This means that they will be able to evolve, over time, into free-standing medical schools, if that is what the health care system requires.

CO-ORDINATION

Rather than creating a new level of administration or bureaucracy to manage this larger academic network, the Expert Panel believes that the Council of Ontario Faculties of Medicine (COFM) should be responsible for co-ordinating Ontario's decentralized training and developing/implementing the integrated plan for rural, northern and underserviced medical education. To ensure that COFM reflects the views and wisdom of those delivering programs in rural and northern areas, the directors of the CECs should be members of COFM.

The integrated plan would not be limited to the development of CECs, but it would include the development of regional networks around the AHSCs that would promote decentralized learning opportunities and resource sharing in all parts of the province as well as other rural, northern and underserviced initiatives designed to shape physician services to meet local and regional needs.

TECHNOLOGY

Ontario's capacity to provide high quality decentralized medical education will depend on the effective use of technology-assisted learning. The CECs will be linked by computer and video to their sponsoring medical school, and will be able to share digital resources. Training programs will make effective use of tele-medicine and web-based learning. While this will be a cost-effective way to educate students, it will require some initial investment.

RESEARCH

The province's medical schools have extraordinary depth in health research[19], yet only a small proportion of that research activity is devoted to health services or population health research. While AHSCs will continue to pursue research that will improve our understanding of biology and the mechanisms of disease, the education system must also know more about the population its students will serve. To provide effective decentralized education, the CECs and the sponsoring AHSCs must understand the health needs of their communities. As part of their mandate, they should be responsible for developing knowledge on their populations' health status, the factors that create inequities, and innovative health interventions.

CLINICAL TEACHERS

The success of the CECs will depend on their ability to recruit clinical teachers. Although the new career opportunities within CECs may attract some skilled clinical teachers from other settings, the CECs will also have to find within their regions practising physicians who are willing and able to teach medical students and postgraduate trainees, and become more involved in research. Although physicians in underserviced areas have expressed an interest in being involved in teaching - particularly postgraduate trainees - this extra demand (for teaching and their own professional development) will increase their workload and may have a negative effect on the amount of clinical care they can provide. Given that these areas already have a shortage of family physicians and specialists, developing and maintaining a pool of skilled, effective clinical instructors may be difficult.

In fact, maintaining the academic medicine workforce is an issue in all parts of the province. Clinical teachers are often overextended, and the funding for their teaching activities (which is largely dependent on the ability of the AHSC to generate clinical income) has not kept pace with inflation rates over the past 30 years or with the increase in requirements for clinical education. As a result, many clinical teachers have chosen to give up their academic appointments (and the burdens of teaching and research) for private clinical practice. The same situation also exists in other professions, such as nursing.

To reverse this trend and make it easier for the CECs to attract and retain high quality clinical teachers, the health care system should make significant investments in developing and retaining clinical teachers, and ensure that they have adequate support and compensation for the vital role they play in teaching, research and clinical care.

19 *In 1998/99, Ontario's five AHSCs accounted for 43.1% ($468.6 million) of the total research expenditures of Canada's 16 AHSCs. Source: Canadian Medical Education Statistics 2000. Association of Canadian Medical Colleges. Vol. 25.*

Recommendations

To increase the capacity to provide medical education in underserved parts of the province, the Expert Panel recommends that:

#3 Ontario's medical schools build on existing relationships and infrastructure to create in Thunder Bay, Sudbury and Windsor university-based clinical education campuses (CECs) that have the capacity to deliver decentralized medical education.

#4 The Ontario Government, in collaboration with the federal government, provide:

- the funding to support the capital development and operating cost of three CECs, including the university and hospital/training site costs to provide decentralized medical education
- the initial investment required to develop the information technology infrastructure required to support decentralized medical education, including broad-band videoconferencing and telemedicine, with particular emphasis on rural and northern sites
- funding to develop, within the CECs, the capacity for research in health services and population health.

#5 The Directors of the CECs immediately become members of the Council of Ontario Faculties of Medicine (COFM), and COFM be responsible for co-ordinating the development of an integrated plan for rural, northern and underserviced medical education in Ontario.

#6 MOHLTC and the AHSCs take steps to address the issue of funding, support and incentives for clinical teachers in CECs and AHSCs.

DEVELOP APPROPRIATE TRAINING STREAMS

Medical education, in addition to being delivered in all parts of the province, should be more targeted and focused on Ontario's health needs. One of the most effective ways to shape services to meet needs may be through the streaming of medical education. In a streamed program, medical students will be selected based on their interest in and suitability for a certain stream, and then given the type of exposure, skills and practical experience that will best prepare them to work in that field.

The Expert Panel believes that streaming is a critical tool in planning and managing physician resources. However, the Panel also recognizes the need for flexibility. Training streams must be broad and flexible enough to keep trainees from being tied to a single career path, and to allow students to pursue any residency or career training stream.

For purposes of this report, the Expert Panel looked at the potential for three types of streams: rural and/or northern medicine, underserviced populations and clinical scholars.

UNDERSERVICED AREAS: RURAL AND NORTHERN EDUCATION STREAMS

Focus

The CECs will be responsible for delivering a dedicated rural and/or northern stream that will prepare medical students for practice in those settings. In addition, the existing medical schools can choose to develop and deliver a rural stream, if they believe that is part of their mission.

While the streams will be focused enough to give medical students the unique skills required for rural or northern practice, they should be comprehensive and flexible enough that students in these streams will:

- have full exposure to different facets of academic and clinical medicine
- be able to apply to any other (non rural/northern) residency program
- have some flexibility to switch streams
- have some exposure to multidisciplinary approaches to care.

Expectations

MOHLTC and the Ministry of Training, Colleges and Universities (MTCU) have traditionally funded the province's medical schools to provide medical education. The decision about the content or focus of that education – or where it is provided – has generally been left to the medical schools, and is usually based on each school's mission and expertise.

In the move to develop rural and northern streams, the Expert Panel believes that the government should be more directive. To ensure that the CECs will have the critical mass of medical students required to mount a high quality education program, the government should work with medical schools to allocate a certain proportion of undergraduate medicine positions and postgraduate positions specifically to the CECs for rural and/or northern training, and contract with the CEC and the sponsoring AHSC to provide that training stream.

The Expert Panel believes it is extremely important for the government to be clear about what it expects from the rural and/or northern medicine streams (i.e., physicians will receive a certain proportion of their training in rural settings, the training will focus on certain skills, a certain proportion of training will be multidisciplinary[39]) and to hold the medical education system accountable for developing and delivering that program. The roles and responsibilities of all stakeholders (i.e., the local university, the sponsoring medical school, the CEC and the ministry), the number of positions, the funding to be provided, the expectations, and the relationship among the partners should all be set out in a contract. The contract should make it explicit that the funding is specifically for positions in rural and northern medicine. The initial contract should be for a long enough period of time (i.e., minimum of four years) to be able to monitor program results. Based on those results, the government will be able to renew, modify or withdraw the funding (and the positions) if the schools are not able to develop or deliver a rural and/or northern stream. Over time, the funding for the positions can also evolve into base funding flowed directly to the CECs.

39 *Lakehead University already has a purposeful multidisciplinary approach to educating physicians, nurse practitioners and nurses – a model that could be adapted and expanded in a rural or northern training stream.*

Recruitment Strategies

The success of rural and northern training will depend, to a great extent, on the programs' ability to attract and recruit students who will make good rural/northern physicians. Every effort must be made to recruit students from rural and northern settings, and to identify the urban students who are likely to thrive in those practice settings. The admissions process and criteria for entry into the rural or northern stream should reflect the best available evidence on the profile of physicians who succeed in rural or northern practice, and will likely include factors such as location of residence, location of secondary schooling, and commitment to rural or northern practice. While the rural/northern programs will have a separate admissions process, every effort must be made to ensure that it does not compromise the quality of the students accepted, or create a second tier mentality.

At the current time, Ontario's medical schools receive a disproportionately small number of applications from students in rural/northern areas, so efforts must be made to promote careers in medicine and other health professions to students when they are in high school. Programs that send speakers into secondary schools to talk about medical careers and use other strategies to recruit high school students can be extremely effective. The University of Ottawa has already demonstrated the effectiveness of aggressive and targeted early awareness/recruitment strategies in its francophone health programs.

In an attempt to address physician shortages, some underserviced regions have developed innovative recruitment and support models that target local students. For example, Brock University in Niagara Region (which is underserviced for physicians), actively promotes and recruits high school students to its Med Plus program, an enriched program that gives undergraduate students tours of health facilities, mentors, volunteer opportunities in health care settings, and career advice. Med Plus helps prepare students who are applying to medical school or other health-related graduate programs. It also helps them make contacts and establish relationships within the Niagara medical community that may motivate the students to return to Niagara to practice.

Nursing organizations, such as the Registered Nurses Association of Ontario (RNAO) and the Registered Practical Nurses Association of Ontario (RPNAO), have developed similar types of outreach programs for high school and university students.

Staging

The proposals for decentralized education reviewed by the Expert Panel indicated that it could take as long as four years for new sites to develop the program components required for undergraduate medical education. However, both northwestern and northeastern Ontario have already developed some capacity to provide undergraduate and postgraduate training, through programs such as NOMP, Family Medicine North, NEP and NOFM.

To develop physicians for rural and northern practice as quickly as possible, the Expert Panel proposes to capitalize both on the capacity of the existing medical schools and on the partnerships and programs already in place in underserviced areas. In this model, CECs would develop their programs at the postgraduate level first and, over a period of four years, develop their capacity to provide undergraduate medical education. In the meantime, undergraduates with an interest in rural or northern medicine would be recruited into a rural/northern stream based at the sponsoring university. Once the CECs have developed their undergraduate programs, existing students would be transferred to the CECs and new students would be admitted directly into programs at the CECs.

The timing and sequence would be as follows:

- in 2002, add a small number of postgraduate training positions (i.e., 25) in the generalist specialties
- in 2003, offer a rural or northern clerkship experience for undergraduates
- in 2004, admit pre-clerkship students directly to the CEC and the rural or northern stream.

While this strategy will produce rural and northern-trained physicians more quickly, the Expert Panel notes that any immediate increase in postgraduate positions may lead to criticism from the other provinces and territories. At the current time, Ontario participates in a national strategy which ensures that, on a national level, the number of postgraduate positions is equal to the size of the national undergraduate class (excluding Quebec). This guarantees that there are postgraduate places for all Canadian medical school graduates. By adding postgraduate positions, Ontario may disrupt that balance, and the new positions will likely attract students who would have filled postgraduate positions in other provinces. This could have a negative effect on the other provinces' training programs and their future physician supply. However, several other provinces (e.g., Alberta, British Columbia) have recently increased their post graduate training spots. It is clear that other provinces are facing the same pressures as Ontario, and have taken actions similar to those the Expert Panel is proposing.

To mitigate the negative effect of the increase in postgraduate positions on the Canadian undergraduate class, MOHLTC could consider opening the 25 positions to Canadians who did their undergraduate training abroad and want to return to Canada for their postgraduate training.

UNDERSERVICED POPULATIONS: ABORIGINAL AND URBAN POOR STREAMS

Not all Ontario's physician supply problems are geographic. Across the province, there are certain populations that are chronically underserved, including Aboriginal people, some other cultural groups, people in long-term care facilities, the urban poor and homeless, people with mental health problems, people with addictions, and people with blood-borne infections.

In some cases, the undergervicing is driven by inequities in physician compensation. Patients with addictions, mental health problems or blood-borne infections tend to be time-consuming to treat, and the current compensation system does not recognize that. However, some of the undergervicing is also due to the fact that the medical training system does not necessarily recruit or prepare physicians to care for these populations.

Ontario's medical schools should help address these inequities and shape services to meet these needs by developing targeted training streams. The existing medical schools and the CECs could identify, as part of their mission, their role in meeting the health needs of certain populations. For example, the northwestern CEC could identify a strong role in aboriginal health, while the University of Toronto medical school could identify a need in its community for services for the urban poor. In each case, the school or consortium would develop a targeted training stream. Like the proposed rural/northern stream, students who enter these streams would still have full exposure to different facets of academic and clinical medicine, and be able to apply to any other residency program. And, like the students in the rural/northern stream, they would be admitted based on factors that would make them effective in this type of practice and be given training that would focus on the needs of that particular population. Given the significant role that other professions, such as nursing, play in providing care for underserviced populations (e.g., a significant amount of the care provided to aboriginal communities is through nursing stations, many programs that serve the homeless are nursing-based outreach services), these training streams should focus on developing effective multidisciplinary teams.

CLINICAL SCHOLARS, ACADEMICS AND RESEARCHERS

The existing AHSCs have developed special training opportunities for clinical scholars and researchers, and the same approach could be used within the CECs. In this program, the CECs would offer scholars who have completed specialty training, a developed practice environment and a significant proportion of protected time to teach or do research in pursuit of a non-clinical degree, such as an MEd, MSc or MHA. The program would target northern/rural physicians who are interested in developing academic or research skills or careers.

This training stream would have significant benefits for the CECs, the scholars and the quality of care in the underserviced region. While the scholars would have the opportunity to pursue their career goals, the CECs would be able to increase their capacity and depth in education, research and organization – and, at the same time, increase the number of practising physicians in the region.

Recommendations

To develop the capacity to provide the type of training physicians will need to meet health needs, the Expert Panel recommends that:

#7 The CECs work with their training sites, communities and the sponsoring universities to develop rural and/or northern medical education streams, including a separate or enhanced admission process based on factors that are most likely to identify students who will choose rural or northern practice.

#8 Ontario's medical schools and CECs work with other health disciplines to identify underserved populations for which they have a responsibility, and develop multidisciplinary streamed training programs designed to meet their health service needs.

#9 Ontario's medical schools and CECs assess the potential for a training stream for clinical scholars, based in rural and northern environments.

#10 HHRAP evaluate the effectiveness of the CECs and sponsoring universities in implementing targeted training streams, and advise MOHLTC on future investments in training for rural and northern medicine, underserviced populations and clinical scholars.

ENSURE QUALITY

The quality of health care delivery is critically dependent on the professions' pursuit of lifelong learning and on evidence-based practice (i.e., the ability to apply evidence to decision making). The explosion in medical knowledge is making it increasingly difficult for individuals to remain current or to critically assess the evidence.

Quality is inextricably linked with appropriateness of care. With high quality appropriate care, patients receive services that provide some tangible benefit. Inappropriate care, on the other hand, is a waste of public resources and creates an unnecessary burden on physician services. A responsible approach to physician workforce planning must include strategies to measure and increase the appropriateness of care.

In a more decentralized system of medical education, with targeted training streams, the issues of quality control and appropriateness of care become even more important. Ontario has a reputation for preparing physicians who are second to none in the world. To safeguard that reputation and ensure the appropriateness of both medical education and medical care, Ontario must take steps to ensure quality, regardless of where education is provided or its focus, and to invest in education and professional development. The Expert Panel proposes three strategies to improve the medical education system's capacity to provide high quality, appropriate care: education masters, common curriculum resources and evaluation tools.

EDUCATION MASTERS

Ontario should develop a cadre of medical education masters or specialists whose role within the AHSC or CEC would be to:

- conduct research in education, evaluation and professional development
- encourage innovation in professional development
- ensure that learning is an integral part of the practice of medicine and other health disciplines.

Education masters would identify the types of learning materials required to support continuous learning, and develop unique, distinctive education resources for all Ontario students and preceptors. A resource to clinical teachers, they would help the medical schools develop clinical education programs for physicians at all stages of professional development. Based on the academic programs in place now and those proposed for the CECs, education masters would be distributed as follows:

AHSC/CEC	# of Education Masters
Lakehead University	2
Laurentian University	2
University of Windsor	2
University of Ottawa	4
Queen's University	3
University of Western Ontario	4
McMaster University	4
University of Toronto	7
Total	**28**

COMMON CURRICULUM/RESOURCES

The five Ontario faculties of medicine, together with the Northern Academic Health Sciences Network (NAHSN), have begun to explore the feasibility of a common core Ontario curriculum and common educational resources. This approach would ensure that all medical students, teachers and practising physicians in Ontario, regardless of where they are trained or practice, would have:

- access to the same high quality, up-to-date information and resources - in the form of modules that would include objectives, cases, question banks and evaluation tools
- the opportunity to use those resources to develop innovative approaches to medical education that will meet the needs of the population they serve

- different means to pursue and attain required continuing medical education.

Although all education sites will benefit from cost-effective common resources, the CECs will have the added advantage of not having to develop their own resources and being able to adapt common resources to meet their education needs. For example, common resources developed in Ontario for the aboriginal health training stream, could be combined with resources designed by other jurisdictions and resources on the role of spirituality in healing in the Aboriginal culture, to help build the program. This means new training streams can be up and running much more quickly.

Common resources will also enable students registered at any Ontario training site to develop an individualized training path and train as rural physicians, specialists or academics, and to pursue unique paths to a PhD, MBA or MPH degrees, even if the diploma is offered by another institution.

The common resources developed for medicine can also be shared with other health disciplines, giving them the same access to high quality information and resources.

In addition to the common curriculum, McMaster University has developed the basis for a digital health library for Ontario, which would give providers across the province easy access to clinical guidelines that synthesize all available evidence as well as annotated and systematic reviews of the literature.

EVALUATION TOOLS

While the education system must develop better ways to teach, it must also develop effective ways to assess the knowledge and practice skills of physicians, and ensure they stay current with new knowledge and continue to provide appropriate care. Using a number of different datasets, it is possible to develop comprehensive information on the quality and appropriateness of physician practice (based on practice profiles, prescription profiles and regional differences) that could be used to identify any need for continuing education or teaching resources.

To support and assist practising physicians, the training system should ensure that regular evaluation is an integral part of ongoing professional development.

To ensure the quality and appropriateness of medical education and practice, and help shape skills and services to meet needs, the Expert Panel recommends that:

#11 MOHLTC provide the funding to support 28 medical education specialists, distributed among the AHSCs and CECs, responsible for:

- conducting research in education and professional development
- developing educational resources for students and preceptors
- improving the quality of medical education in the province.

#12 Government increase its investment in continuing medical education, and provide funding to support the development of:

- common educational resources
- the digital health library
- evaluation tools that can be used to assess the quality/appropriateness of care and guide medical education.

III. Produce the Right Supply and Mix of Physician Services

The decentralizing and streaming of medical education have the potential to improve physician distribution, but they do not deal directly with the issue of appropriate supply. How many physicians does Ontario need? How many physicians will we need in five to 10 years?

FACTORS AFFECTING PLANNING FOR PHYSICIAN SERVICES

The population's need for health services will be affected by many factors, including:

- population growth
- geography
- the education and literacy of the population
- the population's employment opportunities/income
- the aging of the population, and the impact on the demand for health services
- the increase in life expectancy, and the impact on health services
- the increasing sophistication of consumers, who have more access to information, and changing expectations of the health system
- medical and technological advances, new drugs and treatments which may either increase or decrease the need for care.

The effective supply, mix and distribution of physician services will be determined by many factors, including:

- the number of physicians in practice
- the number and distribution of other health professionals
- the range of services they provide
- the impact of age and gender
- spousal and family needs
- workload levels
- their education (including CME)
- migration patterns
- employment opportunities/incentives
- the working environment.

To answer those questions, the province will need increasingly sophisticated planning tools that can take into account the complex factors that affect both the population's need for services and physician supply, mix and distribution (see box).

To improve Ontario's capacity to shape the supply and mix of physician services to meet needs, the Expert Panel proposes a needs-based approach for planning physician services as well as strategies to improve health human resources planning.

DEVELOPING DATA MODELS FOR PLANNING PHYSICIAN SERVICES

The Expert Panel believes that the number, mix and distribution of physician services in Ontario should be needs-based. However, Ontario does not yet have a reliable, consistent way to measure or predict health needs. In his report, Dr. McKendry recommended piloting access modelling for "core services in medical fields where consumers appear to have ongoing problems getting timely care," including family medicine.

The Expert Panel has taken the first steps in exploring the potential of an access modelling methodology designed to predict the number of specialists needed in future years, based on measuring the demand for services in the past, estimating a reasonable level of access to services in the future (as a proxy for future needs), and making assumptions about how services will be delivered. The Panel has also used a slightly modified approach to estimate the number of family physicians required, by looking at how many people have used family physicians in the past, estimating the number of people who will have a regular family physician in the future, and making some assumptions about how primary care will be delivered.

BRIEF SNAPSHOT OF EXPERT PANEL ACCESS MODELLING

The Expert Panel identified "sentinel services" for six specialty services highlighted by Dr. McKendry as being in short supply: anesthesiology, general surgery, obstetrics, ophthalmology, orthopedics, and psychiatry. A sentinel service is one that represents a significant proportion of the workload for the specialty, and is determined by true patient need and not likely to be heavily influenced by physician discretion (e.g., hip or knee replacements in orthopedics, deliveries in obstetrics, cholecystectomies and mastectomies in general surgery, and cataract surgery in ophthalmology).

The Expert Panel looked at the current age/sex adjusted rate of sentinel services and then predicted, based on the projected growth and aging of the population, the rate or amount of sentinel services that would be required each year over the next 10 years. (With the aging of the population, the need for some services, such as hip and knee replacements will increase while the need for others, such as deliveries, will decline.) The Panel also looked at workload (i.e., the amount of sentinel service a full-time physician can reasonably provide in a year) and, from that, calculated the supply of services that will be available given the current workforce (this takes into account new physicians who will enter practice as well as retirements). From that, the Panel was able to estimate the number of physicians required in each of the specialties to meet needs over the next 10 years. It also used a similar approach to estimate the need for total physicians.

Sentinel services	=	essential services the population needs
Need for services	=	services/person x population (adjusted for age/sex)
Services available	=	services/specialist (workload) x # of specialists
# of doctors needed	=	need for services – services available / workload

Because a procedure-based approach would not capture the supportive, ongoing patient/provider relationship that is an integral part of primary care, the Expert Panel used a slightly different methodology to estimate the need for family physicians. That method was based on assigning patients who receive at least 50% of their care from one physician to that physician's caseload, determining the proportion of the population that uses a regular family physician, establishing a reasonable caseload size for family physicians, and estimating the proportion of the population that will need a regular family physician as the population grows.

In an attempt to capture some of the complex factors that affect physician workforce planning, the Expert Panel also examined workload levels to determine whether they were reasonable, estimated the contribution of other professionals who can provide these services (e.g., GP-anesthesiologists, GP-obstetricians, midwives, nurse practitioners), and assessed the potential impact that new technology could have on workload.

LIMITATIONS OF THE MODELLING

The main limitation of the Expert Panel's data modelling approach is that it is utilization-based. It reflects what has happened in the past – which may or may not reflect an appropriate level of service – and it makes no attempt to assess the quality or efficacy of the services provided. This means that the total number of sentinel services[21] delivered in a year may simultaneously include:

- appropriate care to meet health needs
- inappropriate and unnecessary care
- not enough care to meet the current needs of underserviced populations.

The model also has some limitations in its ability to determine the supply of physicians required to provide a certain level of service. The approach used to estimate the number of physicians required is based on a number of assumptions, including:

- the current level of service that physicians are providing is appropriate

21 *Sentinel services are those that represent a significant proportion of the workload for the specialty, and are determined by true patient need and not likely to be heavily influenced by physician discretion (e.g., hip or knee replacements in orthopedics, deliveries in obstetrics, cholecystectomies and mastectomies in general surgery, and cataract surgery in ophthalmology).*

- non-fee-for-service physicians are providing the sentinel service at the same rate as fee-for-service physicians, and the requirement for non-fee-for-service physicians is assumed to increase at the same rate as for fee-for-service physicians within the same specialty. In those specialties where all physicians are non-fee-for-service, the Expert Panel assumed that the requirement for those physicians would increase at the same rate as all fee-for-service physicians combined (i.e., the number is not specialty specific and does not reflect any anomalies that may exist within that specialty).

- there will be no significant changes in physician practice patterns. This is an important assumption because any changes in the way physicians practice could have a significant impact on the number of physicians required, and must be monitored closely.

Despite these limitations, the Expert Panel believes the proposed access modelling method is a useful planning tool that should be evaluated and refined over time. It appears to provide a means to identify and project the demand for procedure-based services, and the system's ability to provide that level of service. It is less useful in specialties, such as psychiatry, that are consultation-based – in large part because it is difficult to define consultation services or to determine what proportion are driven by true patient need, patient expectations, or provider practice patterns.

While the model has potential, its results at this stage in its development should be interpreted with caution. Planners must keep in mind that the model is capturing inappropriate service and underservicing, as well as appropriate levels of service. Planners should also be aware that perceived shortages in the supply of particular services may be due to factors other than the number of physicians, such as: lack of operating rooms, lack of support personnel, or inappropriate incentives that encourage physicians to devote a disproportionate amount of their time to providing non-sentinel services. If services were organized differently, the system might be able to increase its capacity to provide essential/sentinel services with existing resources or with only a modest increase in physician numbers. All these factors must be taken into account when using the model to help shape services to meet needs.

FINDINGS

Because of time constraints, the Expert Panel was only able to apply the model in depth to six of the specialties identified by Dr. McKendry as in serious short supply: anesthesiology, general surgery, obstetrics/gynecology, ophthalmology, orthopedics and psychiatry. For those specialties (except psychiatry), the Expert Panel ran the model looking at both consultations and certain specific sentinel services (see Appendix 3). For psychiatry and for the other specialties listed in the Ontario Physician Workforce Database, the Expert Panel ran the model based on consultations only. As noted in the box on page 49, the Panel used a caseload measure to calculate the future requirement for family physicians.

General Trends

The modelling exercise identified the following general trends, which should be taken into account in future physician service planning.

- **Demand for Services.** The age-sex adjusted rate for sentinel services remained constant for anesthesia for surgical procedure (<1% over five years) but rose significantly for anesthesiology consults (>9%/year)[21]. The age-sex adjusted rate for sentinel services declined slightly for general surgery and obstetrics/gynecology (<1%/year), and increased for ophthalmology (>5%/year for cataract and retinal procedures) and for orthopedics (>1%/year for all procedures; >5%/year for knee replacements and >2.5% for hip replacements).

- **Consultation Rates.** The consultation rate for all specialties dropped by 10% in 1998/99. This may have been the result of stricter OHIP criteria for a consult. The consultation rate was stable from 1995/96 to 1997/98, and from 1998/99 to 1999/2000, so it appears that the demand for consultations has remained relatively constant.

- **Workload.** The average workload per physician remained relatively steady between 1995 and 1999 (i.e., it has increased by only 1% over the past five years). However, during this time, the number of female physicians has increased and the average workload for female physicians is 20% lower than that of males. This means that workload has increased for both female and male physicians, but lifestyle decisions (e.g., working fewer hours, having a more balanced life) have resulted in a near-steady workload state.

- **Migration.** The 1990s were a turbulent time in physician-government relations. Faced with acute fiscal pressures, government initiated policies such as clawbacks, restrictions on billing numbers and discounts for new entrants in selected urban areas. As a result, net physician migration out of Ontario reached historic highs during the mid 1990s.

- **Retirements.** Retirement rates (age-sex adjusted) have been generally stable in Ontario, except in 1995 when the rate doubled. This was likely due to the same factors that adversely affected migration. Retirement rates have been generally lower in Ontario than in other provinces, which offered retirement buyout plans in recent years.

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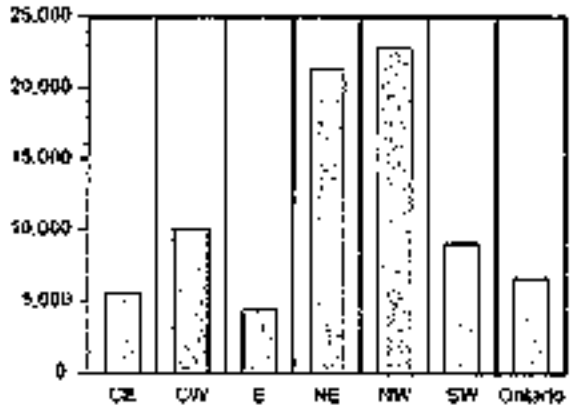
21 Much of the increase in anesthesiology consults may be due to pain consultations. However, consults still represent <5% of anesthesiologists' workload.

- **Contribution of Other Providers.** Some services are provided by more than one type of provider, including: obstetrics (obstetrician/gynecologists, GP/FPs, and midwives) and anesthesiology (anesthesiologists, GP-anesthesiologists).
- **Comprehensiveness of Practice/Proportion of Generalists to Specialists.** The proportion of FP/GPs contributing to specialized care is dropping. The ratio of anesthesiologists to GP-anesthesiologists has been rising, from 77:23 in 1995/96 to 80:20 in 1999/2000. The ratio of obstetricians to GPs doing obstetrics has been rising, from 26:74 in 1995/96 to 31:69 in 1999/2000. This trend has serious implications for smaller communities that do not have the volumes to support a specialist and rely on FP/GPs to provide these services.
- About 197 midwives are licensed to practice in Ontario,[24] and approximately 40 more enter practice each year in Ontario. Although the typical caseload for each midwife is 40 deliveries per year, a significant proportion of deliveries (25% to 30%) involve shared care with an obstetrician/gynecologist.
- Nurse practitioners working collaboratively with a family physician can allow primary care practices to increase their caseload by 33% (with a reported range of 25% to 50%).[25] To date, over 300 nurse practitioners have graduated from Ontario's Primary Health Care Nurse Practitioner Training Program and they work in a variety of health care settings. Over the next three years, the program expects to graduate about 100 more each year.[26]

POPULATION PER PHYSICIAN RATIO BY HEALTH PLANNING REGION FOR PSYCHIATRY (1999)



DISTRIBUTION ISSUES

The actual number of physicians and the amount of service they are able to provide is only one part of the picture. The analysis must also take into account the distribution of physicians across the province, as well as the issue of critical mass. As this chart illustrates, the supply of some specialties (in this case, psychiatry) varies significantly in different regions of the province.

23 *About 170 midwives were in active practice at the end of 2000.*

24 *Expert Panel on Health Professional Human Resources, Working Group on Data and Modelling, Improving Access to Primary Care Services, Opportunities for Collaborative Physician/NP Practice: A summary of research undertaken with NPs and physicians. October 2000.*

25 *Although the program admits 75 students each year, a large proportion are part-time students who take three years to complete the course requirements. That is why more than 75 will graduate each year for the next few years.*

Some communities will also face the issue of critical mass. For example, they may not need four family physicians to manage the size of the local caseload, but they may need at least five physicians to make the total workload (i.e., on call, hospital coverage) tolerable for the physician group. If they do not have the critical mass to make the job attractive, these communities risk burning out or losing the physicians who are there now.

PREDICTING THE FUTURE

As noted earlier, the population's need for health services and the supply of physicians can be influenced by many factors, from age to technology to practice patterns to broad health and fiscal policies. To estimate the number of physicians Ontario will need between 2000 and 2010, the Expert Panel developed three possible scenarios, each based on slightly different assumptions:

- Scenario 1 assumes that the existing age/sex adjusted demand for care will remain constant (i.e., status quo level of health care utilization). The requirement for physicians will be driven primarily by the growth and aging of the population. Physician workload will drop slightly to reflect the higher proportion of women and older physicians in the workforce.[24]

- Scenario 2 assumes that the age/sex adjusted demand for most sentinel services will remain constant, but there will be some growth in the age/sex adjusted demand for selected services in ophthalmology, orthopedics and anesthesiology. Workload will decrease slightly to reflect the higher proportion of women and older physicians in the workforce, and to reflect all physicians' desire to lead more balanced lives. Nurse practitioners will be integrated into collaborative primary care practices with family physicians.

- Scenario 3 makes the same assumptions as Scenario 2 but, in addition, it assumes that the health system will introduce policies designed to: make effective use of other health resources, such as nurse practitioners and midwives; encourage family physicians to provide obstetrical and anesthesiology services; adjust the mix between general internists and medical subspecialists to reflect the needs of smaller communities; and reduce inappropriate patient demand for care.

See the following table for a summary of the detailed assumptions for each scenario.

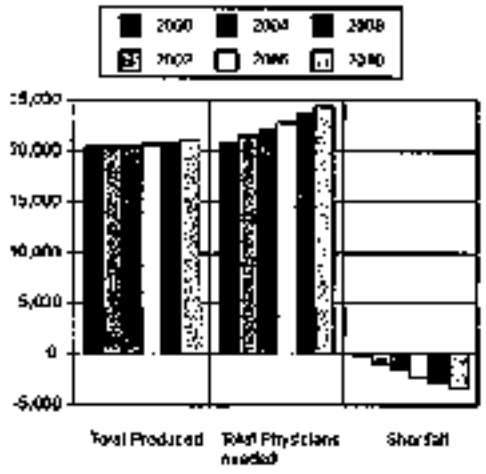
24 *Both these groups are most likely those who physicians to work part-time.*

Assumptions	Scenario 1: Status Quo	Scenario 2: Increase in Demand for Services/ Decrease in Workload	Scenario 3: Increase in Demand for Services/ Decrease in Workload/ Policy Interventions
Demand for physician services	Increase in demand from population growth/aging; no increase in age/sex adjusted sentinel event rate	Increase in demand from population growth/aging; age/sex adjusted sentinel event rate stable in most specialties; slight growth in demand for anesthesia consults, hip/knee replacements and cataract/retinal surgery (1%/year)	Same as scenario 2
Physician workload	Age/sex adjusted workload will remain constant, decrease in overall physician workload due to aging of physician pool and increase in % of female physicians	Will gradually drop by 0.5% physicians /year to account for the increasing number of women and older physicians (0.3%), and for the desire by most physicians for more balanced lives (0.2%), workload in orthopedics and ophthalmology will increase slightly (i.e., 0.5%/year) due to impact of new technologies	Same as scenario 2
Physician supply	Will reflect past five-year trends, including historically high levels of migration and anomalous increase in retirements in 1995, reflects the 10% decline in enrolment (1993) and the increase in 2000 (i.e., 33 from McKendry report, 40 from Expert Panel interim recommendations)	Will reflect the past five-year trends except that, given the improved fiscal climate, physician migration will decline and retirement rate calculation will exclude the 1995 year, includes the 10% decline in medical enrolmens (1993), and the increase in 2000 (i.e., 33 from McKendry report, 40 from Expert Panel interim recommendations), by 2010 the ratio of internal medicine to subspecialist medicine will revert to 1995 levels (i.e., 1%/year increase in internal medicine and 2%/year decrease in subspecialty medicine).	Same as scenario 2

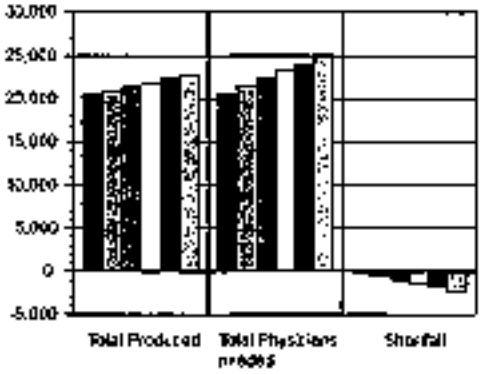
Assumptions	Scenario 1: Status Quo	Scenario 2: Increase in Demand for Services/ Decrease in Workload	Scenario 3: Increase in Demand for Services/ Decrease in Workload/ Policy Interventions
Comprehensiveness of Practice/Proportion of generalists to specialists (e.g., obstetrics, anesthesiology)	Continue to decline at the same rate as the past five years	Will remain constant (i.e., 80:20 anesthesiologists to GP-anesthesiologists, 31:69 obstetricians to GP/FPs doing obstetrics)	Incentives will be offered to restore the ratios of anesthesiologists to GP-anesthesiologists and obstetricians to GP/FPs doing obstetrics to 1995 levels by 2010.
Use of other providers	No use of nurse practitioners; midwives will handle 28 deliveries per year without assistance and 12 with assistance; the assisted deliveries will be counted as part of the obstetrical/ gynecology workload	Over the next 10 years, about 75[27] nurse practitioners will be integrated into primary care each year, allowing GPs working with nurse practitioners to increase caseload by 33%; midwives will continue to be introduced at the current rate and their workload will remain at the current level (see Scenario 1)	Maximum use of nurse practitioners, which will allow GPs working with NPs to increase their caseload by 50%; number of NPs graduating from training programs annually will double (from 100 to 200/year, with from 75 to 150/year going into primary care) beginning in 2005; a modest improvement in the number of "referral-free" deliveries among midwives (i.e., from 28/40 to 30/40); a modest patient demand management program will encourage patients to make more appropriate use of health resources and allow family physicians to increase their caseload by 0.5%/year

27 Each year over the next five to ten years, about 100 more practitioners will graduate from Ontario's training programs. The number "75" is based on the assumption that not all of them will choose to work in primary care/physician practices. Some will be employed in hospitals care settings, emergency departments, home care and other settings.

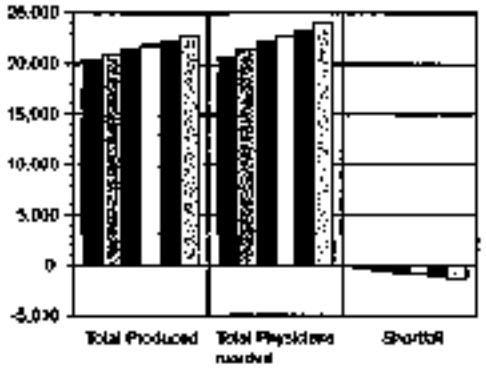
SCENARIO 1: STATUS QUO



SCENARIO 2: INCREASE IN SENTINEL SERVICES/DECREASE IN WORKLOAD



SCENARIO 3: INCREASE IN SENTINEL SERVICES/DECREASE IN WORKLOAD/AGGRESSIVE POLICY INTERVENTIONS



DATA RESULTS

HOW MANY PHYSICIANS WILL ONTARIO NEED?

As these graphs illustrate, the number of physicians Ontario will have, the number it will need and the shortfall varies significantly, depending on the scenario and assumptions used. Ontario's shortfall in physicians in the year 2000 ranges from 274, based on the status quo, to 236, based on a predicted increase in demand, decrease in workload, lower physician migration and the strategic use of other health policies. By 2010, the gap is much greater: 5,356 with the status quo; 2,374 with the increase in demand and decrease in workload but no other supportive policies, and 1,367 with strategic use of health policies.

WHAT TYPES OF PHYSICIANS WILL ONTARIO NEED?

In its data modelling exercises, the Expert Panel focused primarily on six specialties identified in the McKendry report. For a more detailed breakdown of assumptions, physician numbers and shortfalls by the six specialties analyzed, see Appendix 3. At this stage in the model's development, it is difficult to make conclusive judgements about the number of physicians that will be required in each specialty. More work must be done to develop micro models for each specialty.

WHAT IS ONTARIO'S CAPACITY TO MEET PRIORITY HEALTH NEEDS?

During the Panel's deliberations, MOHLTC identified some priority health areas that must be adequately resourced over the next 10 years including cardiac care, cancer care, geriatrics and public health. In most cases, these priorities are the result of demographics.

While the Expert Panel model takes into account the increased demand for hip and knee replacements related to aging, the Expert Panel was not able within its timeframe to specifically address the other priorities. However, the Expert Panel did review several reports identifying the human resource requirements and issues associated with some other high priority areas, including cardiac care, systemic therapy (cancer) services and specialized geriatric services, and believes the needs in these specialties should be analyzed in more depth. The submissions identified significant increases in demand for services and potential current and future human resources shortages that should be studied.

Cardiac Care. Early in 2000, the Cardiac Care Network (CCN) convened a Consensus Panel on Cardiovascular Human Resources to plan for the health human resources required to provide adult cardiac care and to respond to the Fact Finder's conclusions, which the CCN felt were at odds with its perspective on the need for cardiologists and cardiac surgeons. Its report was submitted to the Expert Panel in June[28]. Although the CCN Consensus Panel did not make specific recommendations about the number of professionals required to meet adult cardiac care needs, it did survey cardiac care providers to assess current and future needs. The Consensus Panel noted that, because of a general lack of data on cardiac care professionals and uncertainty about the variables affecting need and supply, it was difficult to develop detailed long-term projections. However, key indicators (e.g., long waits for consultations and procedures, increasing professional workloads, procedure cancellations, intense on-call schedules particularly in rural and northern areas, high migration levels of younger physicians) highlight a potential problem in access to services.

As tertiary cardiac services are one of the few areas in the health delivery system with publicly accepted benchmarks for procedures such as by-pass surgery and catheterizations, the need for physician specialties in cardiac care would lend itself to future iterations of the access modelling approach.

28 *Cardiac Care Network of Ontario. A Discussion Paper by the Consensus Panel on Cardiovascular Human Resources in Ontario. Final Report and Recommendations. Submitted to the Ontario Ministry of Health and Long-Term Care. June 2000.*

Cancer Care. The Expert Panel received several reports from organizations representing pediatric oncologists, medical oncologists, radiation oncologists and providers of systemic therapy. The report of the Systemic Therapy Task Force[29], which the Expert Panel analyzed, outlined a methodology and workload standard that identified the immediate need for an additional 12 medical oncologists. While the Task Force's approach varied from that of the Expert Panel it could be adapted to the access modelling methodology in the future. One critical consideration in this analysis is a reasonable future workload for medical oncologists.

Geriatrics. As the population of Ontario continues to age, the province will need physicians with special skills and training in caring for the elderly. A report of the Regional Geriatric Programs of Ontario[30] prepared in the spring of 2000 identifies a current shortfall in the supply of geriatricians, as well as a problem retaining new geriatricians who graduate from training programs in Ontario. While this particular specialty, which is predominantly paid on a non-fee-for-service basis, would create some challenges for the access modelling approach, special attention should be given to assessing the supply and distribution of geriatricians as well as primary care providers with special skills in geriatrics.

Public Health. Although the Expert Panel received only one formal submission about the shortages in public health, the situation is critical. Given the current urgent need for Medical Officers of Health and community medicine specialists in Ontario, special consideration must be given to producing physicians who are likely to take up positions in public health, and more attention must be given to understanding and overcoming the barriers to this type of practice.

For example, some positions in the existing residency program could be allocated immediately to community medicine, giving family physicians who have an interest in public health the opportunity to receive the training they need. As a short-term or interim measure, MOHLTC could also consider providing bursaries or some form of financial support for family physicians to complete a masters in public health, which is another acceptable and fairly fast route of training for Medical Officers of Health.

REFINING THE MODELS

In developing and using access modelling, the Expert Panel has taken the first steps in establishing data models that can take into account the complex mix of factors that affect both the population's health needs and the supply of physician services. However, if these models are going to become effective planning tools, they must be tested and refined.

The Expert Panel recommends that:

R13 HHRAP continue to develop and refine sophisticated data models and planning tools that can be used to measure both health needs and the capacity of the system to meet those needs.

In particular, HHRAP should:

- update the Expert Panel's access model annually

29 *The Systemic Therapy Task Force: Systemic Therapy Task Force Report, Presented to Cancer Care Ontario. April 2000.*

30 *Regional Geriatric Programs of Ontario. Summary: Survey of Geriatric Physicians. May 2000.*

- ensure that future iterations of the model include micromodelling for each specialty
- use the model to study and assess the need for resources to meet priority health needs
- adapt the model for use in planning at the regional and local level, ensuring that it can take into account the issues of physician distribution and critical mass
- continue efforts to develop a needs-based approach to determining population health needs and related provider requirements.

INCREASING ONTARIO'S CAPACITY TO PROVIDE PHYSICIAN SERVICES

The Expert Panel data modelling exercises confirm the conclusions of the provincial Fact Finder, the findings of the Canadian Medical Forum, and the experience of many health professionals and consumers in communities across the province. Ontario has a problem with effective physician supply, which will increase as the large cohort of older physicians retire and as physicians seek more manageable workloads and more balanced lives.

Problems of physician supply are not unique to Ontario. Within the last eight months, five other provinces have announced increases in enrolment in their medical schools, and jurisdictions such as the United Kingdom and Australia have also made dramatic increases (i.e., 20%) in physician production.

While more work must be done to improve physician workforce data and refine planning models, Ontario cannot wait for the "exact" numbers to develop strategies to increase supply. It must begin now, using the data developed to date.

Of the three scenarios it examined, the Expert Panel believes that the first - the status quo - is unrealistic in its projections of the demand for services and of workforce requirements. The Expert Panel believes it is unreasonable to expect the physician workforce to continue to maintain workload levels that are significantly higher than they were five years ago, particularly given the changing attitude toward work and gender mix within the profession. It is also unreasonable to assume that the high levels of physician migration out of Ontario experienced during the 1990s will continue. Given the investment that Ontario makes in training physicians and the current physician shortage, the province is more likely to ensure that other policies do not encourage emigration.[37]

With the second scenario - the increase in demand for services and decrease in physician workload with no other initiatives to moderate the need for physician services - the shortfall of physicians is significant, and beyond the capacity of the province's educational and fiscal resources. The Expert Panel also believes it would be short-sighted and contrary to Ontario's commitment to providing more multidisciplinary care to try to solve the problem only by adding physicians.

37 As a result of the Restructuring Commission, the province is more actively trying to persuade Ontario physicians who left during the 1990s to return, and a number of the proposed Expert Panel initiatives are also likely to make Ontario more – not less – attractive to physicians.

Of the three scenarios, the Expert Panel believes that the third – the increase in demand for services, decrease in physician workload and strategic use of other health providers and policies – reflects the most realistic view of Ontario's future health workforce. This scenario makes some key assumptions about the potential to encourage physicians to provide more comprehensive care, to make more effective use of nurse practitioners and midwives, and to manage public demand for health services, including physician services. It also gives the province tools to manage the physician shortfall that, given the time it takes to produce new physicians, is likely to get worse before it gets better.

To create the environment described in Scenario 3 and produce both the right supply and mix of physician services, the Expert Panel proposes that the health system increase its capacity to:

- produce physicians
- use the postgraduate training system to manage the mix of physician skills
- make more effective use of existing resources – by capitalizing on health professionals who, with some training and/or other support, would help increase the supply of physicians' services
- manage the demand for physician services.

PRODUCE PHYSICIANS

Based on Scenario 3, Ontario has a shortage of 236 physicians now and will have a shortage of 1,367 physicians in 2010 – if it does nothing to increase the supply of physician services in the province. Even with the supportive policies and strategies that are part of Scenario 3, such as more effective use of nurse practitioners and midwives[37], Ontario will still need to produce a significant number of additional physicians to meet health needs.

Given the preliminary nature of the data model (which does not take into account the contribution of postgraduate trainees to physician supply), the capacity of the medical education system, and the desire to avoid some of the mistakes of the past, the Expert Panel proposes that Ontario be somewhat cautious in its efforts to address the predicted physician shortfall. It suggests that the province aim to increase medical school enrolment by 160 over 1999 levels. It also suggests that Ontario take a relatively conservative approach, phasing in the initial increases in medical school enrolment over four years, and monitoring and evaluating their impact annually.

Academic Year	Cumulative New Intake (over 1999 levels)	Cumulative Minimum # of New Positions that are Streamed to CECs
2000/01	40	0
2001/02	120	20
2002/03	140	40
2003/04	160	60

In addition, the Panel proposes that the new positions be used strategically to help the AHSCs and CECs develop physicians who have the skills and aptitude for rural and remote practice, and to meet other health care needs.

The potential impact of an increase of this magnitude on the medical schools is obvious. What may be less obvious is the potential impact on the training sites. In making its recommendation to increase medical school enrolment, the Expert Panel recognizes that hospitals and other training sites will face increased costs as well as increased demands on their infrastructure. Gearing up to train significantly more students each year will be costly for all training sites, but it will be particularly challenging for non-teaching hospitals that must now develop a teaching capacity. They will need appropriate support and resources to take on that role.

37 *These strategies are discussed in more detail on pages 68 and 70.*

To ensure that Ontario has an adequate supply of appropriately trained physicians, the Expert Panel recommends that:

#14 MOHLTC, MTCU and the AHSCs increase undergraduate medical school enrolment by a total of 160 positions (including the 40 positions already added in the fall of 2000). These increases should:

- be phased in over four years (40 in 2000, 60 in 2001, 20 in 2002 and 20 in 2003) to allow the training system to develop the necessary resources and capacity
- allocate a minimum of 60 of the new positions to northern/rural training, and contract with the sponsoring medical schools and the CECs to provide that education
- allocate a proportion of the new positions to training streams for underserviced populations (based on the recommendations of HHRAP) and contracting with the appropriate AHSC/CEC to provide that education.

#15 MOHLTC increase the province's capacity to provide postgraduate medical training by:

- increasing the number of funded entry level postgraduate training positions by 160 when required to match the increase in undergraduate enrolment
- providing funding for salary support and benefits for the additional postgraduate trainees.

#16 MOHLTC provide additional funding to enable hospitals and other clinical training sites across the province to fulfil their role in undergraduate and postgraduate medical education.

MANAGE THE POSTGRADUATE TRAINING SYSTEM

Simply increasing medical school enrolment will not necessarily provide the mix of physician services Ontario needs. The specialties that physicians choose and the skills they develop depend on the pool of postgraduate training positions. Every effort must be made to manage that pool and to ensure it produces the "right" mix of specialists to meet the population's health needs.

Reallocating Positions. As noted earlier, more work must be done to determine the number of physicians in each specialty required to meet future needs, focusing particularly on specialties identified in short supply and those required to fulfil government commitments to provide priority health services. However, there is enough data now to begin to look at changes designed to adjust the mix of postgraduate positions. While it will take between five and nine years to increase the total number of new physicians produced (i.e., from the increase in undergraduate enrolment made in 2000), it is possible to increase the supply of certain specialties in two to four years by reallocating positions in the postgraduate system now.

Providing Greater Flexibility. Within the postgraduate training system, there is also a need for greater flexibility for existing trainees. In the early 1990s, when the number of postgraduate positions across Canada was reduced to match exactly the total number of undergraduate positions and the rotating internship was eliminated in Ontario, the training system lost any flexibility for trainees to change their specialty during training or for family physicians to re-enter training. At the current time, trainees have to choose a specialty very early in their undergraduate training, and have little or no opportunity to make a change during their education. The Expert Panel believes it is harmful for the health workforce to force trainees to stay in specialties they do not enjoy or for which they are not suited. This is not an effective way to develop the physician workforce or meet health needs. At the same time, it is not in the best interests of the health care system to allow trainees to switch into specialties that are well or over supplied. Instead, the education system should provide opportunities for students to change training programs, but limit those opportunities to specialties (including family medicine) that are in short supply or to priority health needs, as identified by HHRAP or a multi-partite postgraduate planning committee.

To increase flexibility in the system, the Panel proposes that, beginning in 2001, the ministry increase postgraduate (PGY1 or PGY2) positions by about 25 or 5% of the current class size. These positions will be available only to existing trainees in the Ontario system to enable them to transfer to other programs. The new positions will not add to the net output of trainees, but would change the mix based on specialty mix planning objectives. Unused positions and funding will be recovered annually by MOHLTC.

Creating Opportunities for Family Physicians. Through the postgraduate training system, the health care system can also encourage family physicians to take the extra training they may need to provide some specialized services, such as obstetrics, anaesthesiology, emergency medicine and psychiatry.

Building Capacity in the CECs. In the Expert Panel's proposal to decentralize medical education, the CECs would begin providing training at the postgraduate level, where they already have some capacity and where trainees have the potential to provide a significant amount of care (thereby helping to relieve some of the pressure on physicians in underserviced areas and, at the same time, producing new rural/northern physicians as quickly as possible). To enable that to happen, MOHLTC would have to provide funding for a small number of the new postgraduate positions (i.e., 25) for two years before the increase in undergraduate enrolment works its way through the system.

As discussed earlier, the new positions would likely attract trainees from other provinces and may be criticized. However, the Panel believes that this will be the fastest way to produce physicians with the skills to meet Ontario's needs. To mitigate the negative effect of the increase on other provinces, Ontario could consider opening these 25 positions to Canadian students who took their undergraduate medical training outside the country and want to return to Canada for postgraduate training.

To use the postgraduate training system to shape the mix of physician skills in Ontario, the Expert Panel recommends that:

#17 HHRAP, in consultation with COFM, take immediate steps to review and provide advice on the current and future mix of specialty training positions, giving particular attention to:

- specialties identified as being in short supply or having severe problems with distribution, such as anesthesiology, general surgery, obstetrics, ophthalmology, orthopedics, and psychiatry
- priority health programs, such as cardiac surgery, oncology and geriatrics
- public health.

#18 MOHLTC provide funding, beginning in 2001 for up to 25 postgraduate training positions annually to give postgraduate trainees more opportunity and flexibility to transfer between residency positions. To ensure these positions help meet health care needs, they should be limited to specialties identified as in short supply and to specialties required to meet the needs of priority health programs.

#19 MOHLTC provide funding in 2001 for an additional 25 third year residency positions (PGY3) for enhanced Rural Family Medicine targeted to the needs of rural and northern communities.

#20 MOHLTC fund up to 25 of the 160 new entry level postgraduate training positions in 2002 and 2003, with all these positions to be located in the CEEs and targeted to the general specialties in short supply.

#21 HHRAP, beginning in 2001, continually monitor and annually evaluate the impact of increases in undergraduate enrolment and the mix of postgraduate positions, and advise on adjustments required to meet health needs.

MAKE MORE EFFECTIVE USE OF EXISTING RESOURCES

It takes nine to 12 years to prepare a new physician. The Expert Panel's recommendations on physician supply – combined with the earlier increases made after Dr. McKendry's Fact Finder report – will add about 862 doctors to the physician workforce by 2010 and about 1,700 by 2015, when the full impact of the increases will work their way into the system. Based on the initial data and modelling analyses, this may not meet all the population's need for physician services over the next 15 years – without other changes in the health care system. However, the Expert Panel cautions that its forecasts of the need for physician services and physician supply must be revisited regularly to ensure they reflect both changes in the health care system and improvements in forecasting methods.

To close the gap between need and supply, Ontario will have to make more effective use of other resources in the health care system now and in the future. While the Expert Panel's work is focused on medium to long-term, system-wide strategies to meet health needs, it has identified five groups that could play a valuable role in improving the supply, mix and distribution of physician services in the short to medium term: new physicians about to graduate, International medical graduates (IMGs), physicians already in practice, nurse practitioners and midwives. In fact, Ontario must make effective use of these health professionals, or risk a much larger physician shortfall.

Retain New Graduates

Each year, about 500 new physicians complete their post-graduate training and are licensed and eligible to practice in Ontario. Over the past few years, there has been fierce competition for these graduates from other provinces and from the United States. This is an important group of trained physicians, and every effort should be made to persuade them to stay in Ontario to practice, and to encourage them to work in underserved communities.

In his report, Dr. McKendry recommended action to reduce the number of recently certified physicians who pursue their careers outside Ontario. Over the past year, the Professional Association of Interns and Residents of Ontario (PAIRO) has pilot tested an individual resident placement program, designed to help match residents with Ontario communities looking for physicians.

In this program, PAIRO's resident placement officer (RPO) and an MOHLTC Community Development Officer (CDO) meet individually with residents who are nearing graduation to discuss their personal and professional goals. The RPO and CDO then develop a list of communities that can provide opportunities that match the residents' goals. The residents can then contact the communities directly or seek further information through the PAIRO Portal Registry. The online portal is a proven community focused recruitment tool for residents and other physicians seeking job opportunities.

During the pilot, the placement service was offered to a total of 62 residents. As of July 2000, 19 residents (31%) had been placed in northern or smaller communities (eight in permanent placements and 11 in locums), 15 had decided to take more training, and 21 had not yet made a decision.

PAIRO has submitted a proposal for a fully developed program, endorsed by the ministry CDOs, which will provide the matching service to about 100 residents each year, and also assess the potential of providing the service to physicians recently in practice but looking for a career change, and physicians who have chosen to do temporary locums during their first years of practice.

Recruit Qualified International Medical Graduates

While the Expert Panel supports a goal of provincial/national self-sufficiency in the development of the physician workforce, it recognizes that International Medical Graduates (IMGs) have always played and will continue to play a role in our health care system. Already trained, IMGs can be an important short-term solution to some physician supply problems (although historically IMGs have not been effective in addressing problems of physician distribution).

With IMGs, the issue is ensuring their skills and training meet Canadian and Ontario standards. Because of policy changes that occurred at the Royal College of Physicians and Surgeons in 1997, there has not been a mechanism to assess training of IMGs quickly. With the existing IMG program, funded by MOHLTC and offered by the University of Toronto, IMGs receive up to 42 weeks of undergraduate clinical training and must then take the full post-graduate training to meet certification requirements – regardless of whether they have taken post-graduate training outside Canada. This means another two to four years before the physicians in the program are able to practice.

The Expert Panel believes that some IMGs have already received the high quality education to be able to meet Canadian standards with little or no extra training. As of January 1, 2001, the Royal College of Physicians and Surgeons of Canada has also indicated its willingness to allow qualified IMGs who meet certain criteria to write certification exams.

Over the past few months, the College of Physicians and Surgeons of Ontario and the Council of Ontario Faculties of Medicine have collaborated to develop a proposal to screen, assess, train and license IMGs. The goal of the program is to attract fully qualified IMGs who are able to meet community needs and provide needed specialist skills. The program is designed to offer 25 selected candidates each year up to six months of academic assessment of their skills. Those who meet the assessment requirements for their specialty will then be able to take the appropriate certification exams; those who need some additional training will be able to receive up to two years of postgraduate education before taking their exams. Once they have successfully passed their exams, these physicians can be licensed to practise in Ontario.

The program will be open to IMGs who are Canadian citizens or landed immigrants, as well as to foreign nationals living outside Canada. To qualify for the program, IMGs must be qualified in their country of origin and have recently been in active practice. They must also be trained in specialties in need in Ontario. The postgraduate positions would be for the exclusive use of candidates who require training and would not be offered to candidates who, on the basis of their assessment, qualify to sit for certification exams.

Although COFM/CPSO have structured the program primarily to attract IMGs who are already working in some capacity in Ontario, MOHLTC should be aware the program may be criticized for "poaching" physician talent from other countries and from other provinces. Any effort to recruit IMGs must be sensitive to the fact that Canada and Ontario have already been criticized for attracting skilled physicians from less developed countries whose health needs match or exceed our own.

Encourage Physicians to Provide More Comprehensive Care

The Expert Panel's data modelling exercises revealed that a growing number of family physicians no longer offer services, such as obstetrics, emergency services or anesthesiology. If this highly competent, skilled group could be encouraged to provide a more comprehensive range of services, they could add significantly to the effective supply of physician services, particularly in smaller communities.

The Panel's projections on physician supply are based on the assumption that it is possible, with the right incentives, to change physicians' practice patterns and to restore the relative proportion of generalists to specialists providing certain services to 1995 levels.

The main factors that determine comprehensiveness of care are financial. Many physicians feel they are not adequately compensated for services such as delivering babies, and that they can earn more in their office practice than by providing services in hospitals. The use of sessional fees (e.g., in emergency departments) has been effective in the past in encouraging physicians to provide services their communities need, and the Expert Panel believes that similar incentives will work in the future. With regard to obstetrics, the exorbitant cost of liability insurance is also a barrier for family physicians and for a growing number of obstetricians.

To ensure that physicians currently in practice and those who will enter the workforce provide comprehensive care, the ministry and the profession must remove any barriers and provide appropriate incentives.

Promote Collaborative Physician/NP Practice

In its decision to train nurse practitioners and to focus on interdisciplinary primary care teams, Ontario has already made a commitment to the NP role in primary care. However, Ontario's ability to integrate NPs into primary care has been limited by lack of employment opportunities.

In the fall of 1999, MOHLTC established a $10 million (annual) fund for 106 NP positions in four priority settings (i.e., 75 in underserviced areas, 20 in long-term care settings, 5 in Aboriginal health centres, and 5 in the pilot primary care networks).[33] While these positions provide employment opportunities for existing NPs, they will not meet the employment needs of the 300 NPs who will graduate over the next three years.

As noted in the section on data models, effective use of NPs can have a positive impact on the availability of primary care services. Findings of a literature review and research conducted by the Expert Panel indicate that a collaborative physician/NP practice can provide primary care for 25–50% more patients than a physician practice without NPs. Collaborative practices also have the potential to reduce some of the pressure on physicians, particularly in underserviced areas, and to reduce the time that patients have to wait for appointments.

Collaboration doesn't just mean more care, it means different care. While there is some overlap between the primary care services provided by physicians and NPs, each professional also brings unique skills and knowledge to a collaborative practice. Together, they offer more comprehensive patient care, as well as the opportunity to provide more preventive health services. This should translate into healthier patients, less need for health services and lower costs for the health care system. The collaborative relationship also allows both professionals to pursue their strengths and interests, which leads to greater job satisfaction and higher morale.

The Expert Panel also learned that the public responds well to these collaborative working relationships, and that physicians also welcome the relationship, when it has no negative impact on their earning potential.

However, Ontario's ability to make effective use of NPs and to promote collaborative practice is currently limited by:

- the small pool of NPs – given existing training programs, Ontario will only have a total of 600 NPs in three years' time, and not all will choose to work in primary care[34]
- lack of an established ongoing mechanism for primary care organizations/practices to access funding to hire NPs
- lack of adequate compensation for the overhead and consultation costs associated with having an NP in practice with a physician
- concern/conflicting advice about the physician's liability for the NP's care
- lack of office space which, in private practices, is provided by the physician and is part of overhead costs (i.e., in recent years, with the increase in rents, many physicians have downsized their offices to reduce overhead costs and do not have space to accommodate an NP)

33 *Of the 106 positions, 81 are filled or committed, including 58/75 in underserviced areas, 16/20 in long-term care, 4/5 in Aboriginal health and 3/5 in primary care networks.*

34 *The Expert Panel estimates that about 75% of new NP graduates will work in primary care. The remaining 25% will be employed in other settings, such as long-term care facilities, emergency departments, and home care.*

- workload issues, including the learning curve (three to nine months in a family practice and one year in an emergency department) before the NP is working at full capacity, and regulatory and legislative barriers (e.g., the Public Hospitals Act) that prevent NPs from practising to their full scope
- lack of ongoing, permanent funding for NP training – at the current time, all funding is provided by the MOHLTC through time-limited agreements with MTCU; a commitment must be made to provide stable, long-term funding to maintain the NP training programs and adjust enrolment as required
- physician attitudes – some physicians continue to see NPs as a threat to their income/earning potential; however, this is less of an issue for physicians working in areas underserved for primary care, or for physicians working in a salaried model – who seem receptive to working with NPs, if the other barriers can be removed.

To be able to make more effective use of NPs, the Expert Panel stresses that the ministry must address the following issues:

Compensation

- Encourage primary care physicians to shift to alternative funding plans, which would provide the flexibility to hire NPs and cover the associated overhead costs.
- Address the controversial issue of appropriate compensation for fee-for-service physicians by establishing a flat or capitated fee to cover the NP's portion of overhead costs, and considering a flat or capitated fee for physicians' time spent consulting with NPs.
- Provide stable, ongoing funding for all NPs, and a means to pay those in primary care that will reflect the collaborative nature of the practice (i.e., NPs should not be employees of physicians).

Workload Issues

- Remove the regulatory barriers to effective NP practice (e.g., Public Hospitals Act, NP drug formulary).
- Allow specialists to bill for consultations for patients referred by NPs working in collaborative practices with family physicians.
- Have HHRAP examine physician/NP collaborative practices to identify expectations for NPs and provide advice for NP recruitment and training programs.
- Whenever possible, place NPs with the physicians they will work with during their training, and allow the initial development of the working relationship to occur within a learning situation.

Liability Issues

- Request the Canadian Medical Protective Association (CMPA), the College of Nurses (CNO), and the Registered Nurses Association of Ontario (RNAO) to develop joint guidelines on liability for physicians and NPs working in collaborative primary care practices within office, clinic and emergency settings.

Education Issues

- Work with the Ministry of Education and Council of Ontario University Programs in Nursing (COUPN) to develop stable, long-term funding for NP education.
- Ensure that NP education programs continue to attract students who are likely to choose rural, northern or underserviced practice, and provide appropriate training for those settings and populations.

NPs have the potential to increase Ontario's capacity to provide primary care. They can be trained relatively quickly (compared to physicians), and they bring valuable skills to primary care. However, they are currently being produced in such small numbers that it is difficult for them to have a significant impact. For these reasons, the Expert Panel suggests that Ontario consider increasing production of NPs. However, the Expert Panel is aware that there is also a nursing shortage in Ontario. The decision to develop more NPs should take into account any potential negative impact on the supply of nurses and nursing care.

As with the physician workforce, every effort should be made to recruit a proportion of NP trainees who are likely to choose to work in underserviced areas or with underserviced populations. As Ontario's NP training program is already highly decentralized (i.e., in nine sites across the province), it is extremely effective in attracting students from rural and remote communities and in providing training opportunities in smaller communities. All these factors are likely to lead to a proportion of NPs who are likely to choose rural and remote practice settings.

Remove Administrative Barriers to Midwifery Practice

As noted earlier, Ontario educates about 40 midwives each year. Each midwife performs about 40 deliveries per year. Approximately 30% of midwife deliveries require some degree of intervention on the part of an obstetrician-gynecologist. According to anecdotal reports, the interventions are often required for administrative rather than clinical reasons. For example, some hospitals place arbitrary limits on the number of midwives with hospital privileges or on the number of deliveries midwives can do. Because midwives are not allowed to consult directly with an anesthesiologist, a midwife's patient who needs an epidural must be referred to a physician.

If these artificial barriers were removed, midwives would be able to perform a larger proportion of unassisted low risk deliveries, thereby relieving the pressure on obstetricians.

To enable the health care system to make more effective use of existing resources, the Expert Panel recommends that:

#22 MOHLTC provide funding for three years to support the PAIRO Resident Placement Program to assist trainees who are ready to enter the workforce. To determine the long-term potential of this program, HHRAP should:

- evaluate the success of the program in matching new physicians to communities in need
- assess its impact on the supply, mix and distribution of physicians in Ontario
- make recommendations, based on the evaluation, about ongoing long-term funding.

#23 MOHLTC fund, on a four-year pilot basis, the COFM/CPSO proposal to license up to 25 fully qualified IMGs annually. Funding should be provided to screen potential candidates, and to allow each successful candidate to undergo up to six months of assessment and, if necessary, up to two years of postgraduate training. The program will be limited to specialties or communities in short supply. HHRAP should evaluate the impact of the program on the supply, mix and distribution of physician services in Ontario, and advise on the future of this program.

#24 HHRAP assess and provide advice on incentives to encourage existing specialists and family physicians to provide more of the services that are in short supply, such as psychiatry, obstetrical care, emergency and anesthesiologist. HHRAP also assess the impact that the cost of liability insurance has on access to certain health services and provide advice on how to address this issue.

#25 MOHLTC take steps to remove the barriers to collaborative physician/nurse practitioner primary care practice, and provide the funding to integrate a minimum of 75 nurse practitioners a year for the next five years into collaborative physician/NP practice, starting first in settings where collaboration has been successful.

#26 HHRAP assess the potential to double the number of nurse practitioners graduating, beginning no later than 2000. The assessment should include the ability to recruit, train and place nurse practitioners as well as the impact that doubling production of nurse practitioners will have on nursing supply in the province.

#27 MOHLTC work with hospitals to remove any artificial barriers that may prevent midwives from functioning appropriately within their scope of practice, thereby increasing the proportion of unassisted low-risk deliveries that midwives are able to perform each year.

MANAGE DEMAND

While all these initiatives to increase or maximize supply will help, the Expert Panel believes that not all Ontario's efforts to manage the health workforce or health services should focus on supply. As Dr. McKendry suggested, some attention should also be given to managing demand and ensuring that people use health services appropriately. The Expert Panel based its forecast for physician supply on the assumption that Ontario would actively manage demand and recommends that:

#28 MOHLTC develop initiatives designed to reduce inappropriate use of health services by educating the public about when to see a physician or other health care provider

IV. Attract and Retain Physicians Where They are Needed

As of the fall 2000, 107 Ontario communities (33 in the north and 74 in the south) were designated as undersupplied for physician services and were looking for a total of 456 family physicians. In addition, 12 communities in the north were designated as underserviced for specialist services and were looking for a total of 123 different specialists.[15]

These figures highlight the need for physicians in underserviced areas. They also indicate how crucial it is for Ontario to keep the physicians who are already working in rural, northern and underserviced communities. As Dr. McKendry and others have noted, Ontario has invested significant resources in attracting physicians to underserviced areas, but little to persuade them to stay. In fact, many current recruitment programs simply attract physicians from one underserviced area to another, which only moves rather than solves the problem. For this reason, the Expert Panel has focused on meeting the needs of physicians who are in rural and remote practice now, as well as new recruits.

Based on experience in Ontario and in other jurisdictions, physicians are more likely to choose to stay in remote, rural and underserved practice when:

- they are organized in group practices that can provide collegial support, share on-call obligations, and provide a mix of specialized skills such as anesthesia, obstetrics, palliative care
- the compensation system recognizes the difficulties/challenges of this type of practice
- they have access to a range of effective, evidence-based retention strategies
- there is adequate infrastructure, including appropriate hospital resources
- they have appropriate technology and access to continuing medical education
- there is an adequate supply of other health providers to support a multidisciplinary approach to care
- they are able to lead a balanced lifestyle.

According to a recent survey of rural family physicians in Ontario, the supports and incentives most important to them in their practice are: adequate compensation, (particularly for low-volume services such as covering the hospital emergency department, anesthesiology and obstetrics), a reasonable on-call schedule (i.e., no more than one in five nights), quick and easy access to specialists when needed (e.g., by phone, fax or e-mail), opportunities for CME and specialty training, and overhead support.[16]

To make rural practice more attractive, Ontario must ensure the compensation system accurately reflects the difficulties/challenges of working in rural and northern communities and invest in effective recruitment and retention initiatives.

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15 *Specialists are also in short supply in parts of southern Ontario, but there is an emphasis in designated communities for specialized services in the north*

16 Incitti F, Rourke J, Rourke L, Kraemer M. *Survey of Rural Family Physicians and Family Physicians in Training*. In publication. Funded in part by the Ontario Medical Association CME Fund. *Project report prepared by the Southwestern Ontario Rural Medical Education Research and Development Unit*

DEVELOP A RURALITY INDEX

Providing medical care in small, rural or remote communities can be significantly more demanding and difficult than working in larger urban centres, and that should be recognized in the compensation and support provided to physicians. Several attempts have been made in the past to develop a rurality index that could be used to determine the compensation that should be offered. The Expert Panel reviewed past efforts to develop rurality indices, and identified a number of weakness, including:

- the use of geopolitical boundaries rather than actual referral patterns, which means that the index does not accurately represent catchment areas or referral patterns for physician services
- lack of attention to specialist services - indices are generally developed for family physicians and little work has been done to develop a rurality index for specialists services (i.e., Sault Ste. Marie may be well served by family physicians, but have significant shortages of specialist services)
- data used for the rurality indices tend to be based on "active physicians" and not FTEs, which can either over- or under-estimate the effective supply of physician services.

In the Expert Panel's view, a workable rurality index must be able to reflect the challenges in various working environments. As the north will always be at a disadvantage in recruiting and retaining physicians and other providers, an effective rurality index must also be able to distinguish between communities in the north and those in the south.

Despite the difficulty of accurately capturing the challenges of different working environments, the Expert Panel believes that a rurality index would be an effective tool to improve physician retention. To increase Ontario's capacity to attract and retain physicians working in rural, remote and underserviced areas, the Expert Panel recommends that:

It29 **HHRAP develop an equitable, workable rurality index for specialty and family practice that can be used to quantify the degree of rurality and remoteness of physician practice in different communities across Ontario, and form the basis for compensation and incentive programs.**

Once a reasonable, accurate rurality index has been developed, it could be applied to determine the number and level of incentives available to physicians (see recommendation #30). The rurality index could be used in two ways:

- to identify those physician practices with a high degree of rurality that would be eligible for particular incentives
- to determine how incentives that are available to all rural physicians would be weighted to recognize rurality.

For example, all rural and northern physicians should be eligible for some incentives, such as a premium for long service, but the amount of the premium should vary depending on the physician's degree of rurality. That is, those with a high rurality index would receive a higher premium than those with a low rurality index.

DEVELOP A MENU OF RETENTION INCENTIVES

In their recent review of recruitment and retention strategies, Barer and Stoddart noted that "the problem of geographic maldistribution (is) the most difficult to solve of all of the physician resource policy problems ...and that no optimal "solution" was likely possible. What (is) possible (is) a sustained management strategy to reduce the problem;" [37]

To develop that kind of sustained and sustainable management strategy, Ontario should build on its own lengthy experience trying to recruit and retain physicians in underserviced areas, as well as evidence from other jurisdictions.

WHAT WORKS NOW

To identify the kind of incentives that work, the Expert Panel consulted with representatives of the MOHLTC Northern Health Programs office, which administers the Underserviced Area Program (UAP). Based on its experience trying to recruit and retain physicians in underserviced areas, the UAP has generally found the following incentives to be effective:

- community-sponsored contracts (CSCs), a compensation incentive that allows certain small rural and isolated communities in northern Ontario[38] to attract and keep physicians. When the program began, 60% of positions in eligible communities were vacant. Currently, only 8% are vacant. There are now 32 physicians on CSCs in 22 communities: 20 new physicians and 12 existing physicians who remained in the community but transferred from fee-for-service to CSCs.

- incentive grants, a financial incentive to take up practice in rural or remote communities that also exempts physicians from the billing threshold. In the past two fiscal years alone, 159 new incentive grants were awarded to newly recruited physicians (31 to GPs in the south, 65 to GPs in the north and 63 to specialists in the north). A sampling of incentive grants shows that more physicians (239%) remain in the community at least four years (the duration of the incentive grant) than leave the community in less than four years (13%).

- the introduction of nurse practitioners. In February 2000, the ministry announced funding for 76 NP positions in underserviced areas (43 in the north and 33 in the south). As of December, 2000, 58 NPs in that program have started to practice in underserviced communities.

- nursing stations, facilities staffed by a nurse or NP, with arrangements for physicians to make regular visits, established in communities that cannot support a physician. In 1999/2000, a total of 60,294 patient visits were made to the 21 stations (40,756 patients were served by nurses or NPs while 19,638 patients were served by physicians).

- access to specialist services in northern Ontario through the Visiting Specialist Clinic and Specialist Locum Tenens Programs. Those programs provided a total of 9,849 days of specialist services in 1999/2000 alone.

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37 Barer M, Stoddart G. *Improving Access to Needed Medical Services in Rural and Remote Canadian Communities: Recruitment and Retention Revisited, June 1999. Centre for Health Services and Policy Research, UBC*

38 *Communities that have the greatest difficulty recruiting and retaining physicians have the most urgent need for physicians and do not have access to primary care in nearby communities.*

WHAT NEEDS IMPROVEMENT

Based on past experience, the UAP also believes that, with some improvements, the following incentives would be more effective:

- Northern Health Travel Grant (NHTG), which assists patients who must travel at least 100 km to obtain specialty services not available in their own communities. In 1999/2000, NHTG processed 104,932 claims. NHTG is historically underfunded and operates in a deficit. For example, the NHTG budget in 2000/01 is $6 million, but expenditures will be $10 million. More permanent funding could improve patient access to specialist services.
- The underserviced area designation process, which is based on physician-to-population ratios. When larger communities are designated as underserviced (i.e., GP/FP designations in southern Ontario), smaller northern or southern rural communities are less likely to be successful in their recruitment efforts.
- The GP locum program administered by the OMA. Service levels have apparently been reduced significantly since the program was transferred to the OMA.

PROPOSED INCENTIVES

Having reviewed the incentives that appear to be effective, the Expert Panel favours a menu of incentives that physicians can choose from – rather than a cookie cutter approach to compensation and support.

In the Expert Panel's view, the following chart illustrates an attractive menu of incentives as well as the types of incentives that might be available based on different levels of rurality.

To improve the capacity of the system to retain physicians in underserviced areas, the Expert Panel recommends that:

#30 MOHLTC, in consultation with HHRAP and the Physician Human Resources Subcommittee of the OMA/MOHLTC Physician Services Committee:

- **establish a menu of incentives/initiatives which would be available to physicians based on their degree of rurality**
- **make an initial allocation of $10,000,000 in 2001 over and above any existing contracts to fund those incentives**
- **determine the future funding required for incentives.**

MENU OF INCENTIVES

HIGH RURALITY (incentives 1-12)

Low RURALITY (incentives 10-12)

1. providing "turn-key" practices that include infrastructure and overhead costs (e.g. staffing costs, benefits, equipment, operating room time, diagnostic support), which encourage solo physicians to move into group practices
2. increasing incentive grants (which have not changed since 1979) and providing them in a lump sum rather than annually
3. adjusting funding levels for alternative payment plans (APPs) to reflect the critical mass required for on-call, vacations, benefits, CME leaves over and above UAP minimum
4. providing compensation for specialists who provide telephone advice/consults
5. expanding CME funding (including locum coverage) to a wider range of physicians depending on degree of rurality
6. providing funding and locum support for: maternity/paternity/adoption leave, sabbaticals and short-term leaves (The eligibility for funded leaves could vary depending on type of leave and degree of rurality. For example maternity/paternity/adoption leaves should be available for those practising in a low rurality area, whereas funding for sabbaticals may apply only to those in areas of high rurality.)
7. paying financial premiums to physicians for long service (i.e., after four to five years of service in a community), with the premium amount determined based on rurality and on the need for the type of service (e.g., obstetrics, emergency services, anesthesiology, office practice)
8. enhancing levels of funding for locum coverage and expanding current eligibility for locum coverage in direct relationship to enhancements in CME, maternity/paternity, vacations, and sabbaticals (Other strategies to improve the available locum pool should be explored, such as repayment of IRDS contracts via locums, provincial locum license, allow existing doctors in UAP communities to access locum funding if they cannot attract locums.)
9. providing funding support for communications technology and medical informatics
10. funding for nurse practitioners to work collaboratively with physicians, both in a fee-for-service and an alternate payment plan setting
11. expanding eligibility for APPs and AFPs to both family physicians and specialists in all underserviced areas in both the north and the south, and indexing the funding available within an APP/AFP to the practice's degree of rurality
12. expanding additional on-call and emergency room funding (for both APP and fee-for-service physicians), beyond the provisions of the OMA agreement to apply to more specialties, and ensuring the level of compensation reflects rurality and the required call schedule.

Implementation Costs and Timeline

The Expert Panel has laid out an ambitious plan to shape the physician workforce and ensure an adequate supply of physician services for Ontario. Its initiatives are also designed to lead to more comprehensive, integrated health workforce planning in the future.

PRELIMINARY COST ESTIMATES

In implementing the 30 recommendations, the health care system will incur a range of costs. The investment will be relatively modest in the first year, but grow over a period of about six years until all initiatives are implemented. Once implemented, the planning tools, the CECs, the changes in physician education, the effective use of other health resources and providers, and the incentives will require a certain amount of funding each year to maintain.

The following chart lays out some initial, rough estimates of the costs associated with each initiative. The Expert Panel cautions that these costs are preliminary. All the initiatives will have to analyzed in more detail over the next three to four years to determine the exact development and ongoing costs.

PRELIMINARY COSTING OF EXPERT PANEL RECOMMENDATIONS ($ MILLIONS)

Initiative	2001-02 Year 1	2002-03 Year 2	2003-04 Year 3	2004-05 Year 4	2005-06 Year 5	2013-14 Year 14 Maturity-Estimates
Health Human Resources Advisory Panel	0.500	0.500	0.500	0.500	0.500	0.500
Develop health human resources databases and models	0.100	0.350	0.400	0.400	0.400	0.400
Increase undergraduate medical enrolment by 160 (capital and operating)	13.020	22.400	16.800	13.000	13.800	14.200
Increased postgraduate positions (including salaries and operating costs for universities and hospitals)	2.835	6.895	12.201	19.882	34.805	126.370
Decentralize medical education - CECs (capital, one-time and operating)	9.000	12.000	19.000	16.000	15.000	15.000
Assessment and training of IMGs	1.255	4.230	4.230	4.230	4.230	4.230
PARO resident placement proposal	0.212	0.185	0.185	0.185	0.185	0.185
Employ 75 NPs annually and double production by 2008	7.500	7.500	7.500	7.500	9.200	16.700
Recruitment/retention - quality based incentives	10.000	10.000	12.000	12.000	12.000	12.000
Total	44.422	64.060	72.816	72.697	89.921	189.585

Although the costs may seem significant, the Expert Panel stresses that as a proportion of Ontario's $22 billion total health care budget, they represent an addition or reallocation of less than 1% when fully implemented and significantly less during development. This is a relatively small investment to provide equitable access to physician services.

In addition to these development, education and incentive costs, the Expert Panel notes that the health care system will also face the long-term cost of the additional physicians who will enter practice over the next five to 15 years.

PROPOSED IMPLEMENTATION AND EVALUATION TIMELINE

In its recommendations, the Expert Panel has proposed a start date for each initiative, and set out requirements for ongoing monitoring and evaluation. The following chart illustrates when each initiative will be developed and implemented as well as when it will be subject to evaluation.

Expert Panel Recommendations	01/02	02/03	03/04	04/05	2005 and beyond
Health Workforce Planning					
1/2. Establish HHRAP and provide financial support for database development					
Decentralize Medical Education					
3/4. Build on existing relationships to create and fund clinical education campuses					
5. Develop an integrated plan for decentralized medical education					
6. Take steps to address issue of funding and incentives for clinical teachers					
Develop Appropriate Training Streams					
7. CEC's/AHSC's develop rural/northern training stream and admission process					
8. Identify and develop training to address needs of distinct populations					
9. Assess potential of clinical scholars stream for northern/rural					
10. HHRAP evaluate effectiveness of CEC's in implementing training streams					
Ensure Quality					
11. MOHLTC fund development of education specialists program					
12. Government increase investment in CME					
Refine Forecasting Models					
13. HHRAP to continue to develop and refine needs based forecasting models					
Produce Physicians					
14. MOHLTC and AHSCs increase undergraduate positions by a total of 160 positions (including adjustment to implemented in fall of 2000)					
a. Phase in increase over 3 years (00 – 2001, 20 –2002, 20 – 2003)					
Evaluate impact annually (see rec. 21)					
b. Allocate a minimum of 40 positions to CEC's in northern/rural stream					
c. Allocate some of positions for underserviced population training stream					

Expert Panel Recommendations and	01/02	02/03	03/04	04/05	2005 beyond
15. Provide funding to increase residency positions to match undergraduate increase					
16. Provide additional funding for hospitals and other training sites					
a. Start-up/development costs					
b. Ongoing operating costs					
Manage the Postgraduate Training System					
17. Ask IRAP/COFM to immediately review need to redistribute training positions					
19. MOHLTC provide 25 postgraduate positions for career flexibility					
19. MOHLTC to provide funding for 25 PGY3 at FM for CECs					
20. MOHLTC to provide funding for 25 postgraduate positions at CECs in 2002 and 2003					
21. HHRAP to review annually impact of increases in enrolment					
Make More Effective Use of Existing Resources					
22. MOHLTC to provide funding for PAMO Resident Placement Program					
23. MOHLTC fund, on pilot basis, CPSO/COFM MAG proposal					
24. Assess incentives/barriers in providing physician services in short supply					
25. Remove barriers and provide funding for a minimum of 75 NPs per year					
26. HHRAP assess potential to double production of NPs by 2006					
27. Ensure policies/protocols maximize independent midwifery practice					
Managing Demand					
28. Develop public awareness program to reduce inappropriate utilization					
Increase Capacity to Recruit and Retain Physicians					
29. HHRAP to develop rurality index					
30. Establish menu of incentives and provide $40M in first year					

Legend:

Start-up and implementation
Continuation of initiative/program
Continuation pending review/evaluation

Conclusion

It will be several years before the full impact of the Expert Panel recommendations will be felt within the health care system. The following table lists the impact of the 33 postgraduate positions added in response to Dr. McKendry's recommendations along with the increases and other initiatives recommended by the Expert Panel on the supply of physicians in Ontario in 2010 and 2015.

	Cumulative Increase in Supply by 2010	Cumulative Increase in Supply by 2015
McKendry Recommendations: repatriation, expansion of IMG program, expansion of Family Medicine North	268	391
Expert Panel Recommendations: 360 increase in medical school enrolment per year phased in over four years; 25 IMGs per year beginning in 2001; and 26 additional PGY1 positions in 2002 and 2003 only[39]	594	1309
Total	**862**	**1700**

Beginning in 2015, when all the Expert Panel and McKendry increases will have worked their way through the education system and into the workforce, Ontario will be producing 42% more physicians each year than it did in 2000 – a substantial increase. It will also have a much larger pool of postgraduate trainees who will provide a significant amount of clinical care – particularly in hospitals – and will contribute to the effective supply of physician services in Ontario.

With the Expert Panel recommendations, Ontario will not only be able to produce more physicians, it will have the potential to create a more appropriate mix of physician services, and to provide a sustainable source of physicians trained for rural, northern and underserviced practice.

These increases and shifts in the medical education system will go a long way to solving Ontario's need for physician services. However, the health system's ability to meet the population's health needs over the next 15 years and into the future will depend on other resources as well as physicians.

39 Effective 2000, these 25 entry-level positions will become part of the total 160 increase in undergraduate positions. However, by implementing these positions in 2002 and 2003 – two years before the increase in undergraduate enrolment needs to support the postgraduate system – the system will be able to accept 50 additional trainees who will train at the CEC. This will produce 50 additional physicians in approximately 2 to 5 years after the start of their training.

In its deliberations, the Expert Panel has tried to touch on virtually all factors that affect where and how physicians practice and the type of services they provide, including how physician services are planned, where and how physicians are educated, the role of other providers, the impact that other health policies have on physician services, and physicians' working conditions and incentives. The Panel's recommendations represent a comprehensive, strategic, system-wide approach to physician workforce planning. Taken together, they offer Ontario the opportunity to plan and manage physician services effectively. Implemented selectively, they will fail to have the desired impact and could have serious negative effects on the health care system.

Panel members caution the Ministry of Health and Long-Term Care about the risk of implementing certain recommendations, and ignoring others. For example, if the ministry makes the recommended increase in physician supply, without making fundamental changes to the education and training system, the inequities (i.e., distribution problems) in the system will become more acute. If it implements the proposed increase in supply, but does not develop other supportive health policies (i.e., efforts to manage demand for services, policies to encourage more comprehensive practice, and greater collaboration between physicians and nurse practitioners), then the province will continue to struggle with a shortfall in physician services.

To achieve its goals, the ministry must use all the available levers and tools, including planning, undergraduate education, postgraduate training, continuing medical education, incentives and other health policies that can shape physician practice.

The Panel recognizes that its proposals will require significant investment in universities, teaching hospitals and the health insurance system. Based on an initial assessment, Expert Panel initiatives will cost about $45 million in the first year, and about $190 million a year once all programs are up and running. While the costs may seem high, the Expert Panel notes that they actually represent a relatively small proportion - less than 1% – of Ontario's total health care budget.

Five years ago - when spending on health care was constrained in all parts of Canada - this plan would not have been possible. With the current fiscal climate, Ontario has a unique opportunity to establish an ongoing capacity to plan physician services, to reshape the way physicians are trained, to improve the mix and distribution of physician skills, and to confront inequities in health care. It also has the opportunity to lay the groundwork for integrated health workforce planning, which will be vital for the future of the health care system.

At this point in the evolution of Ontario's health care system, the Expert Panel members believe that Ontario must make every effort to capitalize on opportunities to shape the health workforce. The return on the investment in health human resources - measured in improved quality and equity of care, greater patient and provider satisfaction, and the sustainability of the health care system - will be substantial. Without this investment, the quality of health care in Ontario will decline, and Ontario's "blueprint" for a stronger health care system will be at risk. To safeguard the future, Ontario must invest today.

Members of the Expert Panel and the Working Groups

ABOUT THE PANEL MEMBERS

Dr. Peter George is Chair of the Expert Panel. He is a well-known scholar and educator, with considerable experience in senior academic administrative and executive positions. An economist with strong interdisciplinary interests and a former President of the Council of Ontario Universities, he is currently the President and Vice-Chancellor of McMaster University.

Dr. Gail Beck has a psychiatry practice in Ottawa. She is currently Chair of the Women's Issues Committee, which deals with physician resources at the Ontario Medical Association.

Dr. John Bonn was appointed Registrar of the College of Physicians and Surgeons of Ontario in July 1997. Dr. Bonn brings to the Panel expertise in issues related to the licensure of physicians.

Dr. Ben Chan is currently senior scientist with the Institute for Clinical Evaluative Sciences (ICES). Dr. Chan has completed numerous analyses of the utilization of physician services in Ontario including a focus on physician practice patterns and differences in rural and urban physician practices. In addition to his research, Dr Chan provides monthly locum coverage for family physicians throughout Northern Ontario.

Dr. Laurel Dempsey is a family physician in the village of Verona, north of Kingston as part of the pilot project in Primary Care Reform. She maintains an active solo practice with 3000 rural patients.

Mr. Joseph de Mora is currently the President and Chief Executive Officer of Kingston General Hospital. When first appointed to the Expert Panel, he was President and Chief Executive Officer at the Sudbury Regional Hospital. That hospital has a large number of community based ambulatory programs and provides a wide range of special services in northern Ontario. It also provides training to a large number of health professionals, nursing students and medical doctors.

Dr. Brian Gamble has a full time family practice in Chatham as part of the Primary Care Network and is Chief of Staff at the Chatham Kent Health Alliance. Dr. Gamble has particular expertise in Primary Care Reform and the role of technology on physician human resources. He is Chair of the Section on General and Family Medicine of the Ontario Medical Association and also chair of the Practice Technology Committee of the OMA.

Sharon Goodwin is a primary health care nurse practitioner, nurse administrator and current Chair of the Nurse Practitioner Association of Ontario. She is also Director of Operations Clinidata/Direct Health Telephone Triage Service, responsible for the Direct Health 1-800 registered nurse advice service for Northern Ontario. She is a recognized leader in nursing with extensive experience, primarily in rural and northern communities.

Dr. Michael Howcroft is a Toronto ophthalmologist and former board member of the OMA. He has had a longstanding interest in physician resource planning and was previously a member of the Canadian Medical Association (CMA) committee on physician resource planning and chair of the CMA committee on Physician Resource Planning. Dr. Howcroft was also chair of the National Ad Hoc Working Group on Physician Resource Planning (a joint initiative of the CMA and provincial medical associations).

Mary Lapaine is a volunteer and businesswoman from Goderich. She is an active Board member of the Alexandra General and Marine Hospital and a Board member of the Ontario Hospital Association. Ms. Lapaine has been active in her own community and the province in addressing physician supply in rural areas.

Mr. Ronald Loucks is currently Vice President & General Manager for BCE Emergis Inc., Assure Health Division, the leading provider of e-Commerce Solutions in North America. Mr. Loucks is responsible for the corporate development and marketing of BCE Emergis, Assure Health, with insurance carriers, the consulting community, pharmacies, drug manufacturers, physicians and dentists.

Dr. William McCready has practiced as a nephrologist in Thunder Bay since 1982 and is Chair of the Northwestern Ontario Medical Program. He is also an associate clinical professor in the Department of Medicine at McMaster University.

Ms. Neera Mehta is currently an employment counselor with the Kitchener-Waterloo Multicultural Center. She is extensively involved in the development and delivery of training programs for internationally trained professionals and trades. Ms. Mehta is also the co-coordinator for the Kitchener-Waterloo International Physicians and Surgeons support group.

Dr. Linda-Lee O'Brien-Pallas, a registered nurse, is a professor at the Faculty of Nursing at the University of Toronto, with a cross appointment to the Department of Health Administration at the Faculty of Medicine. She has published widely in her areas of research, which include issues related to nursing health human resources. She was recently named as one of the first in Canada to hold a chair in health service and nursing research through a new program of the Canadian Health Services Research Foundation, in partnership with the Canadian Institute of Health Research. She is also Co-Principal Investigator of the Nursing Effectiveness Utilization and Outcomes Research Unit funded by the Ontario Ministry of Health and Long Term Care.

Dr. Jeffrey Remington is the Chair of the Niagara Physician Resource Planning Task Force. He has a family practice in Port Colborne and is Chief of Family Practice at the Port Colborne General Hospital site of the Niagara Health System. Dr Remington has been involved in recruiting family doctors to Port Colborne.

Dr. Joshua Tepper is the immediate Past President of the Professional Association of Internes and Residents of Ontario (PAIRO). A recent graduate of the Rural Family Medicine Program at the University of Toronto, he is currently doing locums in Northwestern Ontario. He has participated in a wide range of activities related to the issues of rural and underserved communities including contributing to the PAIRO/Society of Rural Physicians of Canada (SRPC) "Blueprint" project. Nationally, he is the Chair of the Canadian Association of Internes and Residents (CAIR) Physician Resources Secretariat.

Dr. Peter Walker is Dean of the Faculty of Medicine at University of Ottawa and current Chair of the Council of Ontario Faculties of Medicine. Trained in internal medicine and endocrinology, he is Vice Chair of the Expert Panel.

Dr. Janice Willett is an obstetrician/gynecologist practicing in Sault Ste. Marie. She is affiliated with the Sault Area hospitals and is presently Chair of the Ontario Society of Obstetrics and Gynecology. Dr. Willett also has extensive experience with the Ontario Medical Association particularly in relation to northern and rural specialty care.

WORKING GROUP ON DATA AND MODELLING

Dr. Ben Chan, Chair
Senior Scientist, Institute for Clinical Evaluative Sciences

Dr. Linda Lee O'Brien-Pallas, RN, PhD, Vice-Chair
Co-principal Investigator, Nursing Effectiveness, Utilization and Outcomes Research Unit, University of Toronto

Dr. Stephen Birch, Professor
Department of Clinical Epidemiology and Biostatistics
McMaster University

Mr. Paul Brochu
Knowledge Management Unit, Health Planning Branch
Ontario Ministry of Health

Ms. Lynda Buske
Canadian Medical Association

Mr Neil Johnston
Ontario Physician Human Resources Data Centre (OPHRDC)

WORKING GROUP ON SUPPLY

Dr. Michael Howcroft, Chair
Ophthalmologist, St. Michael's Hospital

Dr. Gail Bech, Vice Chair
Psychiatrist, Ottawa

Dr. John Bonn, Registrar
College of Physicians and Surgeons of Ontario

Dr. Robert Byrick, Chair
Department of Anaesthesia, University of Toronto

Dr. Brian Gamble, Family Physician
Primary Care Network, Chatham, Ontario

Ms. Sharon Goodwin, RN (EC)
Director of Operations, Clinidata

Ms. Mary Lapaine
Board Member, Ontario Hospital Association

Ms. Neera Mehta
Employment Counsellor, Kitchener-Waterloo Multicultural Centre

Muhammad Rafiq, Chair
Association of International Physicians and Surgeons of Ontario

Dr. Murray Ucowitz, Associate Dean
Postgraduate Education, Faculty of Medicine, University of Toronto

Dr. Peter Walker, Chair
Council of Ontario Faculties of Medicine

WORKING GROUP ON DISTRIBUTION

Dr. William McCready, Chair
Northwestern Ontario Medical Program

Mr. Joseph deMora, Vice-Chair
President and CEO, Kingston General Hospital
(former CEO of Sudbury Regional Hospital)

Dr. Laurel Dempsey, Family Physician
Primary Care Network

Dr. Brian Gamble, Family Physician
Primary Care Network

Dr. Carol Herbert
Dean, Faculty of Medicine and Dentistry
University of Western Ontario

Dr. Peter Hutten-Czapski
Society of Rural Physicians of Canada (Ontario Region)

Ms. Mary Lapsme
Board Member, Ontario Hospital Association

Ms Eileen Mahood
Director - Northern (Sudbury) Region
Ministry of Health and Long-Term Care

Johanne Mousseau, RN (EC)
Assistant Professor, Faculty of Nursing, McMaster University

Dr. Jeff Remington
Niagara Physician Resource Planning Task Force

Dr. Joshua Tepper, Past President
Professional Association of Internes and Residents of Ontario

Dr. Janice Willett
Obstetrician/Gynaecologist

Submissions and Presentations to the Expert Panel

Brock University. Submission and letter on "Med Plus Program", B.G. Neuman, Associate VP, Student Services, September 2000

Canadian Medical Forum, Task Force on Physician Supply, Presentation by Dr. Nick Busing, Co-Chair, April 2000

Cancer Care Ontario. Systemic Therapy Task Force Report, April 2000

Cancer Care Ontario. Report on the Task Force on Human Resources for Radiation Services, February 1999, submitted to Panel in September 2000

Cardiac Care Network of Ontario. Final Report of the Consensus Panel on Cardiovascular Human Resources, June 2000

Chairs of Psychiatry in Ontario, letter re. psychiatric manpower in Ontario, submitted by Dr. R.P. Swinson, Morgan Firestone Chair and Professor, Psychiatry and Behavioural Neurosciences, McMaster University

Council of Ontario Faculties of Medicine (COFM). Business Plan for Rural Medicine, presented by Dr. Peter Walker

College of Physicians and Surgeons of Ontario (CPSO) and COFM. Proposal to Establish a New Route for Registering Physicians in Ontario, September 2000

Hutten-Czapski, Dr. Peter, Chair, Ontario Region, Society of Rural Physicians of Canada. Australian Incentive Plans - paper prepared for Expert Panel, Distribution Working Group, May 2000

Johnston, Mr. Neil, Ontario Physician Human Resources Data Centre. Potential uses of the OPHRDC physician database, presentation to the Panel, April, 2000

Joint Provincial Nursing Committee (nursing associations and educational organizations only). letter re: utilization of other health professionals, June 6, 2000

Lyanga, Dr. John. Submission to the Expert Panel of Long Term Supply of Doctors in Ontario, June 21, 2000

McElroy, Dr. Ross. Letter re. reflections on findings of physician fact finder, and HSRC primary health care strategy, February and April, 2000

McKendry, Dr. Robert. Findings of the Physician Fact Finder, presentation to the Expert Panel, April 2000

Neilson, Dr. Peter. Essex Provincial Progressive Conservative Riding Association, "Windsor Regional Medical School", October 3, 2000

Niagara District Health Council. Report of the Physician Resources Planning Task Force, June 2000

Northern Ontario Rural Medical School (NORMS) Liaison Council. "Northern Rural Medical School: Increasing rural medical graduates in Ontario", June 2000. Presentation to Panel, August 23, 2000

Negotiating Ontario's Well-Being (NOW) Alliance. "NOW Alliance Submission to the Expert Panel on Health Professional Human Resources", October 2000

Ontario College of Family Physicians, Where Have all the Family Doctors Gone? November 2000

Ontario Hospital Association, Position Paper on Physician Human Resources Policy and Planning (Working Draft), October 2000

Ontario Osteopathic Association (OOA). Brief of the OOA to the Expert Panel on Health Professional Human Resources, May 2000

Pediatric Oncology Group of Ontario (POGO). Submission of POGO: Health Professional Human Resources in Pediatric Oncology, September 2000

Professional Association of Internes and Residents of Ontario. Resident Placement Program, presentation by Dr. J. Tepper

Professional Association of Internes and Residents of Ontario. "Family Medicine": A proposed model for a limited licensure program for family medicine residents. June 2000

Regional Geriatric Program of Ontario. Survey of Geriatric Medicine Specialists, May 2000

Rourke, Dr. James. Educating Physicians for Rural/Regional/Northern Communities. Presentation to Expert Panel Working Group on Distribution, June 2000

Thames Valley District Health Council, Medical Human Resources Committee. Southwestern Ontario District Health Councils, Proposal to Increase the Supply of Licensed Physicians in Underserviced Areas of Ontario, April, 2000.

Toronto Department of Public Health. Letter from Dr. Sheela Basrur, Medical Officer of Health. December 6, 2000.

Watanabe, Dr. Mamoru. Data analysis to support findings of Physician Fact Finder, presentation to the Expert Panel, March, 2000

Windsor-Essex Medical School Exploratory Committee. Options Paper Implementing Recommendations to Accommodate Increased Enrollment of Medical School Students, June 2000. Presentation to Panel, August 2000.

Access Modelling for Health Care Services

The Expert Panel believes that the number, mix and distribution of physician services in Ontario should strive to be needs-based. However, Ontario does not yet have a reliable, consistent way to estimate or predict health needs. Traditional approaches have focussed on forecasting the supply of physicians, population growth, and future physician-population ratios. Such an approach implicitly assumes that needs are defined by population growth, a definition which is obviously too crude for precise planning.

In his report on the supply of physicians in Ontario, Dr. McKendry recommended piloting access modelling for "core services in medical fields where consumers appear to have ongoing problems getting timely care ... include[ing] family medicine." Access modelling is a method which considers the following:

- what is a reasonable level of access to health care services for patients that we should strive for?
- what is a reasonable workload for physicians/other health professionals who provide these services?
- how many physicians/other health professionals are needed to maintain this level of access over time, as the population grows and ages?

1. ACCESS TO CARE AND 'SENTINEL EVENTS'

The concept of "reasonable level of access to care" deserves some explanation. It is enormously difficult for researchers and policy-makers to define "true need" for health care services. To do so would require information about each patient's clinical condition and the ability to evaluate the appropriateness of every service rendered in the health care system. A more practical approach is to examine the aggregate level of utilization of a particular service and consider other evidence about the aggregate appropriateness of the service.

One approach is to develop a list of "sentinel events" or "services" for each specialty. These are key, high profile services which represent a significant proportion of workload within the specialty. Ideally, such events should also represent situations where the indication for the service is well-defined. If this condition holds, then utilization closely mirrors true need. An example of sentinel services which fit this condition are surgery for hip fractures, obstetrical deliveries and surgery for colon cancer.

The level of access for these sentinel services is defined as the rate of the service in the population (e.g., deliveries per capita per year), adjusted for changes in the age and sex composition of the population. Examination of trends over previous time periods may offer some insight over what a reasonable level of access might be in the future. Other corroborating information, such as data on trends in disease prevalence or changing indications for a service, may offer clues as to what the level of access should be in the future.

In practice, it is difficult to find sentinel events which meet all of these criteria. Hip and knee replacements are common orthopedic procedures of great benefit to patients who fit criteria for appropriateness. Because they are high profile services, they cannot be ignored. Yet, there is greater physician discretion in whether an operation should proceed, and evidence to suggest that inappropriate surgery takes place in Ontario.

In this case, we consider other factors which might indicate a "reasonable level of access." We know that

- hip and knee replacement rates are rising linearly over the past 20 years in Ontario and other jurisdictions
- waiting times for hip and knee replacement are a common phenomenon in Canada
- Scandanavian jurisdictions have an age-sex adjusted hip and knee replacement rate 10 times higher than in Ontario
- within Ontario, areas where high hip and knee replacement rates are higher do not have a level of inappropriateness which is any different from areas with low rates
- many patients who meet the existing appropriateness criteria currently are not having the surgery done.

None of these facts provide solid evidence of true need. In the absence of perfect information, however, it would be reasonable to assume that hip and knee replacement rates continue to grow at their historical levels over the next few years.

2. WORKLOAD

Sentinel events can also be used to measure trends in workload over time. Workload is defined as the average number of sentinel events per physician. (Physicians who do not provide the sentinel event at all are excluded from the calculation.) An increase in workload may indicate any of the following:

- workload for physicians is increasing, and future increases in workload may not be sustainable or desirable. Indeed, the current workload may be too high and it may be desirable to decrease it in the future.
- physician productivity has risen, allowing physicians to comfortably perform more procedures.

The best interpretation of workload changes depends on corroborating information from other sources. Physician focus groups or surveys may provide insight on desired workload. The literature may offer insight into how techniques for performing a service have become more efficient, and what efficiency gains might be expected in the future.

3. ESTIMATING FUTURE PHYSICIAN REQUIREMENTS

Future physician requirements can be estimated from the following formula (simplified to its most basic form):

Sentinel events per capita x population = sentinel events per MD x MDs (1)

In other words:

$$\text{The expected \# of MDs (in year } j) = \frac{\text{sentinel event rate in year } i \times \text{population in year } i}{\text{workload in year } i} \quad (2)$$

a. Accounting for changes in the age/sex composition of the population

Ontario's population is not only growing but also aging. The proportion of the population aged 65 and over is growing 2.2% / year, compared to 1.0% for the under 65 age group. At the same time, the elderly use services much more frequently. To account for these trends, we revise the left side of equation (1) to the following:

$$\text{Total SE}_{\text{year } j} = \sum_{k=1}^{38} \text{SE per capita}_{\text{age/sex group } k} \times \text{population}_{\text{age/sex group } k}$$

Age groups are defined in five year blocks and there are 38 age/sex groups in total (male 0-4 years, female 0-4, male 5-9, female 5-9 up to male 90 and over, female 90 and over).

b. Accounting for multiple providers performing a sentinel event

In a number of situations, more than one type of provider can perform a sentinel event or service. For example, anesthesia can be provided by both anesthesiologists and GP-anesthesiologists. If we make an assumption of the ratio of anesthesiologists to GP-anesthesiologists, we can calculate the number of each provider type required. The assumed proportion in future time periods should consider what the proportion has been in the past as well as future technological trends and desired policy objectives.

Consider anesthesia, where the sentinel event is the number of anesthesia units billed:

T=total units

w_1= units per anesthesiologists

w_2 = units per GP anesthesiologists

z = ratio of anesthesiologists to GP anesthesiologists

x_1 = # of anesthesiologists

x_2 = # of GP anesthesiologists

$T = w_1 x_1 + w2 x2$

$z = x_1 / x_2$

Therefore,

$x_1 = z x_2$

$T = w_1 z x_2 + w_2 x_2$

$x_2 = T / (w_1 z + w_2)$

In some cases, we do not know the ratio, but we do know from other sources what the future supply and workload will be for one type of provider. For example, we know the rate of production of midwives at the present, and can assume this rate of production will continue. We then estimate, for future time periods, the number of unassisted obstetrical deliveries handled by midwives. The remainder (total estimated deliveries minus midwifery deliveries) will be performed by GP/FPs and obstetricians, and the number of these physicians is estimated using the above formula.

c. Accounting for non-fee-for-service physicians and providers within a specialty who do not perform a sentinel event

Most but not all fee-for-service physicians within a specialty will perform a sentinel event. For example, 78% of ophthalmologists performed cataract surgery in 1999/2000. Unless there is evidence to the contrary, we assume this ratio will remain constant over future time periods.

Similarly, there are many physicians who are remunerated primarily on a non-fee-for-service basis. Most are family physicians/general practitioners and a few are specialists. Access modelling examines only the activity of physicians within the fee-for-service sector (including those that submit shadow billings). For non-fee-for-service physicians, we assume that the projected growth rate for physician requirements is equal to the rate calculated for fee-for-service physicians.

There are some specialties where there is no comprehensive fee-for-service data at all. These include public health, community medicine, occupational medicine, pathology, and lab medicine specialties. For these specialties, we assume that the projected growth rate for physician requirements is equal to the average rate calculated for fee-for-service physicians in all specialties.

d. Accounting for multiple sentinel events for a specialty

In some instances, we have chosen more than one sentinel event per specialty. In the case of sentinel events which represent surgical procedures, different sentinel events are given a weight and added together. The weight is based on time needed to complete the procedure. The time is estimated from the time component of anesthesiology billings for the same procedure.

In cases where there is only one sentinel event in a specialty, we must take into account not only the growth in sentinel events, but also the proportion of workload the sentinel event accounts for in a typical physician's practice. For example, procedure X may be growing at 5% per year, but may only account for 10% of workload. If other services in the specialty are not growing, then the total increase in workload for the specialty is only 0.5%.

c. Special case - family / general practice

For primary care, the sentinel service is the number of patients in a physician's practice, adjusted for differences in the age and gender of patients. Such a measure was felt to be preferable to counting the number of office visits, because of the wide degree of variation among physicians in the frequency with which they ask their patients to return for follow-up visits. The method is as follows:

1. Assign any patient who receives at least 50% of his/her care from one physician to that physician's caseload. (Patients who met this criteria accounted for 75% of family physicians' office volumes.)

2. Calculate the average number of office visits for each patient age/sex category. Then, develop a weighting system for each age/sex category, equal to the number of office visits for the category divided by the average number of visits for the entire population.

3. The sentinel service is the number of weighted patients in a physician's practice. For each fee-for-service physician in Ontario, calculate the number of weighted patients in his/her practice. This is the workload measure of interest.

4. Project the future number of weighted patients who will see a fee-for-service family physician, based on projections of the growth and aging of the population. (Note that 99% of the population see a fee-for-service physician; the remainder either do not have a physician at all, or see a non-fee-for-service physician, or see so many different physicians in the course of a year that no single, dominant family physician can be identified. We assume that this proportion remains constant over time.)

5. Calculate the current workload/capacity of primary care contributed by GP-anesthesiologists, and FPs with an extra year of emergency medicine training, and GP/FPs who have neither of these qualifications.

6. Nurse practitioners (NPs) will contribute to primary care physician workload. Based on an extensive literature review and interviews with physicians and NPs, the Expert Panel determined that a physician working with a nurse practitioner can increase his/her patient load by 33% (with range of 25%-50%). Multiplying this proportion by the average GP/FP weighted patient workload gives the contribution to physician workload for each NP added to the system. The remainder (total weighted patients minus the contribution by NPs) is used to calculate the number of GP/FPs, GP-anesthesiologists and FP-emergency medicine physicians using the methods outlined in item b above.

4. PHYSICIAN SUPPLY MODELLING

The stock of physicians in Ontario, in any given year, depends on both the in-flow and out-flow of physicians into the system. In-flows may be from:

- physicians graduating from training programs
- physicians migrating from other provinces
- international medical graduates who accept a pre-arranged position in Ontario
- Canadian physicians returning to active practice from the USA and other international jurisdictions.

Out-flows may be from:

- retirement
- death
- migration to the USA and other jurisdictions
- migration to other provinces

The Canadian Medical Association's Physician Resource Evaluation Template (PRET) tool estimates the supply of physicians in any given year. It examines recent levels of the above in-flows and out-flows and models different scenarios that would reflect either current or changing rates of gains and attrition.

The shortfall in physicians is simply the number of physicians required (as determined by access modelling) minus the supply of physicians (as determined by PRET).

RESULTS OF ACCESS MODELLING AND PRET ANALYSIS

1. SENTINEL EVENTS / SERVICES

We chose the following sentinel events / services:

Specialty	Sentinel Event / Service
GP/FPs	Number of patients in practice (weighted for age and sex)[40]
Orthopedics	Hip fractures Hip and knee replacements Open fractures Arthroscopies Consultations
Ophthalmologists	Cataracts Retinal Surgery Consultations
Psychiatrists	Consultations
Obstetrician / Gynecologists	Obstetrical Deliveries [41,42] Consultations
General Surgeons	Colectomies Mastectomies / lumpectomies Cholecystectomies Inguinal herniorraphies
Anesthesiologists	Anesthesia units [42] Consultations
All other specialties	Consultations

40 Note: practitioners examine to prevent services.

41 Deliveries performed by GP/FPs

42 Deliveries performed by anesthetists.

2. SENTINEL EVENT RATE - GENERAL TRENDS

- The consultation rate for all specialties dropped by 10% in 1998/99. This may have been the result of stricter OHIP criteria for a consult. The consultation rate was stable from 1995/96 to 1997/98, and from 1998/99 to 1999/2000, so it appears that the demand for consultations has remained relatively constant.
- The age/sex adjusted rate for sentinel services remained constant for anesthesiology units, but rose sharply for anesthesia consultations (6%/year). Adjusted sentinel event rates declined slightly for general surgery and obstetrics/gynecology (<1%/year), and increased for ophthalmology (>5%/year for cataract and retinal procedures) and for orthopedics (>1%/year for all procedures and >5%/year for knee replacements and >2.5% for hip replacements).

3. WORKLOAD - GENERAL TRENDS

- The average workload for all physicians, adjusted for the age and sex of the physician, has increased by just over 1% in the past five years.
- Physicians have been complaining that their workload has been increasing over time. Young physicians have indicated a preference for a more balanced lifestyle with more time for leisure and family activities.
- The physician workforce is growing older, and the proportion of physicians who are women is increasing. Both older physicians and females tend to have lower workloads. According to the PRET model, it is estimated that over the next 10 years, these two phenomena will lead to a 3% decline in average workload, all other factors remaining equal.
- The following sentinel events were characterized by rapid increases in workload: cataract surgery (10%/year), retinal surgery (8%/year), hip replacements (6%/year) and knee replacements (8%/year). These increases are influenced, in part, by productivity improvements.

4. PROVIDER MIX - GENERAL TRENDS

- The proportion of FP/GPs contributing to specialized care is dropping. The ratio of anesthesiologists to GP-anesthesiologists has been rising, from 77:23 in 1995/96 to 80:20 in 1999/2000. The ratio of obstetricians to GPs doing obstetrics has been rising from 25:74 in 1995/96 to 31:69 in 1999/2000. This trend has implications for smaller communities that do not have the volumes to support a specialist and rely on FP/GPs to provide these services.
- Approximately 40 midwives enter practice each year in Ontario. The typical caseload for each midwife is 40 deliveries per year. However, a significant proportion of deliveries (25% to 30%) involve shared care with an obstetrician/gynecologist.
- Approximately 100 nurse practitioners enter practice each year in Ontario. In the year 2000, 75% are expected to enter funded positions for primary care, and the remainder of positions are to be allocated for other practice settings. NPs can allow GP/FPs to increase their workload by 33% (with a reported range of 25% to 50%).

5. SUPPLY TRENDS

- Net physician migration to the US and other countries was at an historic high during the mid to late 1990s. The period from 1995 to 1999 was a turbulent time in physician-government relations. Because of acute fiscal pressures, the government instituted policies, such as clawbacks, restrictions on billing numbers and discounts for new graduates in selected urban areas.
- Retirement rates (age/sex adjusted) have been generally stable in Ontario, except for 1995 when there was a doubling of the usual rate. Again, this phenomenon may have been related to the factors cited above.
- Retirement rates have been generally lower in Ontario than in other provinces, which have instituted retirement buyout plans in recent years.
- The impact of the 10% national reduction in medical school enrolment in 1993 is being felt for the first time in fiscal year 1999-2000.
- Recent increases across the country in medical school enrolment. The 33 additional postgraduate positions added in response to the Fact Finder report and the interim increase of 40 positions this summer recommended by the Expert Panel are taken into account in the modelling.

SCENARIOS FOR MODELLING

We present the following three scenarios for consideration.

SCENARIO 1: STATUS QUO

The age/sex adjusted sentinel event rate, for all sentinel events, will remain the same. The increase in demand for services will be driven entirely by population growth and aging.

The physician workload (adjusted for physician age and sex) will remain the same. However, the overall physician workload (unadjusted for physician age and sex) will decline, due to aging of the physician pool and entry of more female physicians who take time off for family obligations.

Physician supply will reflect the past five-year trend (i.e., the historically high level of migration will continue, and the anomalous increase in retirement in 1995 will be included in the calculations).

The relative proportion of GP/FPs to specialists involved in anesthesiology and obstetrics will remain constant.

The health system will not make use of nurse practitioners.

Midwives will handle 28 deliveries per year, without assistance from obstetricians. The other 12 (30% of their total deliveries) will involve significant assistance from obstetricians, and will be counted as part of the obstetrics/gynecology workload.

SCENARIO 2: MOST PROBABLE SCENARIO

Age/sex adjusted demand for physician services will be stable in most specialties. There will be a slight growth in demand for anesthesia, orthopedics and ophthalmology (1%/year) to reflect growth in anesthesia consults, hip/knee replacements and cataract/retinal surgery.[43]

The workload per physician in all specialties except orthopedics and ophthalmology will gradually drop by 0.5%/year. The increasing number of women and older physicians accounts for a decline of 0.3%/year. The remaining 0.2%/year is designed to reflect the desire by both male and female physicians for more balanced lives.

The workload in orthopedics and ophthalmology will increase slightly (i.e., 0.5%/year) to account for the impact of new technologies.

An effort will be made over the next 10 years to restore the ratio of internal medicine to subspecialist medicine that existed in 1995.

The relative proportion of GP/FPs to specialists will remain constant (i.e., 80:20 anesthesiologists to GP-anesthesiologists; 31:69 obstetricians to GPs doing obstetrics).

Over the next 10 years, about 75 nurse practitioners will be integrated into primary care each year, allowing those GPs working with nurse practitioners to increase patient load by 33%.

Midwives will continue to be introduced at the current rate and their workload will remain at the current level, as described in Scenario 1.

The total age/sex adjusted demand for general internal medicine and subspecialty medicine will remain constant. However, over the next 10 years, the ratio of internal medicine to subspecialist medicine should be restored to the level in 1995.

Physician supply will reflect the past five-year trend except for the following:

- with the improved fiscal climate, physician migration will decline to levels found in historical cycles
- the retirement rate calculation will exclude the anomalous year 1998.

43 Note that the increase in demand does not equal the 6 to 8% increase in service unit rates because these specialties provide other services that have not exhibited the same growth rate.

SCENARIO 3: MOST PROBABLE SCENARIO WITH AGGRESSIVE POLICY INTERVENTIONS

Same as Scenario 2, except for the following.

Over the next ten years, the anesthesiologist to GP-anesthesiologist ratio, and obstetrician to GP/FP-doing-obstetrics ratio will be restored to 1995 levels. This will require significant incentives (financial, educational or other) to encourage GP/FPs to return to these domains of practice.

There will be a modest improvement in the number of midwifery deliveries not requiring shared care with an obstetrician (i.e., from 28/40 to 30/40). This will require concerted efforts to remove existing administrative and regulatory barriers to allow midwives to work at their full scope of practice.

The health care system will make maximum use of nurse practitioners, which will allow GPs working with NPs to increase their caseload by 50%.

The output from NP training programs will double from 100 to 200/year, beginning in year 2006. (We continue to assume that 75% will enter a collaborative group practice in primary care.)

The health care system will introduce a modest patient demand management program, which will allow family physicians to increase their caseload by 0.5%/year.

As the following charts indicate, the need for and shortfall in physicians over the next 10 years varies significantly depending on the scenario.

SCENARIO 1: STATUS QUO

TOTAL PHYSICIANS	2000	2002	2004	2006	2008	2010
Total Produced	20,418	20,472	20,583	20,679	20,849	21,049
Total Physicians Needed	20,692	21,421	22,153	22,882	23,636	24,405
Shortfall	(274)	(949)	(1,570)	(2,203)	(2,787)	(3,356)

GP/FPs	2000	2002	2004	2006	2008	2010
Total Produced	9,771	9,772	9,794	9,820	9,873	9,935
Total Physicians Needed	9,907	10,227	10,549	10,866	11,188	11,517
Shortfall	(136)	(455)	(755)	(1,046)	(1,315)	(1,582)

Anesthesiologists	2000	2002	2004	2006	2008	2010
Total Produced	877	899	919	942	961	987
Total Physicians Needed	892	926	961	996	1,034	1,074
Shortfall	(15)	(28)	(41)	(54)	(72)	(92)

General Surgeons	2000	2002	2004	2006	2008	2010
Total Produced	515	501	488	478	469	464
Total Physicians Needed	529	554	581	607	635	664
Shortfall	(14)	(53)	(92)	(129)	(166)	(200)

Obs/Gynecologists	2000	2002	2004	2006	2008	2010
Total Produced	656	641	633	624	615	608
Total Physicians Needed	667	650	669	685	677	687
Shortfall	(11)	(19)	(31)	(44)	(62)	(79)

Ophthalmologists	2000	2002	2004	2006	2008	2010
Total Produced	392	384	376	371	366	361
Total Physicians Needed	403	427	450	473	497	522
Shortfall	(11)	(43)	(74)	(102)	(131)	(160)

Orthopaedic Surgeons	2000	2002	2004	2006	2008	2010
Total Produced	367	309	369	367	365	363
Total Physicians Needed	378	398	418	439	461	483
Shortfall	(11)	(30)	(49)	(72)	(96)	(120)

Psychiatrists	2000	2002	2004	2006	2008	2010
Total Produced	1,715	1,722	1,724	1,723	1,719	1,712
Total Physicians Needed	1,777	1,842	1,902	1,960	2,012	2,064
Shortfall	(62)	(120)	(178)	(237)	(293)	(352)

SCENARIO II - MOST LIKELY SCENARIO, WITHOUT AGGRESSIVE POLICY INTERVENTIONS

TOTAL PHYSICIANS	2000	2002	2004	2006	2008	2010
Total Produced	20,418	20,910	21,375	21,804	22,228	22,676
Total Physicians Needed	20,667	21,495	22,343	23,206	24,111	25,053
Shortfall	(249)	(585)	(968)	(1,402)	(1,883)	(2,376)

GP/FPs	2000	2002	2004	2006	2008	2010
Total Produced	9,771	9,960	10,142	10,299	10,462	10,629
Total Physicians Needed	9,879	10,244	10,621	11,005	11,407	11,825
Shortfall	(108)	(284)	(479)	(706)	(944)	(1,197)

Anesthesiologists	2000	2002	2004	2006	2008	2010
Total Produced	877	909	937	964	986	1,005
Total Physicians Needed	892	933	975	1,018	1,064	1,113
Shortfall	(15)	(24)	(38)	(54)	(78)	(108)

General Surgeons	2000	2002	2004	2006	2008	2010
Total Produced	515	515	511	505	498	492
Total Physicians Needed	529	557	585	615	646	678
Shortfall	(14)	(42)	(75)	(110)	(147)	(185)

Obs/Gynecologists	2000	2002	2004	2006	2008	2010
Total Produced	656	658	658	653	643	641
Total Physicians Needed	660	686	673	682	695	710
Shortfall	(4)	(28)	(15)	(29)	(51)	(69)
Ophthalmologists	2000	2002	2004	2006	2008	2010
Total Produced	392	391	389	387	385	379
Total Physicians Needed	403	429	454	479	504	530
Shortfall	(11)	(38)	(65)	(91)	(119)	(151)

Orthopaedic Surgeons	2000	2002	2004	2006	2008	2010
Total Produced	367	371	374	375	376	376
Total Physicians Needed	378	400	422	444	467	491
Shortfall	(11)	(29)	(47)	(69)	(91)	(115)

Psychiatrists	2000	2002	2004	2006	2008	2010
Total Produced	1,740	1,740	1,740	1,734	1,722	1,707
Total Physicians Needed	1,777	1,845	1,917	1,984	2,045	2,107
Shortfall	(37)	(105)	(177)	(249)	(323)	(400)

SCENARIO III: MOST LIKELY SCENARIO
WITH AGGRESSIVE POLICY INTERVENTIONS

TOTAL PHYSICIANS	2000	2002	2004	2006	2008	2010
Total Produced	20,416	20,910	21,375	21,804	22,228	22,676
Total Physicians Needed	20,654	21,347	22,054	22,680	23,346	24,043
Shortfall	(238)	(437)	(678)	(876)	(1,118)	(1,367)

GP/FPs	2000	2002	2004	2006	2008	2010
Total Produced	9,771	9,960	10,142	10,299	10,462	10,629
Total Physicians Needed	9,865	10,104	10,350	10,511	10,687	10,878
Shortfall	(94)	(144)	(207)	(211)	(225)	(249)

Anesthesiologists	2000	2002	2004	2006	2008	2010
Total Produced	877	909	937	964	988	1,006
Total Physicians Needed	892	931	970	1,010	1,054	1,099
Shortfall	(15)	(22)	(33)	(46)	(66)	(94)

General Surgeons	2000	2002	2004	2006	2008	2010
Total Produced	515	575	611	595	499	492
Total Physicians Needed	529	567	585	615	646	678
Shortfall	(14)	(42)	(75)	(110)	(147)	(186)

Obs/Gynecologists	2000	2002	2004	2006	2008	2010
Total Produced	656	658	658	653	643	641
Total Physicians Needed	662	665	669	674	683	694
Shortfall	(6)	(7)	(10)	(21)	(40)	(53)

Ophthalmologists	2000	2002	2004	2006	2008	2010
Total Produced	392	391	388	387	385	379
Total Physicians Needed	403	429	454	478	504	530
Shortfall	(11)	(38)	(66)	(91)	(119)	(151)

Orthopaedic Surgeons	2000	2002	2004	2006	2008	2010
Total Produced	367	374	374	375	374	376
Total Physicians Needed	378	402	422	444	467	491
Shortfall	(11)	(28)	(47)	(69)	(93)	(115)

Psychiatrists	2000	2002	2004	2006	2008	2010
Total Produced	1,740	1,743	1,740	1,734	1,722	1,707
Total Physicians Needed	1,777	1,849	1,917	1,981	2,046	2,107
Shortfall	(37)	(106)	(177)	(249)	(324)	(400)

LIMITATIONS OF ACCESS MODELLING

Access modelling has the following limitations:

1. NEED VS ACCESS

The concept of "reasonable level of access" strives to measure true need, but obviously falls short of this goal. The level of access suggested in the model is based on an examination of existing utilization trends, which may include both inappropriate utilization and underservicing of populations which could benefit from the service. Both these phenomena may be occuring at the same time.

2. ROBUSTNESS OF THE MODEL

Many of the variables which are inputs into the access modelling approach are subject to large random error, and are highly sensitive to external shocks to the health care system. Major clinical breakthroughs can suddenly make a procedure obsolete, shift the burden of care to a different specialty or result in major increases or decreases in workload. The impact of primary care reform remains to be seen: primary care reform could lead to a major role for nurse practitioners (which could decrease physician requirements), or could lead to more physicians being required to handle 24 hour on-call coverage. It is critically important, therefore, that each variable be measured on a yearly basis, and that the projections be updated yearly.

3. LIMITED NUMBER OF SPECIALTIES

Due to time constraints, the Expert Panel and its Working Group on Data and Modelling were only able to complete specialty-specific analyses on those specialties identified as having particularly urgent supply problems in Dr. McKendry's report.

4. DISTRIBUTIONAL AND CRITICAL MASS ISSUES

The model examined only aggregate supply and access for physicians in the entire province. It did not consider the specific needs of individual regions which have been relatively underserviced. Also, smaller regions may have issues related to critical mass: a smaller secondary centre, for example, may need more specialists of a particular type than what might be expected from examining provincial averages, in order to maintain a reasonable call schedule.

FUTURE ITERATIONS OF THE MODEL

It is recommended that:

a. The access model described here be updated on an annual basis

b. Future iterations of the model should include micromodelling for each specialty

c. The model be adapted to allow for planning at a local level. This would allow for the consideration of issues regarding physician distribution and critical mass.

CONCLUSION

Access modelling represents the first step in a new approach to measuring needs for physician services. Although far from perfect, it is a significant improvement over previous methods which examined only physician-population ratios and supply projections. Furthermore, it encourages policy-makers and the public to ask the question: "what is the level of service we should provide to the population, given its costs?", rather than simply asking the question," how many doctors do we need?" The former question strikes more directly at the issues of greatest importance to the public: access and affordability.

While the model has potential, its results at this stage in its development should be interpreted with caution. Planners must keep in mind that the model is capturing inappropriate service and underservicing, as well as appropriate levels of service. Perceived shortages in the supply of particular services may be due to factors others than the number of physicians, such as, lack of operating rooms, lack of support personnel, or inappropriate incentives that encourage physicians to devote a disproportionate amount of their time to providing non-sentinel services. If services were organized differently, the system might be able to increase its capacity to provide essential/sentinel services with existing resources or with only a modest increase in physician numbers. All these factors must be taken into account when using the model to help shape services to meet needs.

RECOMMENDATIONS OF THE PHYSICIAN FACT FINDER:
THE EXPERT PANEL CHECKLIST

Physicians for Ontario: Too Many? Too Few? For 2000 and Beyond.	Implemented by MOHLTC	Addressed in OMA Agreement	Rec #	Expert Panel – Final Recommendations
Measure and understand societal health care needs				
1. Ontario's health care system should develop Access Modelling pilots for core services in medical fields where consumers appear to have ongoing problems getting timely care. These disciplines include family medicine, anesthesiology, general surgery, obstetrics/gynecology, psychiatry and orthopaedics.			13	HHRAP continue to develop and refine data models and planning tools to measure both health needs and capacity of the system to meet those needs
Develop the capacity to plan for and manage a health workforce to meet societal health care needs				
2. The Ministry of Health and Long-Term Care should establish a permanent, independent Office of Health Workforce Policy and Planning to monitor and anticipate health care needs, and determine the most appropriate mix, supply and distribution of professional skills and services to meet those needs.			1	MOHLTC establish the Health Human Resources Advisory Panel, a permanent expert advisory body responsible for continually monitoring and anticipating the health needs of Ontarians and making recommendations on the appropriate supply, mix and distribution of health human resources to meet health needs. HHRAP to develop capacity for integrated health human resources planning, beginning with building capacity for physician services planning.
3. The Ministry of Health and Long-Term Care should ask Ontario Physician Human Resources Data Centre (OPHRDC) to develop, with input from the Institute for Clinical Evaluative Sciences (ICES), the ministry and the Ontario Medical Association (OMA) a uniform physician database.	✓ (Phase 1)		2	HHRAP with financial support of MOHLTC continue to refine and use the Ontario Physician Workforce Database as the basis for physician workforce planning and work with the other professions to develop comparable high quality workforce databases.
4. The Office of Health Workforce Planning and Policy should work with the Ministry of Health and Long-Term Care to develop a model to: projection and monitoring the effective supply of physician services in the province.	✓ (Phase 1)		13	See recommendation 13 above In addition, HHRAP should: • Update Expert Panel's access model annually • Ensure that future iterations of the model include micromodelling for each specialty • Use the model to study and assess the need for resources to meet priority health needs • Adapt the model for use in planning at the regional and local level, ensuring that it considers physician distribution and critical mass • Continue efforts to develop a needs-based approach to determining population based health needs and provider requirements.

RECOMMENDATIONS OF THE PHYSICIAN FACT FINDER:

THE EXPERT PANEL CHECKLIST

Physicians for Ontario:Too Many? Too Few? For 2000 and Beyond.	Implemented by MOHLTC	Addressed in OMA Agreement	Rec #	Expert Panel – Final Recommendations
Ensure an adequate supply of physician services to meet current and future health care needs				
5. The Ministry of Health and Long-Term Care should recruit/repatriate Canadian medical school graduates who have taken their postgraduate training in the United States and fund up to two years of postgraduate training in Ontario to enable these physicians to become eligible for the College of Family Physicians of Canada (CFPC) or Royal College of Physicians and Surgeons of Canada (RCPSC) certification.	✓			
6 The Ministry of Health and Long Term Care should provide the necessary resources to allow the University of Toronto to increase the existing Ontario International Medical Graduates (IMGs) program from 24 to 36 positions. Beginning in the year 2000	✓			
7. The Ministry of Health and Long Term Care should work closely with the medical schools and the Professional Association of Interns and Residents (PAIRO) to reduce the number of recently certified physicians who pursue their careers outside Ontario			22	MOHLTC provide funding for three years to support the PAIRO Resident Placement Program. HHRAP should evaluate its impact on the supply, mix and distribution of physicians in Ontario, and make recommendations about ongoing long-term funding
8 The Ministry of Health and Long-Term Care should develop a pilot recruiting campaign that targets expatriate Canadian trained physicians now practising in the USA or other countries.				
9 Underserviced communities who are able to recruit International Medical Graduates (IMGs) should be aware and take advantage of the practice eligible route to certification offered by the College of Family Physicians of Canada (CFPC) and the Alternative Assessment and Evaluation program being pilot tested by the Royal College of Physicians and Surgeons of Canada (RCPSC).				See Recommendation 23 CPSO/COFM proposal to be consistent with RCPSC evaluation and assessment program for community-sponsored IMGs.
10 The College of Physicians and Surgeons of Ontario (CPSO) should consider providing time-limited special licenses for International Medical Graduates (IMGs) sponsored by underserviced communities who are currently practising elsewhere in Canada and who are pursuing the College of Family Physicians of Canada (CFPC) practice eligible route to certification				The Expert Panel considered this approach, but determined that a more appropriate route would be to enable IMGs to qualify for unrestricted licenses through the CPSO/COFM assessment, training and licensure proposal (rec.23).
11 The Ministry of Health and Long-Term Care should fund a limited number of postgraduate training positions for community-sponsored International Medical Graduates (IMGs) who do not qualify for the practice eligible route to licensure			23	MOHLTC fund, on a four-year pilot basis, the COFM/CPSO proposal to license up to 25 fully qualified IMGs annually. Funding to be provided to screen potential candidates to undertake up to six-month assessment and up to 2 years of postgraduate training if necessary. Program to be limited to specialties and communities in which supply and HHRAP to evaluate impact of this program.

Physicians for Ontario: Too Many? Too Few? For 2000 and Beyond.	Implemented by MOHLTC	Addressed in OMA Agreement	Rec #	Expert Panel – Final Recommendations
Encourage more effective distribution of physician services across the province				
12. Ontario should increase undergraduate enrolment in the province's existing medical schools by approximately 10% (95 students) beginning in the year 2000 and allocate these positions to those schools that give priority to training rural physicians	✓ (interim increase of 40 in Aug 2000)		14	MOHLTC, MTCU and AHSC increase undergraduate medical school enrolment by a total of 100 positions and allocate a minimum of 60 positions to northern/rural training and contract with sponsoring medical schools and clinical training centres to provide education.
13. Ontario should consider the advisability of creating a new medical school in rural medicine with a specific mission to attract students who are interested in working in the province's small, rural and remote communities.			3-12	Establish three clinical education centres in Windsor, Thunder Bay and Sudbury to educate and train undergraduate and postgraduate students, including the development of separate admissions process
14. The Ministry of Health and Long-Term Care, in collaboration with other stakeholders, should assess the potential benefits of a new school for rural medicine compared to other rural medical training options and prepare a report on or before July 2000			3-12	See above.
15. The Ministry of Health and Long-Term Care should make greater use of group practice recruitment incentives that have proven effective in the north (e.g., community-sponsored contracts) and offer similar programs (with suitable modifications) in communities in the south.			29-30	Establish a menu of incentives.
16. The Ministry of Health and Long-Term Care should work with local communities and physicians to develop a comprehensive retention program, that would include the following features • Financial incentives for at least six years • Long service leave • Pact maternity leave • Information technology grants.	✓		29-30	Establish a menu of incentives. *Note: Maternity leave included as part of OMA/MOHLTC agreement. Information technology funding provided through primary care networks*
17. The Ministry of Health and Long-Term Care should make the following changes to the Underserviced Area Program (UAP) to increase its effectiveness. • Rename the Underserviced Area Program (UAP) the Appropriate Physician Services Supply Program. • Keep the current definition used to determine "underserviced" communities, but simplify and streamline the application and evaluation process, and reduce the time required • Hire three additional Community Development Officers	✓			
18. The Appropriate Physician Services Supply Program (APSSP) should ensure that the physicians already practising in underserviced communities are actively involved in all efforts to recruit and retain new physicians, including initiatives designed to repatriate Ontario physicians (see recommendation 81.				

Physicians for Ontario: Too Many? Too Few? For 2000 and Beyond.	Implemented by MOHLTC	Addressed in OMA Agreement	Rec #	Expert Panel – Final Recommendations
19. The Appropriate Physician Services Supply Program (APSSP) should provide realistic recruitment incentives that achieve the objectives.			29-30	Develop rurality index and menu of incentives.
20. The Appropriate Physician Services Supply Program (APSSP) should work with Group 1 and Group 2 communities (as defined by the 1993 OMA/Government agreement) to ensure they provide community clinic facilities suitable for group practice either by fee-for-service physicians or physicians on alternative funding plans.			29-30	Develop rurality index and menu of incentives.
Adjust the mix of physician services to meet current and future health care needs				
21. To provide more flexibility in the length and type of training available to physicians already working in rural and remote areas, the Ontario Medical Association (OMA) and the Ministry of Health and Long-Term Care should work with the province's academic health science centres to develop a competitive, short-term Continuing Medical Education (CME) Skills Acquisition Program			29-30	Development of CECs and decentralized education resources and infrastructure will facilitate CME and skills acquisition for physicians working in rural and remote areas. Develop rurality index and menu of incentives
22. To improve the physician mix over the longer term and increase the number of family physicians with the skills to work in rural, remote areas, the Ministry of Health and Long-Term Care should provide the resources required to: • Increase the number of entry level residency positions in family medicine in Sudbury and Thunder Bay by 26% (6 positions) from 24 to 30 • Increase the number of family medicine PGY3 positions in obstetrics, emergency medicine, anesthesiology, care of the elderly and psychiatry in Sudbury and Thunder Bay from 4 to 10.	✓ ✓			
23. To develop a cadre of physicians with the skills to provide some specialty services in rural/remote areas, the Ministry of Health and Long-Term Care should expand the re-entry/return of service program from 25 to 40 positions.	✓			
24. The Ministry of Health and Long-Term Care and the Ontario Medical Association should revise the existing re-entry training/return-of-service programs to reduce barriers and attract more applicants.	*Note – program was reviewed MOHLTC Findings currently under consideration.			
25. The Office of Health Workforce Policy and Planning should monitor the mix of specialty physician services in Ontario to determine the right number and mix of postgraduate positions to meet provincial health care needs			17	MHRAP in consultation with COFM, take immediate steps to review and provide advice on the current and future mix of specialty training positions, giving particular attention to specialties in short supply or with distribution problems, priority health programs and public health.

Physicians for Ontario: Too Many? Too Few? For 2000 and Beyond.	Implemented by MOHLTC	Addressed in OMA Agreement	Rec #	Expert Panel – Final Recommendations
26. In the unacceptable short-term, the Ministry of Health and Long-Term Care should provide incentives that will increase the effective supply of emergency services, anesthesia, obstetrics, surgery and in-patient care in small, rural and remote communities.		✓		
27. The Ministry of Health and Long-Term Care, the Ontario Hospital Association (OHA) and the Ontario Medical Association (OMA) should develop a task force to review and refine the proposal from the Ontario Society of Rural Physicians (OSRP) (October 1999) for an affordable, fair insurance plan for physician services in rural and remote communities.			29-30	Rurality Index and menu of incentives.
28. The Ministry of Health and Long-Term Care should review existing discipline-specific workforce reports for those disciplines with the most acute shortages (e.g., anesthesiology, orthopedic surgery and psychiatry) to identify/implement the recommendations most likely to improve the mix of physician services.	✓			Reviewed and considered by Expert Panel (Access modelling). Future review to be undertaken by HHRAP.
Make effective use of other health care professional's current scope of health needs				
29. Ontario should continue to explore effective ways to use nurse practitioners who have the training and scope of practice to work collaboratively with physicians and provide team care.			25	MOHLTC take steps to remove the barriers to collaborative physician/nurse practitioner primary care practice, and provide the funding to integrate a minimum of 75 nurse practitioners a year for the next five years into collaborative physician/NP practice, starting first in settings where collaboration has been successful
30. To encourage more effective working relationships among physicians and nurse practitioners, the Ministry of Health and Long-Term Care and the Ontario Medical Association (OMA) should determine the most effective way to compensate physicians in a team care model (e.g., fee-for-service, blended payments, alternative payment plans).			28	See above.

Physicians for Ontario: Too Many? Too Few? For 2000 and Beyond.	Implemented by MOHLTC	Addressed in OMA Agreement	Rec #	Expert Panel – Final Recommendations
Wider diffusion and use of technology to meet health care needs				
31. Ontario should continue to invest infrastructure to support telemedicine applications which involve the use of co-ordinated electronic communications networks to transmit information and data and to provide appropriate clinical services.	✓ (Funding provided for pilot projects in Budget)		4	Ontario government in collaboration with federal government provide funding to support capital development of CECs, including investment for information technology infrastructure, broad band videoconferencing and telemedicine.
32. To support the provision of telemedicine services, the Ministry of Health and Long-Term Care should consider a number of options for appropriately compensating physicians for services delivered, including working with the Ontario Medical Association (OMA) to amend the current fee schedule.			30	Menu of incentives. Medium rurality – provided compensation to specialists for telephone advice/consults.
33. The Ministry of Health and Long-Term Care should consider expanding tele-triage services to southern Ontario. A service similar to that being piloted in the south should be offered in the south.	✓ (Expansion to south announced in Budget 2000)			
34. Tele-triage services should be evaluated for their impact on access to care and on utilization of health services.	✓			

A Fair Share for Rural Health Care at the Millenium. Submission approved at the Annual General Meeting of the Section on Rural Practice, Ontario Medical Association. November 1999.

Barer M, Stoddart G. Improving Access to Needed Medical Services in Rural and Remote Canadian Communities: Recruitment and Retention Revisited. Centre for Health Services and Policy Research, UBC. June 1999.

Barer M, Stoddart G. Toward Integrated Medical Resource Policies for Canada. Prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health, Winnipeg, Manitoba. May 1991.

Canadian Institute of Health Information. Supply, Distribution and Migration of Canadian Physicians, 1999. August 2000.

Canadian Medical Education Statistics 2000. The Association of Canadian Medical Colleges. Vol 22.

Chan B. Supply of Physicians' Services in Ontario. Report 1, Atlas Reports, Uses of Health Services. Institute for Clinical Evaluative Sciences. November 1999.

Council of Ontario Faculties of Medicine (COFM). Educating Physicians for Rural and Northern Communities: A Provincial Plan for the New Millenium. Report prepared by the COFM Task Force on Education of Physicians for Rural and Northern Communities. April 1999.

First Ministers Meeting Communique on Health. Canadian Intergovernmental Conference Secretariat. Ottawa, Ontario. September 11, 2000.

Improving Access to Primary Care Services: Opportunities for Collaborative Physician/NP Practice. Unpublished summary of research undertaken for the Expert Panel Working Group on Data and Modelling. October 2000.

Incitti F, Rourke J, and Rourke L. Results of Survey of Ontario Rural Family Physicians and Family Physicians in Training. (In publication) Funded in part by the Ontario Medical Association CME Fund. Project support provided by the Southwestern Ontario Rural Medicine Education, Research and Development Unit.

Inoue K, Hirayama Y, and Igarashi N. A medical school for rural areas. Department of Community and Family Medicine, Jichi Medical School. Medical Education, 1997, Vol 31, pp 430-434.

Interjurisdictional Survey of Physician Resource Management Strategies. Unpublished research prepared for the Expert Panel on Health Professional Human Resources. May 2000.

List of Areas Designated as Underserviced. Prepared quarterly by North Region, Health Care Programs, Ministry of Health and Long Term Care.

McKendry R. Physicians for Ontario: Too Many? Too Few? For 2000 and Beyond. Report of the Physician Fact Finder. Ontario Ministry of Health and Long-Term Care. December 1999.

McKendry R. Ontario Physician Resources, Medical Education and Rural/Remote Practice Location. Abstracts of International Experience. Prepared for the Expert Panel on Health Professional Human Resources. April 4, 2000.

O'Brien-Pallas L, Baumann A,. Towards evidence based policy decisions: A case study of nursing health human resources in Ontario, Canada. Nursing Inquiry (7) 4:248-257.

Provincial Co-ordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR). Equitable Health Human Resources Distribution: Fulfilling Underserviced Area Needs. Prepared by the PCCCAR Subcommittee on Underserviced Area Needs. Ontario Ministry of Health. May 1995.

Provincial Co-ordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR). An Interim Guide for Physician Resources Planning in Ontario. Prepared by the Expert Panel on Physician Resources, Ontario Ministry of Health. October 1995.

Physician Resource Planning in Canada. The Report of the National Ad Hoc Working Group on Physician Resource Planning. September 1995.

Pong RW, Hogenbirk J, McDonald M, Mulloy J. Medical Training and Practice Locations: A Tale of Two Programs. Centre for Rural and Northern Health Research, Laurentian University and Northeastern Ontario Family Medicine Program. August 2000.

Professional Association of Internes and Residents of Ontario and the Society of Rural Physicians of Canada. From Education to Sustainability: A Blueprint for Addressing Physician Recruitment and Retention in Rural and Remote Ontario. December 1998.

Rabinowitz HK, Diamond JJ, Markham FW. Hazelwood CE. A Program to Increase the Number of Family Physicians in Rural and Underserved Areas: Impact After 22 Years. Journal of the American Medical Association, Jan 20, 1999, Vol. 281 No. 3.

Royal Commission on Health Services. (Hall Report) Government of Canada 1964.

Summary of Canadian Rurality Indices. Unpublished research prepared for the Expert Panel Working Group on Distribution, Ontario Ministry of Health and Long-Term Care, June 2000.

Task Force on Physician Supply in Canada. Canadian Medical Forum Task Force co-chaired by Dr. H Scully, President of Canadian Medical Association and Dr. Lorne Tyrell, President of the Association of Canadian Medical Colleges. November 1999.

Payments to Ontario Physicians from Ministry of Health and Long-Term Care Sources 1992/93 to 2009/10

ICES Investigative Report

FEBRUARY 2012

ICES Institute for Clinical Evaluative Sciences

TAB 47

Payments to Ontario Physicians from Ministry of Health and Long-Term Care Sources 1992/93 to 2009/10

ICES Investigative Report

Authors
David A. Gratzer
Susan E. Schultz
Richard H. Glazier
R. Sacha Bhatia
Irfan A. Dhalla
Andreas Laupacis

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Institute for Clinical Evaluative Sciences (ICES)
G1 06, 2075 Bayview Avenue
Toronto, ON M4N 3M5
Telephone: 416-480-4055

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AUTHORS' AFFILIATIONS

David A. Henry, MBChB, MRCP, FRCP (Edin)
President and Chief Executive Officer, Institute for Clinical Evaluative Sciences / Professor, Faculty of Medicine, University of Toronto / Adjunct Professor, School of Medicine and Public Health, University of Newcastle, Australia

Susan E. Schultz, MA, MSc
Epidemiologist, Institute for Clinical Evaluative Sciences

Richard H. Glazier, MD, MPH, CCFP, FCFP, ABNP
Senior Scientist, Institute for Clinical Evaluative Sciences / Scientist, Centre for Research on Inner City Health, St. Michael's Hospital / Professor, Department of Family and Community Medicine, University of Toronto

R. Sacha Bhatia, MD, MBA
Clinical and Research Fellow, Massachusetts General Hospital / Research Fellow, Harvard Medical School / Fellow, Institute for Clinical Evaluative Sciences

Irfan A. Dhalla, MD, MSc, FRCPC
Scientist, Department of Medicine and Li Ka Shing Knowledge Institute, St. Michael's Hospital / Adjunct Scientist, Institute for Clinical Evaluative Sciences / Assistant Professor, Department of Medicine and Institute of Health Policy, Management and Evaluation, University of Toronto

Andreas Laupacis, MD, MSc, FRCPC
Executive Director, Li Ka Shing Knowledge Institute of St. Michael's Hospital / Adjunct Scientist, Institute for Clinical Evaluative Sciences / Professor, Faculty of Medicine, University of Toronto

ACKNOWLEDGEMENTS

This report analyzes public sector payments to physicians in Ontario between 1992 and 2009. The original plan to conduct this work was developed within ICES and resulted from discussions between the authors regarding the necessity of creating a publicly available source of accurate information on payments to doctors in Ontario. The project was proposed to the Ministry of Health and Long-Term Care, and resources were made available through the core agreement (2010–2015) between ICES and the MOHLTC.

The work was overseen by a working group chaired by Susan Fitzpatrick, Assistant Deputy Minister, Negotiations and Accountability Management Division at the MOHLTC. We are very grateful for the support provided by Ms. Fitzpatrick. We are also indebted to many staff at the MOHLTC who assisted us in identifying data gaps, facilitated access to data and tirelessly responded to questions regarding the characteristics of the data. We are also grateful to staff at The Ontario Medical Association and the Ontario Hospital Association and to others who provided extremely useful advice and insights.

ABOUT OUR ORGANIZATION

The Institute for Clinical Evaluative Sciences (ICES) is an independent, non-profit organization that produces knowledge to enhance the effectiveness of health care for Ontarians. Internationally recognized for its innovative use of population-based health information, ICES evidence supports health policy development and guides changes to the organization and delivery of health care services.

Key to our work is our ability to link population based health information, at the patient level, in a way that ensures the privacy and confidentiality of personal health information. Linked databases reflecting 10 million of 33 million Canadians allow us to follow patient populations through diagnosis and treatment and to evaluate outcomes.

ICES brings together the best and the brightest talent across Ontario. Many of our scientists are not only internationally recognized leaders in their fields but are also practicing clinicians who understand the grassroots of health care delivery, making the knowledge produced at ICES clinically focused and useful in changing practice. Other team members have statistical training, epidemiological backgrounds, project management or communications expertise. The variety of skill sets and educational backgrounds ensures a multi-disciplinary approach to issues and creates a real-world mosaic of perspectives that is vital to shaping Ontario's future health care system.

ICES receives core funding from the Ontario Ministry of Health and Long-Term Care. In addition, our faculty and staff compete for peer-reviewed grants from federal funding agencies, such as the Canadian Institutes of Health Research, and receive project-specific funds from provincial and national organizations. These combined sources enable ICES to have a large number of projects underway, covering a broad range of topics. The knowledge that arises from these efforts is always produced independent of our funding bodies, which is critical to our success as Ontario's objective, credible source of evidence guiding health care.

"ICES brings together the best and the brightest talent across Ontario. Many of our scientists are not only internationally recognized leaders in their fields but are also practicing clinicians who understand the grassroots of health care delivery."

Executive Summary

BACKGROUND

In Canada, payments to physicians consume approximately 20% of provincial health care budgets. In the last decade, this expenditure increased at a rate exceeding inflation. Expenditure was relatively flat during the 1990s when Canadian governments capped payments and controlled physician supply. In 1998, these policies were discontinued in favour of a more sophisticated approach that centred on negotiating alternate funding arrangements with groups of physicians.

In Ontario, these policies were designed to encourage graduates to enter and stay in under-supplied specialties (e.g., family practice and general internal medicine), and to reduce wait times for key surgical procedures, certain diagnostic tests and emergency care.

Here, we report on trends in public sector payments to Ontario physicians between 1992/93 and 2009/10, the variation between specialty groups and the resulting financial impacts on the province. We also report on the impacts of changes in the different models of payment (fee for service, capitation and alternate payment plans).

The data provide an assessment of the magnitude of, and trends in, payments during the different policy environments. However, the analyses were not designed to measure impacts beyond the financial outcomes. In other words, we did not try to determine if the increased investments led to better outcomes for patients.

The work was initiated by ICES scientists, most of whom are physicians. The motivation behind the work was a belief that the public should have access to a source of accurate information on payments to doctors in Ontario. The project was proposed to the Ministry of Health and Long-Term Care, and resources were made available through the core agreement between ICES and the MOHLTC. ICES conducted the work under its mandate, which is to carry out independent research that stimulates improvements in health system performance and promotes better health for Ontarians.

REPORT OBJECTIVES

1 / To estimate public payments to individual physicians from multiple sources between 1992/93 and 2009/10 and report these by specialty, specialty group and overall, using several different measures:

- the average payment per physician,
- the median (and selected percentiles) of the distribution of payments, which illustrates the range of payment levels; and
- the total of all payments to physicians in a given group.

2 / To analyze and report on changes over time in overall physician supply and in the main specialty groups between 1992/93 and 2009/10 as supply is an important component of expenditure.

3 / To analyze how payments and supply varied between the main specialty groups, and how each contributed to the rise in overall physician payments.

4 / To analyze how changes in the different types of payments (fee for service and other models) contributed to the observed increases in total payments and payments to physicians.

METHODS

Because payments to physicians in Ontario come from multiple sources, we combined data from different databases at the level of individual physicians. This was done with linked de-identified data. Analysts did not have access to the names or addresses of individual doctors at any stage.

We obtained payment data from the following sources:

- Ontario Health Insurance Plan Fee-for-Service billings (1992/03–2009/10)
- Ontario Health Insurance Plan Architected Payments (2003/04–2009/10)
- Academic Health Sciences Centre governance payment database (2003/04–2009/10)
- GAPP (Generalized Alternate Payment Plan) database (2005/06–2009/10)
- Primary Care Network capitation payments (1999/00–2003/04)
- Miscellaneous payments (2005/06–2009/10)

The payments presented here exclude direct payments from hospital budgets, payments by the Workplace Safety and Insurance Board, hospital on-call funds administered by the Ontario Medical Association (OMA) and private payments for uninsured services. We have not corrected the totals for practice overhead costs, which are commonly quoted as being around 33% of gross payments and can vary among specialties.

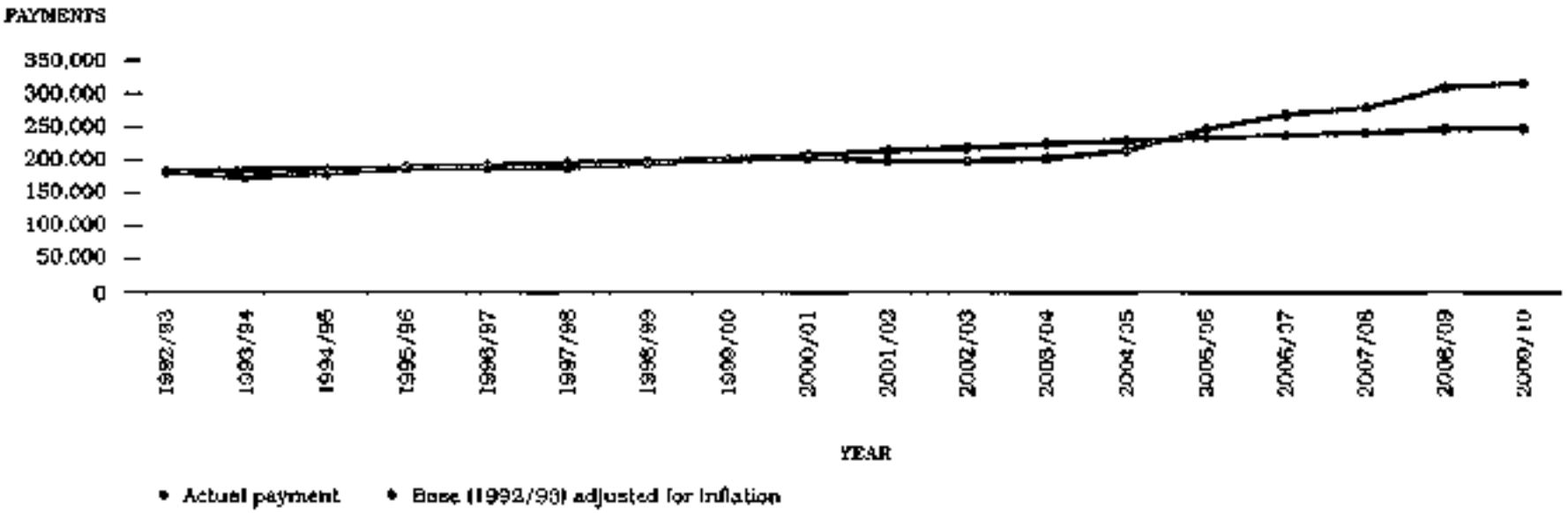
RESULTS

Overall Payments to Physicians

We identified payments of approximately $8 billion to doctors in Ontario in 2009/10. This is more than twice the amount, or approximately $4.3 billion more, than they were paid in 1992/93 (all in unadjusted dollars). On a per-specialty basis, by far the largest increase in total payments was to general practitioners/family physicians (GP/FPs)—an increase of more than $1.5 billion between 1992/93 and 2009/10. The next in rank order was the increase in payments to anesthesiologists ($298 million) followed by radiologists ($294 million), emergency physicians ($256 million), cardiologists ($223 million) and pediatricians ($193 million). Four of these are in the top five specialties ranked by increases in numbers of active physicians.

On a per-physician basis, the mean payments to physicians in Ontario, having remained fairly flat between 1992/93 and 2003/04, rose by around $100,000 between 2004/05 and 2009/10 (all unadjusted dollars). As figure 1 below makes clear, the average payment remained at or below the rate of inflation (using 1992/93 as the base year) until 2004/05, after which it rose at a rate well above the rate of inflation. This increase followed the implementation of the 2004/05 agreement between the OMA and the MOHLTC that included the strengthening of a number of new policies, in particular alternate payment plans for GP/FP and a number of other specialties, and additional payments to support the wait times strategy. It is important to note that these are gross payments and do not take account of practice costs, which vary among specialties and are believed to average around 30% of gross payments.

FIGURE 1 Mean annual payments per head to all Ontario physicians and inflation-adjusted base (1992/93) payment, 1992/93 to 2009/10



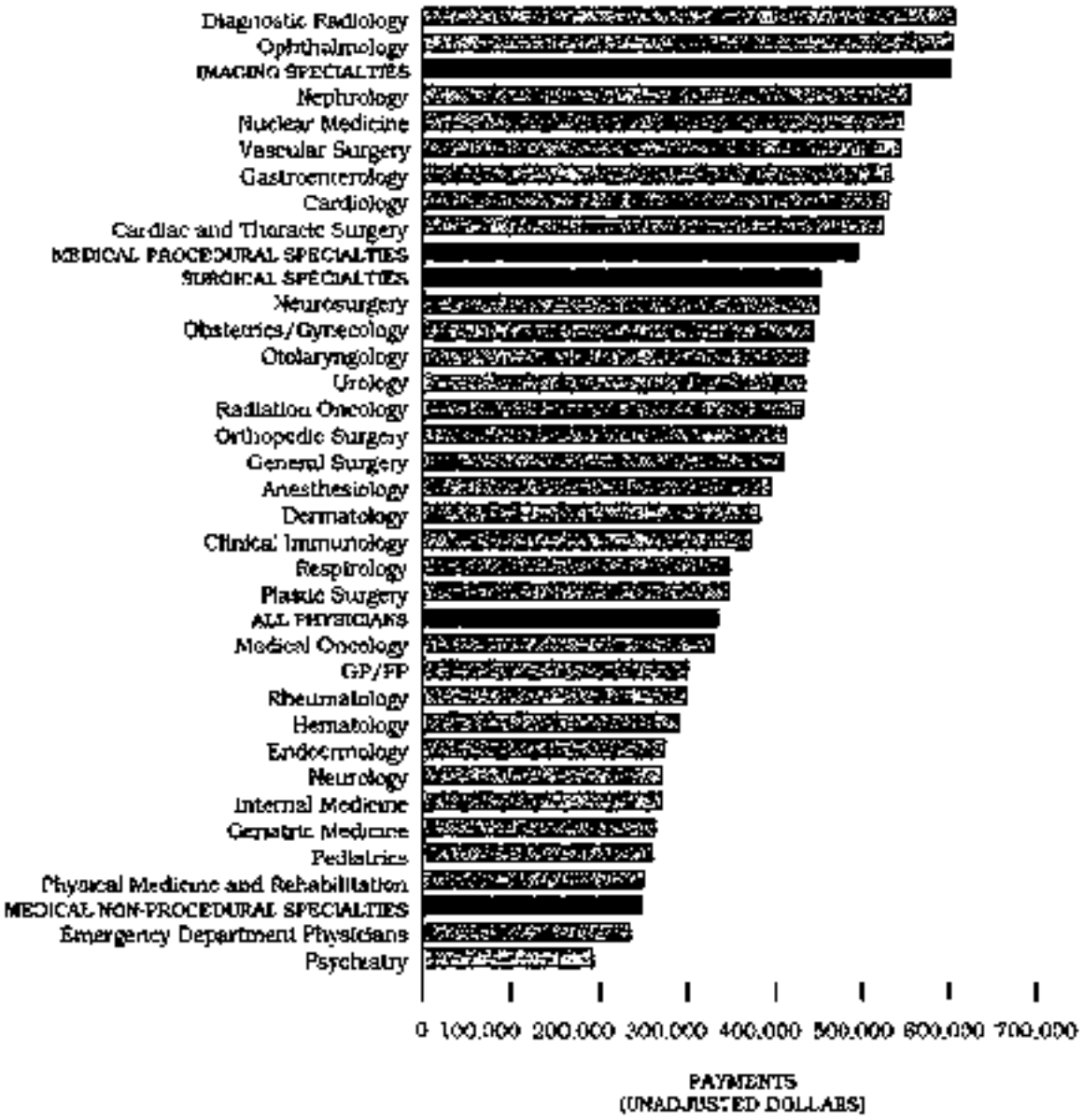
Payments to Individual Specialties

The average payments per physician in the main specialty groups in 2009/10 are summarized in figure 2.

The highest payments to individual physicians went to those in surgical, diagnostic and medical procedural specialties and the lowest payments went to those in non-procedural medical specialties. The estimate for psychiatrists is unreliable as it does not include mental health sessional fees.

Approximately 63% of the $4.3 billion increase in total payments was related to an increase in average payments per physician. The other 37% was a result of the increase in physician supply. Additional analyses at the physician level showed that between 2004/05 and 2009/10 the substantial increases in OHIP payments to radiologists, nephrologists and ophthalmologists were due almost exclusively to an increase in the average number of services provided by each specialist.

FIGURE 2 Average payment per physician from all sources by specialty and specialty group, in Ontario, 2009/10



Trends in Payments to Specific Groups of Physicians

We observed the following trends among specialty groups:

- *General Practitioners/Family Physicians*
  The median payment per active GP/FP was relatively flat from 1992/93 to 2004/05 and rose steadily between 2005/06 and 2009/10. Fee-for-service payments remained relatively flat over the whole time period, with a slight increase from 2005/06 to 2007/08 and a small decrease thereafter. Payments specific to primary care models, the majority of which were capitation-based, rose rapidly after 2004/05 and accounted for a large proportion of the observed increase.
- *Medical Procedural Specialists*
  Within this group, notable increases in total and individual payments were seen for cardiology, gastroenterology and nephrology, and most of the payments to these specialists continue to be in the form of fee for service.
- *Medical Non-Procedural Specialties*
  Payments to these groups remained generally at the low end of the distribution for all physicians. Alternate payment plans appear to have been an important factor in determining retention and payments in several of these specialties.
- *Imaging Specialists*
  Payments to diagnostic radiologists and nuclear medicine specialists have risen substantially in recent years and both remain in the upper range of payments to physicians. The great majority of payments are by fee for service.
- *Surgical Specialties*
  Some of the traditional surgical specialties have seen only small rates of growth in supply. This may reflect the impact of non-invasive medical procedures, which in some cases are replacing open surgery. Payments to these groups have remained in the upper range for all physicians. The number of ophthalmologists increased only slightly during the observation period. However, this specialty received the largest increase in mean payments, approximately $300,000, between 1992/93 and 2009/10.

Physician Supply

The overall number of physicians for whom we had payment information increased by 4,811 (24%) between 1992/93 and 2009/10. This is slightly higher than overall population growth (about 20%) during the same period. Growth was not constant over time, and there was a slight contraction in the number of doctors between 1993/94 and 1999/00. Growth was greatest (2.3% per year) between 2005/06 and 2009/10. Growth in physician supply was variable across specialty groups. Proportionally, the greatest increases have been seen in emergency medicine, medical procedural specialties, anesthesia and diagnostic imaging. The smallest overall proportional increase (4.5% between 1992/93 and 2009/10) was among GP/FPs. However, this overall figure disguises a decline of almost 8% between 1993/94 and 1999/00, which then reversed.

CONCLUSIONS

Physician payments account for about 20% of total health care costs in Ontario. Although overall physician supply rose in line with population growth, this varied considerably among specialties. The rise in payments since the turn of this century has been substantially greater than the overall increase in physician numbers and has been growing significantly above the average rate of inflation since 2004/05. Directed increases in physician payments, achieved through negotiated agreements with the Ontario Medical Association in 2004 and 2008, were aimed primarily at reducing wait times and improving access to physician services, particularly primary care. This policy intervention represents the largest financial investment in physicians made by the provincial government. The most important positive outcome arising from it has been the reversal of the decline in GP/FPs seen in the 1990s. Much of the impact of this policy appears to have been related to the change in financial models, with a shift from fee-for-service to capitation-based payments. Efforts to reduce wait times in a fee-for-service environment have disproportionately benefited key surgical, medical procedural, and diagnostic specialties. These groups have also gained financially from demographic changes, technological advances and increased health system capacity (i.e., increased hospital funding) that have enabled larger numbers of services to be provided by certain specialists in recent years.

The government of Ontario spent $8 billion on physician services in 2009, $4.3 billion more than in 1992. This investment has provided a larger number of active physicians and an increase in services, particularly in areas targeted by certain policies. Alternative payment plans have supported certain government priorities and policy directions, particularly in primary care and the non-procedural medical specialties. This report cannot answer whether this increased investment has led to improved patient outcomes or to improved functioning of the health care system. To our knowledge, no such impact analysis has been undertaken. We believe this subsequent work is critical to ensuring that taxpayer dollars invested in the health care system provide maximal benefits for the patients of Ontario.

List of Exhibits

CHAPTER 1

Introduction

There are a number of reasons why reporting on payments to physicians is important. For one, they represent 20% of public expenditure on health care in Canada. In a recent study,[1] the Canadian Institute for Health Information (CIHI) found that spending on physicians' services has been among the fastest growing health care expenditure categories in recent years, increasing at an annual rate of 6.8% per year from 1998/99 to 2008/09. CIHI investigators found that payments to doctors grew at a faster rate than the average weekly wages of other health and social services workers, and exceeded the Industrial Composite Wage Index.

Prior to 1998/99, as noted in the CIHI report, physician compensation grew more slowly than the prices of other public goods and services. During this time, several Canadian provinces capped payments to physicians.[2] This was at a time when physicians in Canada were paid through fee for service (FFS), and the capping policy was credited with containing payments. But it may have been at a cost by precipitating a loss of doctors who could find better-paid work in the United States.[3] Since the billing caps were lifted in 1998, payments for physician services have risen, and governments have started to move away from FFS payments to alternate payment plans and, in the case of general practitioners/family physicians (GP/FPs), various models of capitation.

Payments to physicians matter for reasons other than total costs. Relative payments between the different specialty groups is important. It has long been believed that the fee-for-service model favour specialty groups that perform procedures, rather than practitioners who provide consulting services, such as GP/FPs, psychiatrists and general internal medicine specialists. Recognizing this, governments have created incentives for medical graduates to enter these and other specialty groups. In Ontario, these incentives include capitation models for GP/FPs, alternate payment plans for general internists working in hospitals, and incentives directed at emergency physicians, particularly those working in under-served areas. These programs have been most active during a period that has included a significant financial recession commencing in 2008/09. This has meant that inflation-driven increases in physician payments have coincided with a fall in government revenues, increasing the pressure on the public purse.[1]

It is appropriate and timely to review past and current trends in payments to physicians in Ontario and the distribution of these payments among the different specialty groups. However, the exercise is not entirely straightforward. It might seem a simple matter to total the payments made to each physician in the province during the relevant years. Indeed, if all payments were in the form of fees paid under the Ontario Health Insurance Plan (OHIP), it would be relatively easy. But as noted by the Auditor General of Ontario in his 2011 annual report,[1] a large number of physicians in the province participate in alternate payment plans. Participation in these plans is variable, even within defined groups; therefore, calculating total payments requires the collation of multiple streams of funding at the level of the individual practitioner. We thought it appropriate that this work should be done at ICES for although it does not involve personal health information, the data are sensitive, and ICES has a long history of protecting the privacy of personal information of all types and has rigorous data security procedures in place. No individual data are provided in this report, and all analyses were performed on de-identified data; this is consistent with all previous work done at ICES on the same and related topics.

"It is appropriate and timely to review past and current trends in payments to physicians in Ontario and the distribution of these payments among the different specialty groups."

BACKGROUND

Two recent international reports that have analyzed payments to physicians help to put Canadian data in context. Laugesen and Glied compared health spending in six countries in 2008 and analyzed the impact of physician payments.[3] In Canada, total health care spending was higher than in Australia and the United Kingdom but lower than in the United States. Laugesen and Glied questioned what was driving the very high costs of health care in the United States. Their main conclusion was simple: it was due to the high prices paid for a wide range of services. To quote the authors: "We conclude that the higher fees, rather than factors such as higher practice costs, volume of services, or tuition expenses, were the main drivers of higher US spending, particularly in orthopedics." The authors underscore the importance of studying physician payments as a general driver of health system costs.

Another recent international comparison of fees paid to doctors in different countries was conducted by the International Federation of Health Plans in 2010.[4] This study summarized data collected from 100 health insurance plans in 30 countries. Across a series of procedures (routine office visits, normal deliveries of newborns, cesarean sections, appendectomies, cataract surgeries and hip replacements) that enumerated physician fees, Canada ranked in the middle or the bottom half of a group of countries that included Argentina, Australia, Chile, France, Germany, New Zealand, Spain, Switzerland, the United Kingdom and the United States.

A more detailed analysis of the situation in Canada was conducted by CIHI.[1] This investigation found that Canada has an overall physician supply of 2.2 per 1,000 population—lower than many other OECD countries—but the rate of growth in physician supply increased between 2003 and 2008 compared with previous years. Prior to 1998, rates of increase in physician compensation followed rates of increase in the Government Current Expenditure Implicit Price Index (GCEIPI). Since 1998, rates of increase in physician compensation have exceeded rates of increase in the GCEIPI. Fee increases have been the major cost driver for physician expenditure during the last 10 years. Physician compensation increases have accounted for approximately one-half of annual growth in expenditure since 1998.

The CIHI report concluded that "after years of moderation, FFS prices have risen quite sharply since a nadir in 1997 and in the last decade have exceeded the GCEIPI, and since 1998 physician compensation has exceeded the rates of increase in the industrial composite wage index. This is compounded by an increase in rates of utilization in the last decade. As a result, increases in the prices of physician services have been the major cost driver of physician expenditures over the last 10 years."[1]

Several of these themes were also picked up in the Auditor General's 2011 annual report and provide important background to this report. The Auditor General observed that more than 60% of the province's almost 12,000 GP/FPs were participating in the new primary care models, and more than nine million Ontarians had enrolled with these physicians.[5] Based on data from 2007/08 (the latest available at the time of the audit), family physicians who were paid through Family Health Group (FHG) and Family Health Organization (FHO) models earned, on average, over 25% more than those being paid through the traditional FFS model. The Auditor General also noted that there were 10 major types of alternate funding arrangements for specialists, with approximately half of the almost 13,000 specialists in Ontario being paid, at least in part, through one of them.

All of this serves to illustrate the importance of understanding not only how much physicians are being paid, but how this has changed over time and which policies and programs are driving these changes.

POLICIES AND PROGRAMS AFFECTING PHYSICIAN PAYMENT

Between 1992/93 and 2009/10, the Ontario government initiated or participated in a number of actions that affected payments to doctors in particular groups. The following interventions should be considered when viewing the exhibits presented in subsequent chapters:

1 / *Imposition of expenditure caps.* As Archibald and Flood reported, Ontario imposed "a global ceiling on expenditures for medical services during the three fiscal years beginning with 1993/94. An overall ceiling on expenditures was set in each year payments in excess of the ceiling were 'clawed back' by reducing each physician's billings by an equal across-the-board percentage."[1] Use of payment caps ceased in 1998.

2 / *Introduction of physician supply controls.* In Ontario, temporary restrictions on new billing numbers for out-of-province graduates were put in place between 1993 and 1996. From 1997 to 1999, financial penalties were instituted for recent graduates who wanted to establish a practice in selected urban areas designated as 'over-serviced.'

3 / *Funding enhancements to improve wait times.* This covers a range of strategies used to reduce wait times for cancer surgery, cardiac procedures, cataract surgery, hip and knee replacement, and magnetic resonance imaging (MRI) and computed tomography (CT) scans. Hospitals were provided with funding in addition to their base funding to help clear wait lists for procedures and MRI/CT. The extra funds provided additional operating room capacity for orthopedic surgeons, cardiologists and others to do more procedures and shorten wait lists. It also gave them an opportunity to increase their incomes. This money came with conditions: Participating centres had to use the Wait Time Information System to show improvements in wait times. The same was done for MRI/CT.

4 / *Development of alternatives to the fee-for-service model.* Since 1996, the MOHLTC has been steadily introducing programs designed to move physicians in certain specialties away from a purely FFS payment model. This process began in 1996 with emergency departments in remote and northern communities, followed in 1999 with alternate funding arrangements (AFAs) being offered to nearly all EDs in the province. This has since expanded to other specialties, so that today nearly half of all specialists receive funding from some type of alternate funding source, either an AFA, an alternate payment plan (APP) or a mixture of both.[7]

The introduction of new alternate funding models for GP/FPs began in 1999 with the first Primary Care Networks (PCNs), which were capitation-based. By 2009/10, approximately two-thirds of GP/FPs belonged to one of the primary care patient enrolment models. It has been estimated that in 2009/10 there were 302 separate contracts between the MOHLTC and the Ontario Medical Association on behalf of various physician groups.[8] This multiplicity of payment methods has implications both for physician payment itself and for tracking such payments. This latter issue will be addressed in more detail in Chapter 2.

REPORT OBJECTIVES

1 / To estimate public payments to individual physicians from multiple sources between 1992/3 and 2009/10 and report these by specialty, specialty group and overall, using several different measures:

- the average payment per physician;
- the median (and selected percentiles) of the distribution of payments, which illustrates the range of payment levels; and
- the total of all payments to physicians in a given group.

2 / To analyze and report on changes in overall physician supply and in the main specialty groups between 1992/93 and 2009/10, as supply is an important component of expenditure.

3 / To analyze how payments and supply varied between the main specialty groups, and how each contributed to the rise in overall physician payments.

4 / To analyze how changes in the different types of payments (fee for service and other models) contributed to the observed increases in total payments and payments to physicians.

REPORT STRUCTURE

This report examines payments to physicians from MOHLTC sources from 1992/93 to 2009/10. Payments are reported overall for Ontario and by individual specialties. Three exhibits are presented for all physicians combined and for each specialty.

- The first exhibit in each series shows the median and selected percentiles of the distribution of payments from 1992/93 to 2009/10.
- The second exhibit shows the mean (average) payment for an individual physician and for a full-time equivalent (FTE) physician.
- The third exhibit shows the total of all payments to physicians in the specialty for each year, broken down by payment source.

Chapter 1 provides an introduction and Chapter 2 explains the methods used. Chapters 3 to 10 present results for the 32 specialties, grouped as follows:

Chapter 3 /
All Ontario Physicians

Chapter 4 /
General *Practitioners/Family Physicians*

Chapter 5 /
Medical Non-Procedural Specialists
- General internal medicine
- Clinical immunology
- Dermatology
- Endocrinology
- Geriatrics
- Hematology
- Medical oncology
- Neurology
- Pediatrics
- Physical medicine and rehabilitation
- Psychiatry
- Rheumatology

Chapter 6 /
Medical Procedural Specialists
- Cardiology
- Gastroenterology
- Nephrology
- Radiation oncology
- Respirology

Chapter 7 /
Surgical Specialists
- Cardiac and thoracic surgery
- General surgery
  (including pediatric general surgery)
- Neurosurgery
- Obstetrics/gynecology
- Ophthalmology
- Orthopedic surgery
- Otolaryngology
- Plastic surgery
- Urology
- Vascular surgery

Chapter 8 /
Imaging Specialists
- Diagnostic radiology
- Nuclear medicine

Chapter 9 /
Anesthesiologists

Chapter 10 /
Emergency Department Physicians

Chapter 11 /
Summary
- provides a summary of the results, including exhibits that facilitate comparisons between specialties and specialty groups.

Chapter 12 /
Discussion and Conclusion
- contains the discussion of the overall results and our conclusions.

REFERENCES

1 Canadian Institute for Health Information. *Health Care Cost Drivers: The Facts*. Ottawa: CIHI; 2011. Accessed January 13, 2012 at http://secure.cihi.ca/cihiweb/products/health_care_cost_drivers_the_facts_en.pdf.

2 Barer ML, Lomas J, Sanmartin C. Reminding our Ps and Qs: medical cost controls in Canada. *Health Aff (Millwood)* 1996; 15(2):216–34.

3 Chan B. *Supply of Physician's Services in Ontario*. Research Atlas. Toronto: Institute for Clinical Evaluative Sciences; 2004. Accessed January 13, 2012 at http://www.ices.on.ca/file/mod2rp1.pdf.

4 Office of the Auditor General of Ontario. 2011 *Annual Report of the Office of the Auditor General of Ontario*. Toronto: Queen's Printer; 2011. Accessed January 13, 2012 at http://www.auditor.on.ca/en/reports_en/en11/2011ar_en.pdf.

5 Laugesen MJ, Glied SA. Higher fees paid to US physicians drive higher spending for physician services compared to other countries. *Health Aff (Millwood)* 2011; 30(9):1647–56.

6 International Federation of Health Plans. *2010 Comparative Price Report: Medical and Hospital Fees by Country*. Presentation delivered at IFHP Council Meeting, San Francisco, CA. November 2010. Accessed January 13, 2012 at http://www.ifhp.com/documents/IFHPpricereport151210.pdf.

7 Archibald T, Flood CM. *The Physician Services Committee: The Relationship between the Ontario Medical Association and the Ontario Ministry of Health and Long-Term Care*. IRPP Working Paper Series No. 2004-03. Montreal: Institute for Research on Public Policy; 2004. Accessed January 13, 2012 at http://www.irpp.org/wp/archive/medicare_basket/wp2004-03.pdf.

8 Ontario Ministry of Health and Long-Term Care. Ontario Wait Times. Accessed January 13, 2012 at http://www.health.gov.on.ca/en/public/programs/waittimes/strategy.aspx.

9 Health Force Ontario. Specialist Practice Models. Accessed January 13, 2012 at www.healthforceontario.ca/Work/OutsideOntario/PhysiciansOutsideOntario/PractisingInOntario/SpecialistPhysician.aspx.

10 Fitzpatrick S. Physician Payments: The Ontario Experience. CHSRF Researcher on Call webinar presentation. June 2, 2011. Accessed January 13, 2012 at http://www.chsrf.ca/programs/oncall/FullSchedule/ArticleView/?1-06-02/0834f3b2-c447-4d09-83e8-ef10a6ee0a6e.aspx

CHAPTER 2

Methods

INTRODUCTION

We believe that this is the first independent attempt to make a comprehensive estimate of how much Ontario physicians are being paid from all Ministry of Health and Long-term Care (MOHLTC) sources. The biggest challenge we faced was bringing together the data from disparate sources, a number of which were new to ICES and/or had not been used previously for research purposes. The most important of these were data sources containing information about payments from the various alternate funding programs

In the past, studies have attempted to compensate for missing alternate payment information by using shadow billings. Shadow billings are records submitted by physicians for patient services that are funded through sources other than fee for service (FFS). These records are identical to FFS billings including having a FFS fee code, but the payment amount is zero. In the past, it was thought that 'adjusting' the shadow billings, that is, applying the current price for each shadow-billed fee code, would provide a good approximation of the physician's total remuneration, including alternate payments. In recent years, as the range of non-FFS payments, such as capitation, premiums and bonuses, grew more diverse, confidence in this methodology declined. To be confident that we were representing physician payments accurately, it was necessary to obtain and use the actual data. This chapter outlines the data sources used in this study and how they were applied to estimate payments at the individual physician level.

DATA SOURCES

The following data sources were used in this study:

- ***Ontario Health Insurance Plan (OHIP) Fee-for-Service billings (from 1992/93 to 2009/10)***
  This is a database of all OHIP FFS and shadow billings. Physicians bill for the services they provide using fee service codes defined in the Schedule of Benefits.[1] In summing the payments from this source, duplicate records and invalid claims were removed, where possible. Then the payment field was summed for each physician for each fiscal year. Shadow billings were not removed but did not contribute to the total because their payment amount was zero dollars.
- ***OHIP Architected Payments (from 2003/04 to 2009/10)***
  This is a database of summary payments made on a monthly basis that do not pertain to an individual service provided to an individual patient. Rather, this database comprises such payments as premiums, bonuses and fees that can be summed across a physician's entire practice and paid at the end of the month. For example, physicians are eligible for age premiums for providing care to patients who are very young or very old, as these patients often require more of the physician's time during a visit or consultation. To illustrate with a hypothetical example: If the premium for seeing a patient in the 75- to 79-year age group was $30 and physician A saw 10 such patients during the month, then the database would record a $300 payment for the age premium. Since there is often a lag between when the service is rendered and when the payment is made, the database record includes both the payment month and the fiscal year when the eligible service occurred. To be consistent with the FFS payments, payments were included in the year in which the service was performed, not the year in which they were paid.
- ***Academic Health Sciences Centre (AHSC) governance payment database (from 2003/04 to 2009/10)***
  The AHSC program is a funding arrangement designed to compensate physicians in teaching hospitals for the time they spend training residents and doing research; this is non-clinical work for which they cannot bill OHIP. Although there may be as many as 500 physicians from a variety of specialties covered by an AHSC contract in a large teaching hospital, all payments flow through the AHSC governance group. This means that in the AHSC payment data, there are only a couple of large aggregated payments per month to each AHSC. The AHSC governance data were used to identify which physicians were affiliated with each AHSC in each year of observation. Payments not targeted for a specific specialty were divided up equally among all affiliated physicians. Specialty-specific payments were divided equally among all affiliated physicians in the designated specialty.

- *Generalized Alternate Payment Plan (GAAP) database (from 2005/06 to 2009/10)*
The GAPP is a database of all non-OHIP-related payments (including those to AHSCs). It includes information on the payment amount, the payment month, the payment type and the original payment data source. Many payments also include the model name, which identifies the type of APP or agreement (e.g., Emergency, Northern Specialists, Family Health Organization). With respect to identifiers, a payment record can have one or more of the following: physician billing number (encrypted), group billing number (encrypted) or contract number. For payments that only had contract numbers, the MOHLTC provided 'crosswalks' that identified groups and physicians and thereby facilitated the assignment of payments. A small proportion of payments were not be assigned because they could not be linked to any physicians.
- *Primary Care Network (PCN) capitation payments (from 1999/00 to 2003/04)*
The first capitation-based PCNs were introduced in 1999/00. We were able to obtain a database that captured payments to this early primary care model. Depending on the group, some payments listed the physician billing number (encrypted) as well as the group; others listed only the group billing number (encrypted). In the latter case, we were able to use the OHIP Corporate Provider Database (CPDB) to identify physicians affiliated with the group and divide the payment equally among them.
- *Miscellaneous payments (from 2005/06 to 2009/10)*
There are several databases that report manual payments (and sometimes charges) to physicians. These payments may be administrative in nature (e.g., processing charges). Often, it is difficult to determine the reason for the payment; these payments/charges are included in the physicians' totals, and their source is listed as 'Other.'

Missing Data

Within the data sources described above, there are several gaps that need to be acknowledged. The most important of these is APP/AFA data prior to 2005/06. The initial AFAs for emergency departments, for example, began in 1999/00 or 2000/01, but we were only able to obtain payment information beginning in 2005/06. The same is true for other APPs. For this reason, results for some or all of the years between 2000/01 and 2004/05 for certain specialties have been suppressed. In the case of other specialties, the results for these years need to be treated with caution. We have identified these examples in the exhibit footnotes.

Another type of missing data concerns physicians on alternate payment plans prior to 1999. We do not have any payment information from Community Health Centres, Health Service Organizations or early academic comprehensive agreements, such as the one with the Hospital for Sick Children. If the physicians in these plans also had FFS billings, their payments will have been underestimated. If they had no FFS billings, they will have been excluded completely prior to 2005/06.

INCLUSION/EXCLUSION CRITERIA

Payments

The totals reported in this report exclude payments to Academic Health Sciences Centres for administrative costs, and payments to Family Health Teams (FHTs) to cover such things as computer hardware and software, legal fees and human resources. They do not include payments to FHTs for other providers, such as nurse practitioners, nurses or dieticians.

Diagnostic tests and other procedures often have two fees: a professional fee and a technical fee. Professional fees are paid to the physician who performs and interprets the test, and technical fees are paid to the facility (e.g., the hospital) to offset the costs associated with providing the services (e.g., technicians' salaries, overhead expenditures, capital outlays and amortization). It was our intention to include only professional fees paid to physicians in this analysis. However, prior to 2000/01 not all technical fees could be identified as some procedures had three fees: technical, professional and a combined fee that included both. We did not attempt to remove the technical portion from the combined fee, so payments for certain specialties, particularly diagnostic imaging, are somewhat inflated prior to 2000/01 when the combined fee was discontinued.

A cautionary note is included on the exhibits where the results may include some technical fees.

Physician Specialties

Certain physician specialties have been excluded from this report. They include laboratory medicine specialties (anatomical pathology, general pathology, hematological pathology, neuropathology medical microbiology and medical biochemistry) because their payment data in the sources we used were unreliable. Many laboratory physicians work in hospitals and are paid out of the hospital global budget. There were also about 30 physicians who were listed in our data under other specialties, but whose billings were almost entirely for laboratory tests. These physicians were also excluded. Finally, where the number of physicians in a specialty was very small (fewer than 50 physicians in 2009/10), the specialty was either combined with a larger specialty or was excluded. The following specialties were combined: pediatric cardiology with cardiology, thoracic surgery with cardiac and thoracic surgery, pediatric general surgery with general surgery, community medicine with GP/FPs. The following specialties were excluded because they were both very small and there were questions about the completeness of their data: medical genetics, infectious diseases, occupational medicine.

Physicians

Physicians were included in the analysis for a given year if they met one of the following criteria: they were "active" according to information from the Ontario Physician Human Resources Data Centre (OPHRDC) and had total payments that were more than $0, or their status was "inactive" according to OPHRDC but they had OHIP billings during the year.

ASSIGNING PAYMENTS TO INDIVIDUAL PHYSICIANS

Payments were allocated to individual physicians in the following manner:

1 / If there was a physician billing number (encrypted) associated with the payment (as in OHIP FFS billings), the payment was allocated to that physician.

2 / For payments where only a group billing number (encrypted) was available, physicians affiliated with that group at the time of payment were identified using the OHIP Corporate Provider Database (CPDB). The payment was then divided equally among affiliated physicians.

3 / For payments where only a contract number was available, a lookup table was used to identify the group billing numbers associated with the contract. Then the CPDB was used to identify physicians affiliated with the groups. Each physician was included only once per contract. The contract payments were divided equally between all physicians associated with that contract.

4 / Payments without identifiers or with contract numbers that had no groups associated with them could not be allocated.

DEFINING PHYSICIAN SPECIALTIES

Physicians were classified according to their derived specialty in the Ontario Physician Workforce Database (OPWD). OPWD is a collaborative database created under a data sharing agreement between the OPHRDC, ICES and the MOHLTC. The derived specialty is based on a combination of physician certification and self-report. There were two exceptions to this: physicians who provided more than 50% of their FFS-billed services in the emergency department were classified as emergency physicians; and physicians who had more than 50% of their FFS billings for lab tests (with fee service codes beginning with 'L') were classified as laboratory medicine physicians and were excluded from this analysis.

ANALYTICAL METHODS

As a descriptive observational study, most of the analytical methods used are quite straightforward. The most complex part of the study involved ensuring that payments were correctly assigned to each physician and correctly identified as to the source of the payment. Once this was done, payments from all data sources were combined to achieve a total for each physician and year. The median and mean were calculated using PROC MEANS in SAS version 9.2 (SAS Institute, Cary, NC).

Means were calculated on both a per-head and per-full-time-equivalent (FTE) basis. FTE is a measure of workload and was calculated using the method originally developed by Health Canada to estimate FTE using FFS billings. For this report, FTE was calculated using total payments from all sources. The assumption is that physicians who work harder get paid more. In the standard formula, all physicians are ranked in order by the total sum of their payments. Those who fall between the 40th and 60th percentiles are assigned an FTE of 1.00.

When reporting total payments by specialty or overall, figures have been rounded to the nearest 100 and reported in thousands of dollars. However, means, medians, percentages and FTEs were all calculated on unrounded numbers. All payments are reported in actual dollars unadjusted for inflation. All the data reported are for gross payments to physicians and have not been adjusted for overhead costs.

TIME FRAME

The report examines physician payments for fiscal years 1992/93 to 2009/10, the earliest and most recent years for which data are available. In chapters 3 to 10, which present results for individual specialties, the median, mean and total payments are shown for the entire study period.

The Summary chapter (Chapter 11) contains exhibits that allow the reader to easily make comparisons between specialties and groups of specialties. These summary exhibits contain data from one or all of the following years: 1993/94, 1999/00, 2005/06 and 2009/10. These years were chosen for the following reasons.

- The 1990s represent a period when physicians were paid almost exclusively on a fee-for-service basis, so a comparison of 1993/94 and 1999/00 is illustrative of what was happening in respect of FFS.
- Comparing 1999/00 and 2005/06 shows the impact of the first wave of alternate funding plans.
- Differences between 2005/06 and 2009/10 show the impact of Ontario Medical Association agreements in 2004 and 2008, which mainly affected primary care funding

REFERENCE

1 Ontario Ministry of Health and Long-Term Care. Ontario Health Insurance (OHIP) Schedule of Benefits and Fees. Accessed January 13, 2012 at http://www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html.

CHAPTER 3

Results for All Ontario Physicians

INTRODUCTION

In Ontario, the 1990s witnessed the capping of fee payments and the control of physician supply. These measures were implemented for one main purpose: cost containment. The Ontario government imposed a global ceiling on expenditures for medical services during the three fiscal years beginning in 1993/94. Payments in excess of the ceiling were 'clawed back' by reducing each physician's billings by an equal across-the-board percentage. Use of payment caps ceased in 1998. Temporary restrictions on new billing numbers for out-of-province graduates were put in place between 1993 and 1996. From 1997 to 1999, financial penalties were instituted for recent graduates who wanted to establish a practice in selected urban areas designated as 'over-serviced.'[1]

Since then, agreements between the Ontario Medical Association and the MOHLTC have governed the development of more sophisticated payment schemes for physicians. As a consequence, specialists in Ontario may now be compensated through a fee-for-service system or through a range of alternate funding arrangements. Alternate funding arrangements are contractual agreement between the MOHLTC and groups of physicians and may include other organizations, such as hospitals and universities. The process of deliberately moving GP/FPs away from a purely fee-for-service model began in earnest in 1999/00. A major expansion of primary care models began in 2001/02; details of the various models are given in the Introduction to this report.

As described in the exhibits accompanying this chapter, capping policies kept payments to physicians flat during the 1990s. The switch in policies and the introduction of strategies to reduce wait times for specific procedures and diagnostic tests led to increasing payments; these are reported in more detail in the chapters covering specific specialty groups.

As noted in Chapter 2, the following specialties have been excluded from this report: all laboratory medicine physicians (including anatomical pathologists, general pathologists, neuropathologists, hematological pathologists, medical microbiologists and medical biochemists); medical geneticists; occupational medicine specialists; public health physicians; and infectious disease specialists. These specialties were excluded because their numbers are very small (fewer than 50 physicians in 2009/10) and their payment information is not reliable. Many are paid out of hospital global budgets or by other agencies, such as the Workplace Safety and Insurance Board, whose information we could not access.

FINDINGS

Median, Mean and Total Payments (exhibits 3.1 to 3.3)

The number of active physicians in Ontario increased from 20,208 in 1992/93 to 25,019 in 2009/10 (24%). This is broadly in line with overall population growth (around 20%) during the same period. Growth was not constant, however; there was a slight contraction in the number of doctors between 1993/94 and 1999/00. Most of the expansion in physician numbers occurred in the past decade, with a 22% increase since 2000/01.

We identified payments of approximately $8 billion to Ontario's doctors in 2009/10, $4.3 billion more than they were paid in 1992/93. These estimates are in unadjusted dollars. This increase was not evenly distributed over time. Between 1992/93 and 1999/00, payments increased by 14.6%, or a yearly average of 2.4%. During this period, the average annual rate of inflation in Canada was 1.4%. Between 1999/00 and 2005/06, physician payments increased by 6.4% annually, compared with an average annual rate of inflation of 2.4%. Between 2005/06 and 2009/10, payments to physicians increased by 9.9% annually, compared with an average annual rate of inflation of less than 2% during the same period.

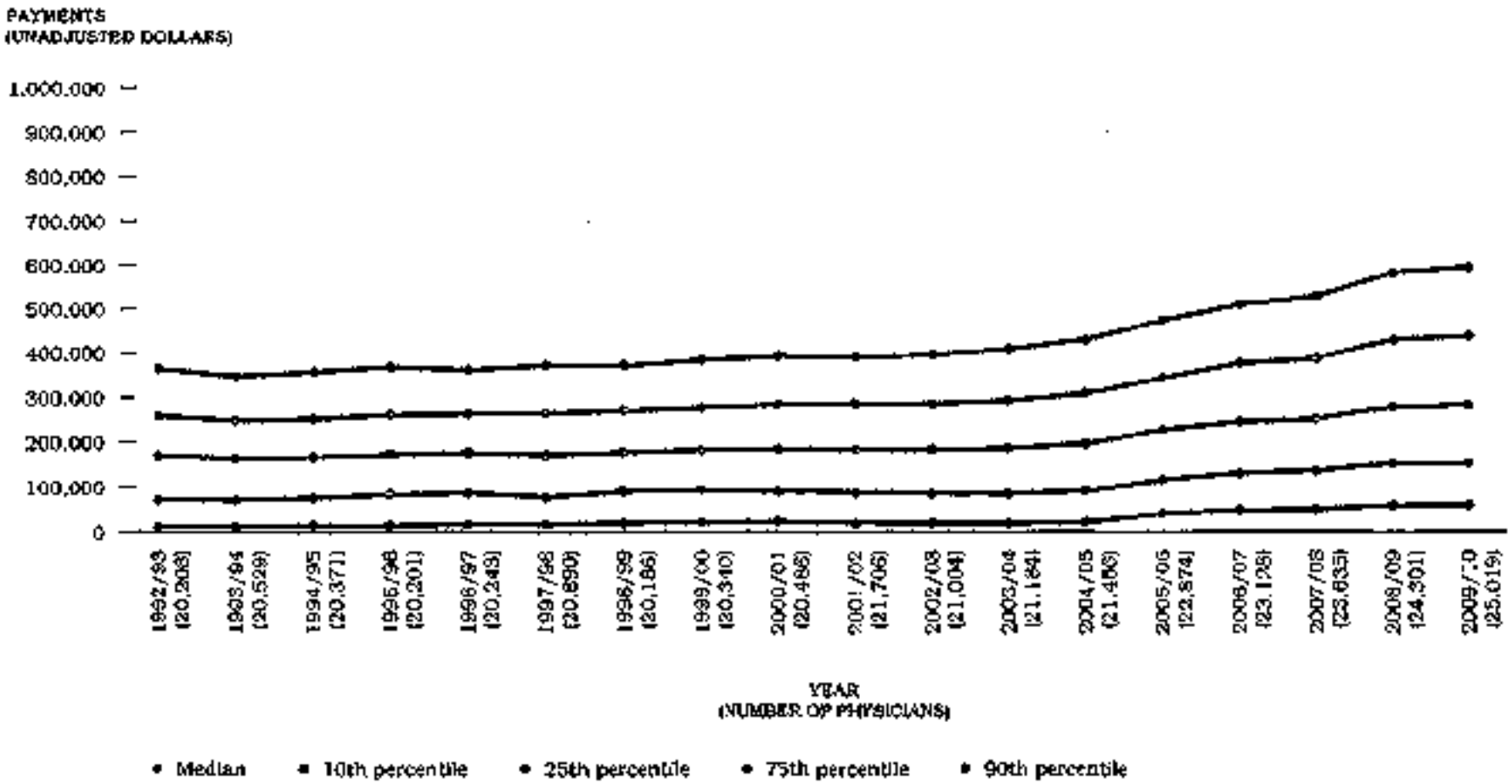
The median annual payment for all physicians combined was just under $170,000 in 1992/93 and remained flat during the 1990s (in unadjusted dollars). Between 2005/06 and 2009/10, the median payment per physician increased by 25%, from approximately $227,000 to $283,000. The mean payment per physician in 2005/06 was higher than the median at just under $250,000. This rose by 28%, to about $318,000, in 2009/10. [Note: these increases were not adjusted for inflation.] Payment by methods other than fee for service were negligible until 2004/05, but by 2009/10, they constituted 30% of total payments. From 2003/04 onward, 63% of the increase in payments to all physicians was made through some form of alternate payment plan. However, FFS payments rose during this period by 32%. Funding for the new primary care models totalled almost $1.2 billion or about 15% of the total, this was about the same as for all other payment streams combined.

REFERENCE

1 Archibald T, Flood CM. *The Physician Services Committee: The Relationship Between the Ontario Medical Association and the Ontario Ministry of Health and Long-Term Care*. IRPP Working Paper Series No. 2004-03. Montreal: Institute for Research on Public Policy; 2004. Accessed January 13, 2012 at http://www.irpp.org/wp/archive/medicare_basket/wp2004-03.pdf.

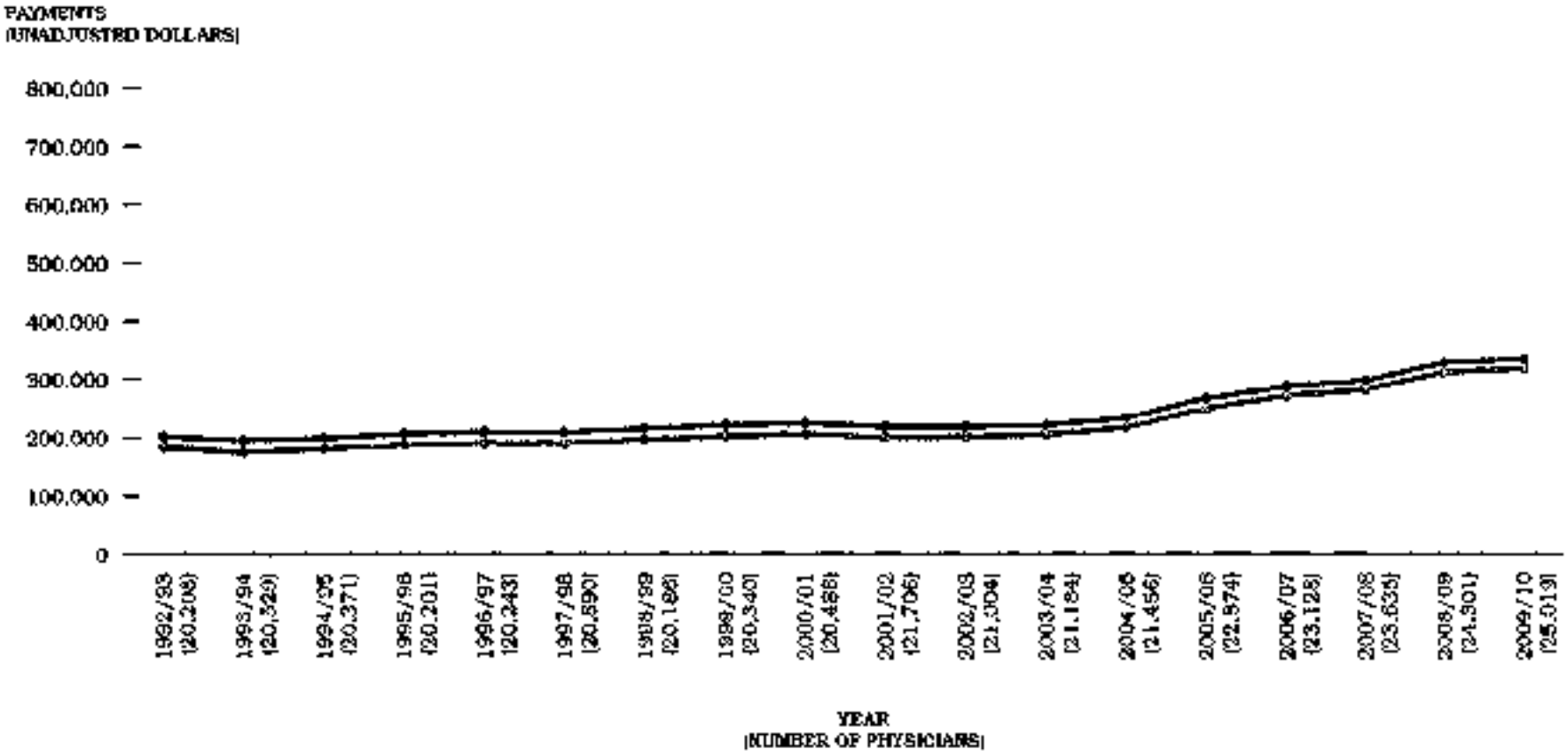
ALL PHYSICIANS

EXHIBIT 3.1 Median and percentiles of payments (in unadjusted dollars) to all individual physicians, in Ontario, 1992/93 to 2009/10



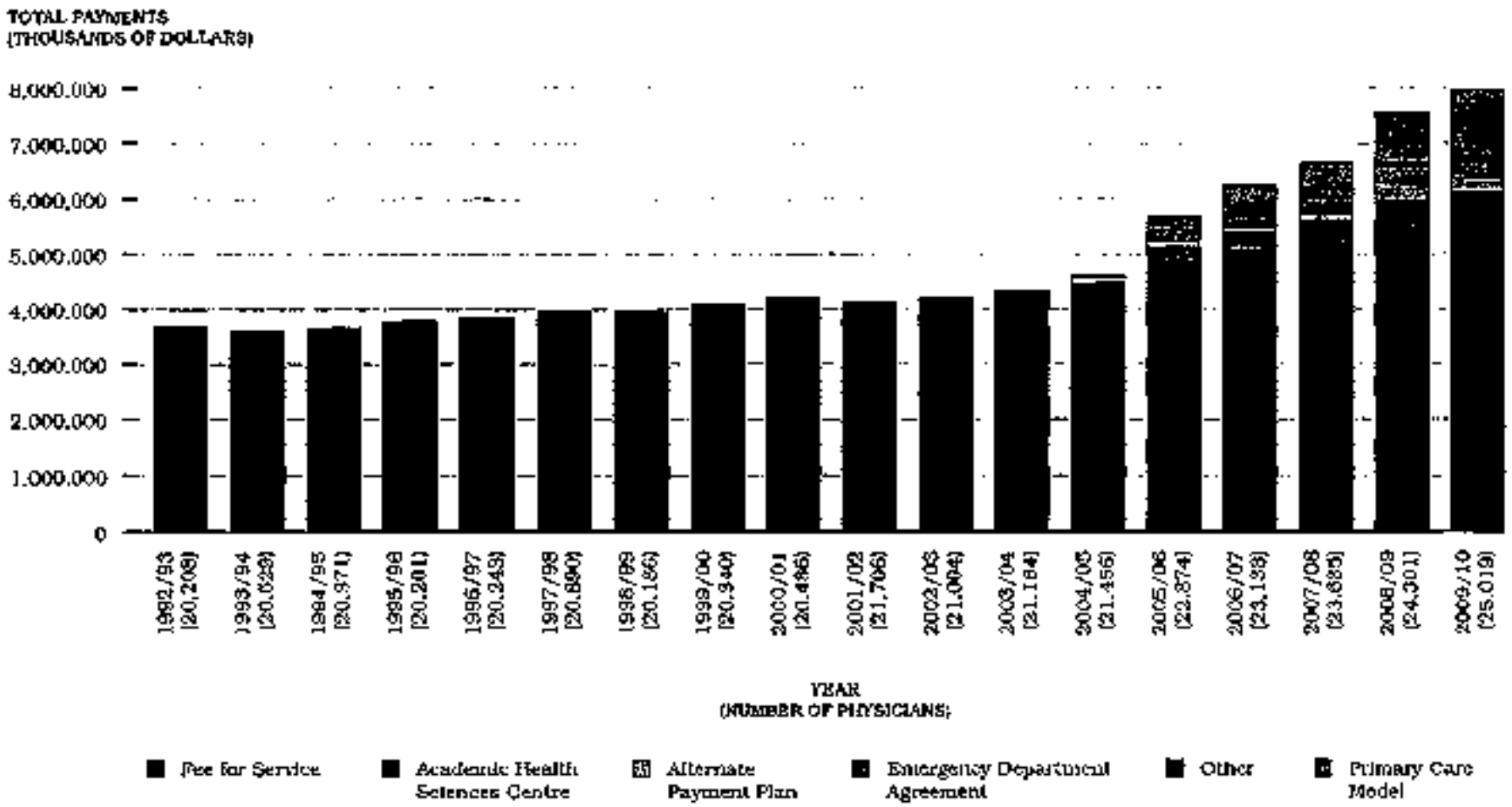
ALL PHYSICIANS

EXHIBIT 3.2 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to all physicians. In Ontario, 1992/93 to 2009/10



ALL PHYSICIANS

EXHIBIT 3.3 Total payments to all physicians by payment source, in Ontario, 1992/93 to 2009/10



CHAPTER 4

Results for General Practitioners/ Family Physicians

INTRODUCTION

This chapter presents data for the largest group of physicians—general practitioners/family physicians (GP/FPs). GP/FPs are responsible for providing primary care to the population, and for most people, they are their main source of health care. Although GP/FPs work mainly through office-based practice, their practice venues and range of services have traditionally been very diverse. This includes, in addition to in-office visits, providing primary care to residents in nursing homes, providing supportive care to their patients who are hospitalized, working in the emergency department, providing obstetrical care in remote communities and even assisting with surgery. As well, there has always been a subgroup of physicians in this specialty who prefer to focus on a single area of practice, such as psychotherapy, allergy medicine or sports medicine. For the purposes of this report, this chapter includes all GP/FPs except those who provided more than 50% of their services in the emergency department.

Prior to 1999/00, virtually all GP/FPs were paid on a fee-for-service (FFS) basis. The exceptions to this were two alternate payment models: Community Health Centres (CHCs) in which physicians were salaried employees, and Health Service Organizations (HSOs) in which physicians were paid a set amount for each patient on their roster (capitation). In the late 1990s, a number of capitation-based Primary Care Networks (PCNs) were formed

The following decade saw a major expansion of primary care models, including:

- 2001/02—blended capitation Family Health Networks (FHNs);
- 2003/04—blended FFS Family Health Groups (FHGs) and Comprehensive Care Models (CCM, similar to FHG but for solo practice physicians);
- 2004/05—the group payment-based Rural-Northern Physician Group Agreement (RAN);
- 2006/07—blended capitation Family Health Organizations (FHOs), into which HSOs and PCNs were integrated.

By the end of 2009/10, more than two-thirds of Ontario's primary care physicians belonged to one of these models, with FHOs being the most popular.

The first three exhibits in this chapter show the median, mean and total payments for all GP/FPs combined from 1992/93 to 2009/10. The final two exhibits focus on the most recent years, showing the differences in payments between the various patient enrolment models (PEMs) for the years 2005/06 to 2009/10 only. Physicians often move from one type of PEM to another during the year. For the purposes of this analysis, physicians were assigned to the PEM with which they were affiliated at the midpoint of each year.

FINDINGS

Median, Mean and Total Payments (exhibits 4.1 to 4.3)

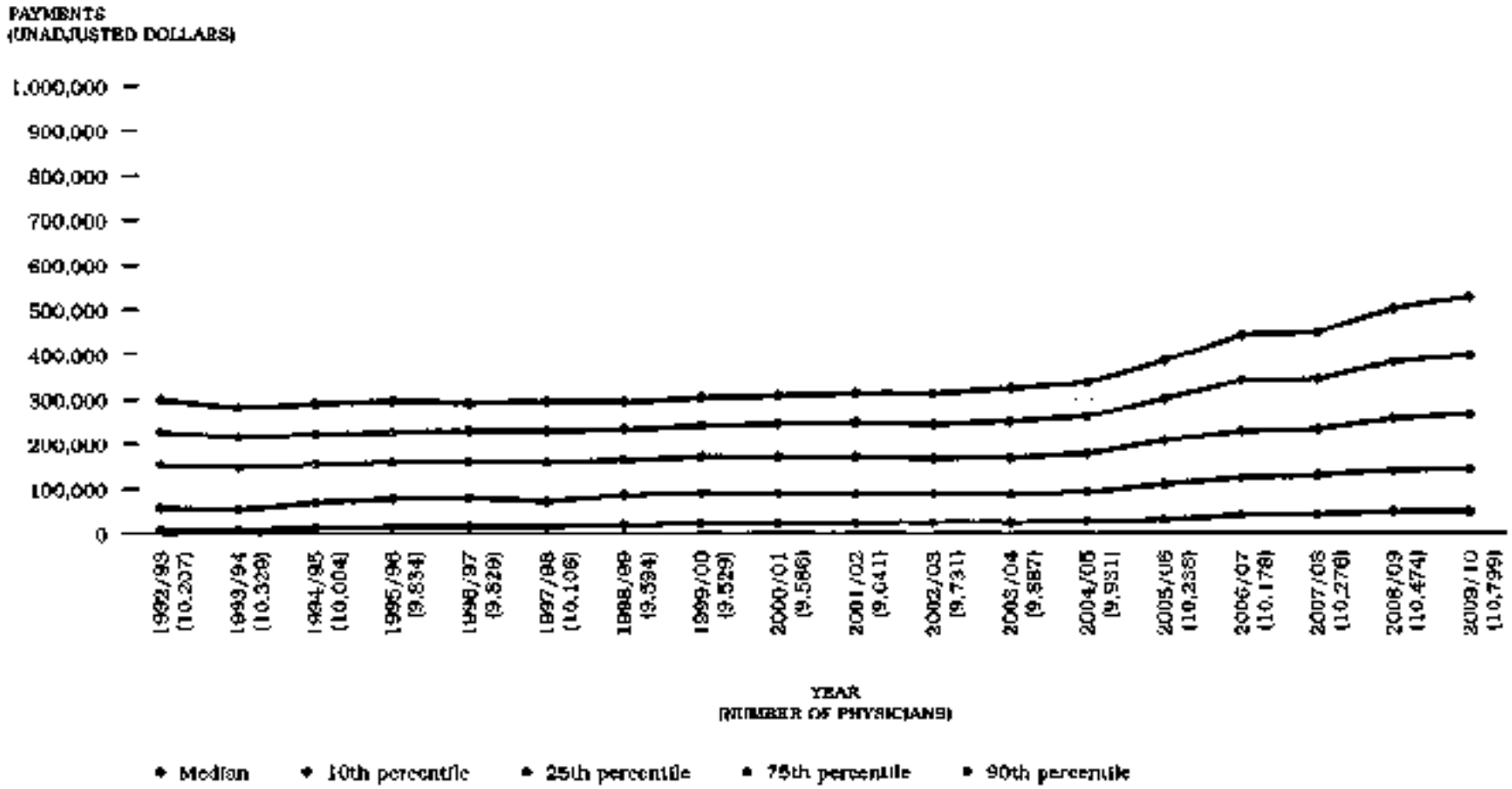
Excluding those working mainly in emergency departments, the number of GP/FPs declined approximately 7% between 1992/93 and 1999/00. Thereafter, numbers increased, and by 2009/10 there were 10,799 GP/FPs, about 6% more than in 1992/93. Between 2003/04 and 2009/10, the number of GP/FPs increased by almost 9%. Total payments to GP/FPs in 2009/10 amounted to $3.1 billion, an increase of $1.3 billion (77%) from 2003/04, or 58% after adjusting for inflation. The median payment per active GP/FP was relatively flat from 1992/93 to 2004/05, then rose steadily between 2005/06 and 2009/10. The variation in payments from the bottom 10th percentile to the top 90th percentile increased, from a gap of about $300,000 in 1992/93 to almost $500,000 in 2009/10. The mean payment per FTE for GP/FPs in 2009/10 ($301,100) was somewhat lower than that for all physicians ($334,700). Fee-for-service payments remained relatively flat over the whole time period, with a slight increase from 2005/06 to 2007/08 and a small decrease thereafter. Payments specific to primary care models, the majority of which were based on capitation, rose very rapidly after 2004/05 and accounted for a large proportion of the increase in payments.

Payments by Patient Enrolment Model (exhibits 4.4 and 4.5)

The Family Health Group (FHG), an enhanced fee-for-service model, remained the most popular patient enrolment model until the end of 2009/10, but payments to physicians in FHGs started to decline after 2007/08. Payments to physicians in Family Health Networks (FHNs), a blended capitation model, also began to decline after 2007/08. Payments to physicians in Family Health Organizations (FHOs), a blended capitation model with a larger per capita payment and basket of services than the FHN model, rose rapidly in 2008/09 and 2009/10, with the majority of the increase being capitation payments. Payments to physicians outside of patient enrolment models decreased after 2005/06, and payments in other models remained relatively flat between 2005/06 and 2009/10. Average payments per active GP/FP were highest among those in FHOs, followed by FHNs and FHGs. Payments in all models showed a general increase between 2005/06 and 2009/10.

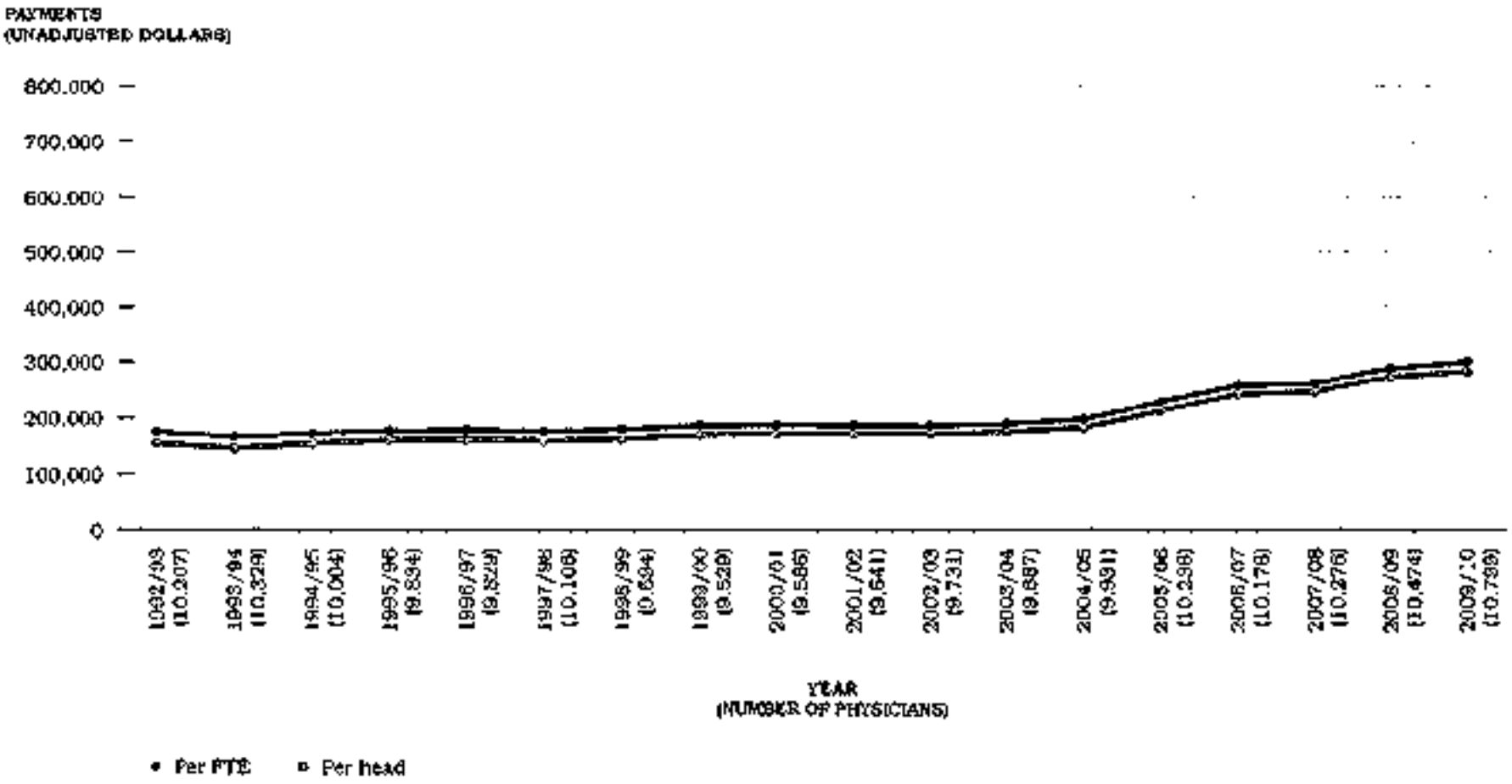
GENERAL PRACTITIONERS/FAMILY PHYSICIANS

EXHIBIT 4.1 Median and percentiles of payments (in unadjusted dollars) to individual GP/FPs, in Ontario, 1992/93 to 2009/10



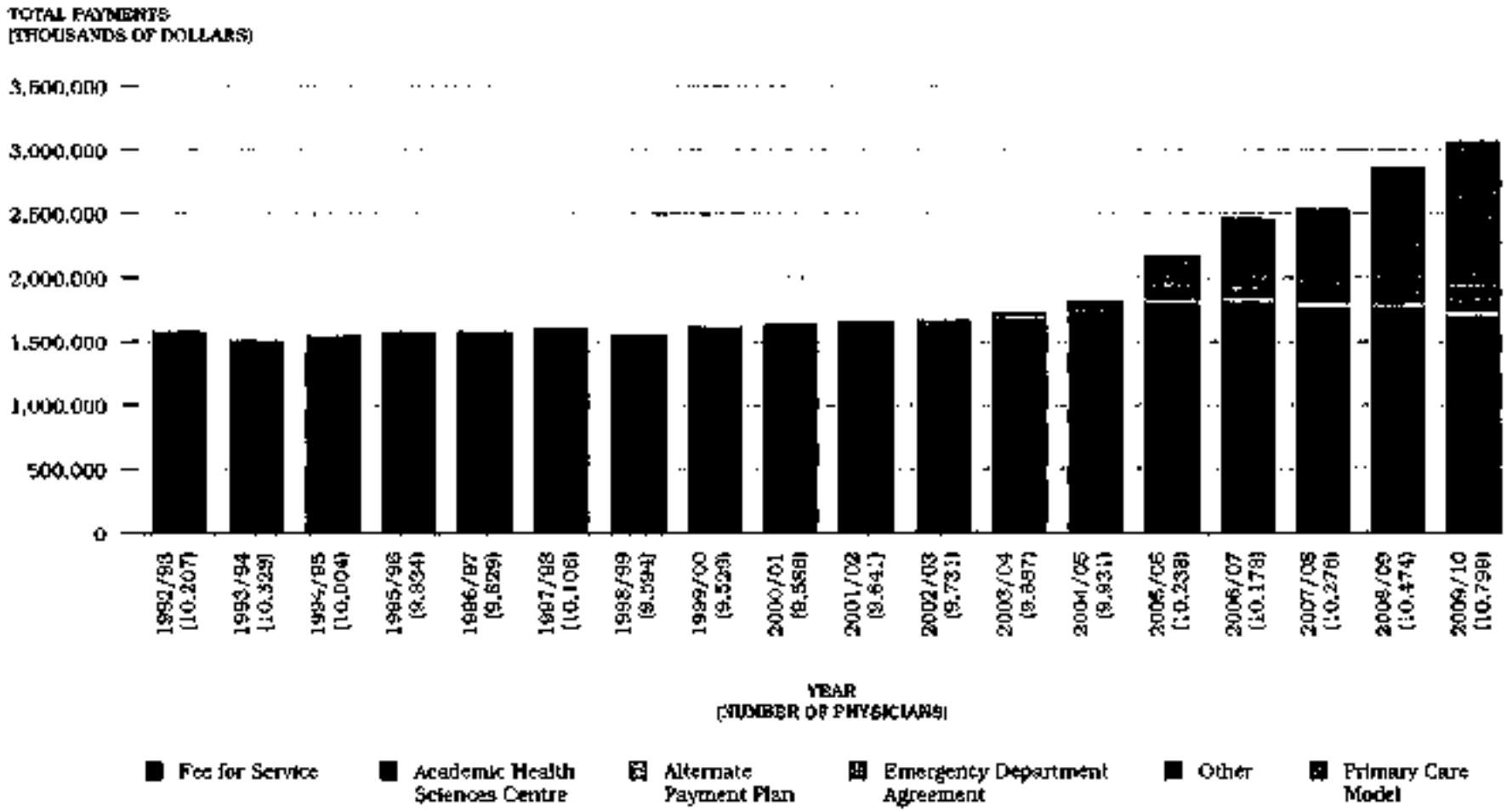
GENERAL PRACTITIONERS/FAMILY PHYSICIANS

EXHIBIT 4.2 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to GP/FPs, in Ontario, 1992/93 to 2009/10



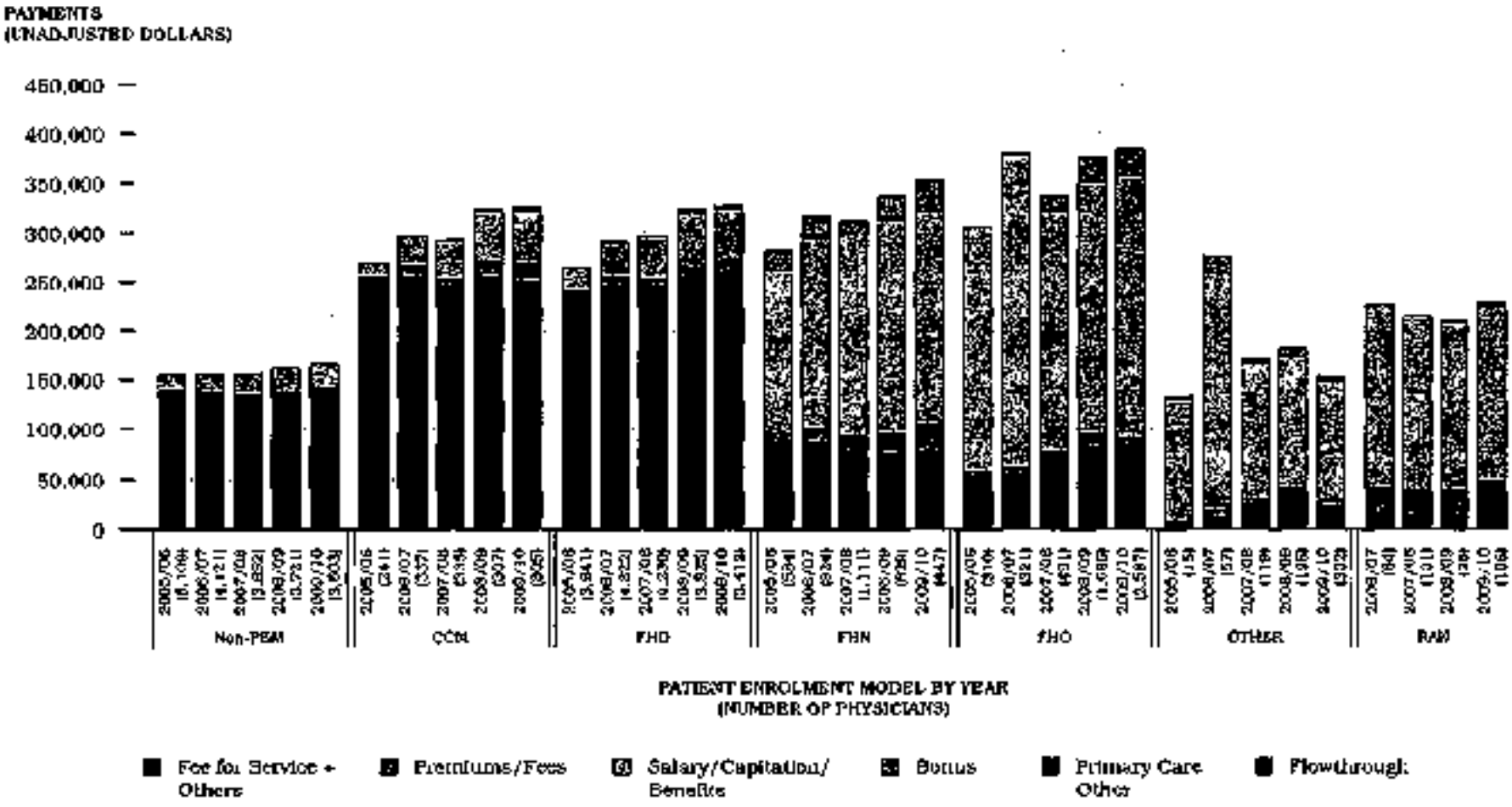
GENERAL PRACTITIONERS/FAMILY PHYSICIANS

EXHIBIT 4.3 Total payments to GP/FPs by payment source, in Ontario, 1992/93 to 2009/10



GENERAL PRACTITIONERS/FAMILY PHYSICIANS

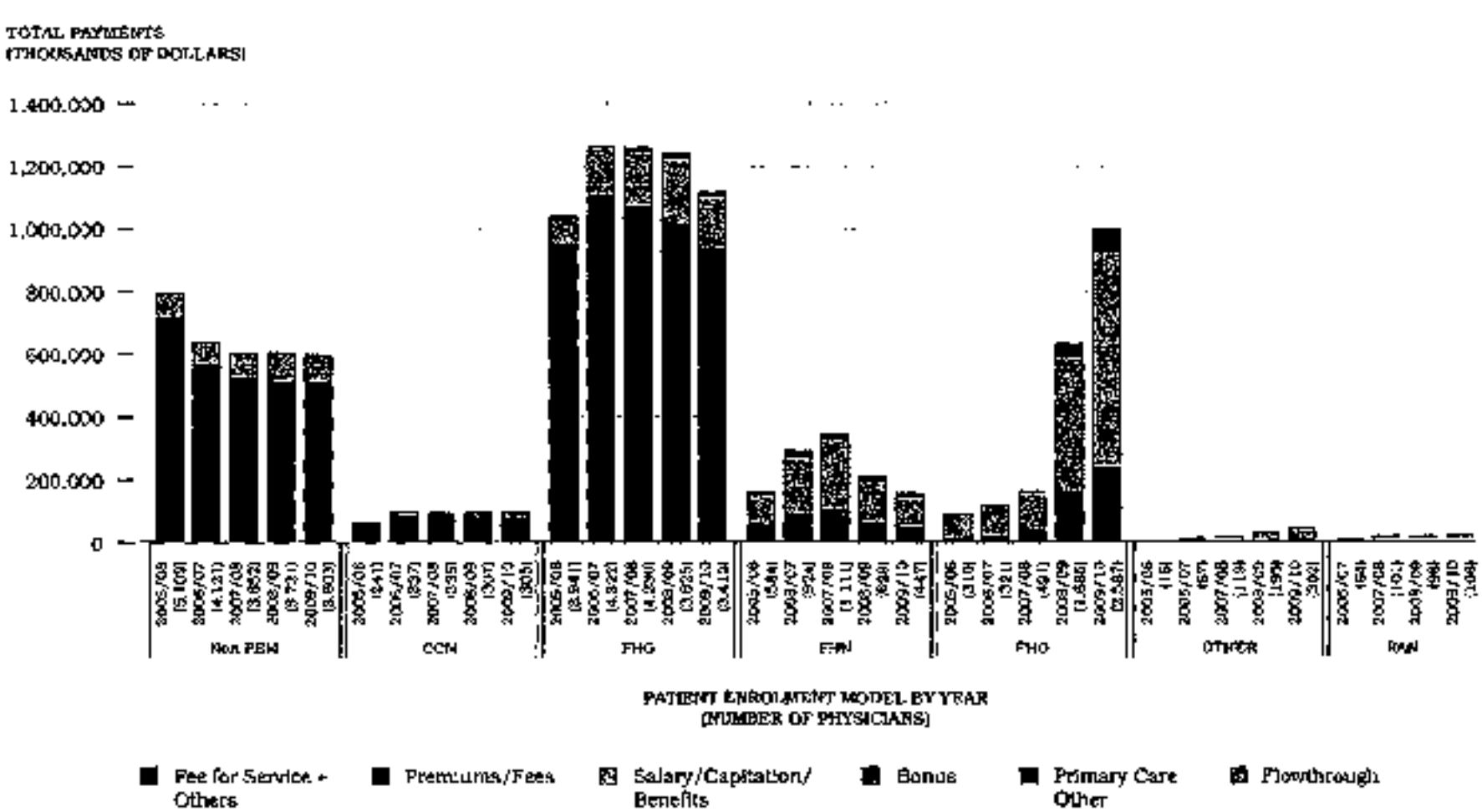
EXHIBIT 4.4 Mean payments (in unadjusted dollars) to GP/FPs by payment type and patient enrolment model, in Ontario, 2005/06 to 2009/10



Note: Each physician was assigned to only one payment model per year. Assignment was based on the physician's affiliation at the midpoint of each year.
Non-PEM = Not in a Patient Enrolment Model CCM = Comprehensive Care Model FHG = Family Health Group FHN = Family Health Network
FHO = Family Health Organization RAN = Rural-Northern Physician Group Agreement

GENERAL PRACTITIONERS/FAMILY PHYSICIANS

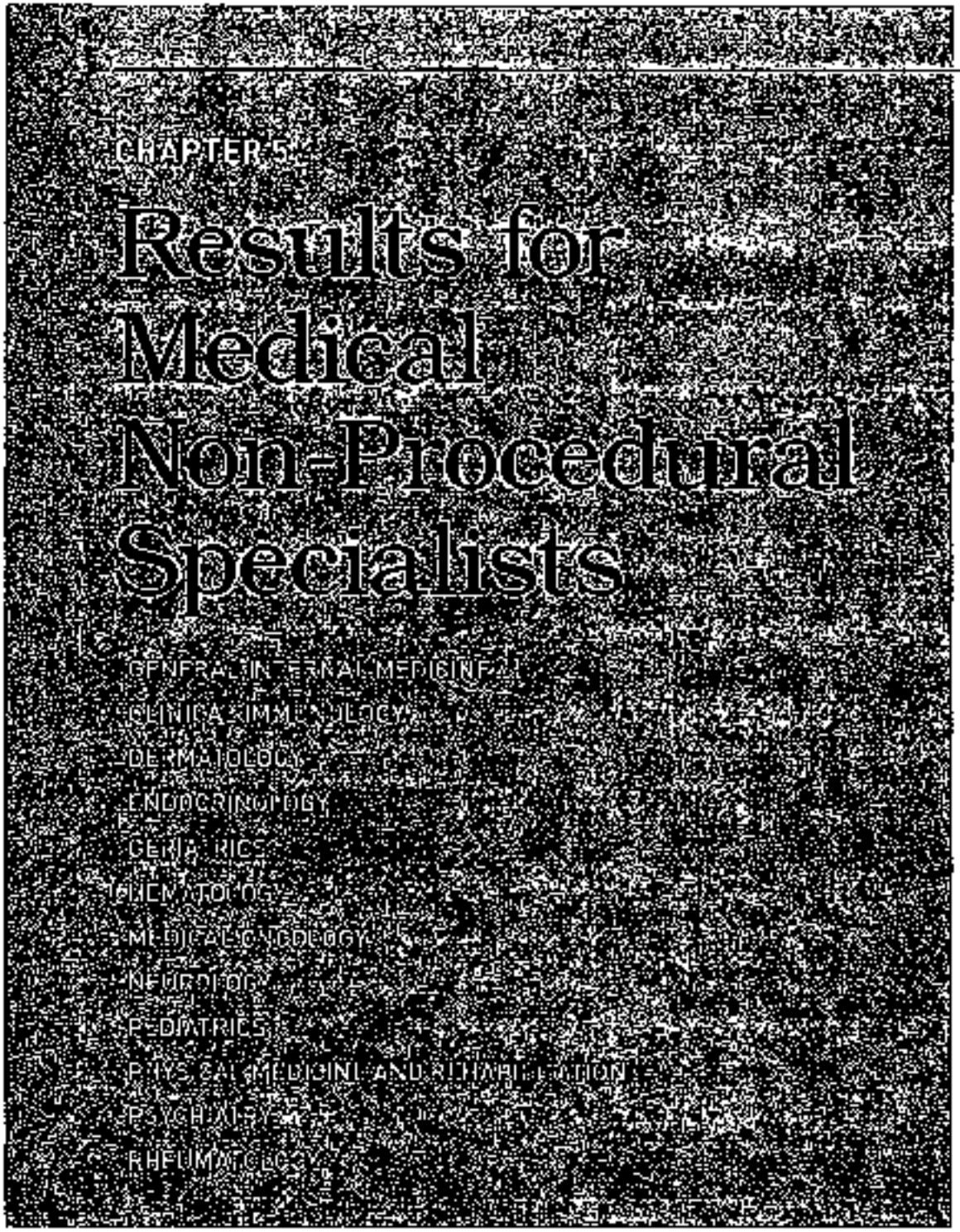
EXHIBIT 4.6 Total payments to GP/FPs by payment type and patient enrolment model, in Ontario, 2005/06 to 2009/10



Note: Each physician was assigned to only one payment model per year. Assignment was based on the physician's affiliation as the midpoint of each year.
Non-PEM = Not in a Patient Enrolment Model CCN = Comprehensive Care Model FHG = Family Health Group FHN = Family Health Network
FHO = Family Health Organization RAN = Rural-Northern Physician Group Agreement

CHAPTER 5

Results for Medical Non-Procedural Specialists



INTRODUCTION

Medical non-procedural specialists are specialist physicians whose clinical work does not involve procedures. Specialists such as internists, neurologists and endocrinologists may order tests, but their clinical work is primarily devoted to consultations and patient visits. By contrast, a gastroenterologist will often carry out both a consultation and a procedure (e.g., gastroscopy or colonoscopy) and may bill for both. In a fee-for-service (FFS) environment, this leads to higher payments to procedural specialists than to non-procedural specialists. This difference is exacerbated by factors such as the aging of the patient population and by technical advances that allow physicians to perform more procedures per day. Because of this, many non-procedural physicians are now part of a non-FFS payment plan, such as membership in an Alternate Payment Plan (APP) or Academic Health Sciences Centre (AHSC) group.

FINDINGS FOR INDIVIDUAL SPECIALTIES

General Internal Medicine (exhibits 5.1 to 5.3)

The number of general internists reached a nadir of 517 in 1999/00, then rose to 966 in 2009/10. Overall payments fell to approximately $80 million in 2003/04 and roughly trebled to over $240 million in 2009/10. In recent years, an increasing proportion of payments have been from non-FFS sources, but this remained at only 14% in 2009/10. Median payments to general internists remained flat through the 1990s and were below those to all physicians in Ontario throughout the study period. The distribution of payments was wide and included 25% that were below $100,000 annually. This suggests that either a large proportion of internists worked part-time or that some earned income from hospital salaries, which would not be captured in this report.

Clinical Immunology (exhibits 5.4 to 5.6)

This is a small specialty, and the total number in practice remained between 60 and 70 throughout the study period. Median payment was slightly higher than that of all physicians in Ontario. Mean payment in 2009/10 was 12% higher than that of all physicians. Ten percent of clinical immunologists were paid $600,000 or more (the second highest 90th percentile value in this group of specialties). FFS dominated with 92% of payments by this route.

Dermatology (exhibits 5.7 to 5.9)

The number of dermatologists in Ontario reached a nadir of 185 in 2006/07 and rose to 200 in 2009/10. The trend in total payments roughly paralleled supply, increasing from approximately $50 million in 2003/04 to approximately $78 million in 2009/10. The median annual payment to dermatologists remained flat at around $300,000 throughout the study period, somewhat higher than that of all physicians. However, the distribution widened substantially in recent years, with 25% of dermatologists paid more than $500,000 in 2009/10, and 10% paid more than $700,000 in that year. The mean annual payment rose to approximately $383,000 in 2009/10. These numbers do not take into account payments for cosmetic procedures or minor surgeries, which are not covered by OHIP. The great majority of public payments to dermatologists continue to be by FFS.

Endocrinology (exhibits 5.10 to 5.12)

The number of endocrinologists increased by around 70% during the study period, peaking at 174 in 2009/10. Median annual payments to individual endocrinologists remained slightly below those to all physicians throughout the study period. The mean payment per head and per full-time equivalent were almost identical and similar to the median value. From 2004/05 onward, a proportion of total payments were APP and AHSC payments, but the proportion of FFS payments was still high, reaching 88% in 2009/10.

Geriatrics (exhibits 5.13 to 5.15)

Geriatrics remains a small specialty in Ontario despite a doubling in the number of specialists to 102 in 2009/10, with total payments of approximately $26 million in that year. The median annual payment was flat at or below $100,000 through the 1990s, which may indicate that payment was also being received from other sources not included in our data. The data from 2005/06 onward are complete and indicate that the mean and median payments remained significantly below those of all physicians in Ontario. Although the majority of payments (65%) were still by FFS, the impact of alternate payment sources is clear for this specialty, with 28% (of the total) derived from APP and 6% from AHSC.

Hematology (exhibits 5.16 to 5.18)

The number of hematologists increased by about 50% during the study period reaching 152 in 2009/10, at a total cost of approximately $46 million in that year. Mean and median annual payments were lower than those for all physicians during most of the study period, not including any payments received from other sources not included in our data. The data from 2002/03 to 2004/05 are incomplete and have been censored. The data from 2005/06 onward are complete and show payments to individual hematologists that are similar to those for all physicians. Notably, in recent years the proportion of total payments from non-FFS sources has increased to about 50%.

Medical Oncology (exhibits 5.19 to 5.21)

The number of medical oncologists in Ontario more than doubled from 77 in 1992/93 to 187 in 2009/10, with total payments of just under $60 million in 2009/10. The data reveal that FFS payments were a relatively small component of payments to medical oncologists (less than 25% of the total). Payment levels were relatively low during the 1990s, because medical oncologists were at least partially paid out of hospital budgets. In the period for which we have complete data (2005/06 onward), mean and median annual payments to medical oncologists were similar to those made to all physicians. There was little variation in later years because most oncologists are now paid through a single APP, meaning the medians and 25th and 75th percentiles are very similar.

Neurology (exhibits 5.22 to 5.24)

During the study period, the number of neurologists in Ontario increased by 47%, reaching 295 in 2009/10, at a total cost of nearly $80 million in that year. Mean and median annual payments to neurologists remained fairly flat during most of the study period. Mean payments per head and per full-time equivalent rose to a lesser degree than those for all physicians after 2004/05 and remained significantly lower in 2009/10. The majority of payments (around 84%) were in the form of FFS.

Pediatrics (exhibits 5.25 to 5.27)

The number of active general pediatricians in Ontario increased by nearly 60% from 1992/93 reaching 1,165 in 2009/10, with total payments of over $300 million in that year. Although pediatricians comprise about 5% of all physicians, their total payments represent about 4% of total payments to physicians. Mean and median annual payments to pediatricians remained below those to all physicians, particularly in the later years. In 2009/10, general pediatricians received about 57% of payments from FFS, 37% from APPs and the remainder from other non-FFS sources. Pediatricians who worked in children's hospitals, such as the Hospital for Sick Children and the Children's Hospital of Eastern Ontario, were paid from APPs, while community-based pediatricians were paid primarily through FFS.

Physical Medicine and Rehabilitation (exhibits 5.28 to 5.30)

The number of physical medicine and rehabilitation specialists increased by 52% to 164 over the study period. Total payments in 2009/10 were approximately $40 million. Mean and median annual payments remained below those to all physicians throughout the study period. Around 81% of payments were from FFS, 10% from AHSC and the remainder from other non-FFS sources.

Psychiatry
(exhibits 5.31 to 5.33)

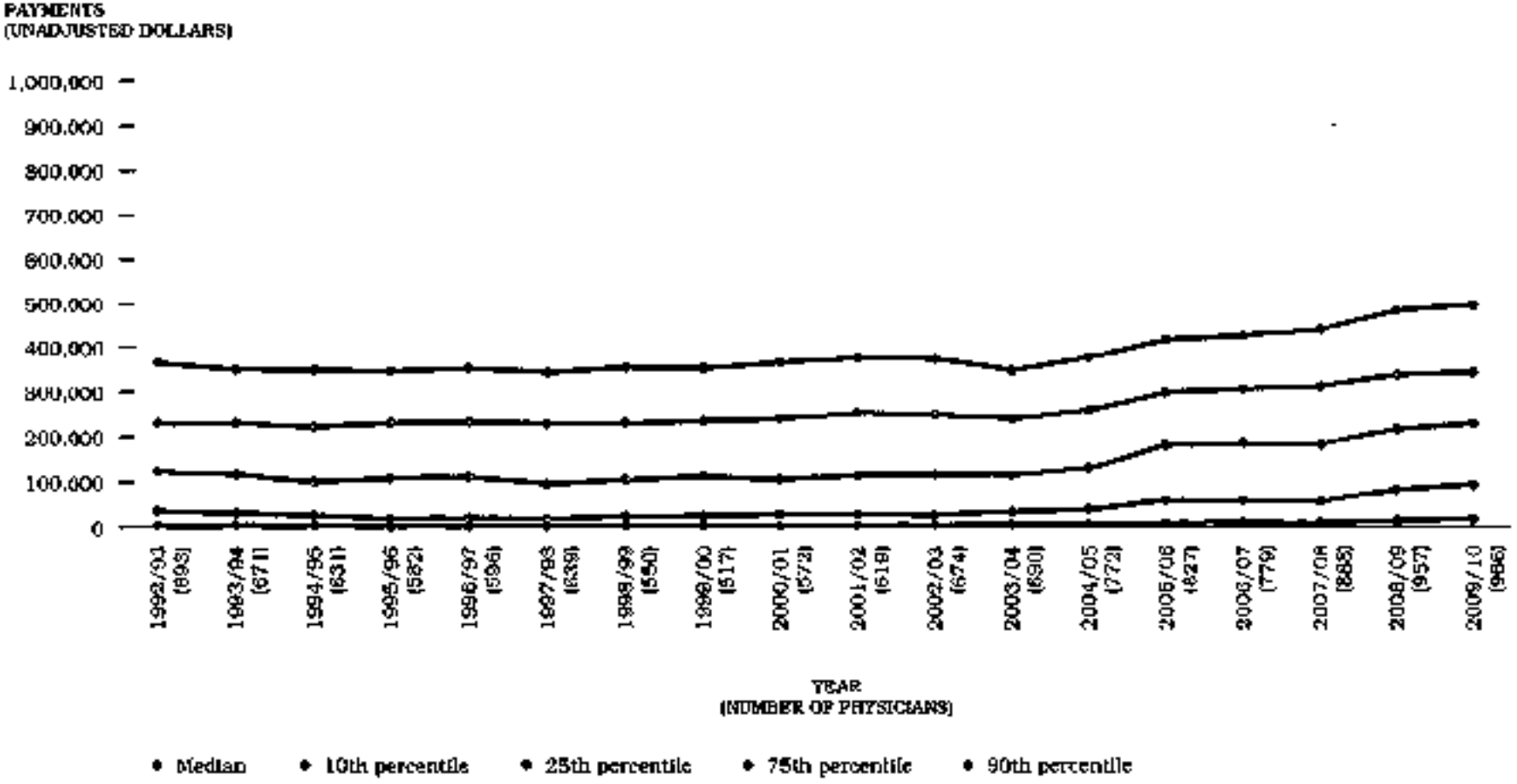
After general practice/family medicine, psychiatry is the second most populous specialty in Ontario, comprising about 8% of active physicians in 2009/10. This represents an increase of 25% since 1992/93. Total payments were over $350 million in 2009/10. It is important to realize that these numbers do not include direct payments by hospitals to psychiatrists or payments of mental health sessional fees managed directly by the Local Health Integration Networks in recent years. From the data accumulated for this study, we calculated that mean and median annual payments to psychiatrists remained fairly constant until 2004/05 and then rose modestly. These values (which we know are underestimates) are well below the average values for all physicians in Ontario. Most of these payments were from FFS with approximately 15% coming from other sources.

Rheumatology
(exhibits 5.34 to 5.36)

The number of rheumatologists increased by 38% during the study period, to a total of 160. Total payments to this specialty were nearly $50 million in 2009/10. During the 1990s, mean and median annual payments to rheumatologists were similar to those for all Ontario physicians combined, and they increased at approximately the same rate as for all physicians after 2004/05. Only a small proportion of payments was from non-FFS sources.

GENERAL INTERNISTS

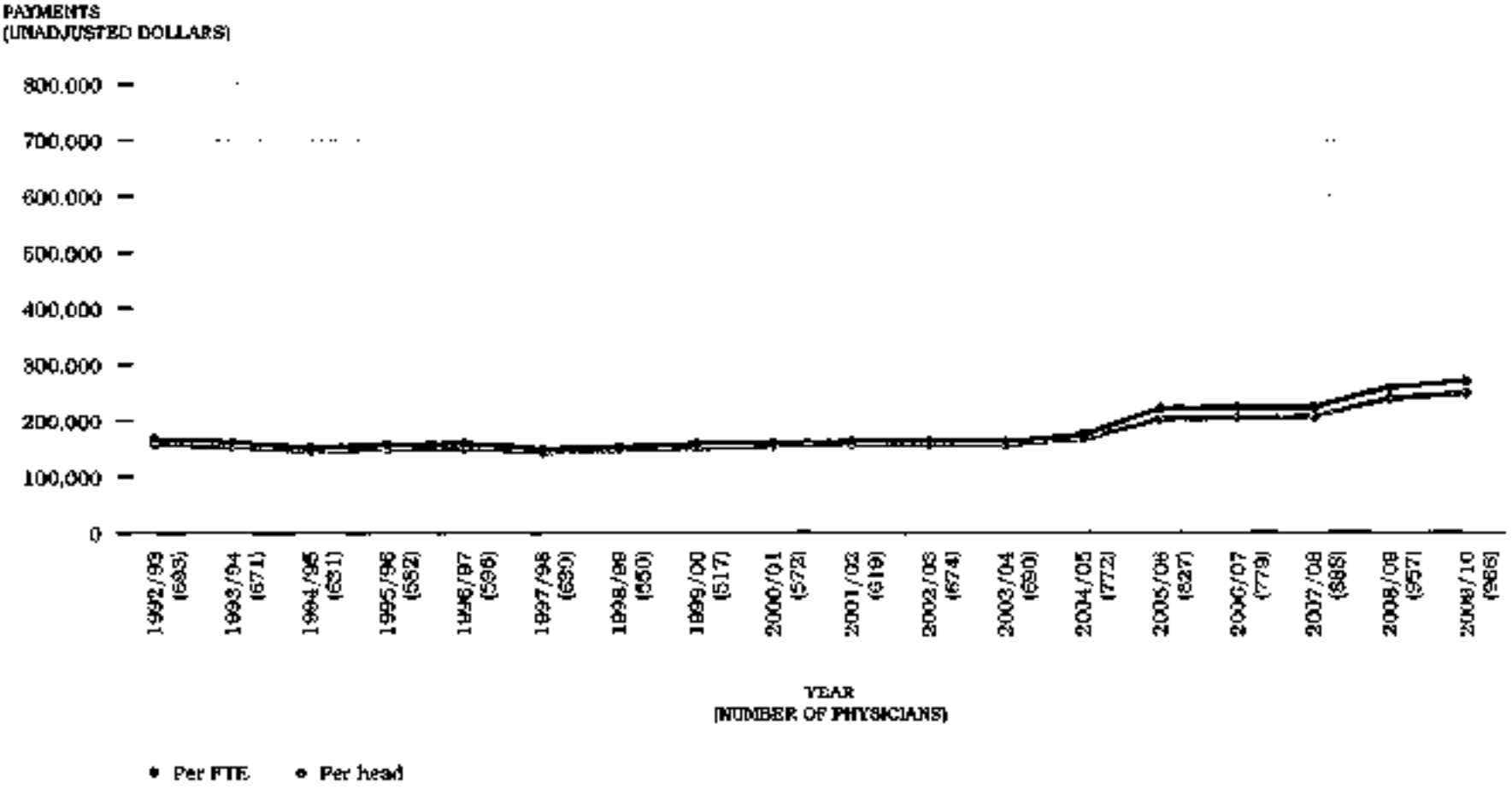
EXHIBIT 5.1 Median and percentiles of payments (in unadjusted dollars) to individual general internists in Ontario, 1992/93 to 2009/10



Note: Data from 2000/02 to 2004/05 should be treated with caution due to missing APP payment information.

GENERAL INTERNISTS

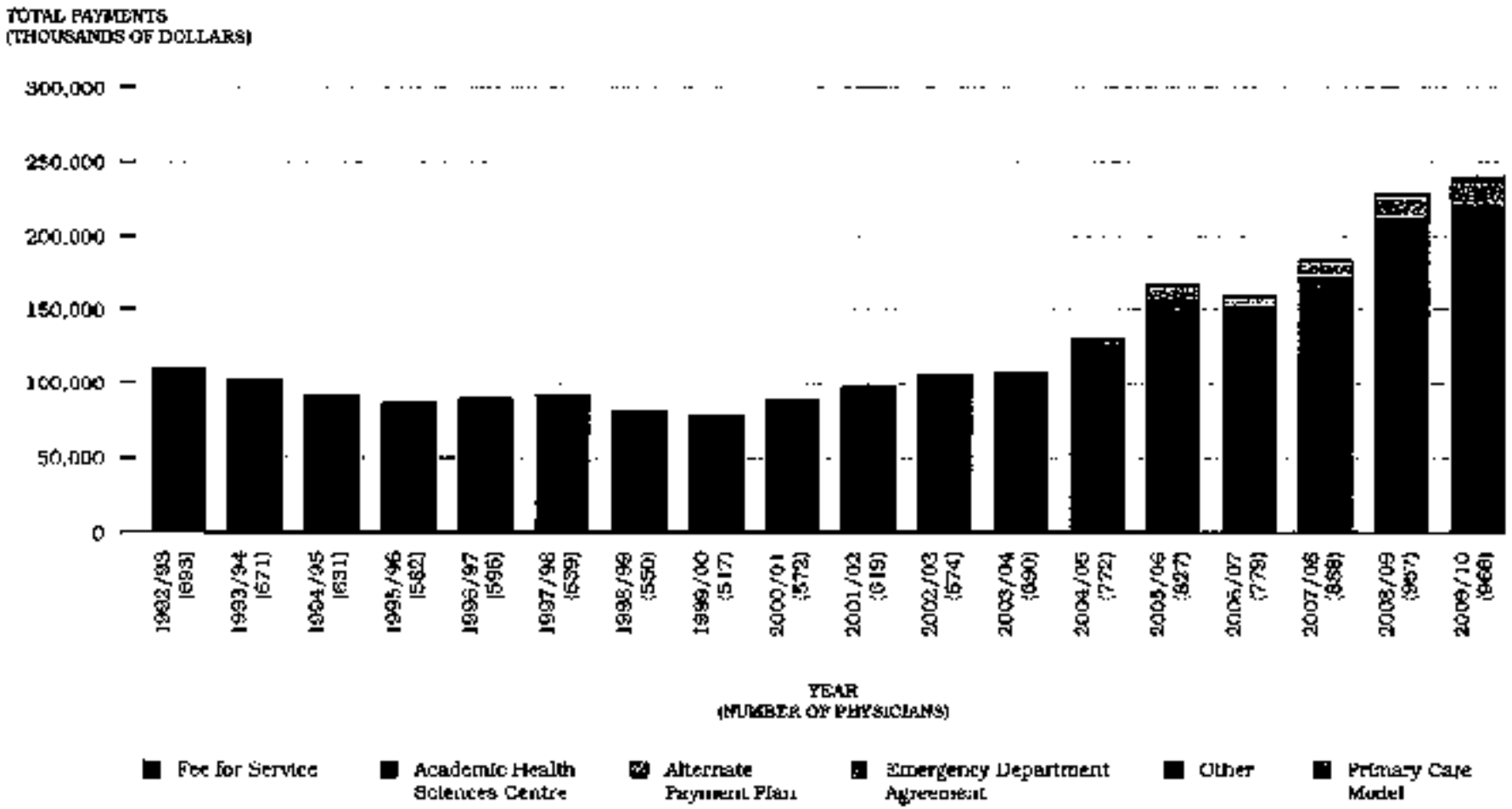
EXHIBIT 5.2 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to general internists, in Ontario, 1992/93 to 2009/10



Note: Data from 2005/06 to 2004/05 should be treated with caution due to missing APP payment information

GENERAL INTERNISTS

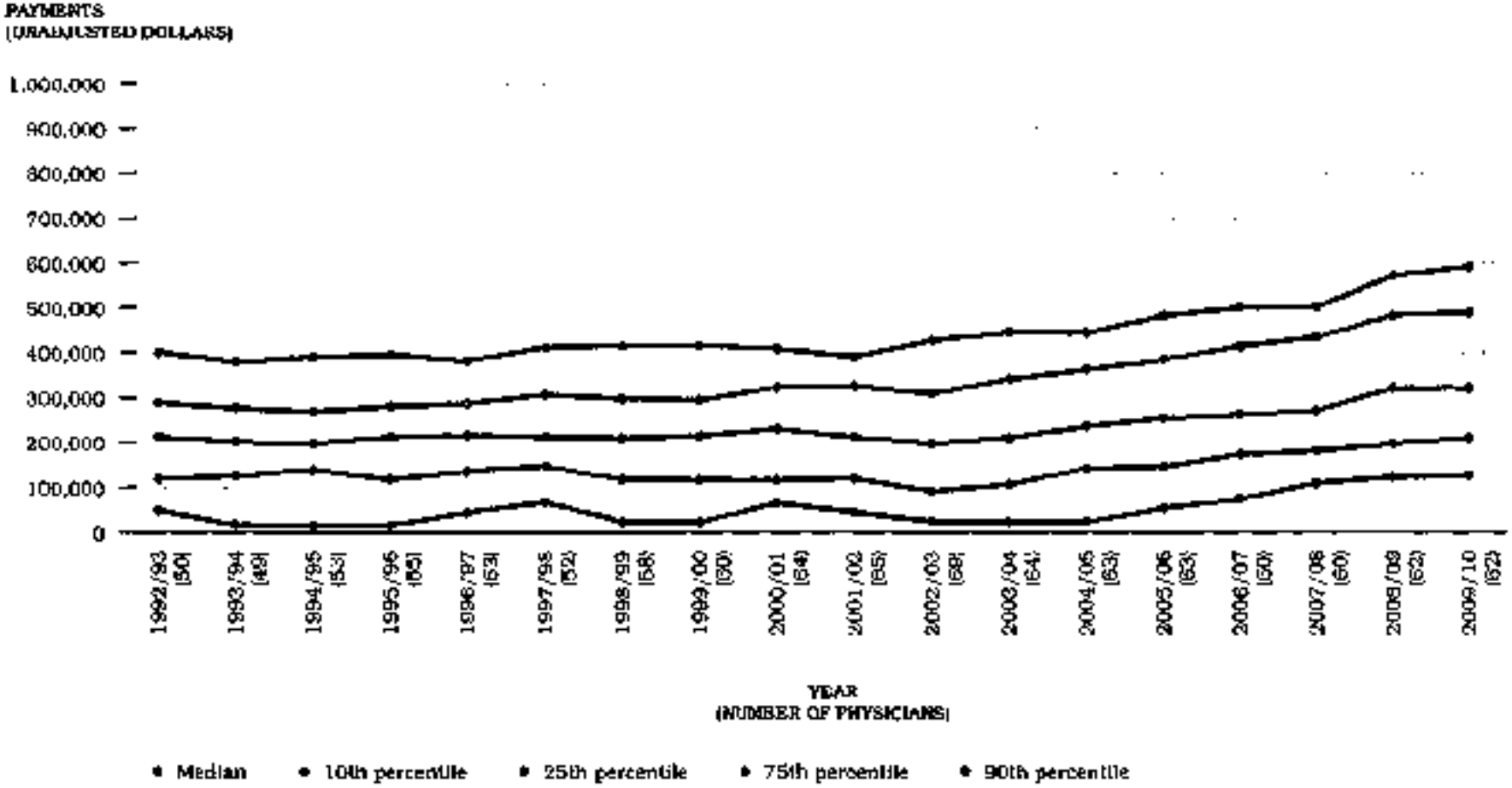
EXHIBIT 5.3 Total payments to general internists by payment source, in Ontario, 1992/93 to 2009/10



Note: Data from 2003/02 to 2004/05 should be treated with caution due to missing APP payment information

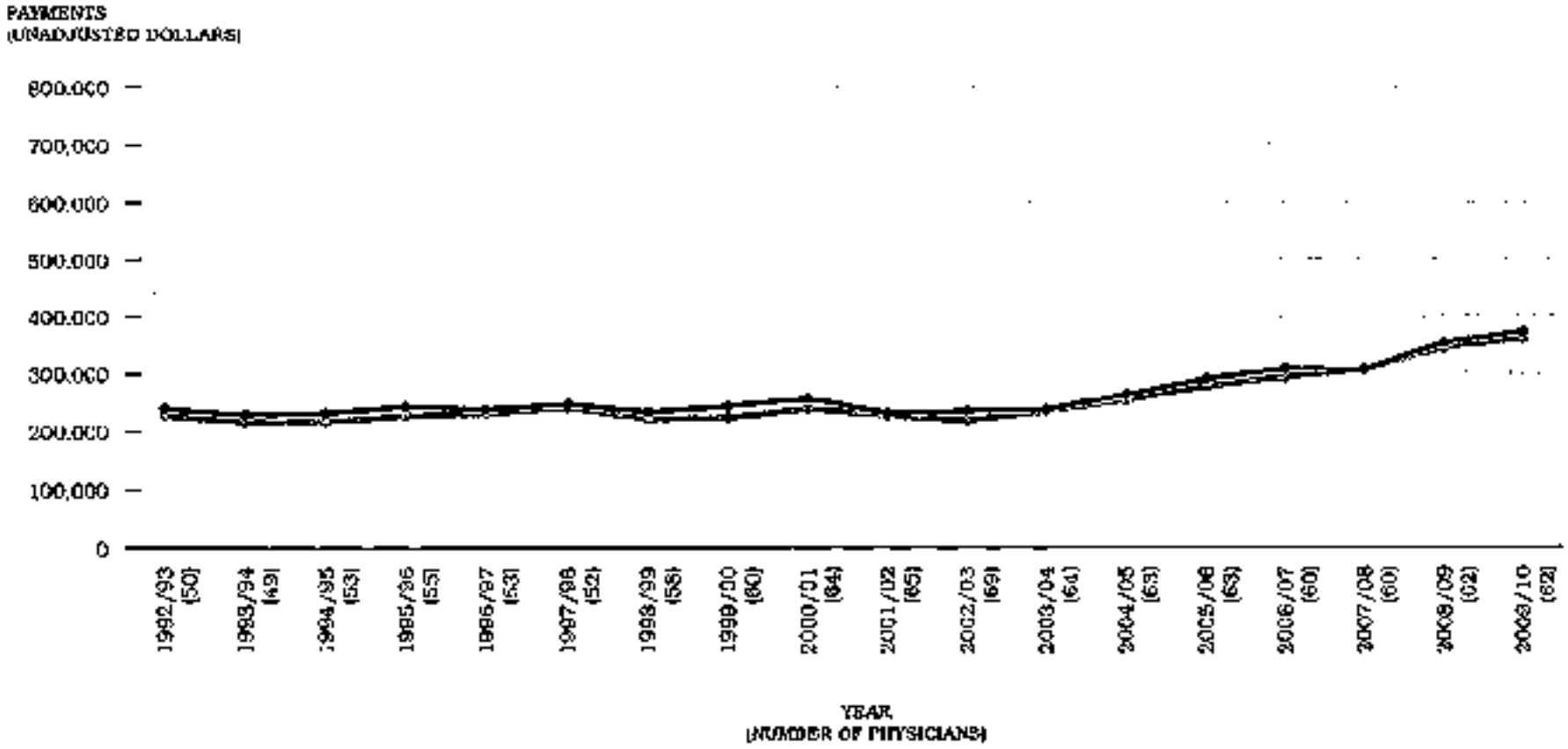
CLINICAL IMMUNOLOGISTS

EXHIBIT 5.4 Median and percentiles of payments (in unadjusted dollars) to individual clinical immunologists, in Ontario, 1992/93 to 2009/10



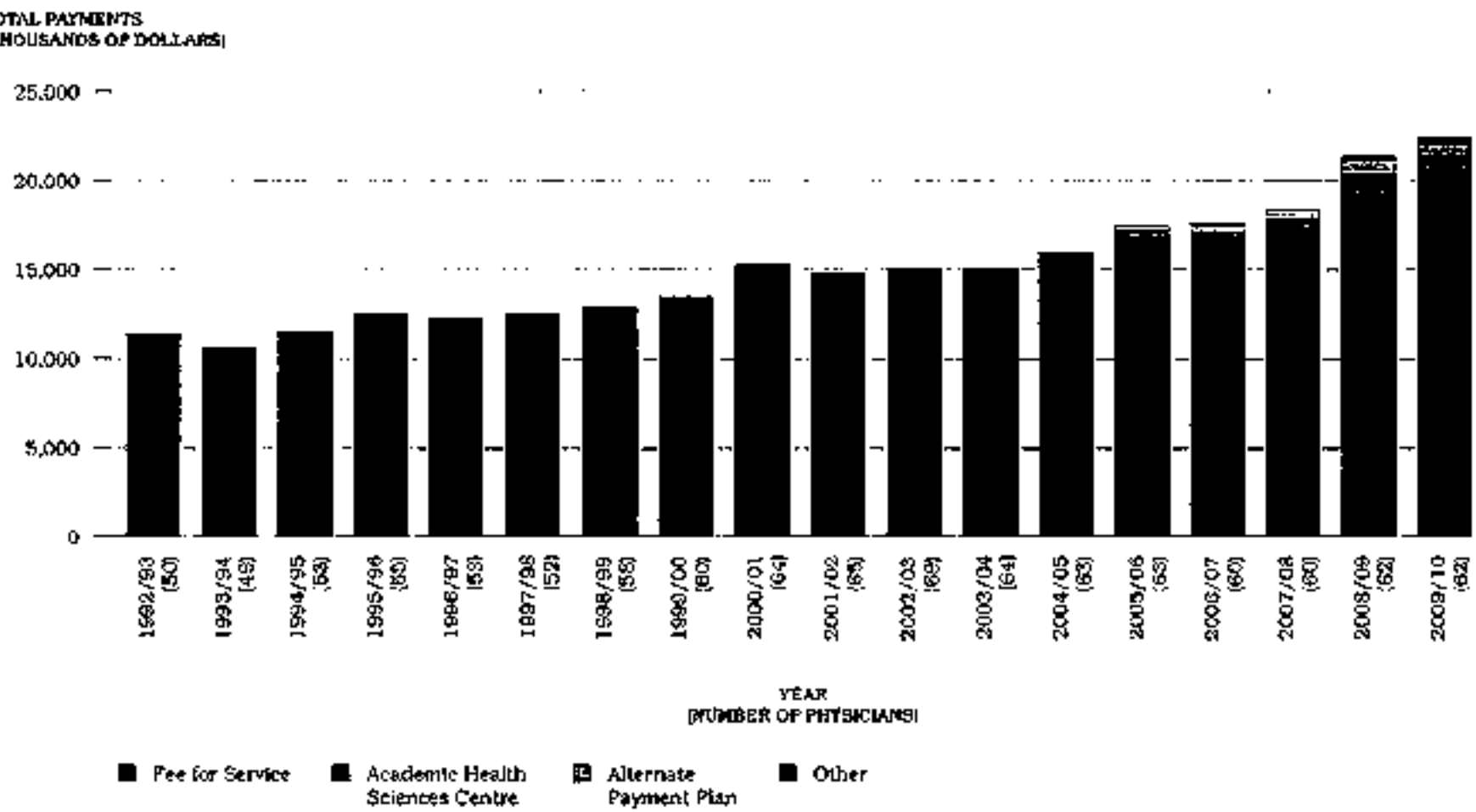
CLINICAL IMMUNOLOGISTS

EXHIBIT 5.5 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to clinical immunologists in Ontario, 1992/93 to 2009/10



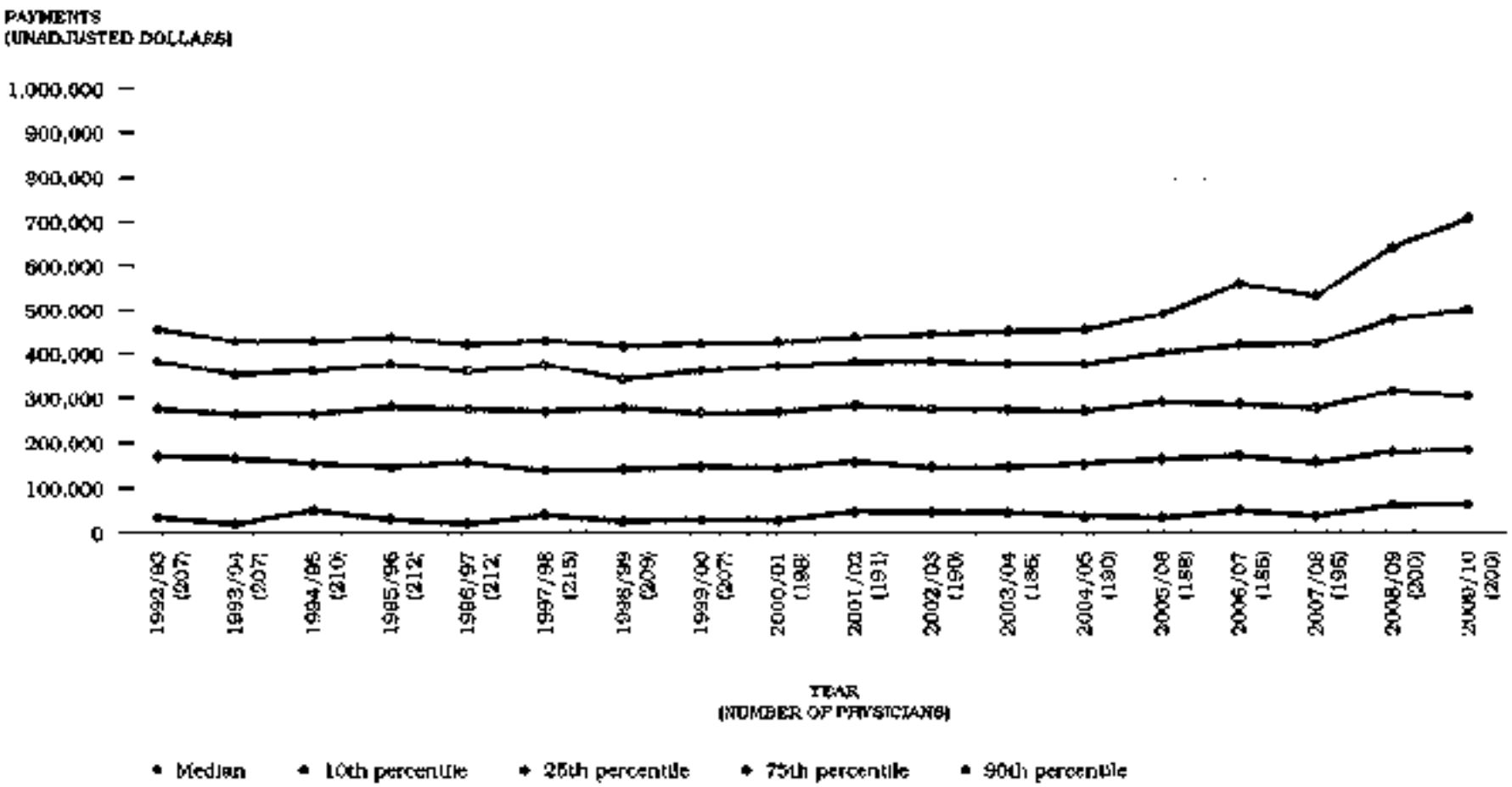
CLINICAL IMMUNOLOGISTS

EXHIBIT 5.6 Total payments to clinical immunologists by payment source, in Ontario, 1992/93 to 2009/10



DERMATOLOGISTS

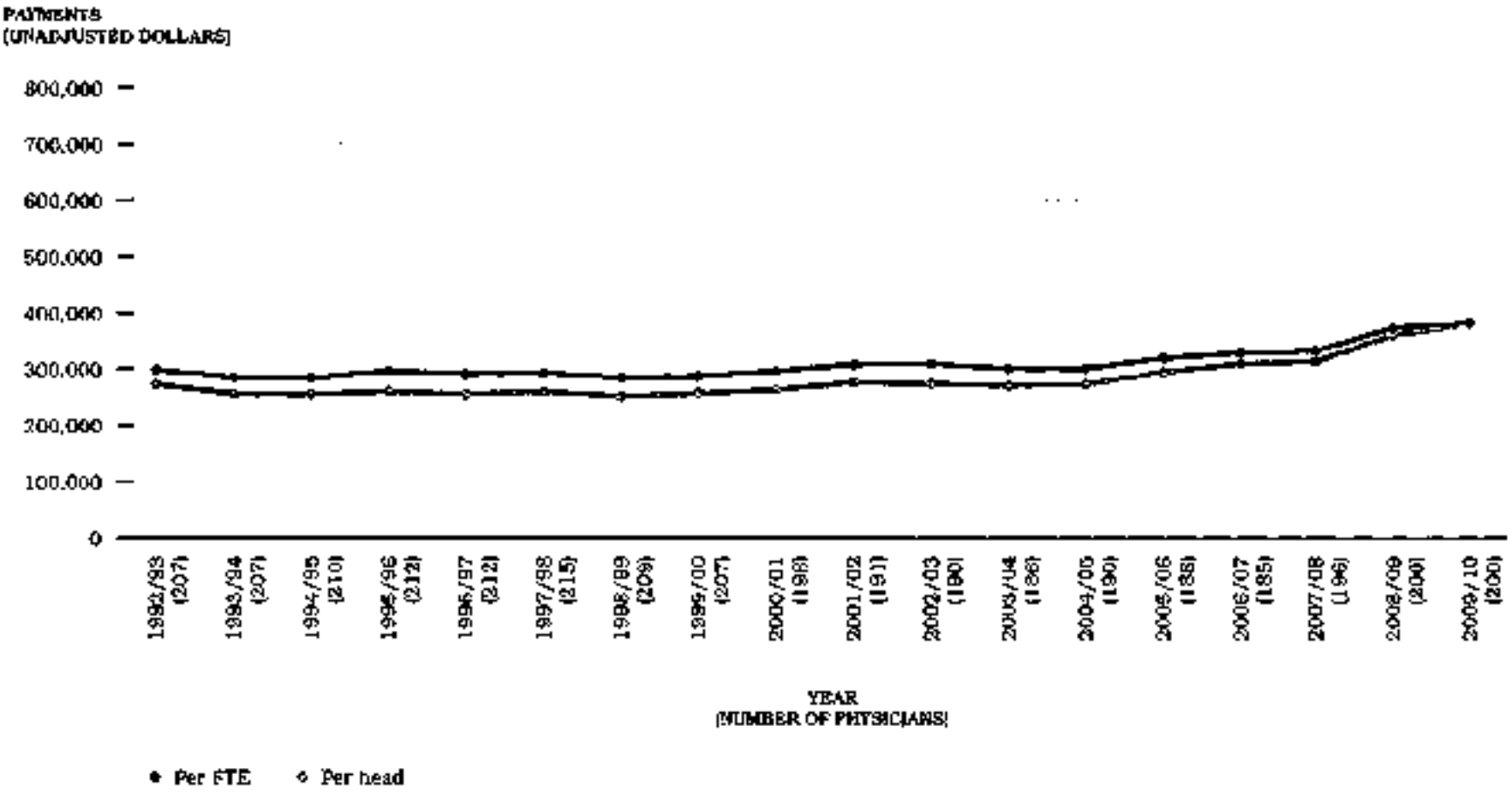
EXHIBIT 5.7 Median and percentiles of payments (in unadjusted dollars) to individual dermatologists, in Ontario, 1992/93 to 2009/10



Note. Data exclude payments for OHIP-insured services only and do not reflect payments for cosmetic procedures and other non-insured services.

DERMATOLOGISTS

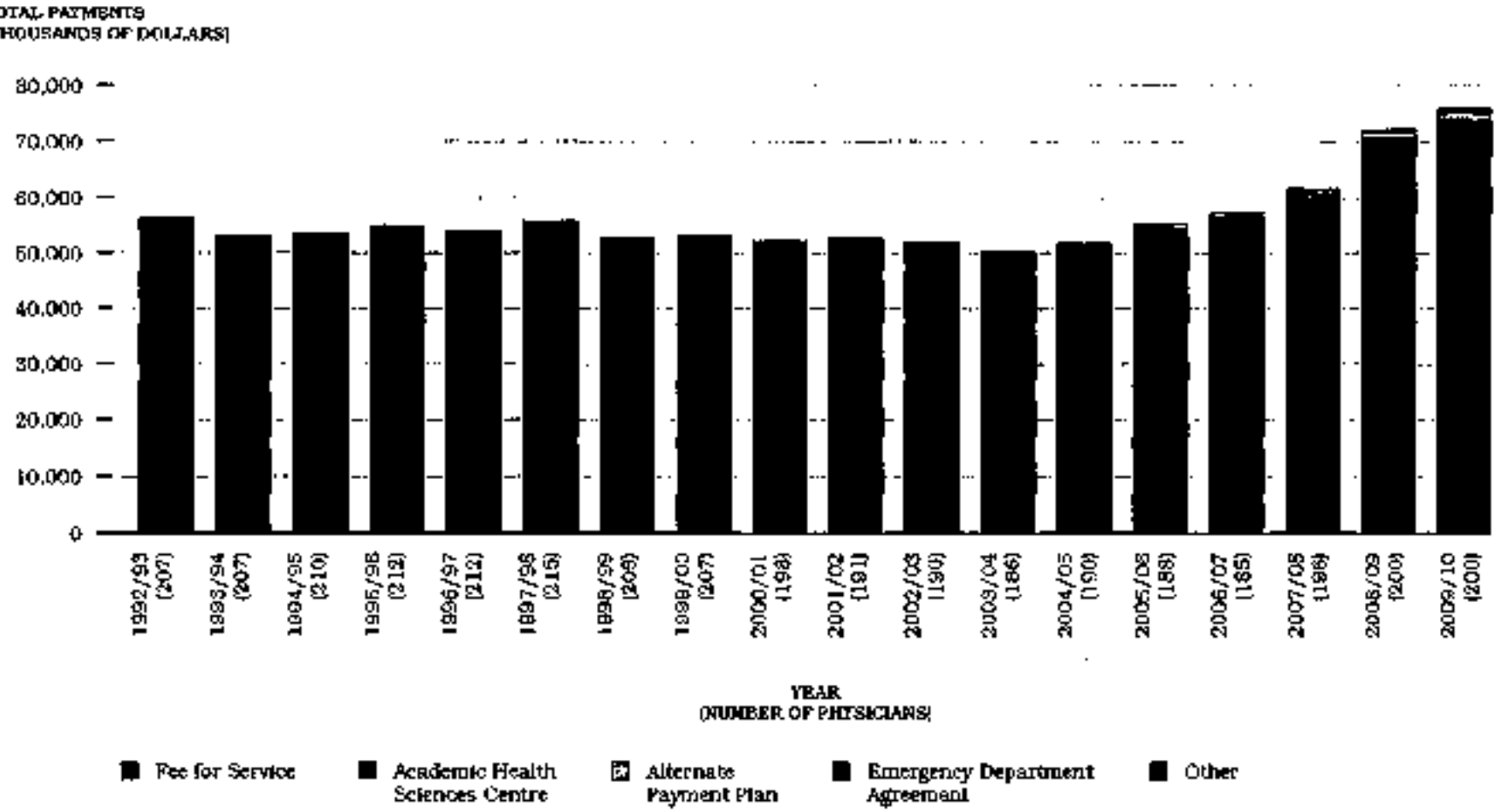
EXHIBIT 5.8 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to dermatologists, in Ontario, 1992/93 to 2009/10



Note: Data include payments for OHIP-insured services only and do not reflect payments for cosmetic procedures and other non-insured services.

DERMATOLOGISTS

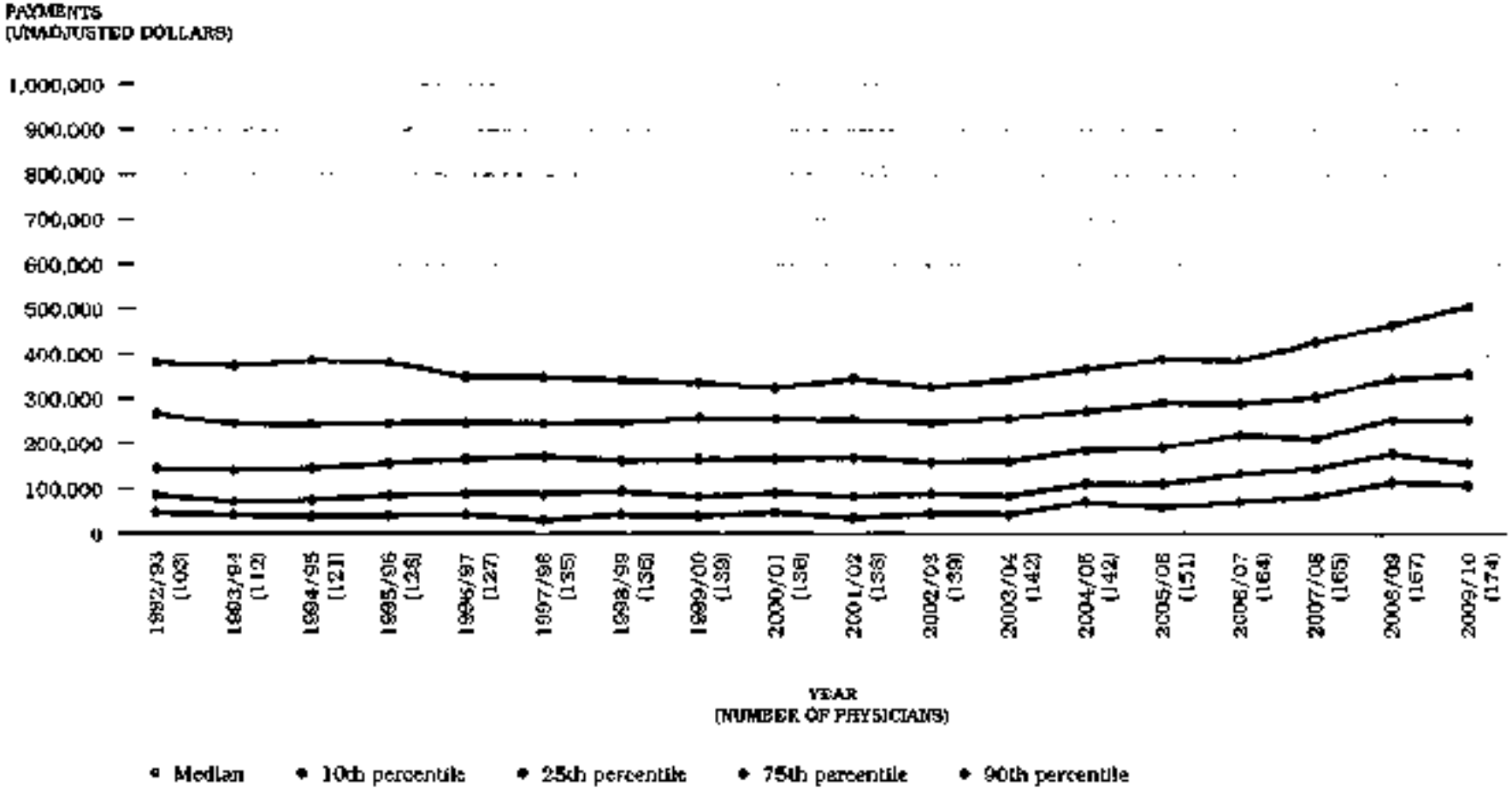
EXHIBIT 5.9 Total payments to dermatologists by payment source, in Ontario, 1992/93 to 2009/10



Note: Data include payments for OHIP-insured services only and do not reflect payments for cosmetic procedures and other non-insured services.

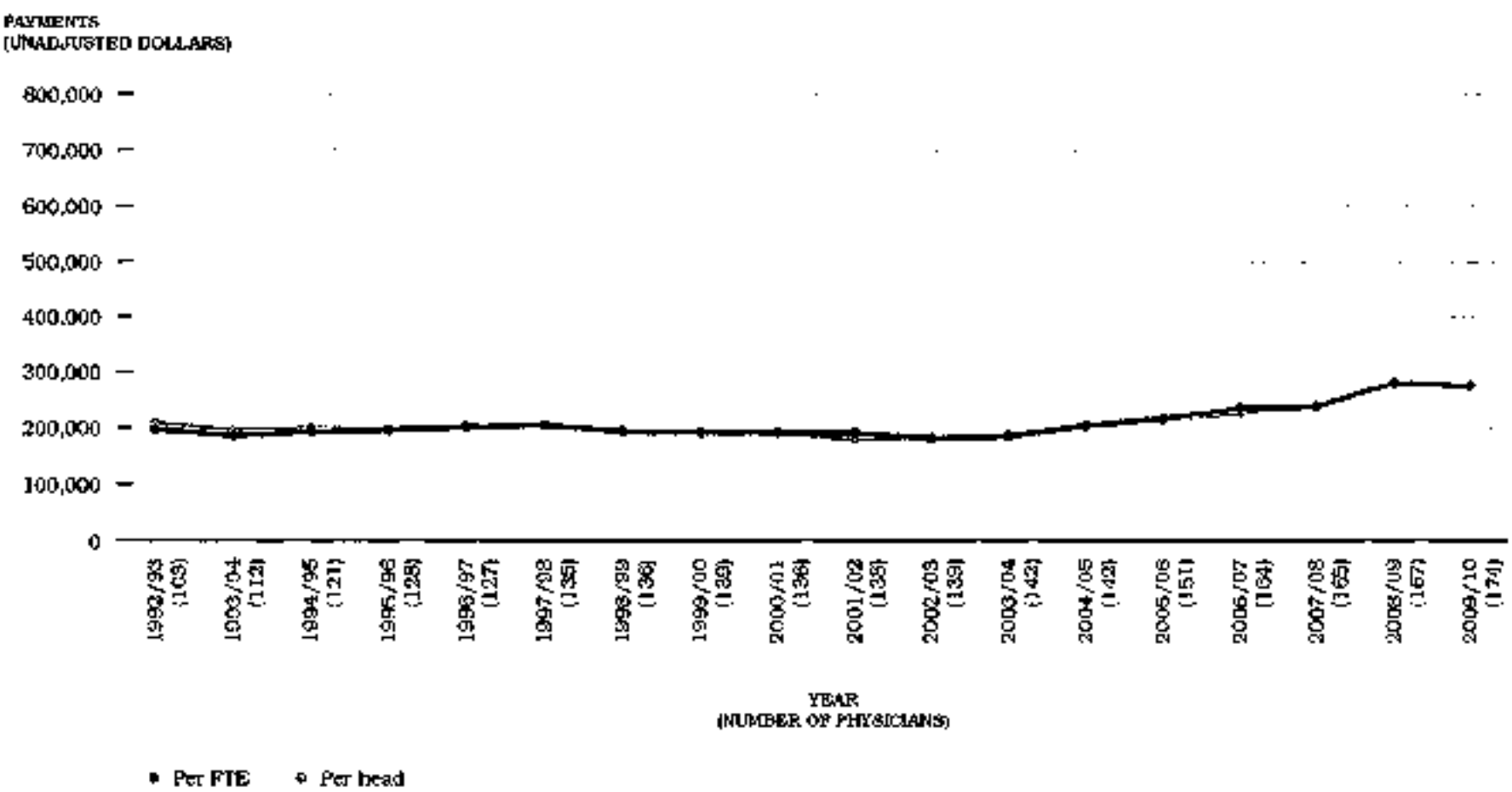
ENDOCRINOLOGISTS

EXHIBIT 5.10 Median and percentiles of payments (in unadjusted dollars) to individual endocrinologists in Ontario, 1992/93 to 2009/10



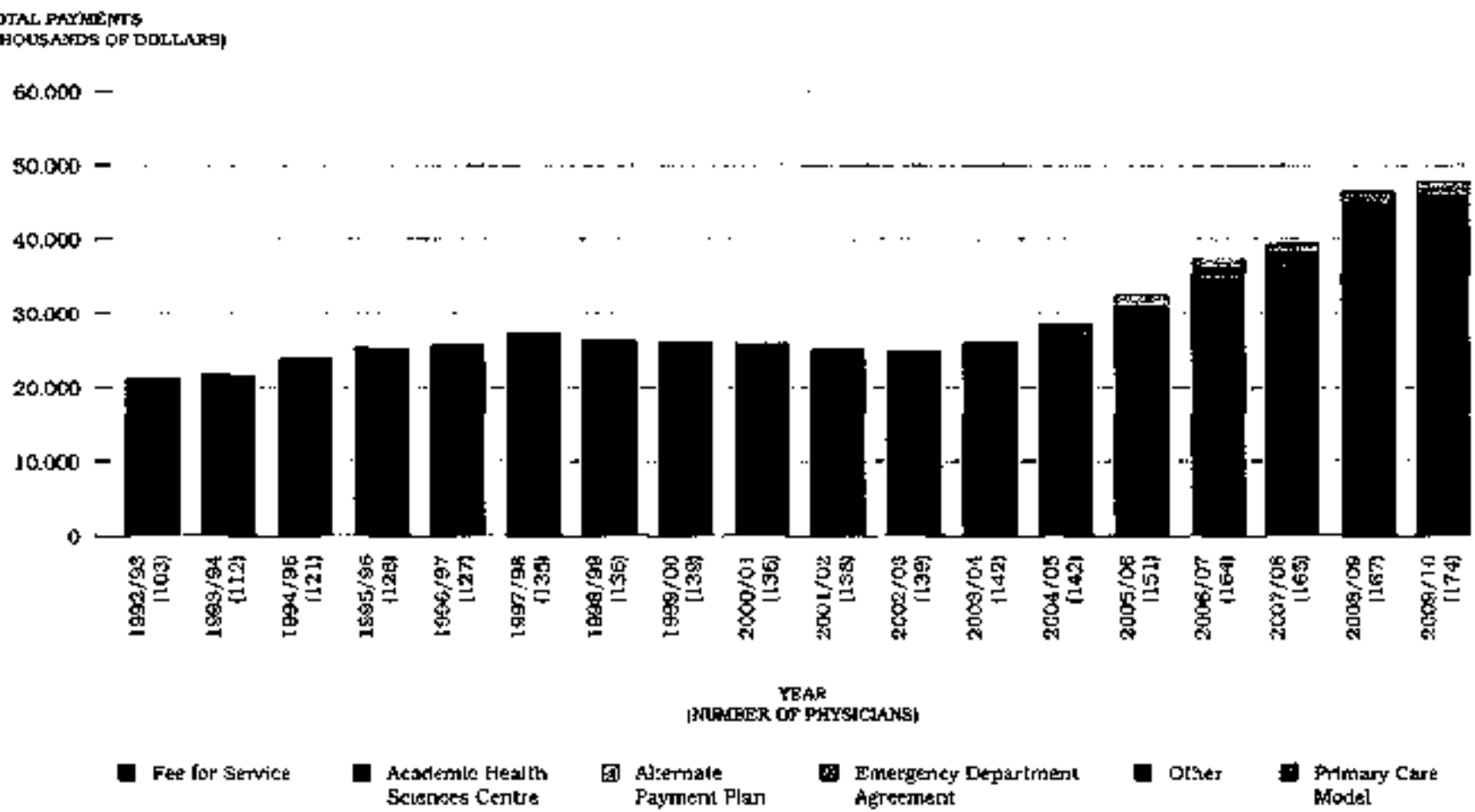
ENDOCRINOLOGISTS

EXHIBIT 5.11 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to endocrinologists, in Ontario, 1992/93 to 2009/10



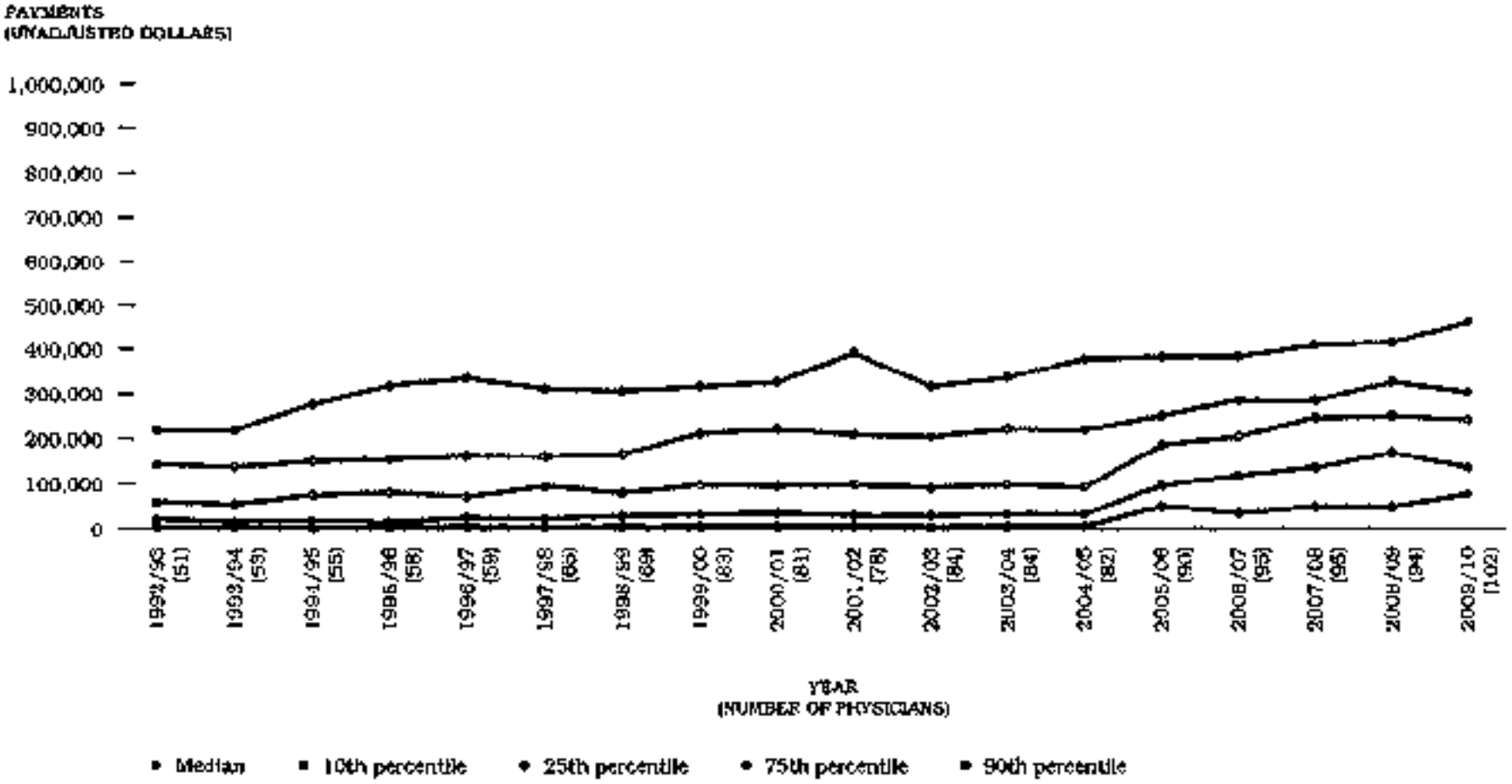
ENDOCRINOLOGISTS

EXHIBIT 5.12 Total payments to endocrinologists by payment source, in Ontario, 1992/93 to 2009/10



GERIATRICIANS

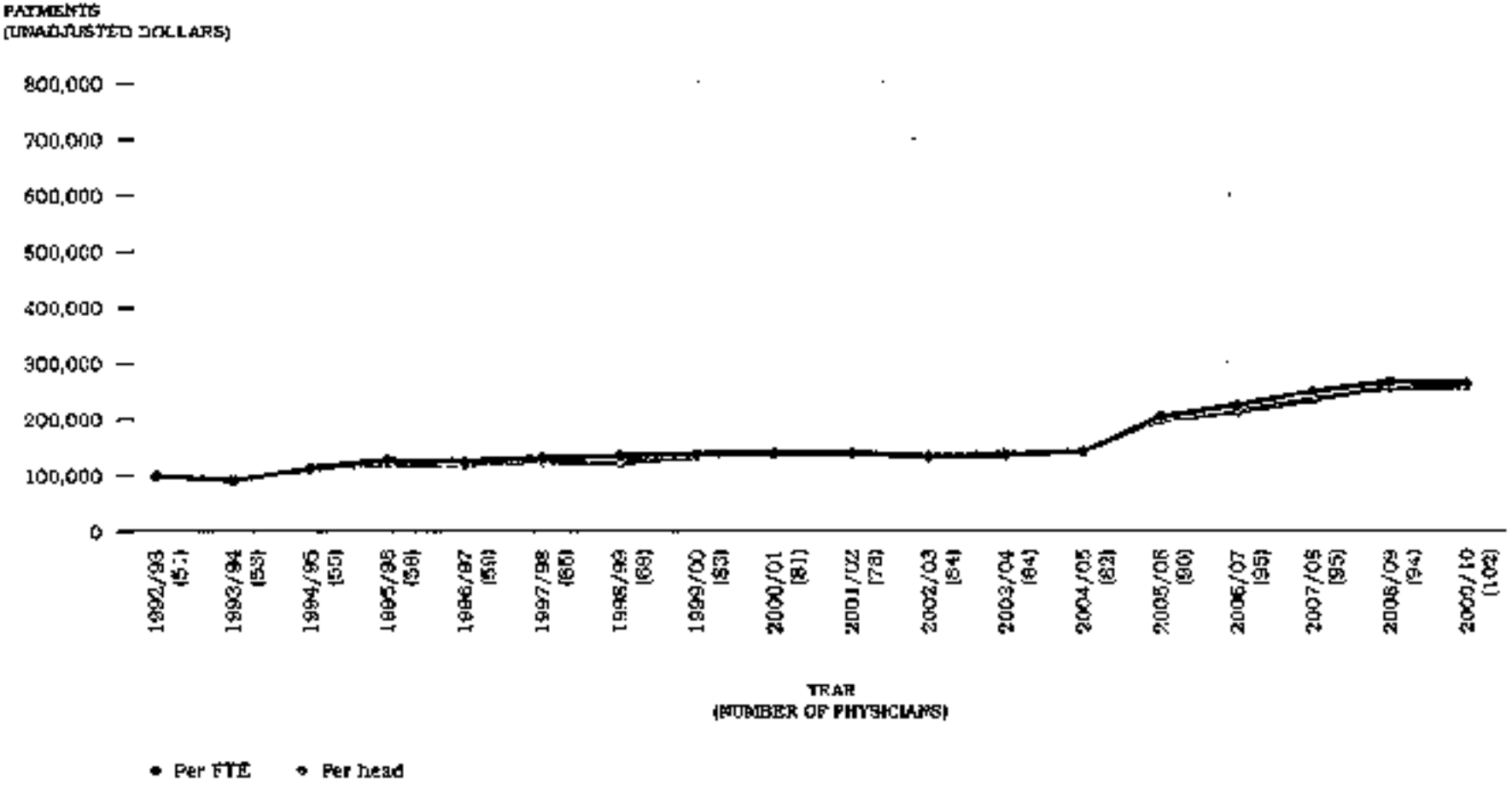
EXHIBIT 5.13 Median and percentiles of payments (in unadjusted dollars) to individual geriatricians, in Ontario, 1992/93 to 2009/10



Note: Data prior to 2005/06 may be incomplete and should be treated with caution.

GERIATRICIANS

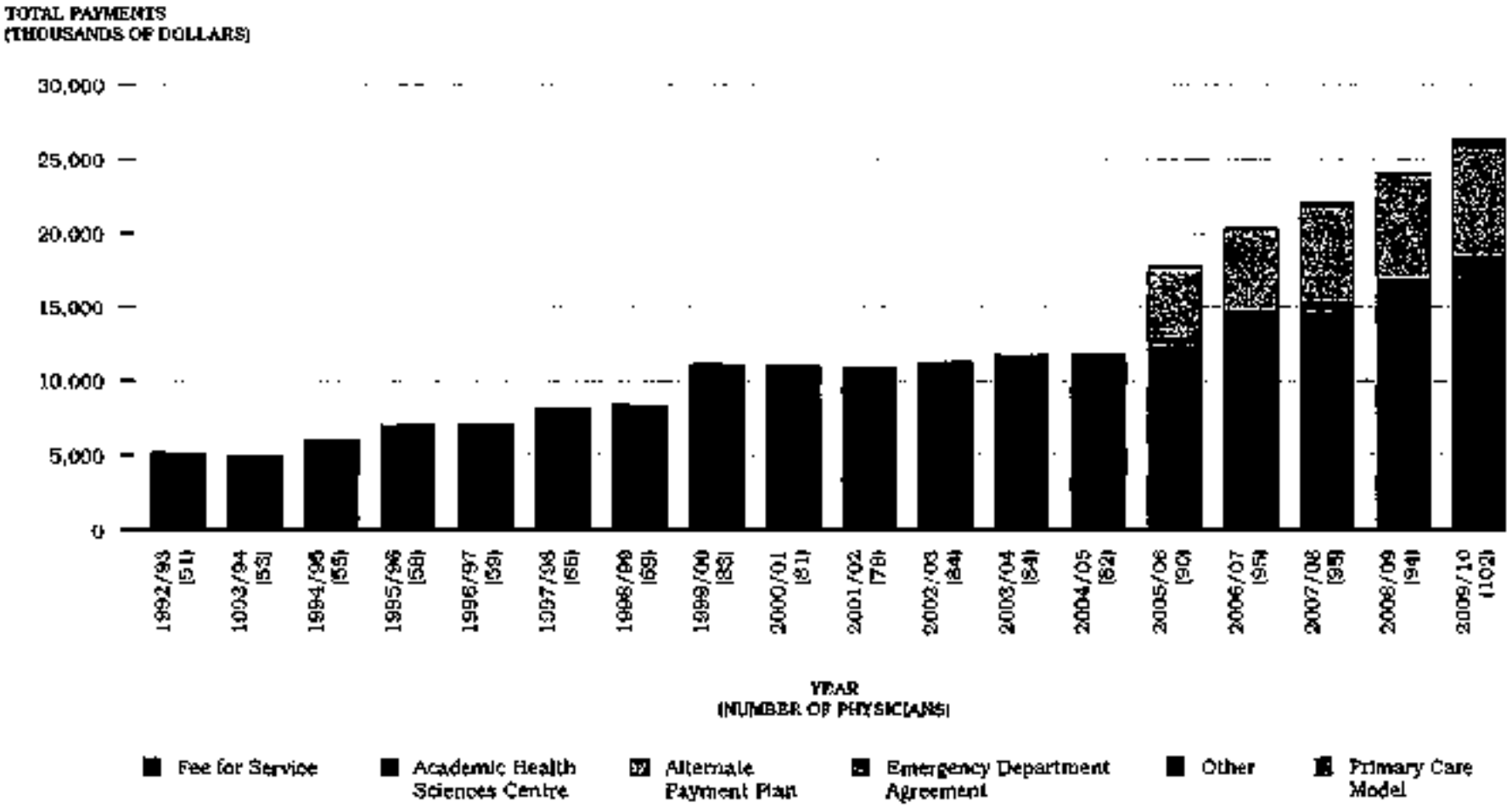
EXHIBIT 5.14 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to geriatricians, in Ontario, 1992/93 to 2009/10



Note: Data prior to 2005/06 may be incomplete and should be treated with caution.

GERIATRICIANS

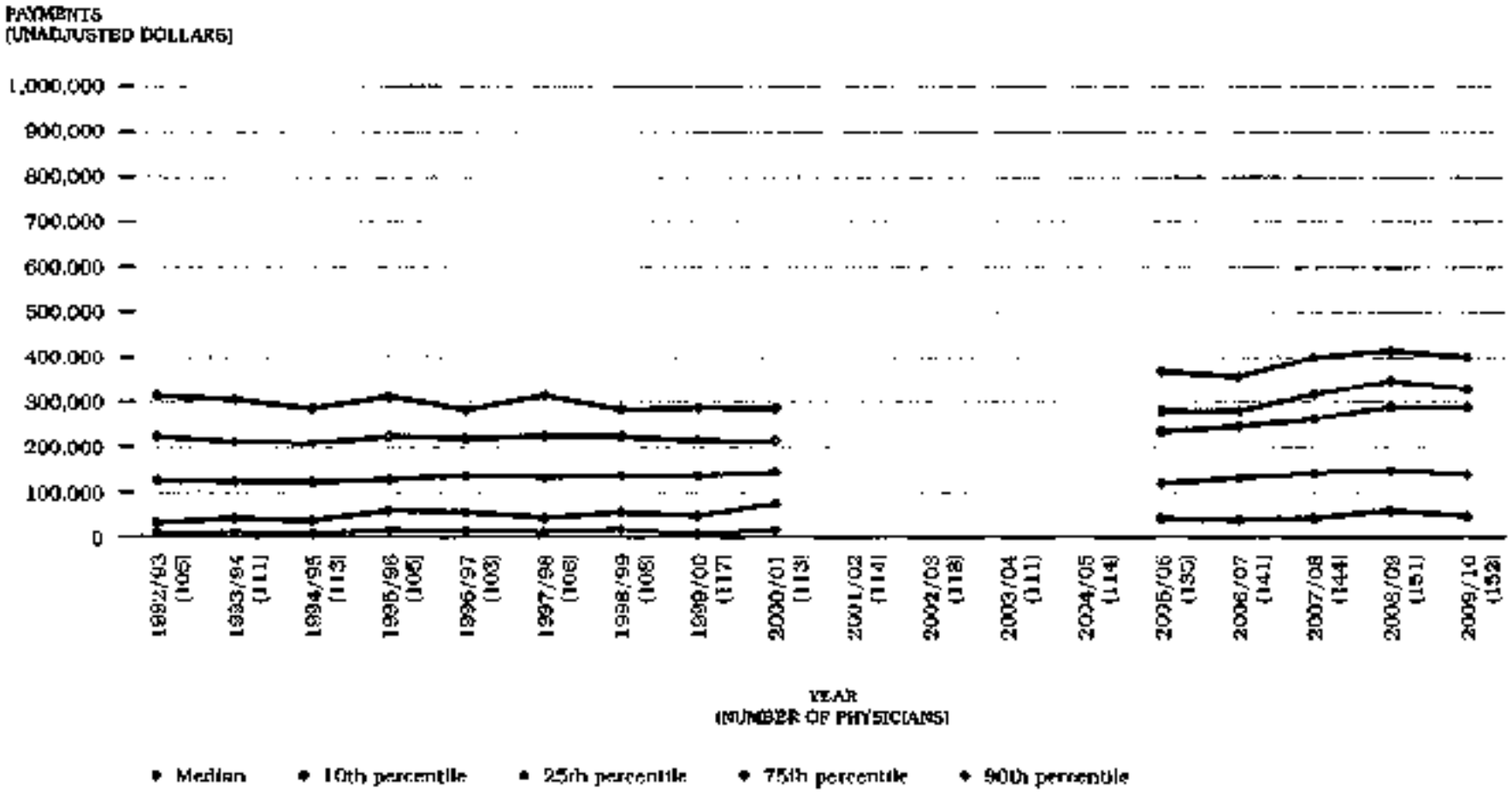
EXHIBIT 5.15 Total payments to geriatricians by payment source, in Ontario, 1992/93 to 2009/10



Note: Data prior to 2005/06 may be incomplete and should be treated with caution.

HEMATOLOGISTS

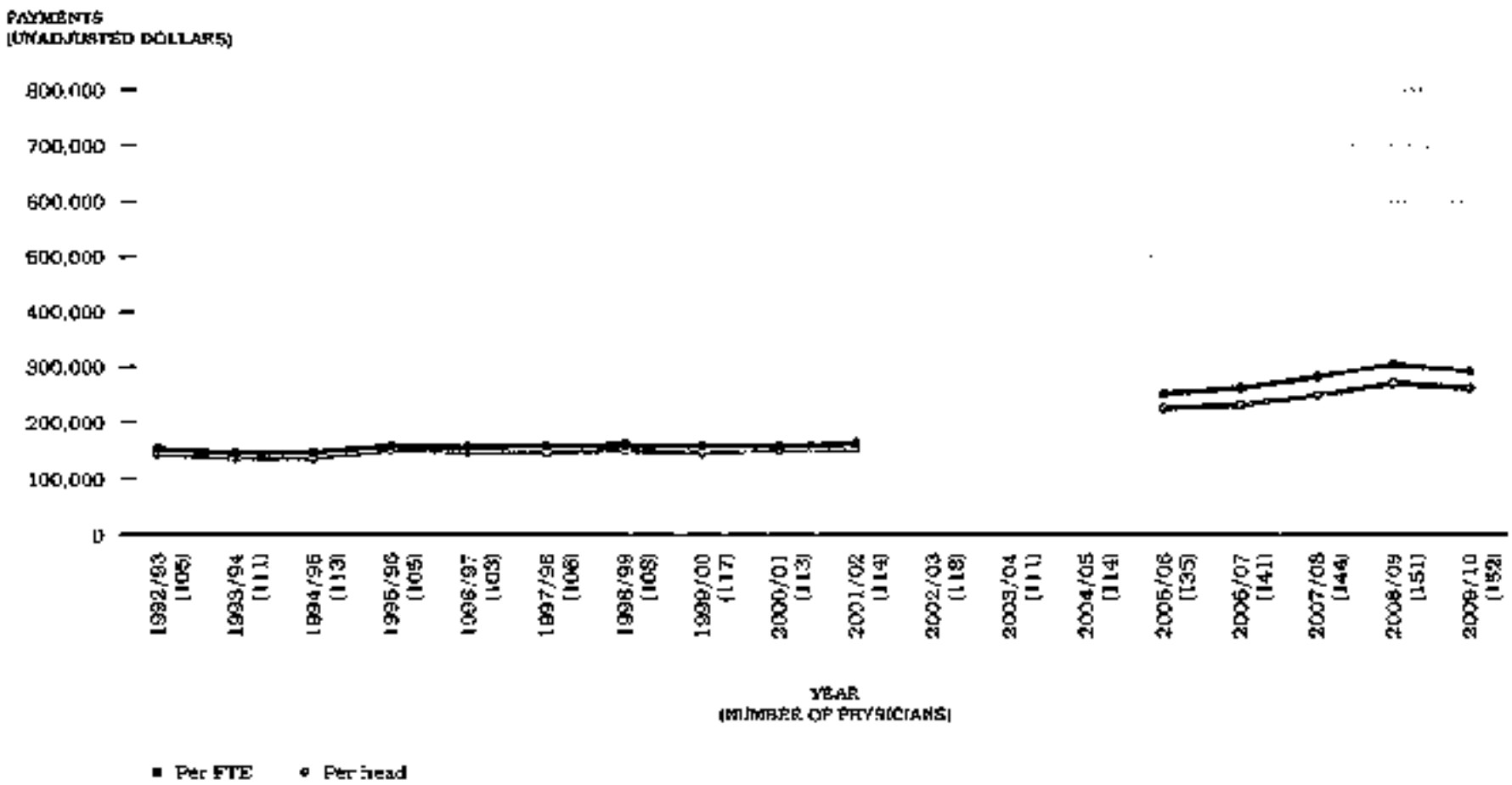
EXHIBIT 5.16 Median and percentiles of payments (in unadjusted dollars) to individual hematologists, in Ontario, 1992/93 to 2009/10



Note: Results for 2002/03 to 2004/05 have been suppressed due to missing data.

HEMATOLOGISTS

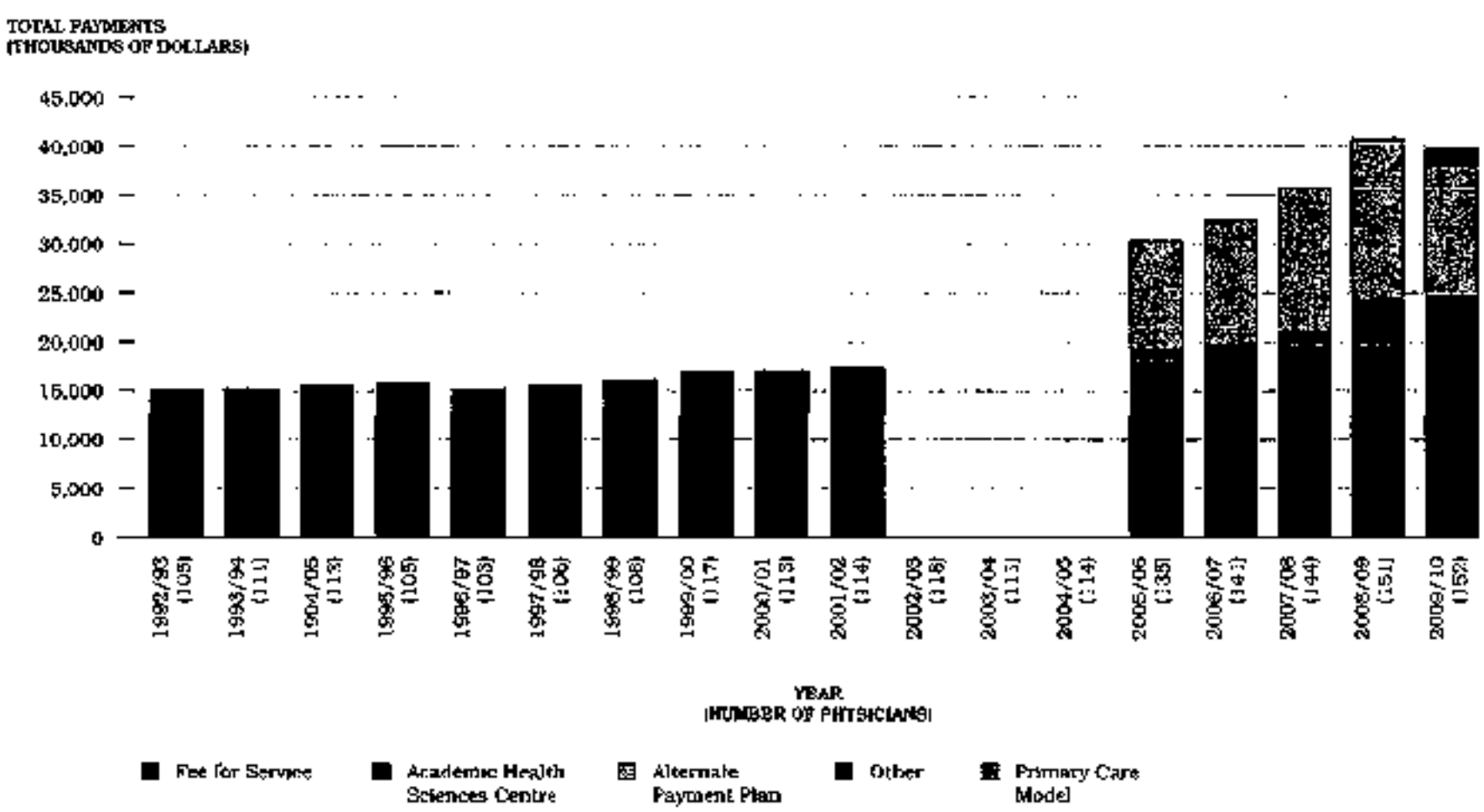
EXHIBIT 5.17 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to hematologists. In Ontario, 1992/93 to 2009/10



Note: Results for 2002/03 to 2004/05 have been suppressed due to missing data.

HEMATOLOGISTS

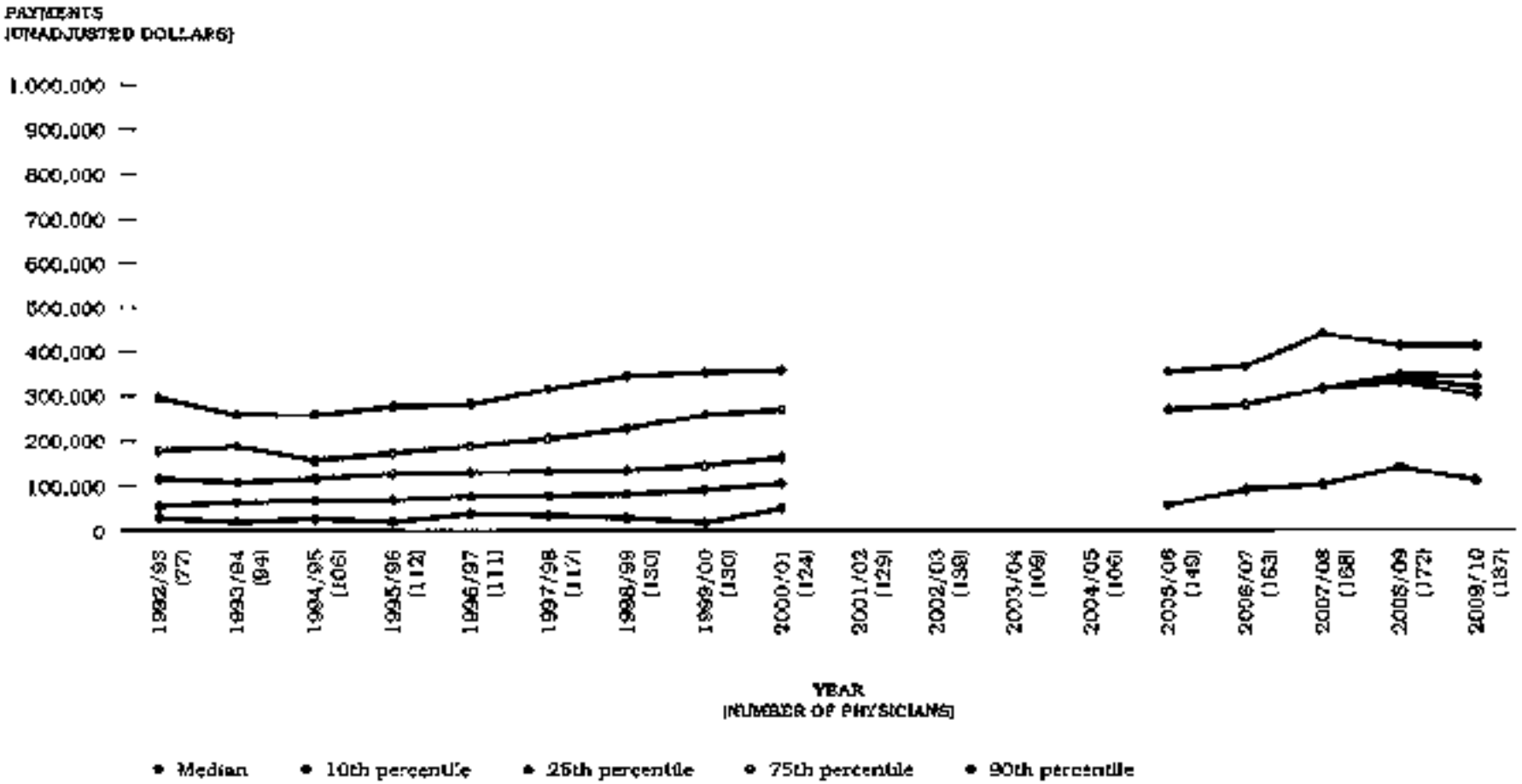
EXHIBIT 5.18 Total payments to hematologists by payment source, in Ontario, 1992/93 to 2009/10



Note: Results for 2002/03 to 2004/05 have been suppressed due to missing data

MEDICAL ONCOLOGISTS

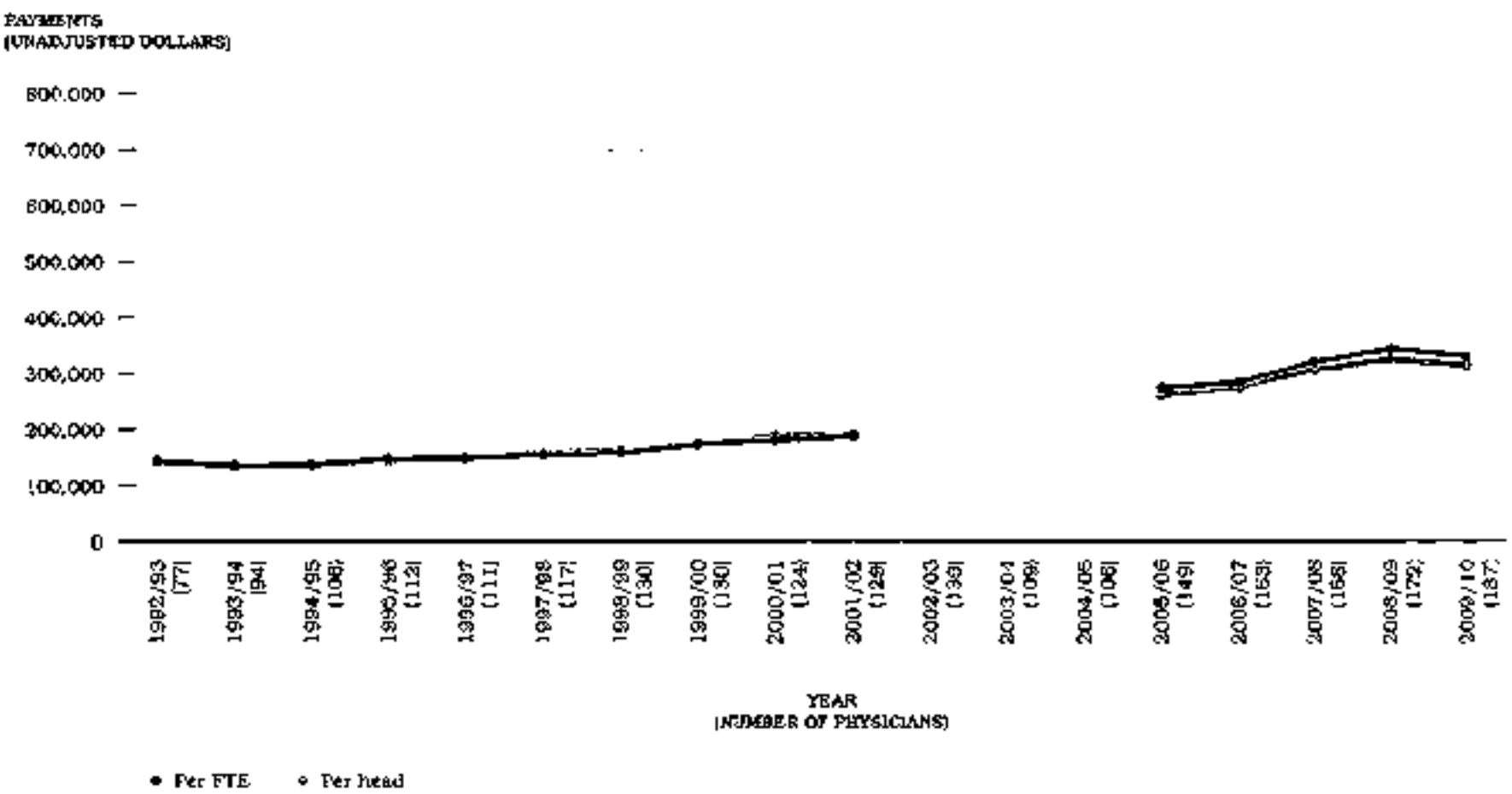
EXHIBIT 5.19 Median and percentiles of payments (in unadjusted dollars) to individual medical oncologists, in Ontario, 1992/93 to 2009/10



Note: Results for 2002/03 to 2004/05 have been suppressed due to missing data.

MEDICAL ONCOLOGISTS

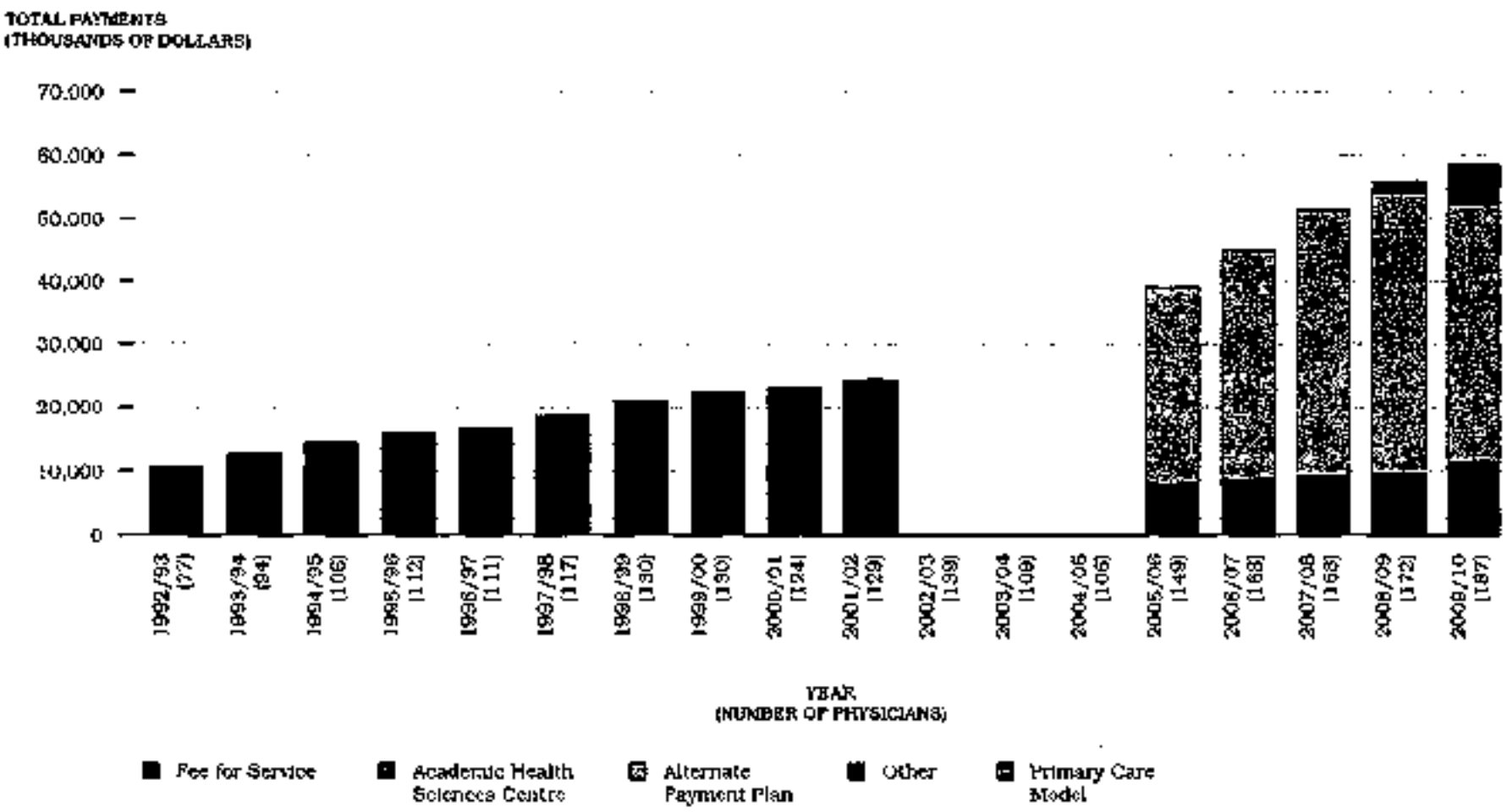
EXHIBIT 5.20 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to medical oncologists, in Ontario, 1992/93 to 2009/10



Note: Results for 2002/03 to 2004/05 have been suppressed due to missing data.

MEDICAL ONCOLOGISTS

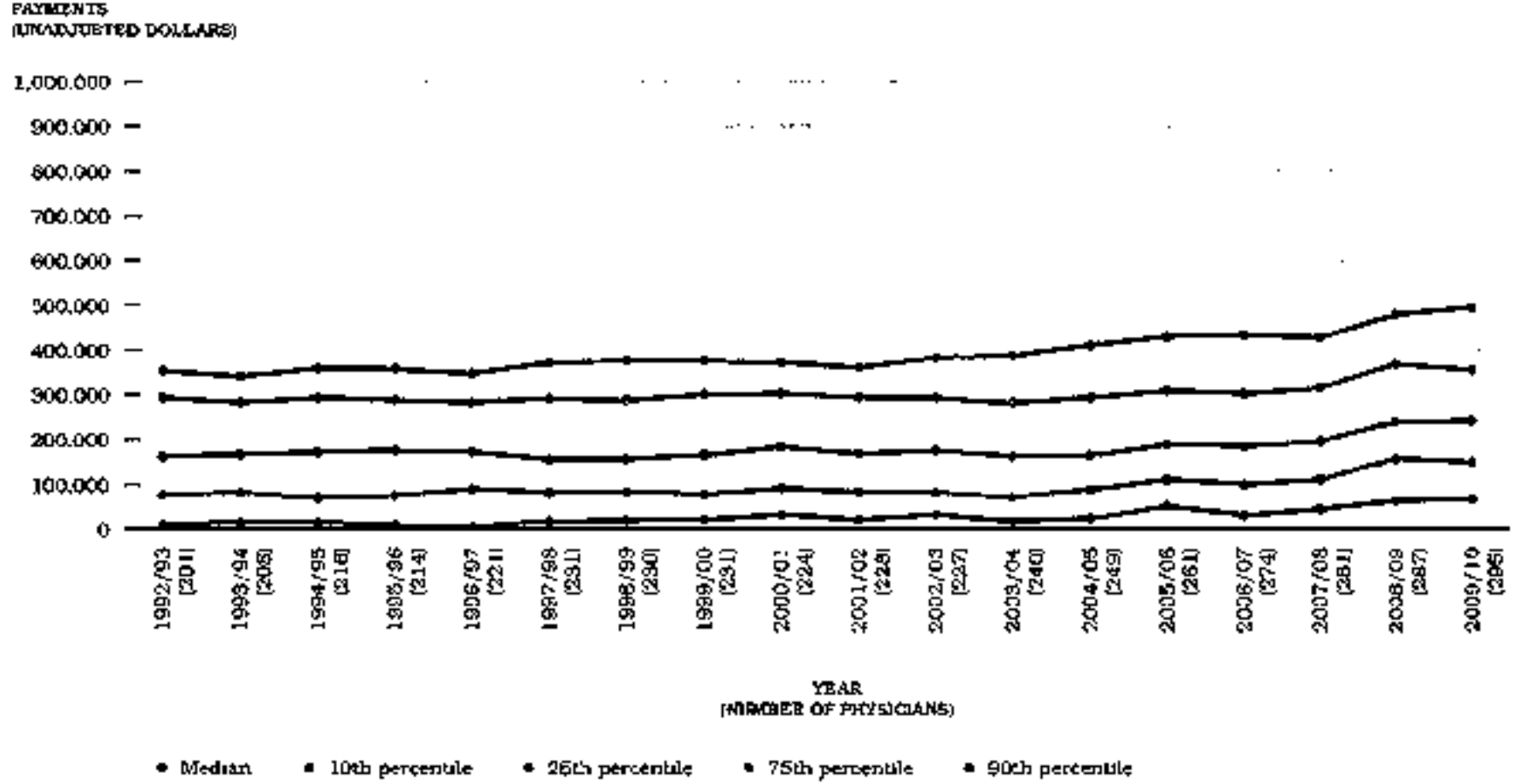
EXHIBIT 5.21 Total payments to medical oncologists by payment source, in Ontario, 1992/93 to 2009/10



Note: Results for 2002/03 to 2004/05 have been suppressed due to missing data.

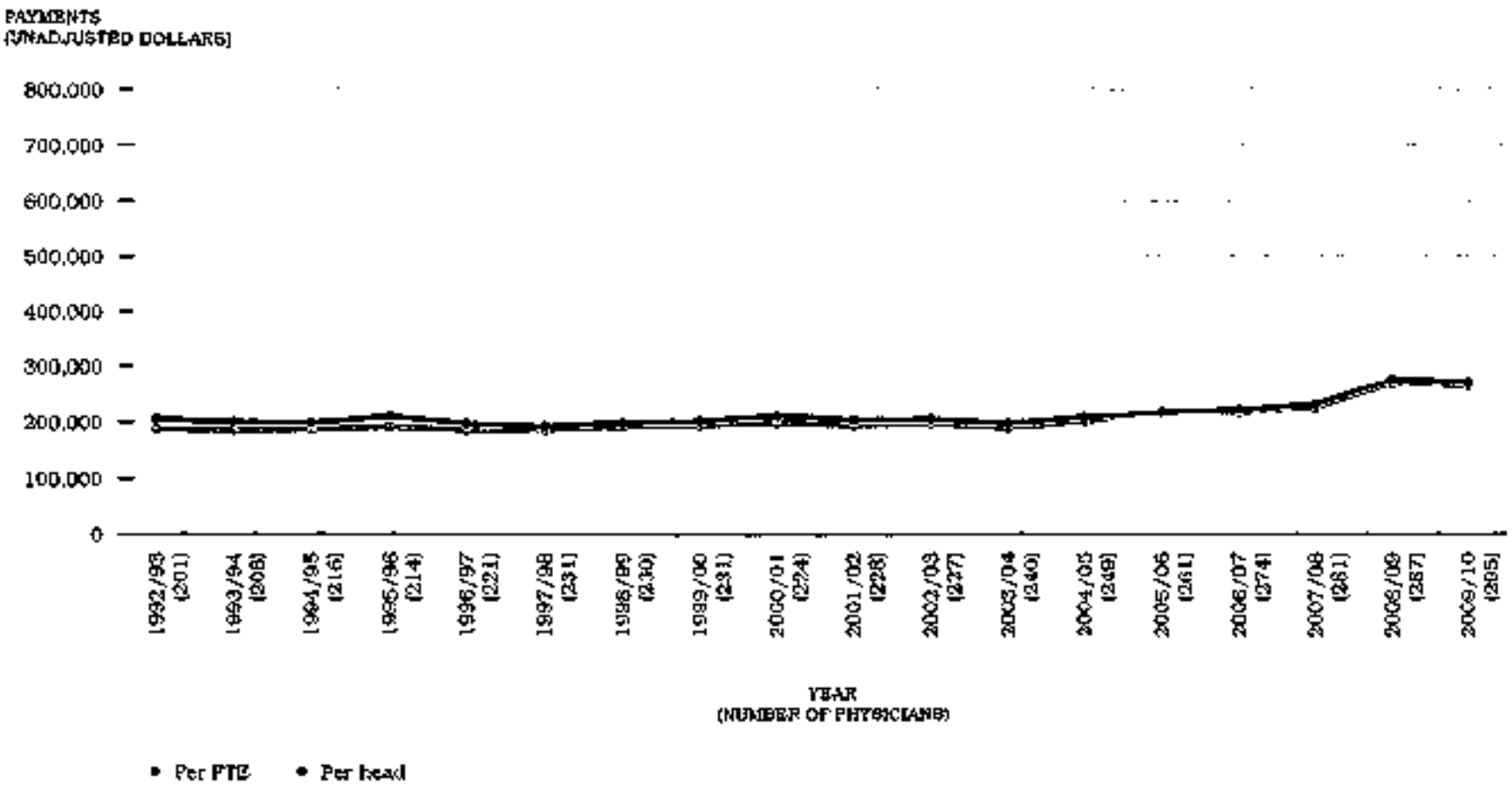
NEUROLOGISTS

EXHIBIT 5.23 Median and percentiles of payments (in unadjusted dollars) to individual neurologists, in Ontario, 1992/93 to 2009/10



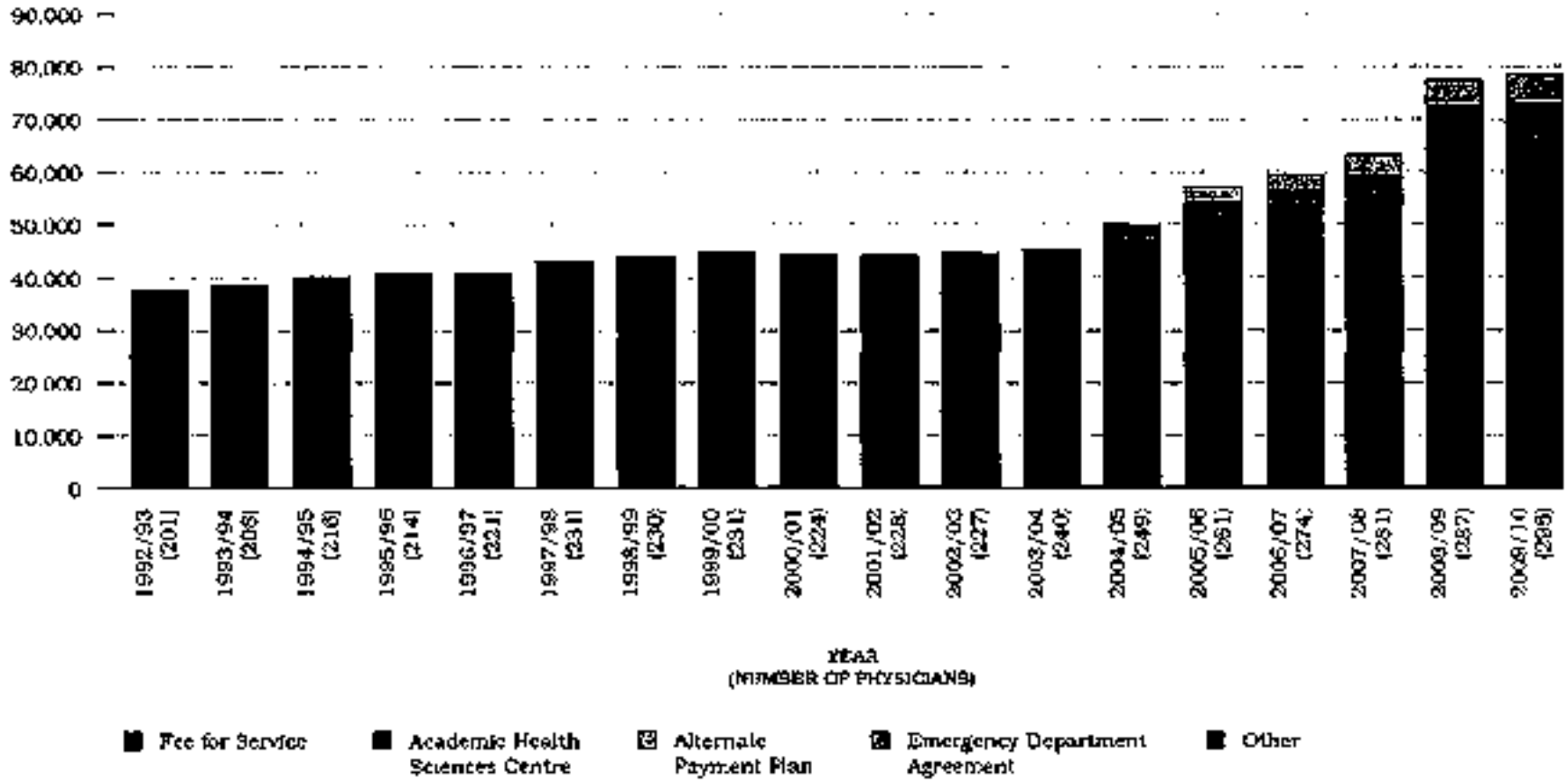
NEUROLOGISTS

EXHIBIT 5.23 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to neurologists. in Ontario, 1992/93 to 2009/10



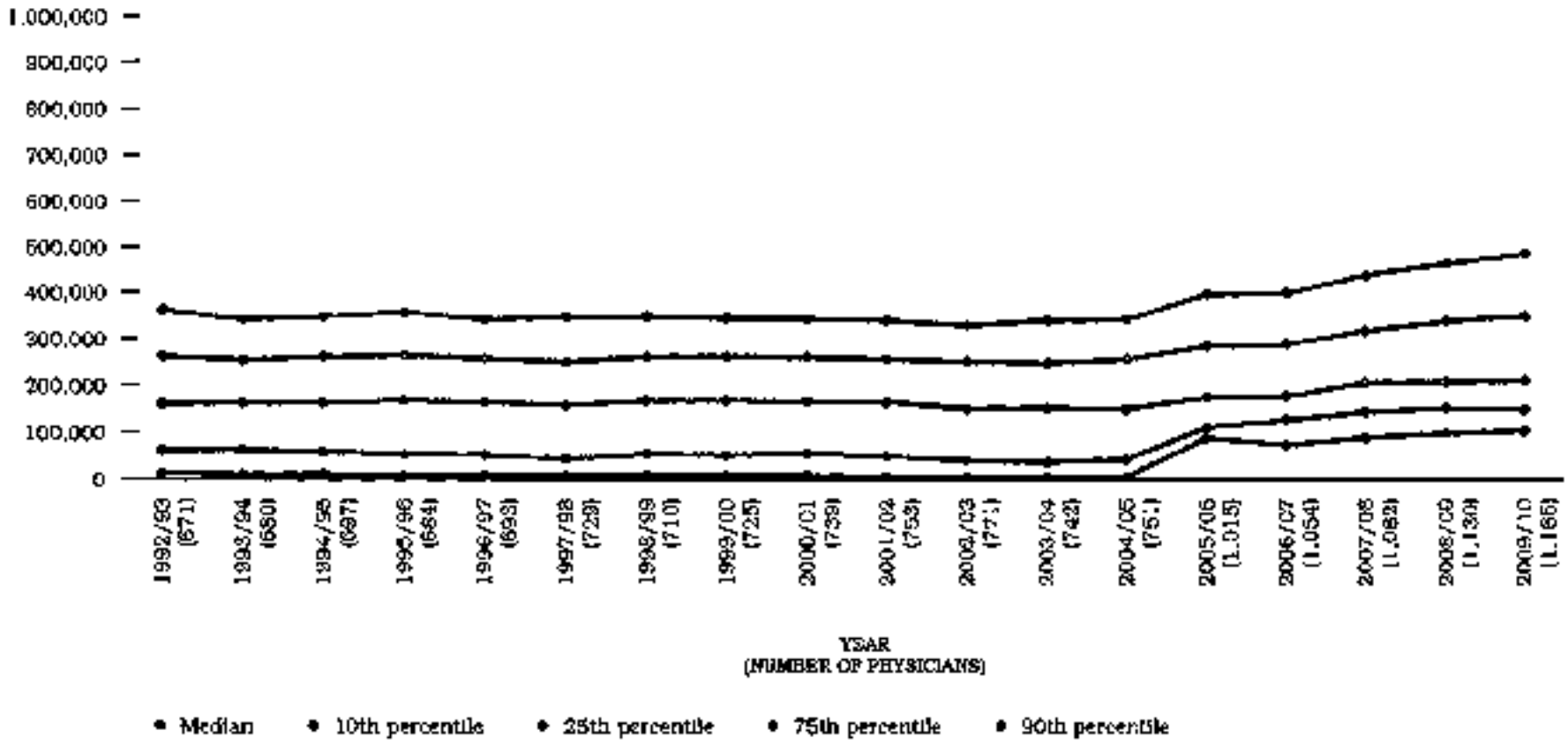
NEUROLOGISTS

EXHIBIT 5.24 Total payments to neurologists by payment source, in Ontario, 1992/93 to 2009/10



PEDIATRICIANS

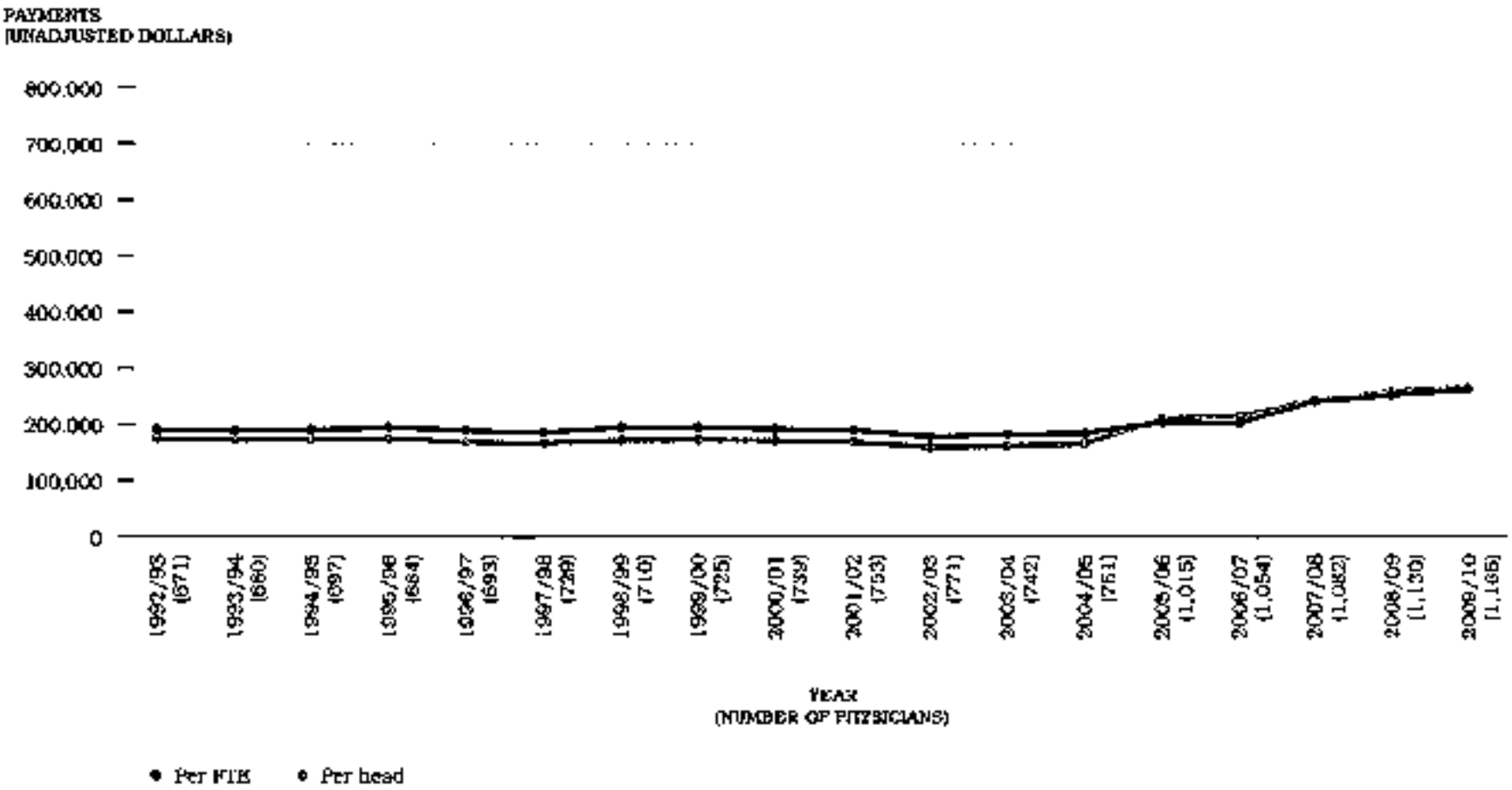
EXHIBIT 5.25 Median and percentiles of payments (in unadjusted dollars) to individual pediatricians, in Ontario, 1992/93 to 2009/10



Note: Data from 2001/02 to 2004/05 should be treated with caution due to missing AFP payment information.

PEDIATRICIANS

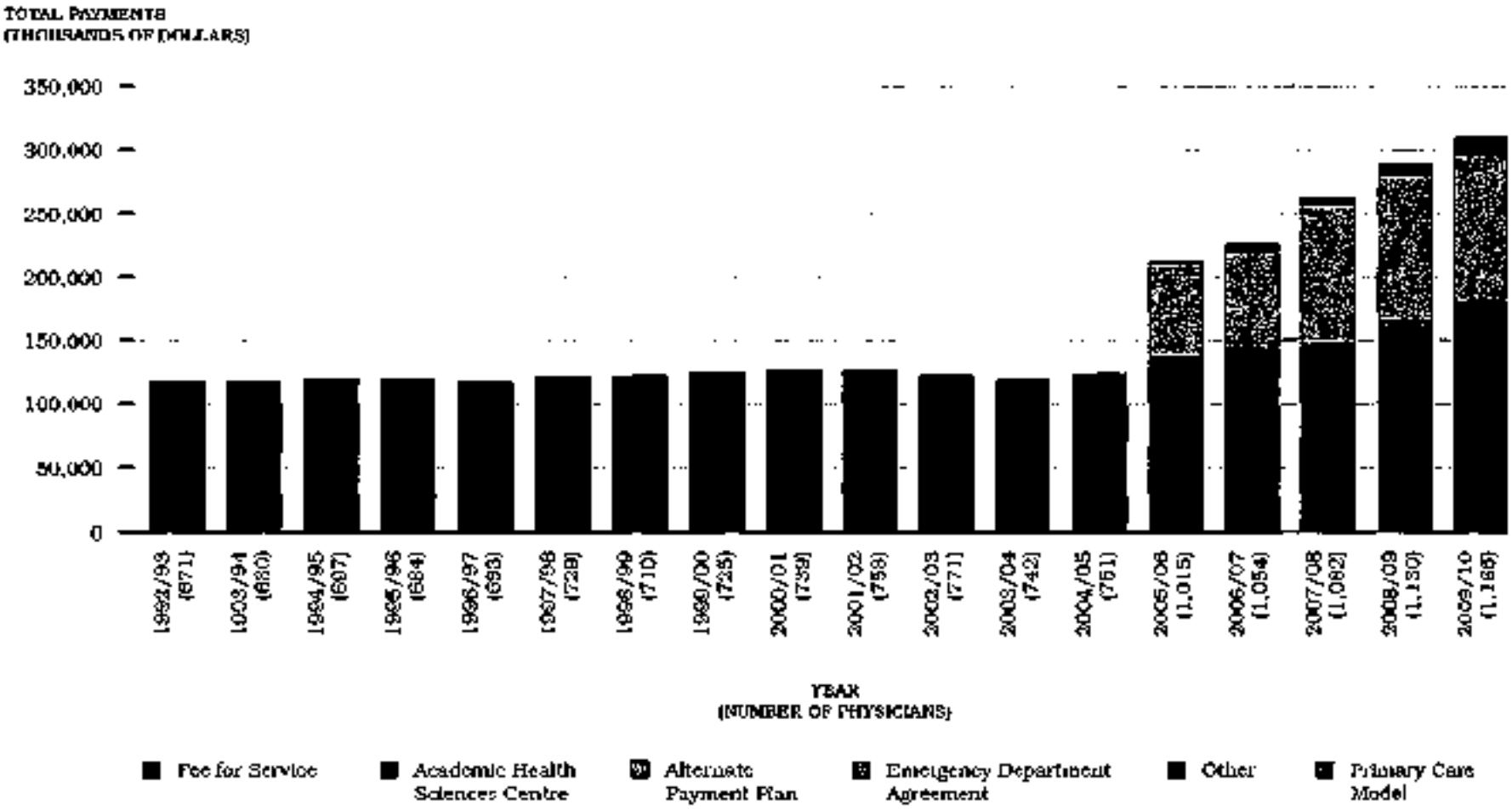
EXHIBIT 5.26 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to pediatricians in Ontario, 1992/93 to 2009/10



Note. Data from 2001/02 to 2004/05 should be treated with caution due to missing APP payment information.

PEDIATRICIANS

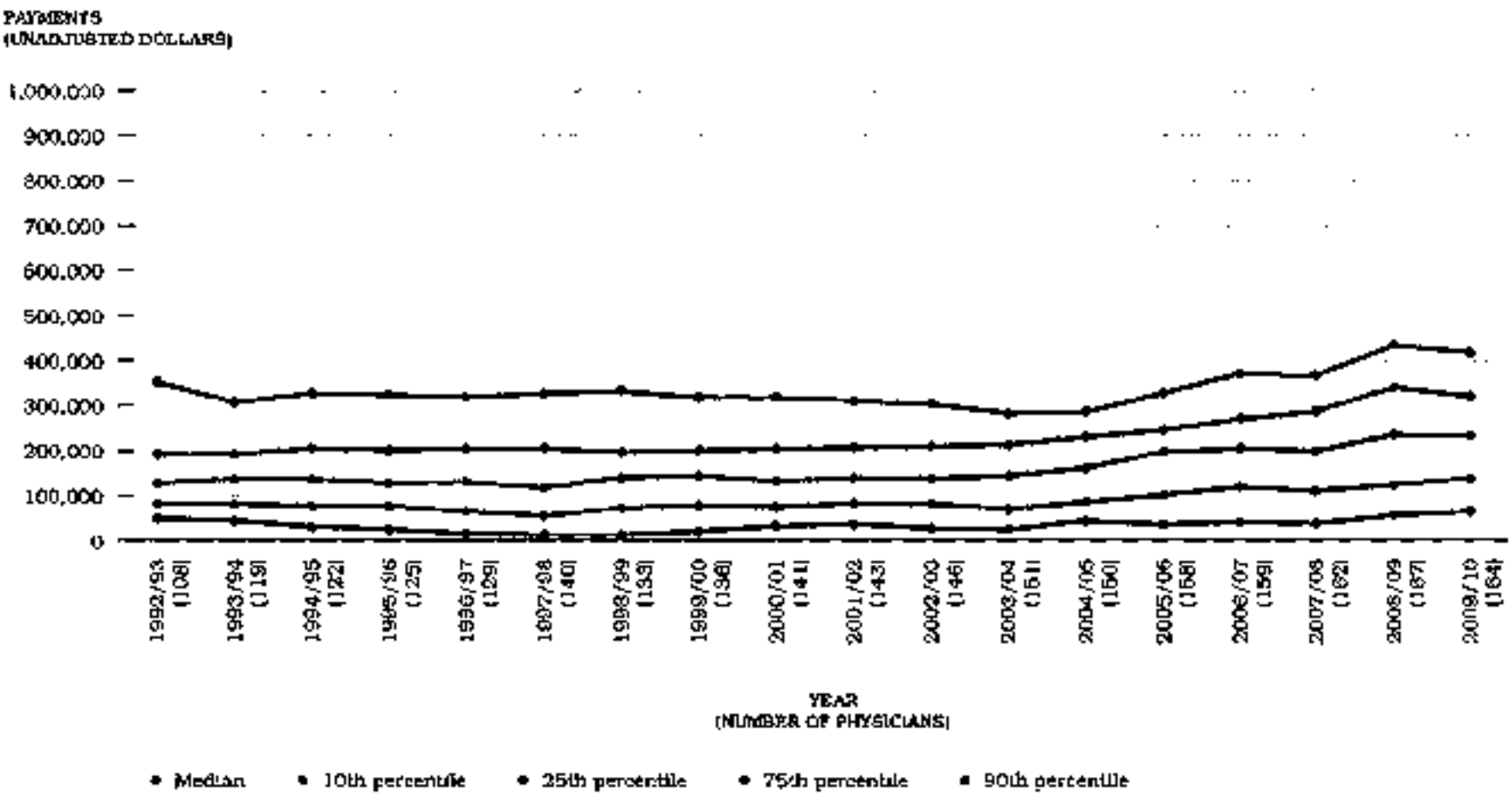
EXHIBIT 5.27 Total payments to pediatricians by payment source, in Ontario, 1992/93 to 2009/10



Note: Data from 2001/02 to 2006/07 should be treated with caution due to missing APP payment information

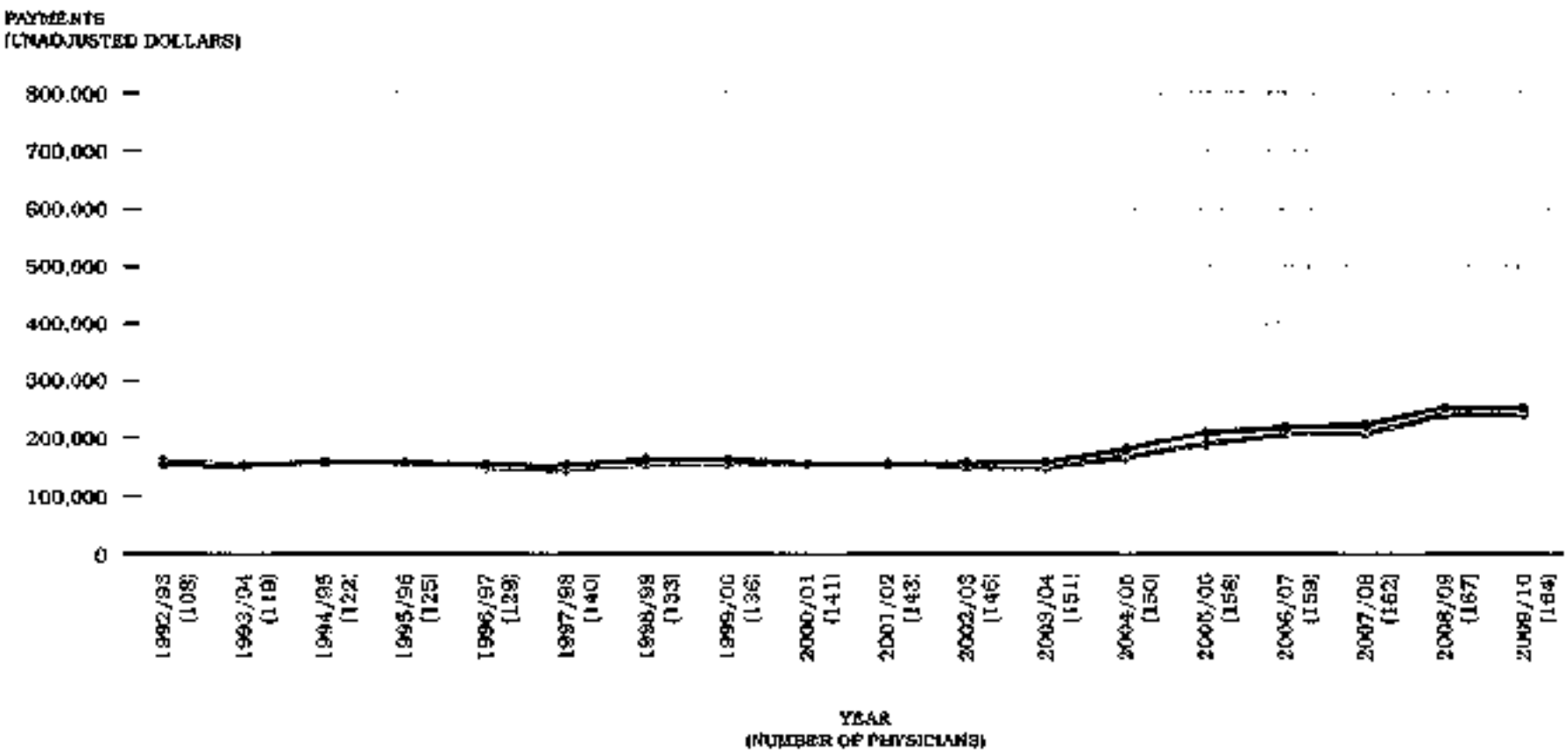
PHYSICAL MEDICINE AND REHABILITATION SPECIALISTS

EXHIBIT 5.28 Median and percentiles of payments (in unadjusted dollars) to individual physical medicine and rehabilitation specialists, in Ontario, 1992/93 to 2009/10



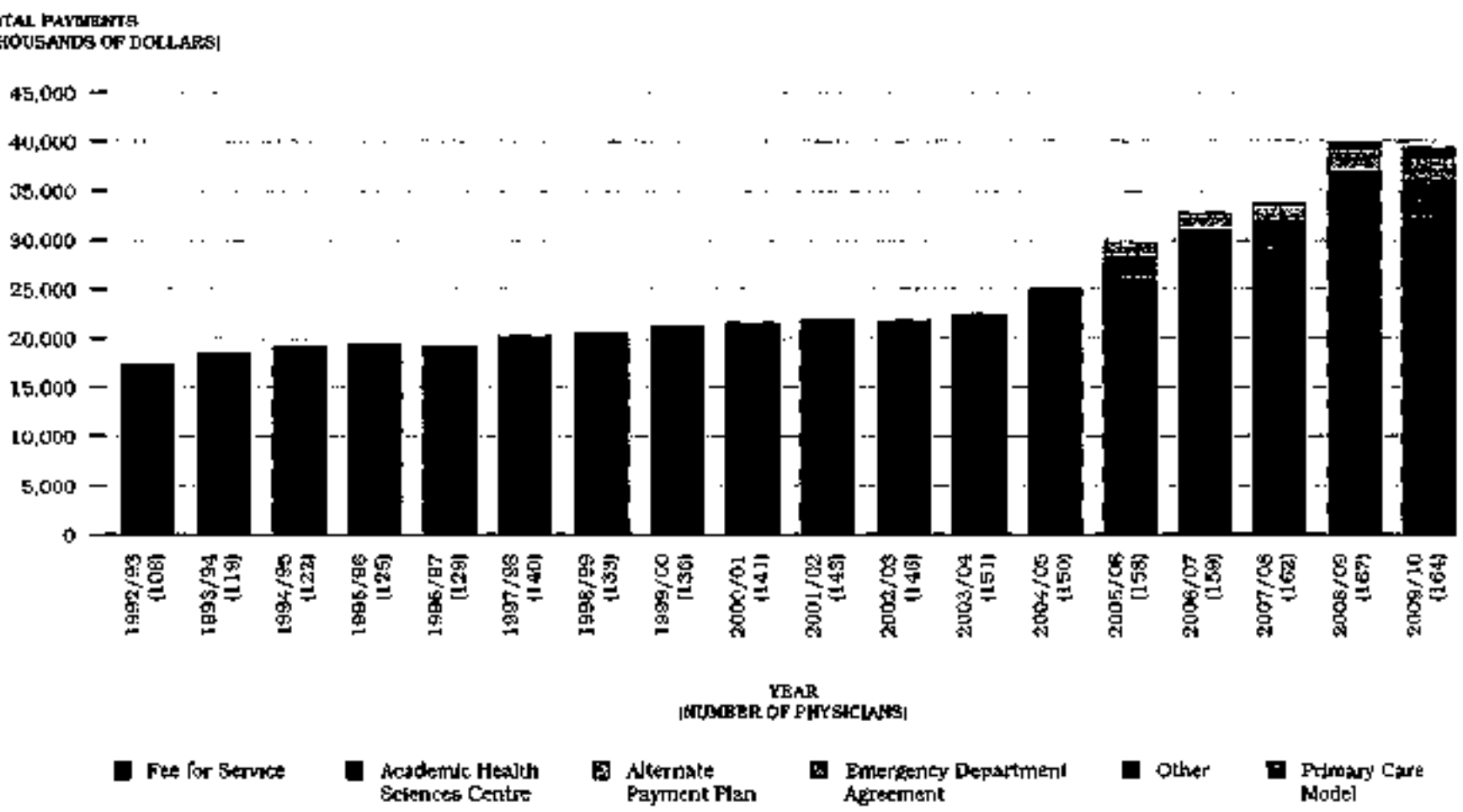
PHYSICAL MEDICINE AND REHABILITATION SPECIALISTS

EXHIBIT 5.29 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to physical medicine and rehabilitation specialists, in Ontario, 1992/93 to 2009/10



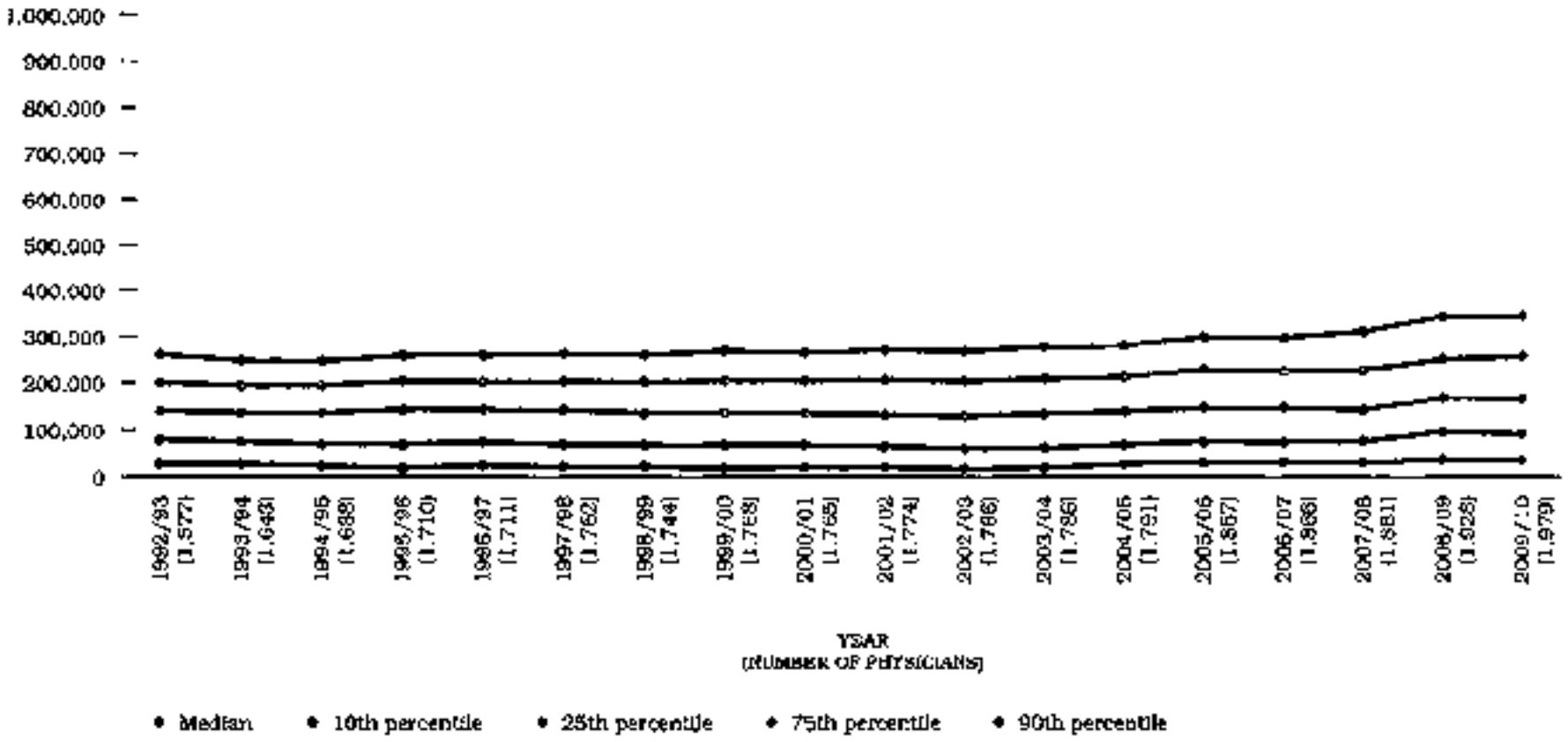
PHYSICAL MEDICINE AND REHABILITATION SPECIALISTS

EXHIBIT 5.30 Total payments to physical medicine and rehabilitation specialists by payment source, in Ontario, 1992/93 to 2009/10



PSYCHIATRISTS

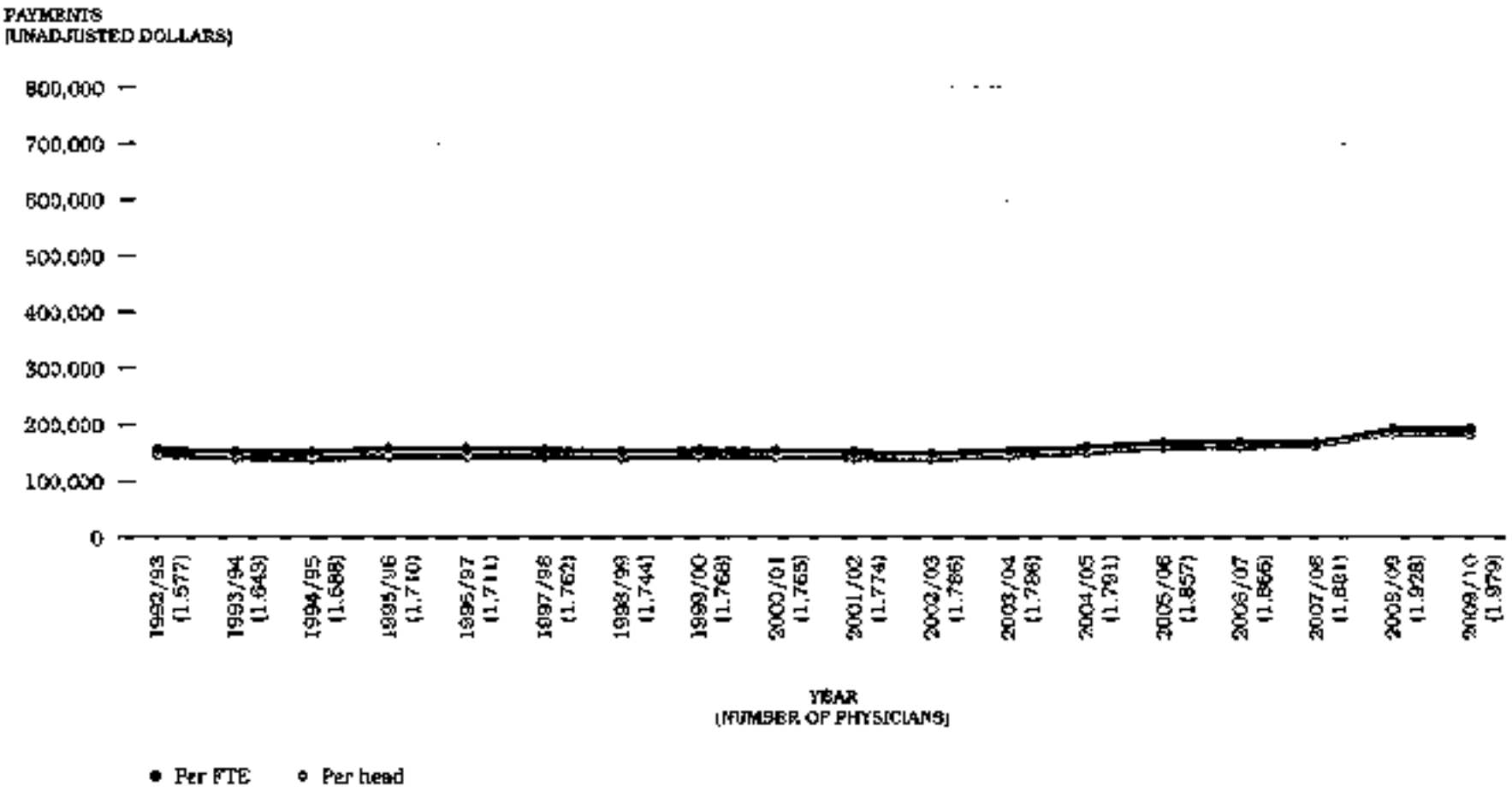
EXHIBIT 5.31 Median and percentiles of payments (in unadjusted dollars) to individual psychiatrists, in Ontario, 1992/93 to 2009/10



Note: The data do not include payments from provincial psychiatric hospitals or mental health sessional fees.

PSYCHIATRISTS

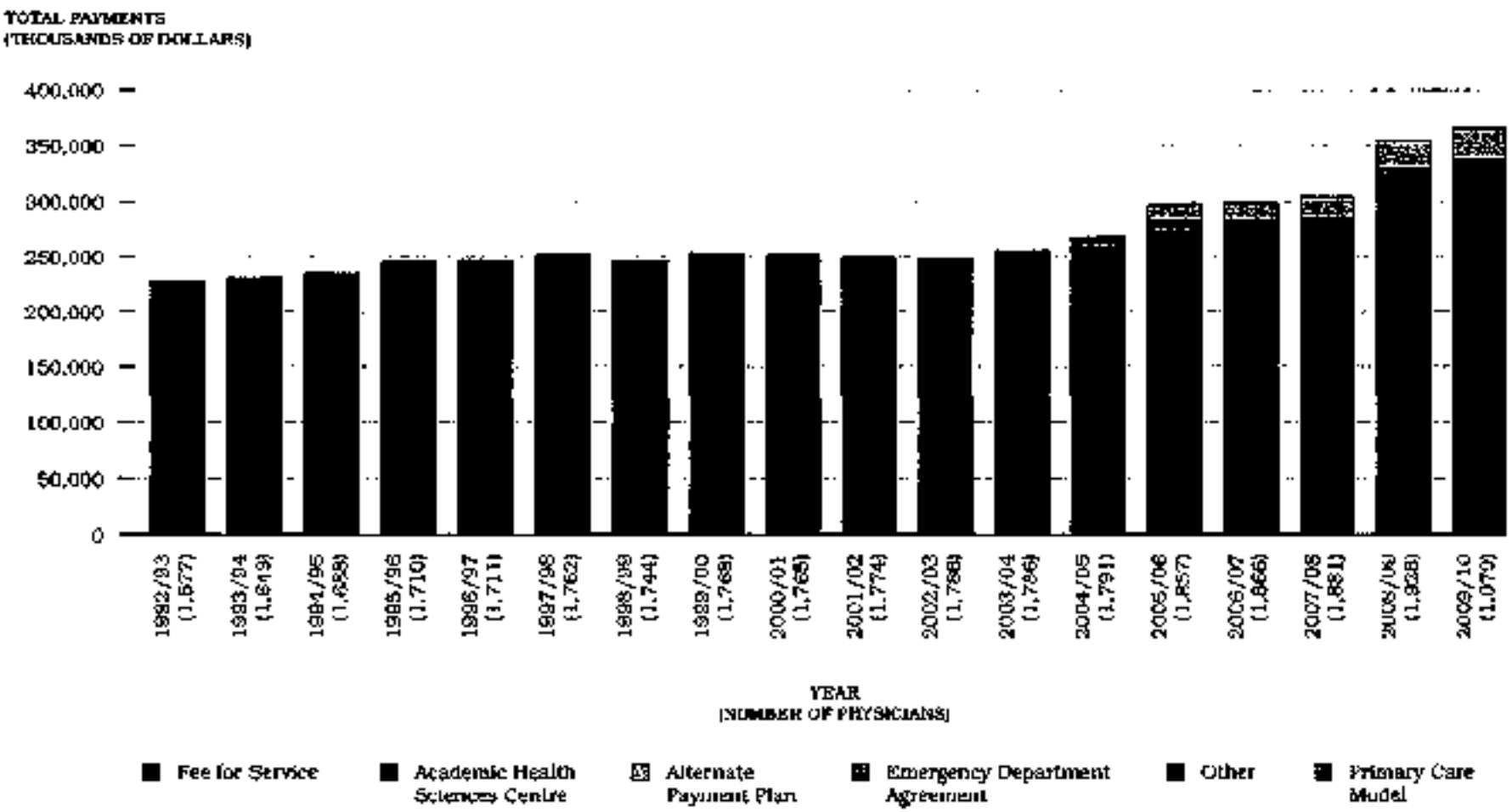
EXHIBIT 5.32 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to psychiatrists. in Ontario, 1992/93 to 2009/10



Note: The data do not include payments from provincial psychiatric hospitals or mental health sessional fees.

PSYCHIATRISTS

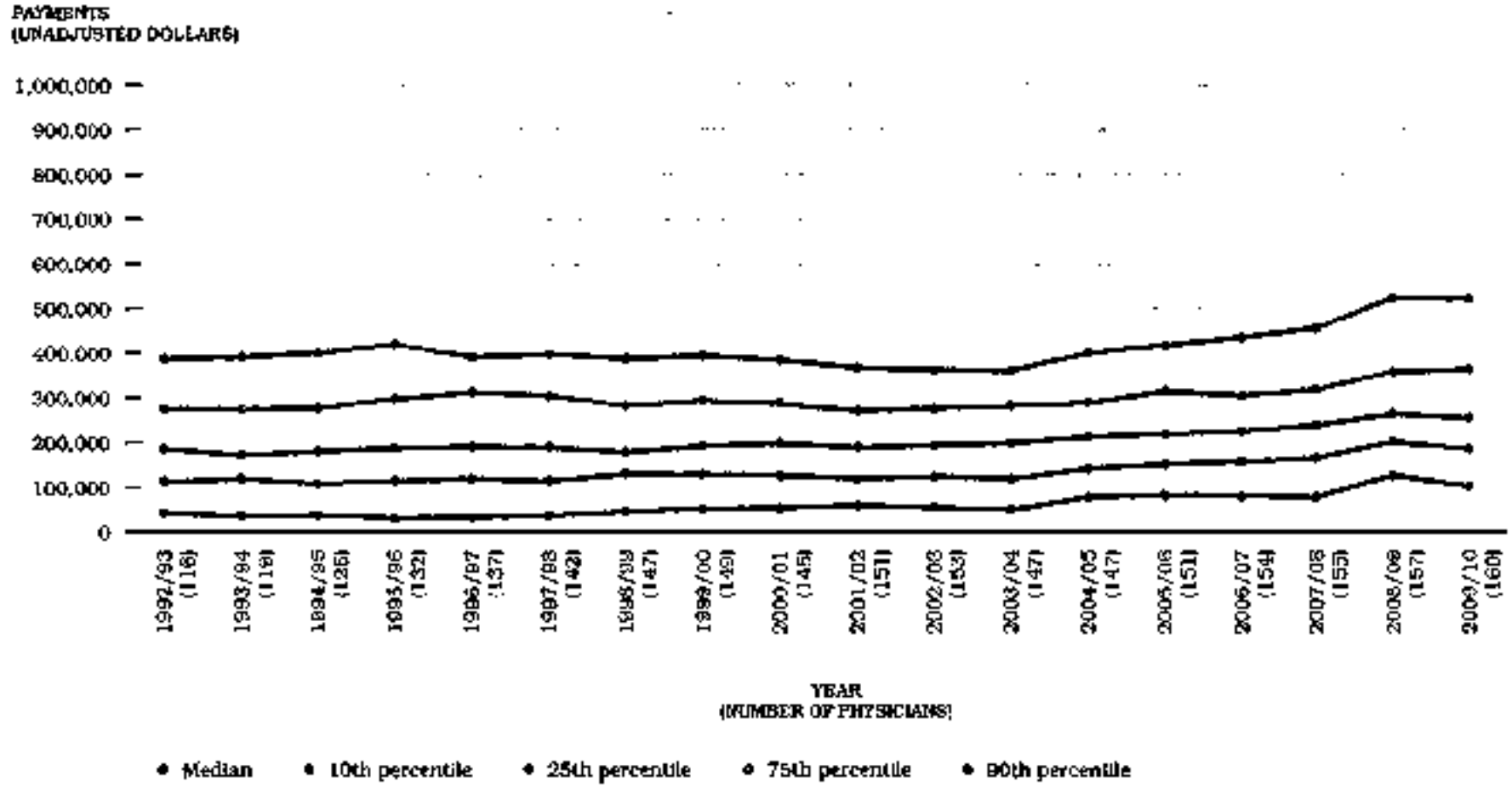
EXHIBIT 3.33 Total payments to psychiatrists by payment source, in Ontario, 1992/93 to 2009/10



Note: The data do not include payments from provincial psychiatric hospitals or mental health sessional fees.

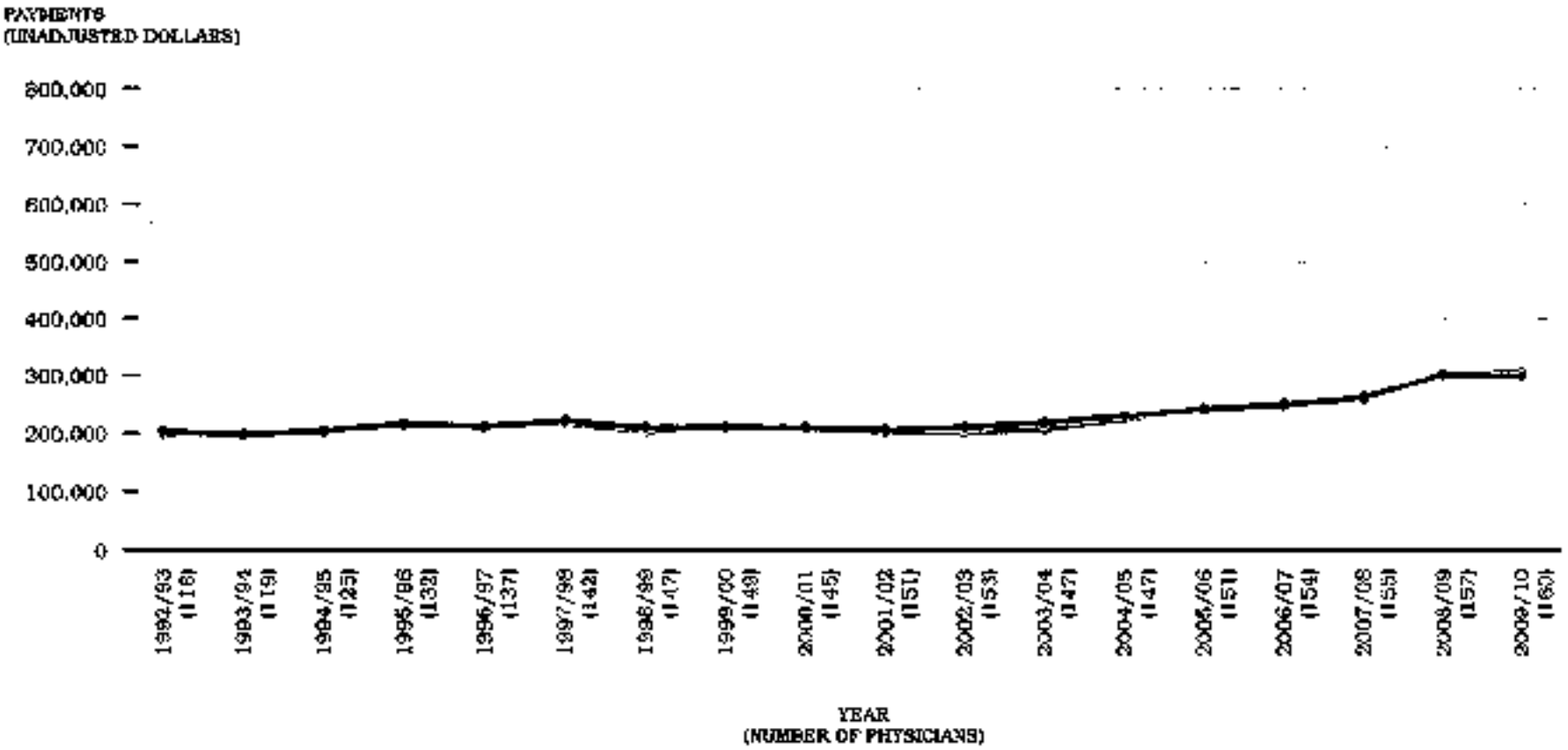
RHEUMATOLOGISTS

EXHIBIT 5.34 Median and percentiles of payments (in unadjusted dollars) to individual rheumatologists, in Ontario, 1992/93 to 2009/10



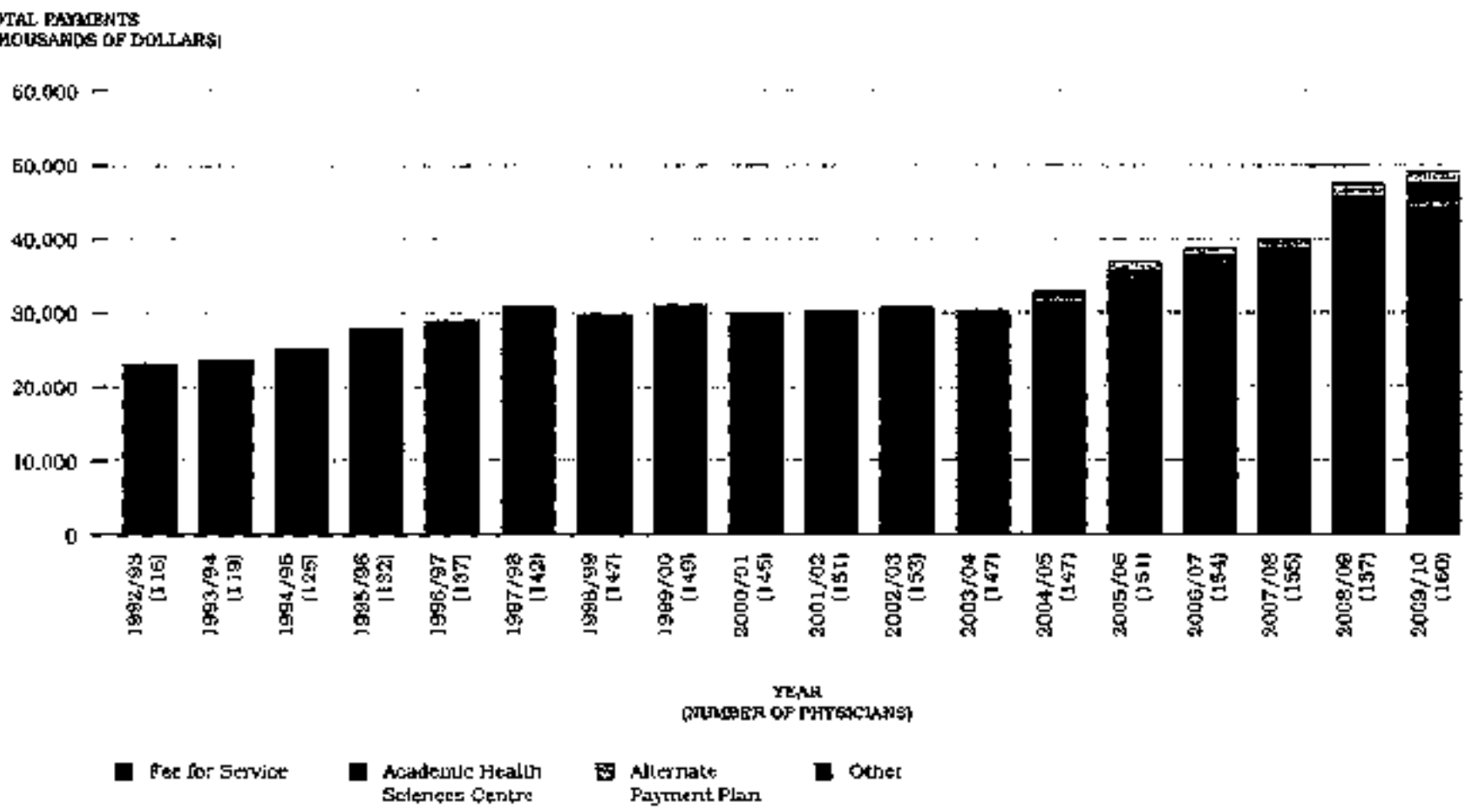
RHEUMATOLOGISTS

EXHIBIT 5.35 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to rheumatologists in Ontario, 1992/93 to 2009/10



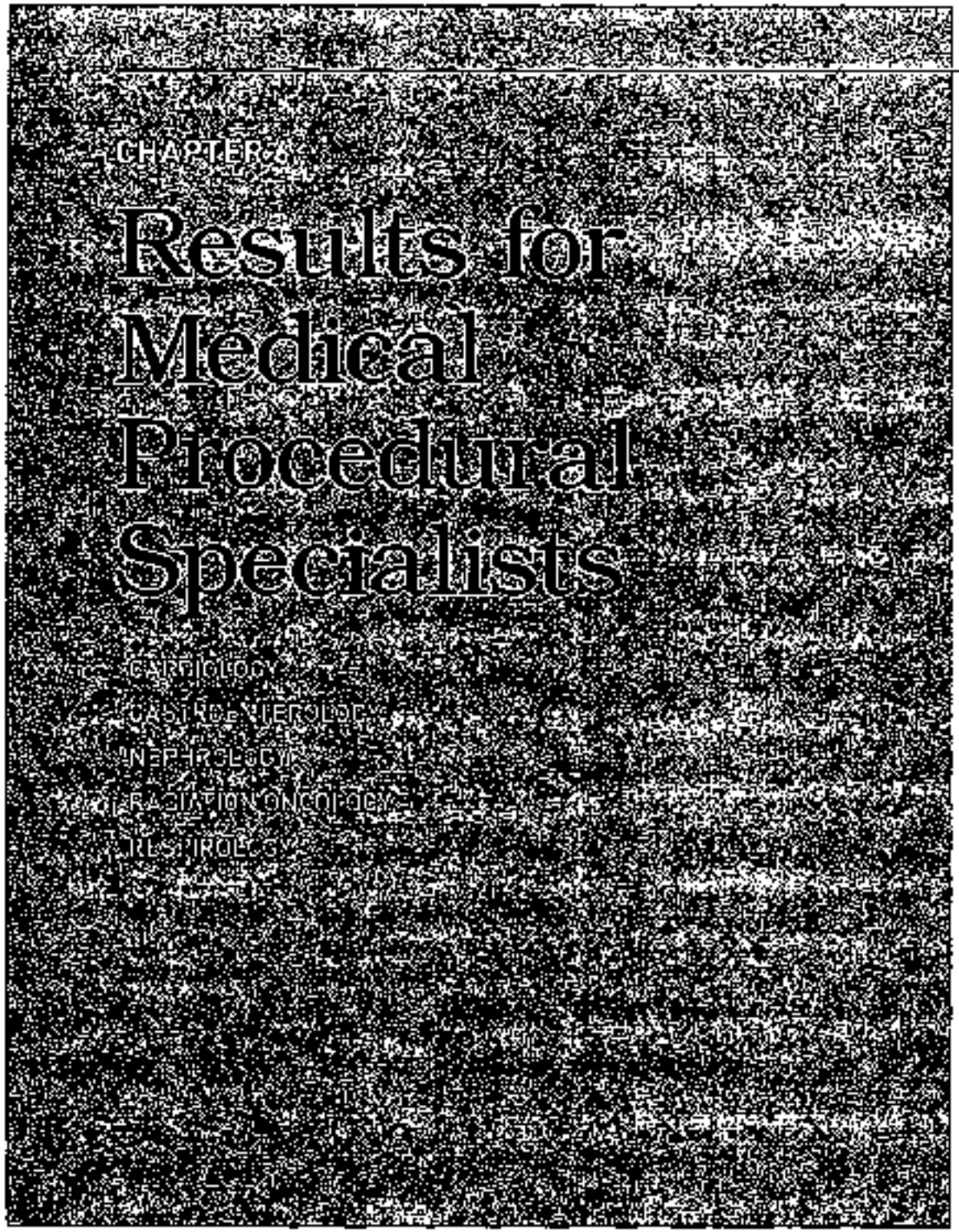
RHEUMATOLOGISTS

EXHIBIT 5-36 Total payments to rheumatologists by payment source, in Ontario, 1992/93 to 2009/10



CHAPTER 6

Results for Medical Procedural Specialists



INTRODUCTION

Medical procedural specialists are specialist physicians who perform procedures that are not considered surgical because they are either non-invasive (do not involve working through a sterile incision in an operating room), do not require anesthesia, or can be performed on an outpatient basis. Many (but not all) of the procedures performed by specialists in this category involve visualization of the gastrointestinal tract, the respiratory tract, and the cardiovascular system through the use of fibre-optic endoscopes or catheters placed in blood vessels. Medical procedural specialists perform procedures such as biopsies, removal of small lesions, dilation of strictures and placement of stents through endoscopes or catheters. Some of these procedures have replaced open surgery—for instance, the shift from open coronary bypass surgery to angioplasty and stent placement in recent years. These specialties also include some physicians who do not perform procedures, but we cannot easily separate them in this analysis, but for practical reasons they have been categorized as belonging to this group. We included radiation oncology in this group as these physicians perform a range of increasingly sophisticated procedures that utilize ionizing radiation and nephrology, as these practitioners are extensively involved in the provision of dialysis to patients with end-stage renal failure.

Demand for the services provided by some procedural specialists has increased dramatically in the past decade or so. Some of this is related to the rapid development of technology that enables non-invasive procedures that previously required surgery, and some is related to increasing demand due to an aging population and the rising prevalence of many chronic conditions. For example, renal failure is a complication of diabetes, and the increase in the prevalence of Type II diabetes over the past two decades has led to an increased need for dialysis, which is managed by nephrologists. Similarly, an increase in the prevalence of congestive heart failure has led to an increased demand for echocardiograms and other studies of heart function. In the case of gastroenterology, the campaign to encourage Ontarians 50 years and older to get screened for colorectal cancer has increased demand for colonoscopy.

For some procedures there are two types of fees: a technical fee, which is payable to the institution to cover infrastructure costs and equipment, and a professional fee, which is paid to the physician who performs or supervises the procedure and interprets the results. Where these were billed separately, the technical fees have been excluded from our analyses. In the 1990s, there were a few procedures for which physicians could bill a combined technical and professional fee. Such fees were discontinued in 2000/01, and some of the exhibits illustrate a drop in payments from 2000/01 to 2001/02 resulting from this change. This change is most noticeable in the case of respirologists, where it affected billings for sleep studies. There was a lesser effect on payments to cardiologists. Payments to the other specialties in this group were unaffected by this change.

FINDINGS FOR INDIVIDUAL SPECIALTIES

Cardiology (exhibits 6.1 to 6.3)

By 2009/10, there were 590 cardiologists practicing in Ontario, an increase of 74% from 1992/93. This is one of the larger specialties, and total payments in 2009/10 were $316 million. In 2009/10, individual cardiologists received, on average, approximately 75% more in payments compared with all physicians combined. The 90th percentile for payments in 2009/10 was $940,000, meaning that 10% of cardiologists were paid more than this. Ten percent of cardiologists were paid less than $155,000 in that year. The 90th percentile for payments increased from being 75% higher than the median in the 1990s to nearly 95% higher in 2009/10, indicating a widening variation in payments to cardiologists. Cardiologists are primarily paid on a FFS basis, with 93% of their 2009/10 payments coming from this source.

Gastroenterology (exhibits 6.4 to 6.6)

In 2009/10, there were 289 gastroenterologists practicing in Ontario, an increase of 82% from 1992/93. Total payments to gastroenterologists were nearly $150 million in 2009/10. Median and mean annual payments to individual gastroenterologists increased steadily from 1997/98 and were about $500,000 in 2009/10, over

68% higher than the average for all physicians in Ontario. The distribution of payments was wide and increased over the period of the study, particularly since 2002/03. As a result, the top 10% of gastroenterologists were paid over $850,000 in 2009/10 and the lowest 10% were paid $175,000 or less. The great majority of payments (93%) to this specialty are from FFS.

Nephrology (exhibits 6.7 to 6.9)

This specialty has grown substantially. In 2009/10, there were 191 practicing nephrologists in Ontario, an increase of 136% from 1992/93. Total payments to nephrologists in 2009/10 were $102 million. The median payment to a nephrologist in 2009/10 was $500,000 and the mean was approximately $550,000. The median payment in 2009/10 was more than double that in 1992/03, was 75% higher than that for all physicians, and increased steadily throughout the observation period. In contrast to the average results for payments to all doctors, payments to nephrologists did not display the flat trend observed during the 1990s when income capping was in place. The variation in payments was wide and increased throughout the study. By 2009/10, the upper 10% of nephrologists were paid over $900,000 (88% higher than the equivalent value for all physicians), and the lowest 10% were paid $145,000 or less. The great majority of nephrologists (94%) are paid through FFS.

Radiation Oncology (exhibits 6.10 to 6.12)

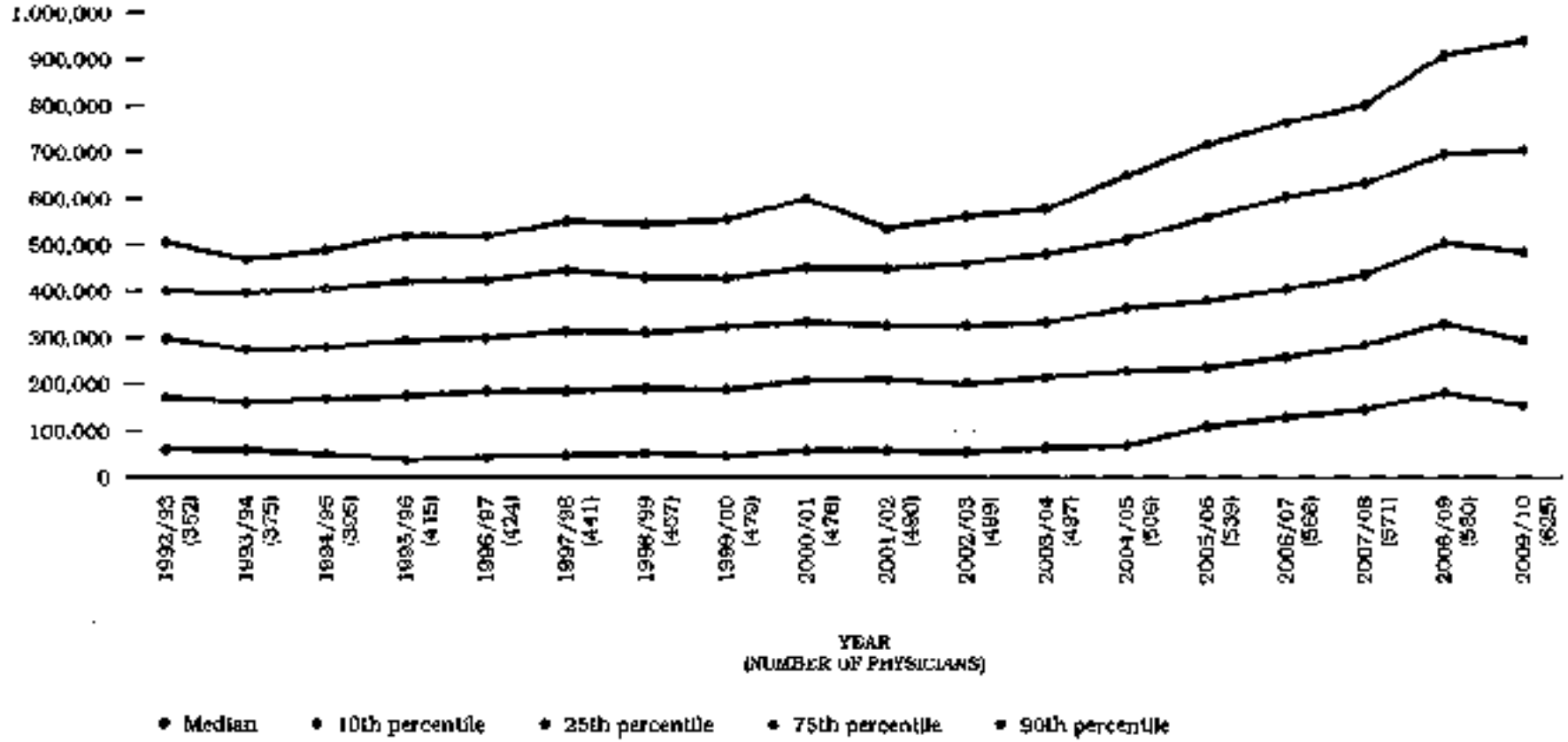
The number of radiation oncologists in Ontario rose from 105 in 1992/93 to 182 in 2009/10, a 73% increase. Total payments in 2009/10 were $76 million. We cannot analyze the increase in payments due to missing data prior to 2005/06, so apparent trends prior to that date need to be regarded with caution. Payments to radiation oncologists are more complex than for other procedural specialties in that approximately 63% are in the form of FFS, with the remaining 37% through APPs. In 2009/10, the mean payment to radiation oncologists was over $400,000, about 30% higher than for all physicians. This value increased by about 16% from 2005/06 to 2009/10 (the period for which we have reliable data). In 2009/10, the median payment to radiation oncologists was approximately 50% higher than for all physicians. The observed distribution in payments is quite narrow. The highest 10% of radiation oncologists were paid just over $500,000 or more, a value that is only 25% more than those at the median. The lowest 10% were paid approximately $280,000 or less.

Respirology (exhibits 6.13 to 6.15)

The number of respirologists increased 72% during the study period, from 137 in 1992/93 to 236 in 2009/10. Total payments in 2009/10 were just under $80 million. Average payments to individual respirologists increased modestly by 19% between 2005/06 to 2009/10, a period during which there was rapid growth in some other specialties. This value was lower than the 28% increase in average annual payments to all physicians. Nevertheless, the median and mean payments in 2009/10 were slightly higher than the average for all physicians. In other words, respirologists have not seen the large increases in payments evident with other procedural specialists. The variation in payments across this specialty is narrower than that seen with other procedural physicians. In 2009/10, the highest 10% of respirologists earned $580,000 or more, compared with $100,000 or less for the lowest 10%. In 2009/10, nearly 90% of payments were in the form of FFS.

CARDIOLOGISTS

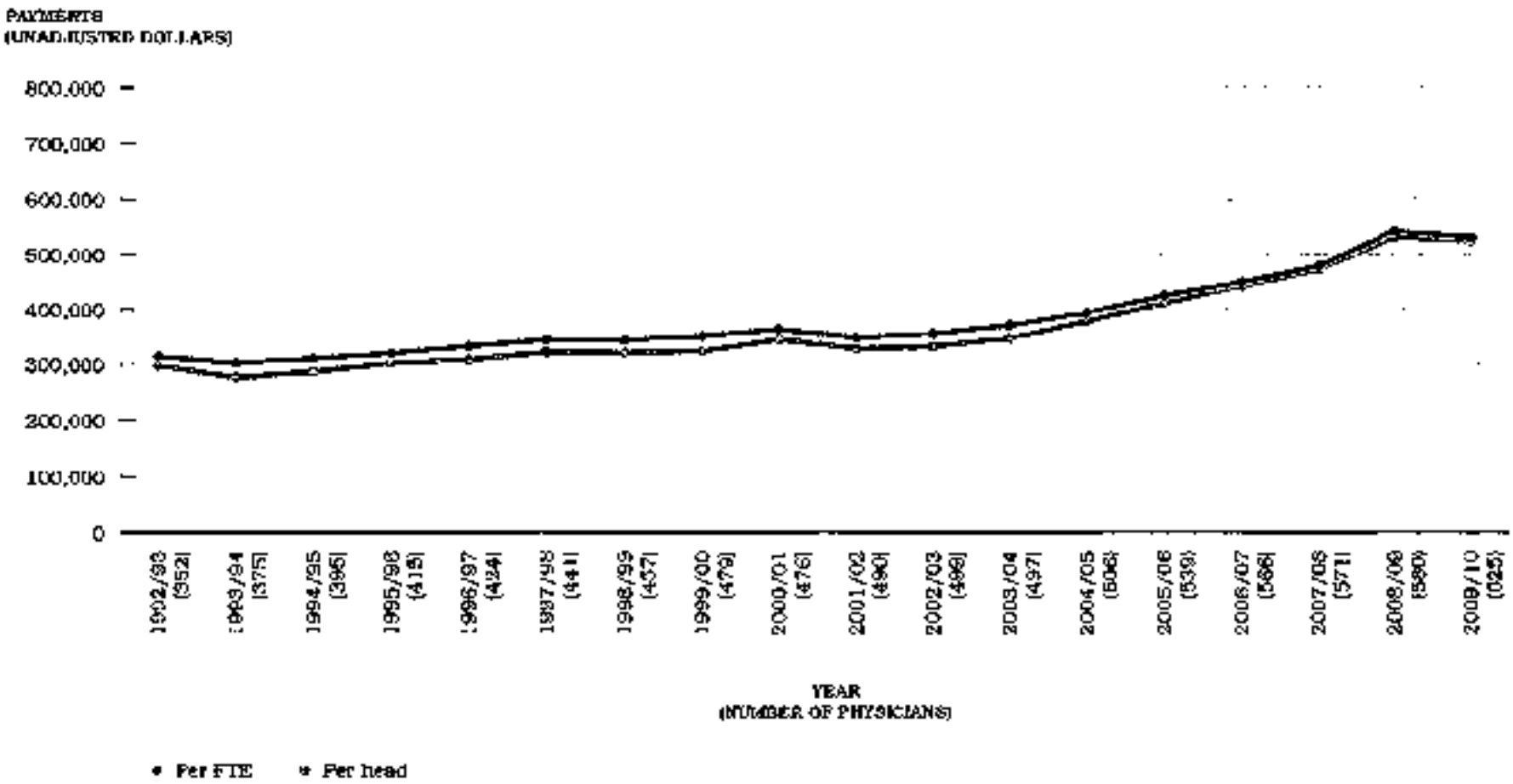
EXHIBIT 6.1 Median and percentiles of payments (in unadjusted dollars) to individual cardiologists, in Ontario, 1992/93 to 2009/10



Note. Data prior to 2009/10 include some fees that combined technical and professional fees. Such combined fees were discontinued in 2000/01.

CARDIOLOGISTS

EXHIBIT 6.2 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to cardiologists, in Ontario, 1992/93 to 2009/10



Note: Data prior to 2001/02 include some fees that combined technical and professional fees. Such combined fees were discontinued in 2000/01.

CARDIOLOGISTS

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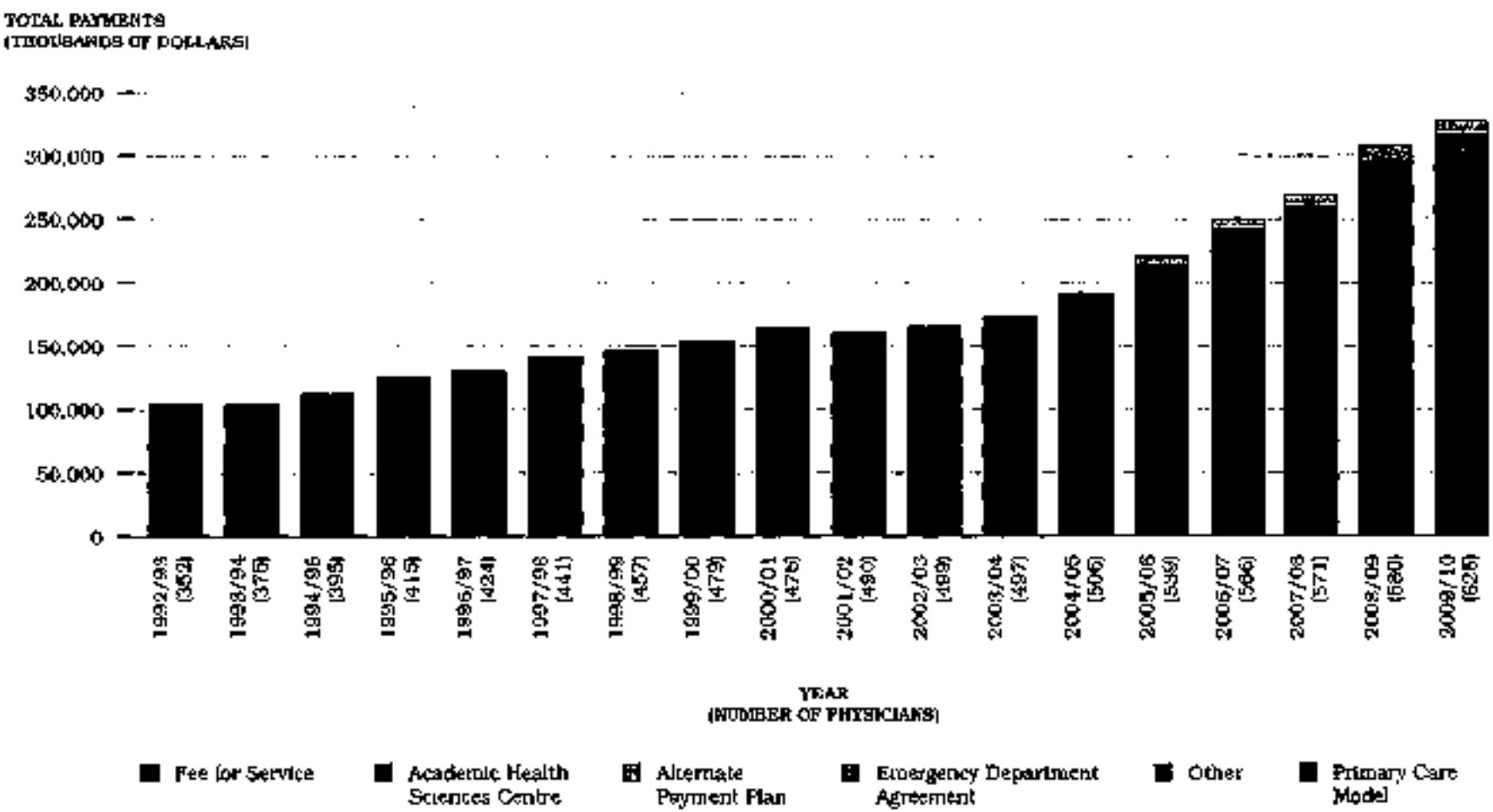
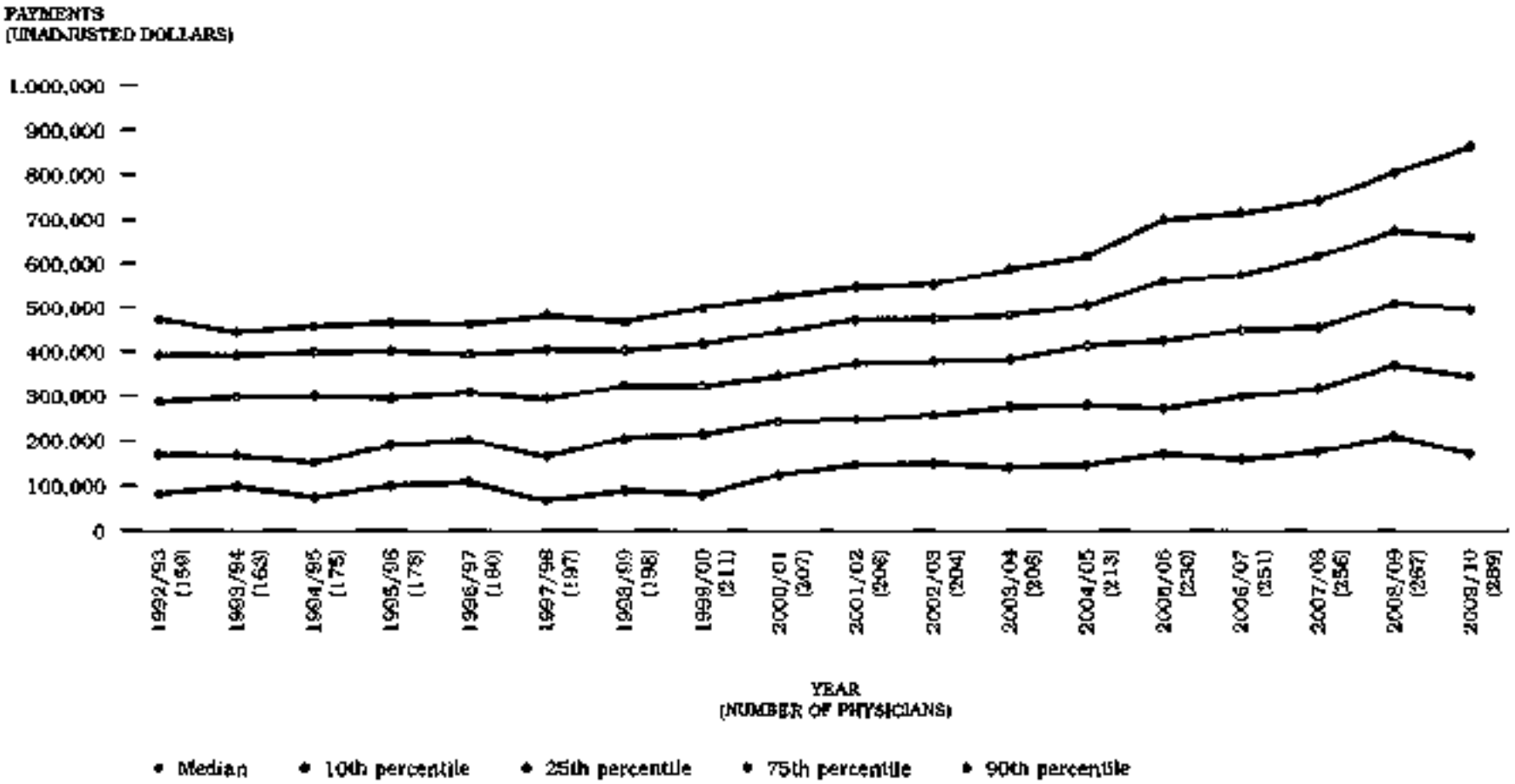
EXHIBIT 6.3 Total payments to cardiologists by payment source, in Ontario, 1992/93 to 2009/10



Note: Data prior to 2001/02 include some fees that combined within call and professional fees. Such combined fees were discontinued in 2000/01.

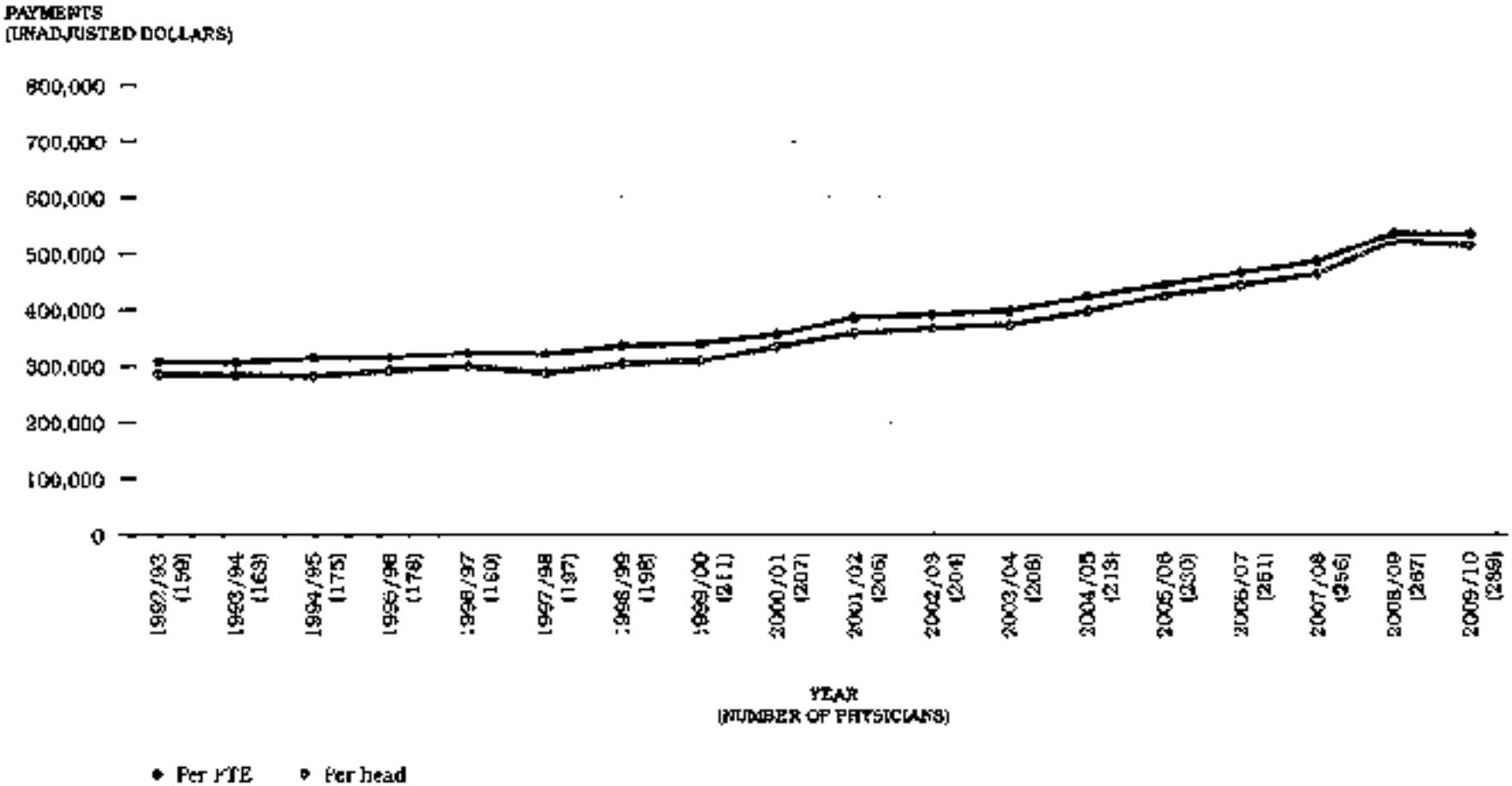
GASTROENTEROLOGISTS

EXHIBIT 6.4 Median and percentiles of payments (in unadjusted dollars) to individual gastroenterologists, in Ontario, 1992/93 to 2009/10



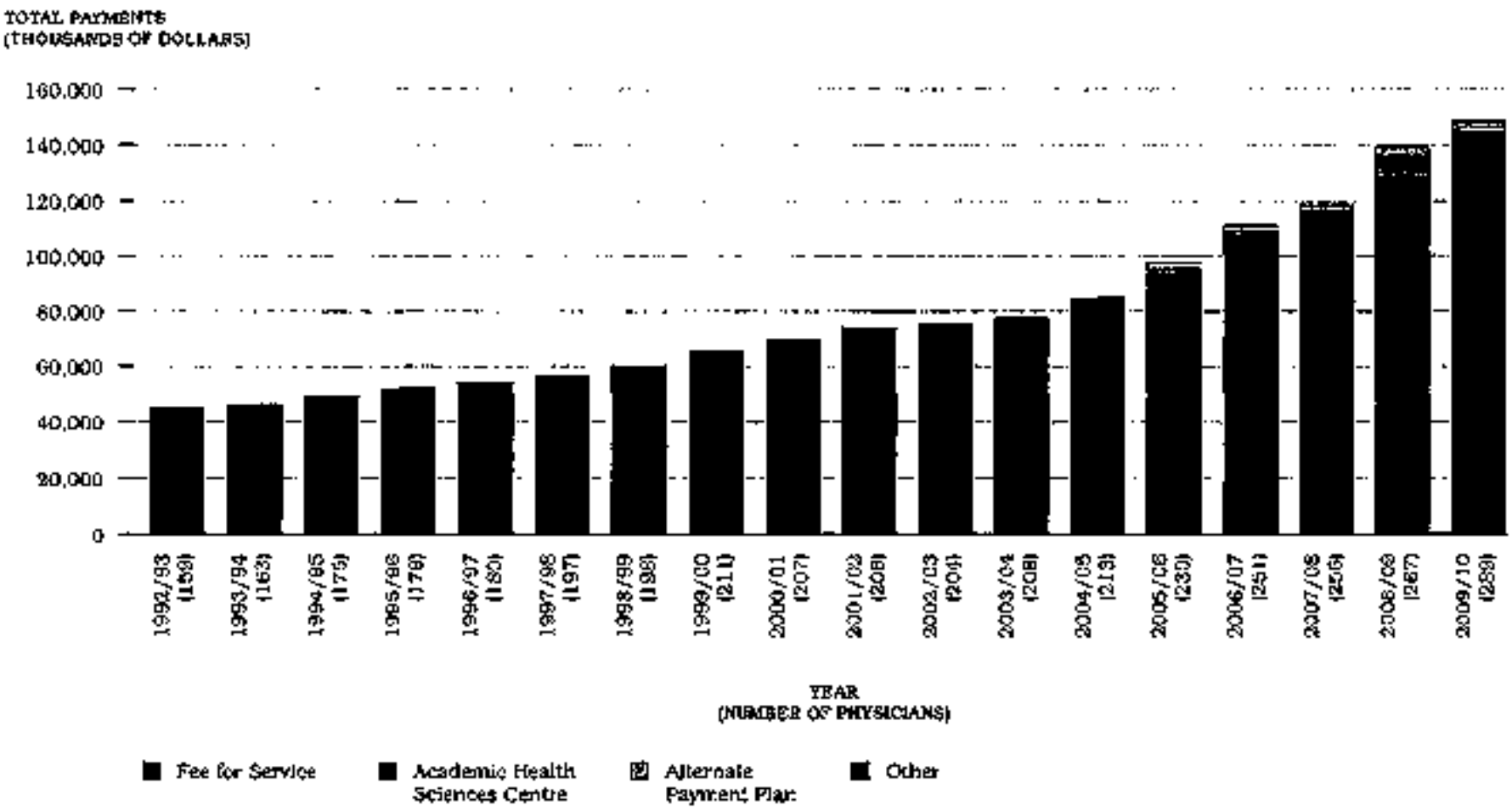
GASTROENTEROLOGISTS

EXHIBIT 6.5 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to gastroenterologists, in Ontario, 1992/93 to 2009/10



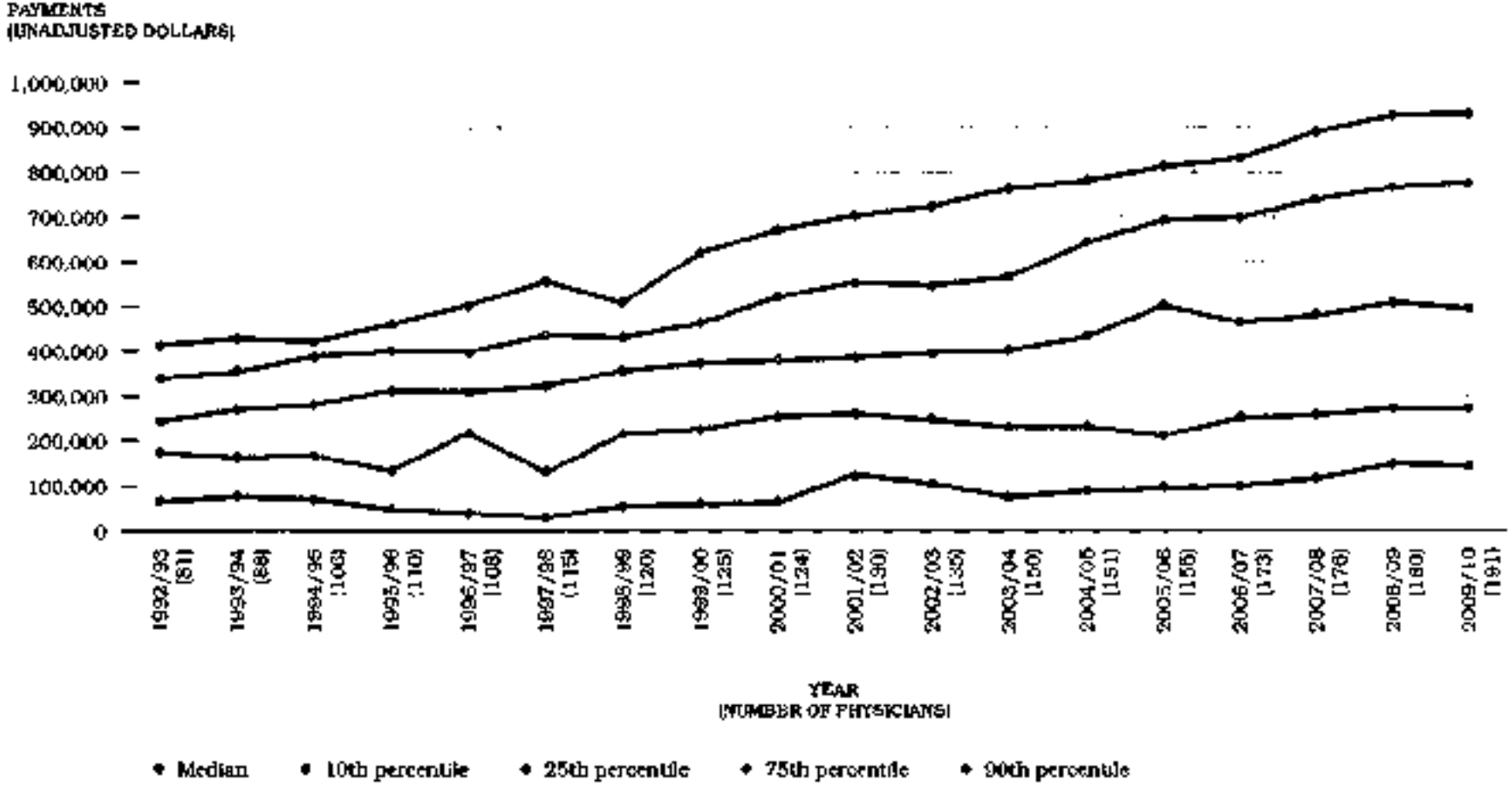
GASTROENTEROLOGISTS

EXHIBIT 6.6 Total payments to gastroenterologists by payment source, in Ontario, 1992/93 to 2009/10



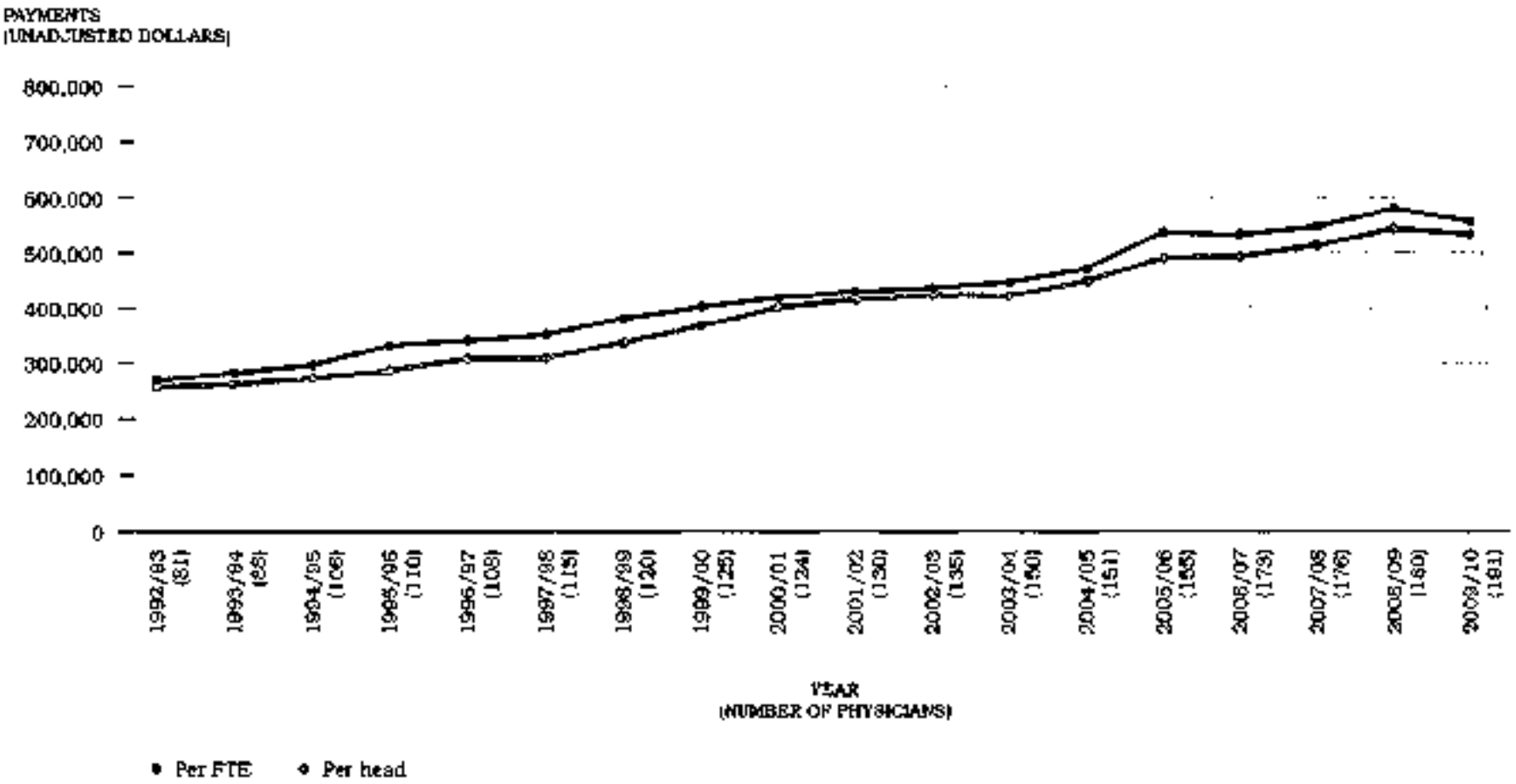
NEPHROLOGISTS

EXHIBIT 6.7 Median and percentiles of payments (in unadjusted dollars) to individual nephrologists, in Ontario, 1992/93 to 2009/10



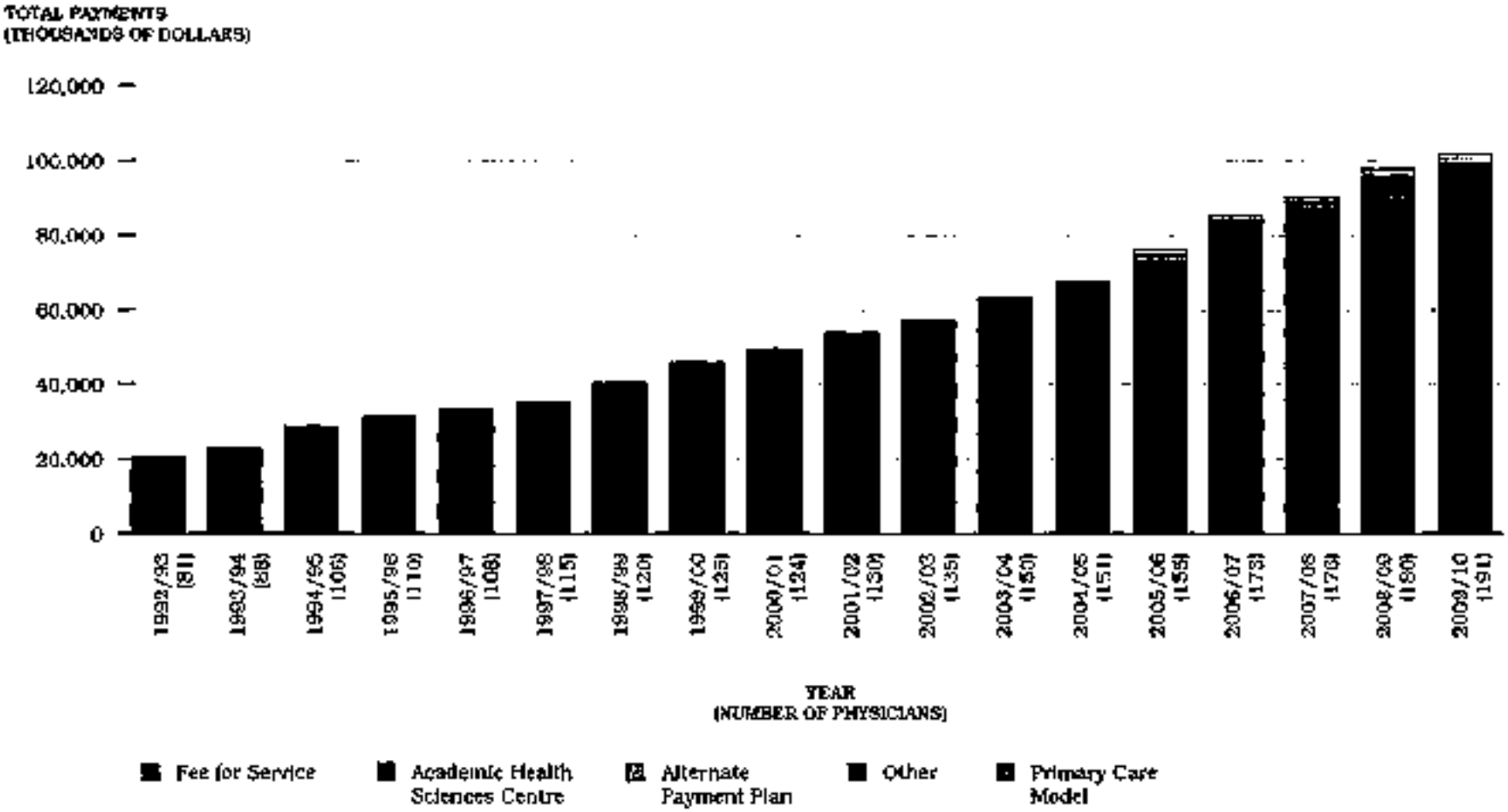
NEPHROLOGISTS

EXHIBIT 6.6 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to nephrologists, in Ontario, 1992/93 to 2009/10



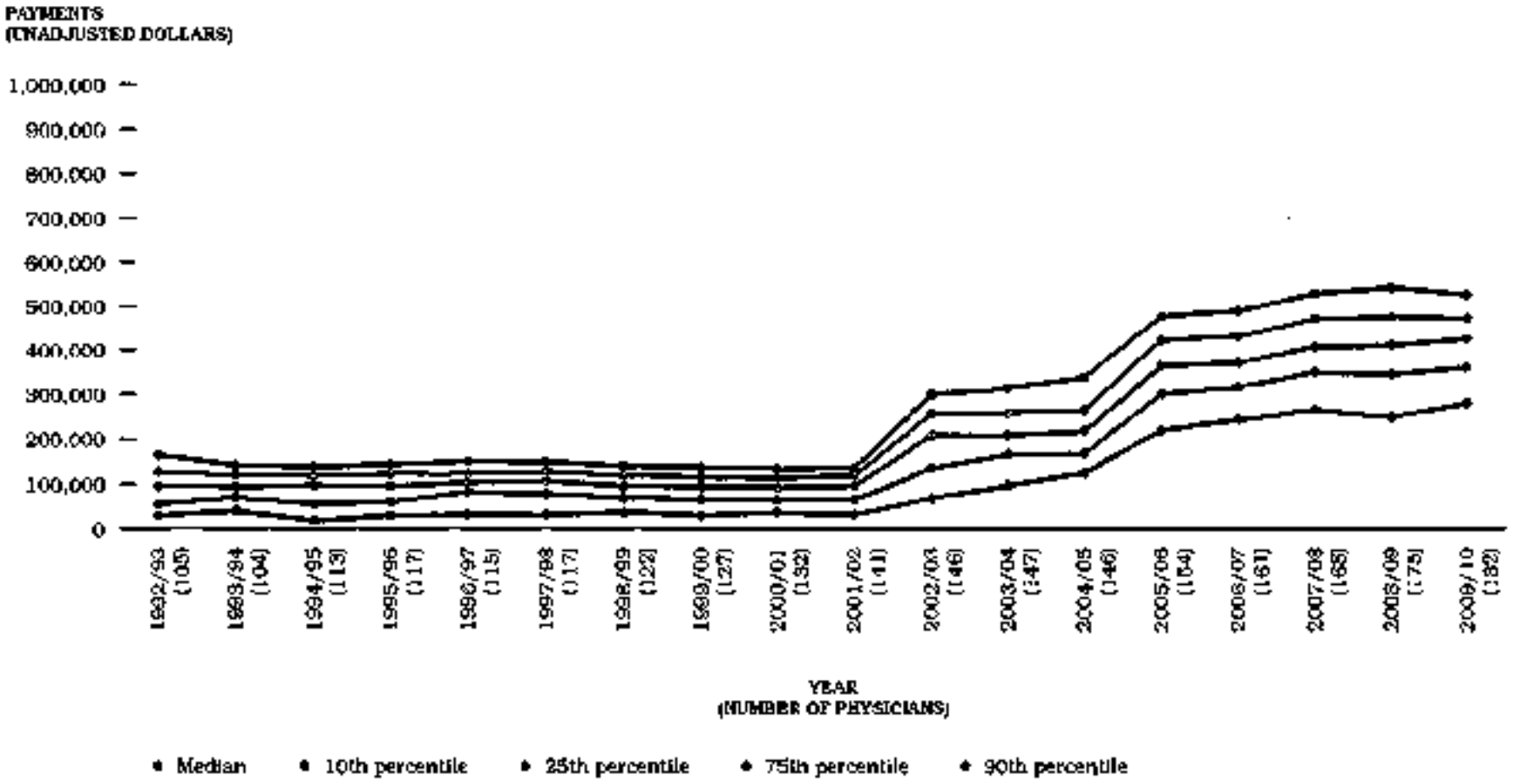
NEPHROLOGISTS

EXHIBIT 6.9 Total payments to nephrologists by payment source and year. in Ontario, 1992/93 to 2009/10



RADIATION ONCOLOGISTS

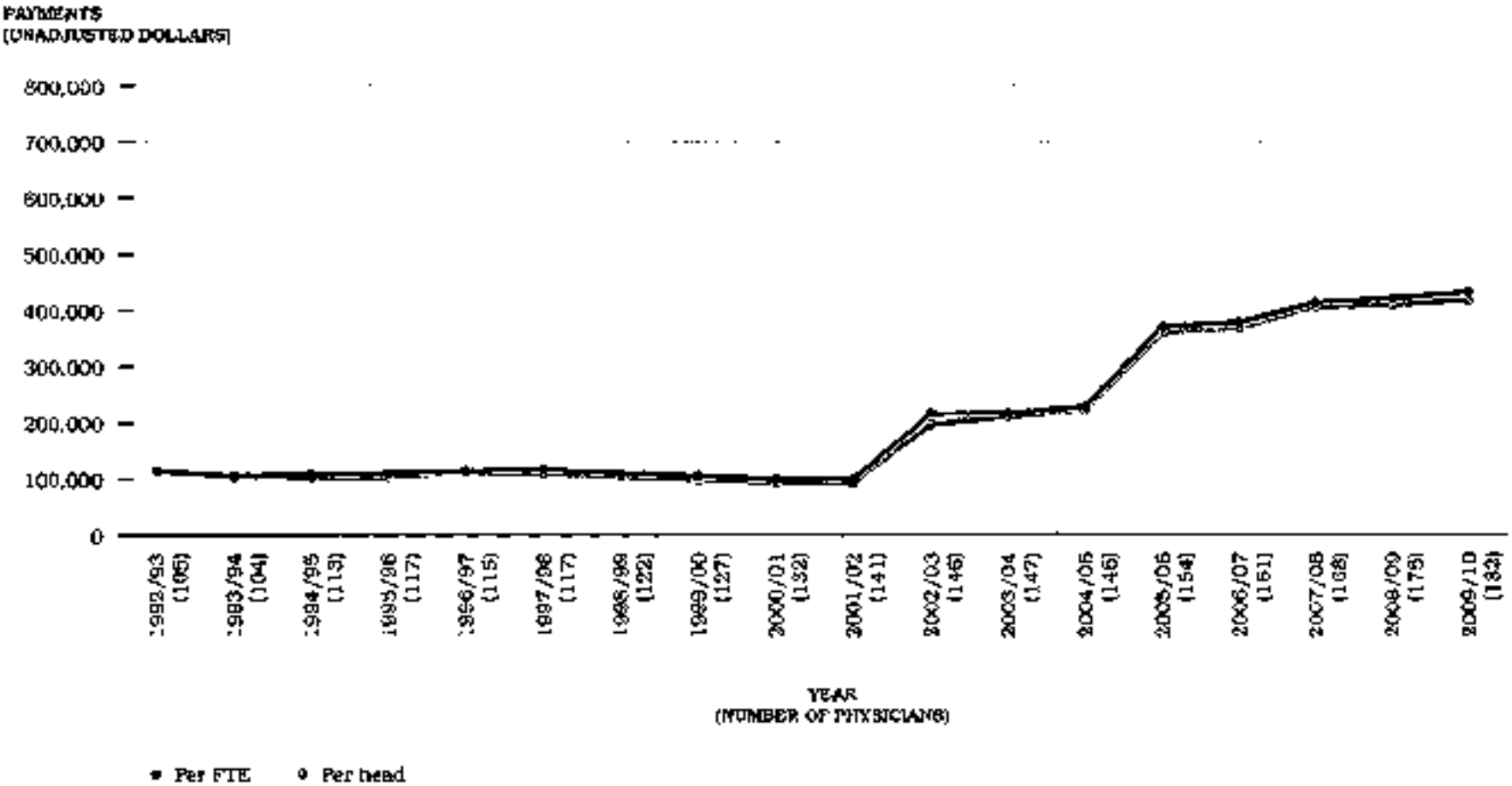
EXHIBIT 6.10 Median and percentiles of payments (in unadjusted dollars) to individual radiation oncologists, in Ontario, 1992/93 to 2009/10



Note: Results for radiation oncologists must be treated with caution prior to 2005/06 due to missing data.

RADIATION ONCOLOGISTS

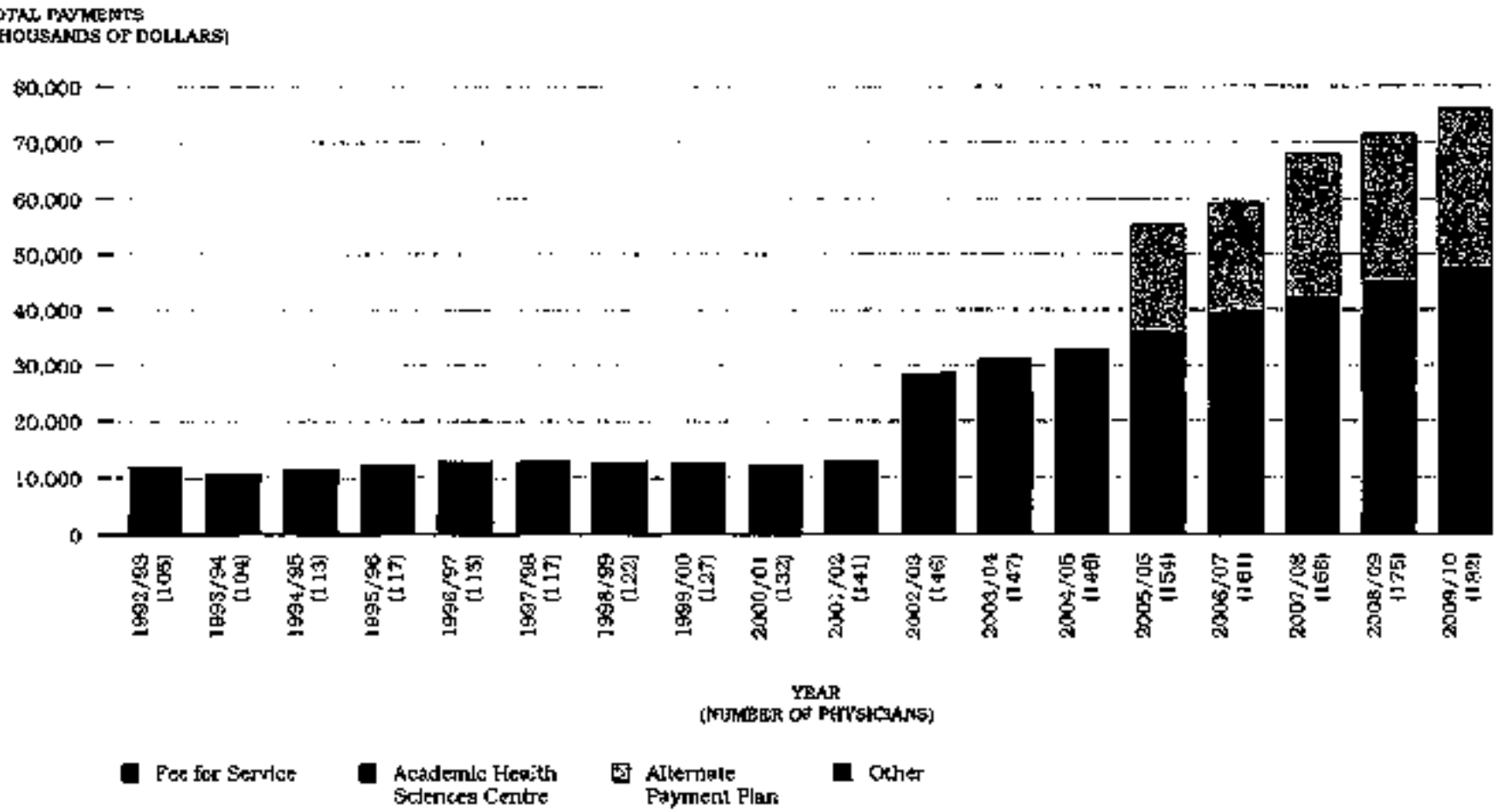
EXHIBIT 6.11 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to radiation oncologists, in Ontario, 1992/93 to 2009/10



Note: Results for radiance oncologists must be treated with caution prior to 2005/06 due to missing data.

RADIATION ONCOLOGISTS

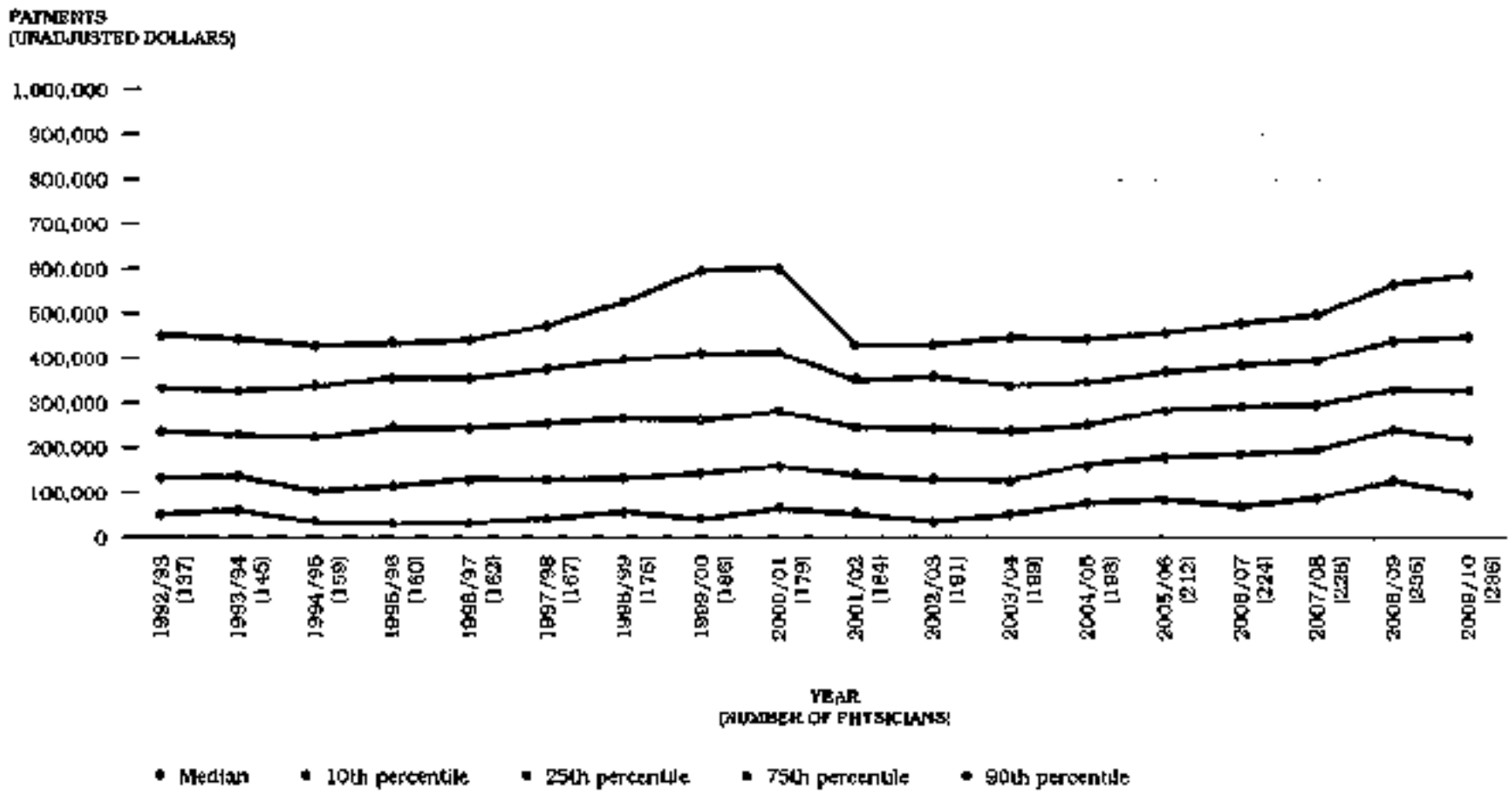
EXHIBIT 6.12 Total payments to radiation oncologists by payment source, in Ontario, 1992/93 to 2009/10



Note: Results for radiation oncologists must be treated with caution prior to 2005/06 due to missing data

RESPIROLOGISTS

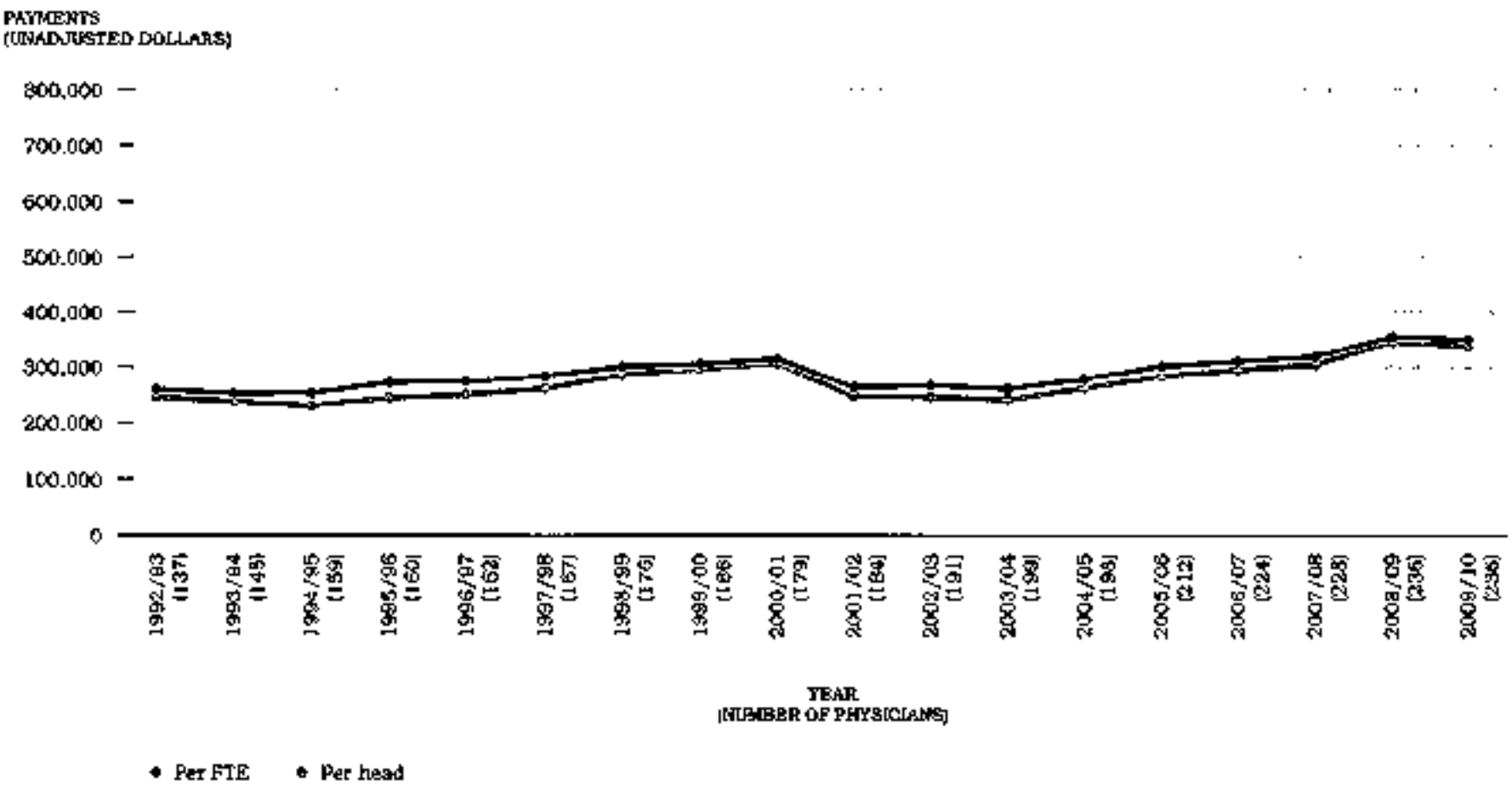
EXHIBIT 6.13 Median and percentiles of payments (in unadjusted dollars) to individual respirologists, in Ontario, 1992/93 to 2009/10



Note: Data prior to 2001/02 include some fees that combined technical and professional fees. Such combined fees were discontinued in 2000/01

RESPIROLOGISTS

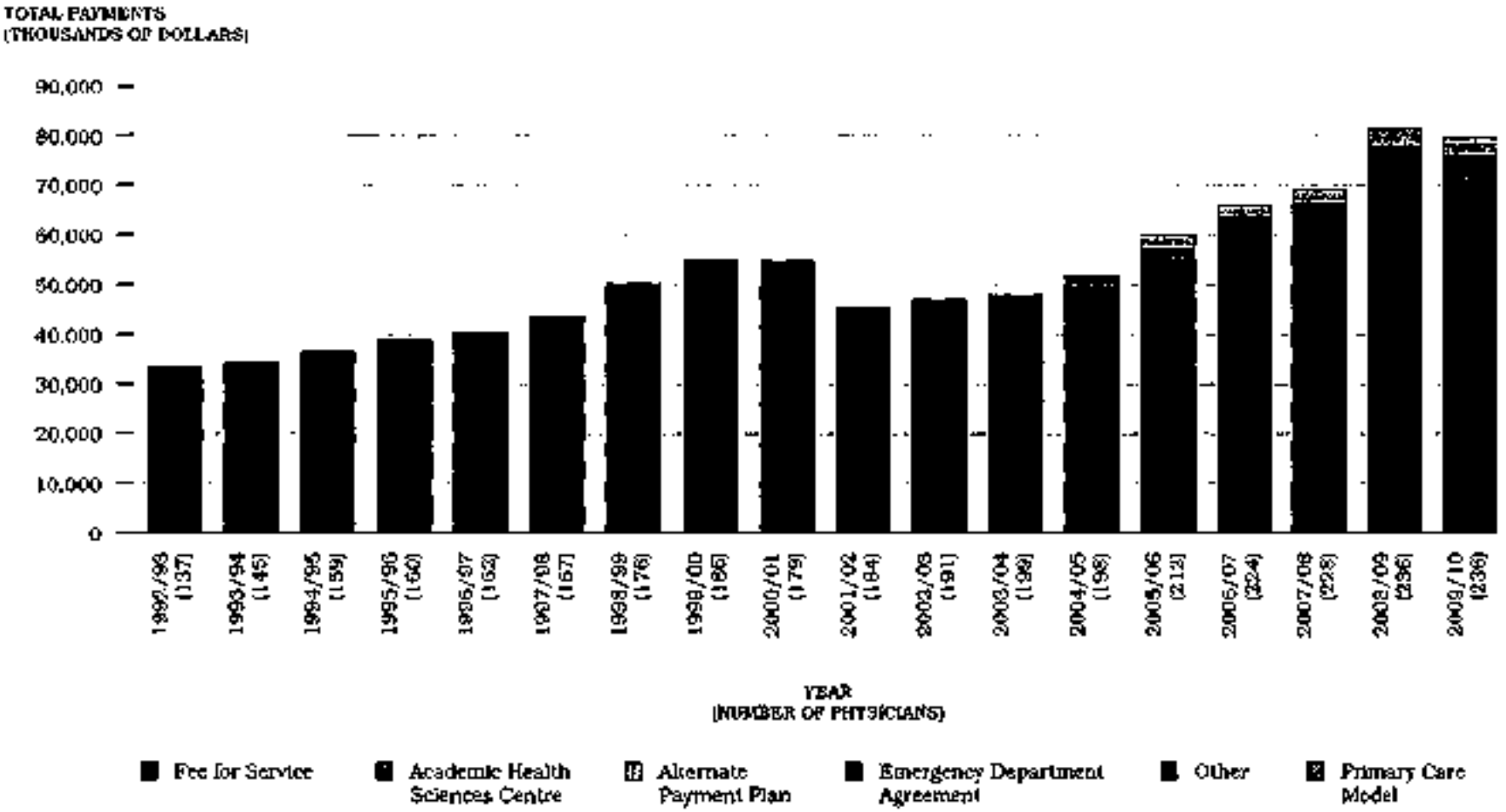
EXHIBIT 6.14 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to respirologists, in Ontario, 1992/93 to 2009/10



Note: Data prior to 2001/02 include some fees that combined technical and professional fees. Such combined fees were discontinued in 2000/01.

RESPIROLOGISTS

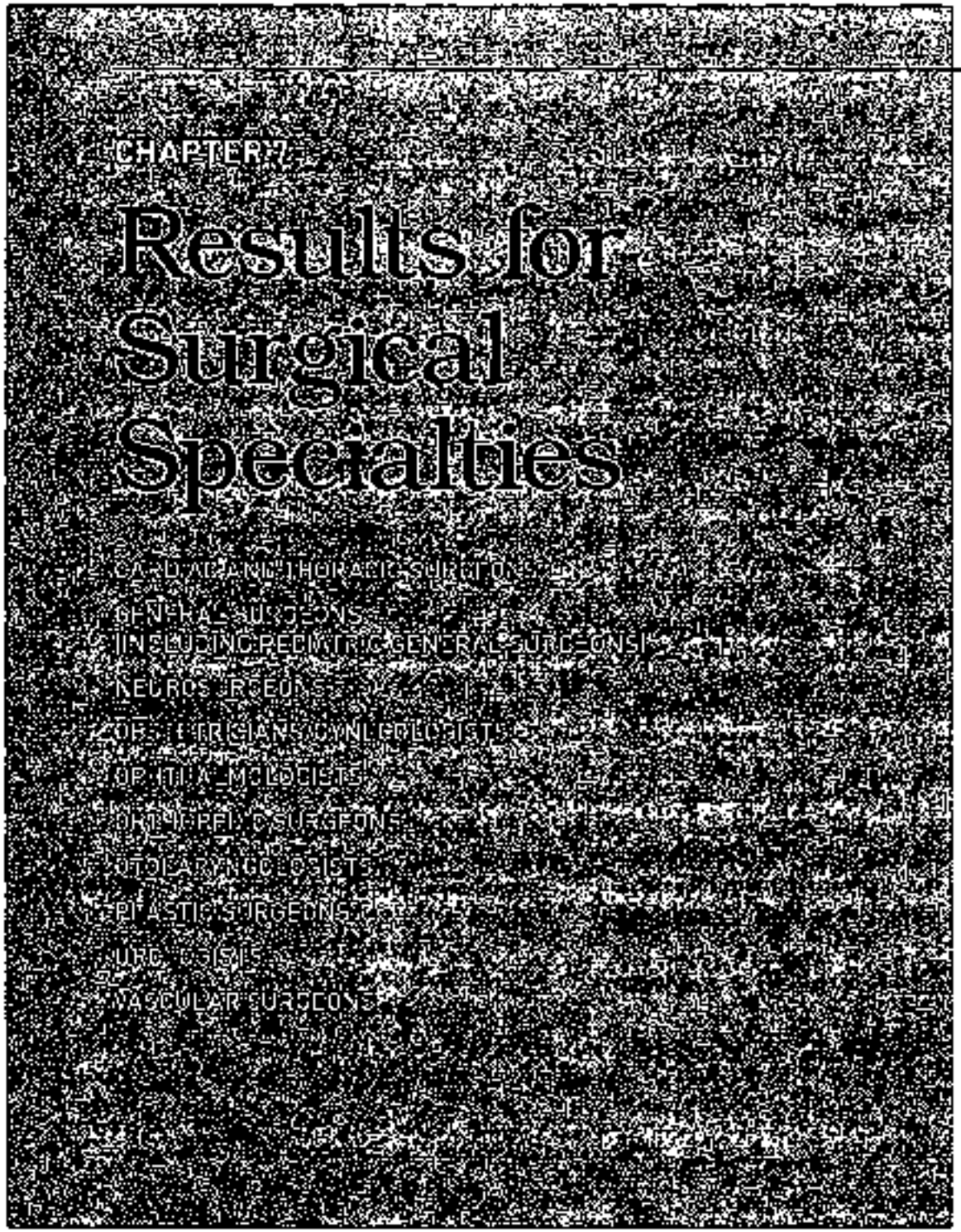
EXHIBIT 6.15 Total payments to respirologists by payment source, in Ontario, 1992/93 to 2009/10



Note: Data prior to 2001/02 include some fees that combined technical and professional fees. Such combined fees were discontinued in 2000/01.

CHAPTER 7

Results for Surgical Specialties



INTRODUCTION

This chapter describes payments to physicians who perform surgical procedures.

Surgery, perhaps more than other types of medical practice, is a collaborative effort. Most surgeries require, in addition to a surgeon, access to an operating room, an anesthesiologist, nursing staff and sometimes one or more additional doctors to provide assistance. Limits in any of these areas can have an effect on the number of surgeries performed and thus on payment levels. Conversely, investment in these areas, such as opening and staffing additional operating rooms, can increase the number of surgeries.

As noted elsewhere in this report, Ontario made a commitment in the early 2000s to reduce wait times for a range of surgical procedures. Hospitals received funding to increase the number of surgeries performed and thus reduce their waiting lists and patients' wait times. The initial strategy focused on wait times for three types of surgery: cataract removal, hip and knee replacement and cancer surgery. Subsequent funding initiatives have included general and pediatric surgery.

As discussed in the previous chapter in relation to procedural specialists, advances in technology have enabled a widening array of minimally invasive procedures to be performed under imaging guidance or through catheters or fibre-optic endoscopes. Some of these procedures (e.g., laparoscopic cholecystectomy and hysterectomy) continue to be performed by surgeons, but others are performed by medical procedural specialists, which are reviewed elsewhere in this report. Some surgeons have found efficiencies by focusing on a small range of procedures, with staffing and protocols in place that allow the surgeon to maximize the number of procedures that can be performed in a given time period. Two examples of this are cataract surgery and arthroscopic knee surgery.

Note: In compiling this chapter, we combined cardiac, cardiothoracic and thoracic surgeons into one group called 'cardiac and thoracic surgeons' because of the small number in the thoracic surgery group. For the same reason, pediatric general surgeons were included with general surgeons.

FINDINGS FOR INDIVIDUAL SPECIALTIES

Cardiac and Thoracic Surgery (exhibits 7.1 to 7.3)

Cardiac and thoracic (CT) surgery is a relatively small specialty. Although its numbers increased by 50% during the study period, there were fewer than 100 practicing CT surgeons in Ontario in 2009/10. Total payments to this group in 2009/10 amounted to $45 million. The median and mean annual payments to CT surgeons rose steadily through the period, amounting to $500,000 in 2009/10, an increase of about 20% from 2005/06. The median annual payment to CT surgeons was consistently higher than for all physicians combined. In 1992/93, it was about 82% higher; in 2009/10, it was 79% higher. The range of payments was wide, with the top 10% of CT surgeons being paid a minimum of $800,000 compared to the bottom 10% who received $100,000 or less. The size of this difference suggests a wide variation in practice patterns, with those at the low end either working part-time or perhaps devoting more time to teaching or research.

General Surgery (exhibits 7.4 to 7.6)

The supply of active general surgeons fell 12% during the 1990s from 655 in 1992/93 to 575 in 2001/02. Since then it has grown to 699 in 2009/10, an overall increase of only 7% from 1992/93. Total payments to general surgeons in 2009/10 amounted to $264 million. The median and mean annual payments to general surgeons have increased steadily since around 1997/98 and have remained above the levels paid to all physicians. Approximately 10% of general surgeons were paid more than $650,000 in 2009/10 and the lowest 10% were paid $50,000 or less. General surgeons received about 88% of their payments from FFS in 2009/10.

Neurosurgery (exhibits 7.7 to 7.9)

This is a relatively small specialty. The number of neurosurgeons declined from 85 in 1992/93 to 65 in 2003/04 (a 24% decrease) before rebounding to 97 in 2009/10 (an overall increase of 14%). The total of all payments to neurosurgeons in 2009/10 was $41 million. The median payment for this specialty in 1992/93 was higher than that for all physicians. The median payment began to increase in 1997/98 and by 2009/10 had risen 126%. The range of payment was wide with 10% of neurosurgeons being paid more than $800,000 and 10% less than $100,000. Alternate funding in addition to FFS for neurosurgery was introduced in 2002/03 (although data were only available from 2005/06). In 2009/10, only 68% of neurosurgery funding was by FFS; the rest was from alternate funding sources.

Obstetrics and Gynecology (exhibits 7.10 to 7.12)

Obstetricians and gynecologists (OB/GYNs) comprise a large specialty that numbered 790 in 2009/10, an increase of 18% from 1992/03 (667). The total of all payments to this specialty in 2009/10 was $323 million. The median and mean payments to OB/GYNs rose steadily from 1999/00 and remained approxmately 50% higher than those for all physicians throughout the period of observation. Ten percent of OB/GYNs were paid more than $670,000 in 2009/10 and 10% were paid less than $100,000. The great majority of payments (89%) were by FFS.

Ophthalmology (exhibits 7.13 to 7.15)

The number of ophthalmologists rose only 8% over the study period, from 408 in 1992/93 to 441 in 2009/10. Total payments to this specialty amounted to $257 million in 2009/10. The median payment rose steadily from just under $300,000 in 1997/98 to $500,000 in 2009/10 and remained well above that of all physicians with the difference increasing over time. However, the mean payment to ophthalmologists rose sharply to around $600,000 in 2009/10, indicating a skewed distribution of values. This is confirmed by the fact that 10% of ophthalmologists were paid more than $1.1 million in 2009/10, whereas the bottom 10% were paid $100,000 or less. The great majority of payments (98%) were by FFS.

Orthopedic Surgery (exhibits 7.16 to 7.18)

The supply of orthopedic surgeons in Ontario increased by 40%, from 374 in 1992/93 to 524 in 2009/10. The total of all payments to this specialty in 2009/10 was $192 million. The median payment to orthopedic surgeons was about $100,000 higher than for all physicians throughout the study period. Payments were fairly flat during the 1990s and rose after 2003/04. The mean and median values were quite similar with a fairly equal distribution of values above and below the median. The top 10% of orthopedic surgeons were paid more than $500,000 in 2009/10 and the bottom 10% received less than $50,000. Approximately 90% of payments were by FFS.

Otolaryngology (exhibits 7.19 to 7.21)

The supply of otolaryngologists changed very little over the study period, rising from 235 in 1992/93 to 248 in 2009/10. All payments to this specialty totalled $97 million in 2009/10. Mean and median annual payments to individuals in this group remained about $100,000 higher than for all physicians, staying fairly flat through the 1990s and rising after 2003/04. The median payment in 2009/10 was around $400,000 with 10% of otolaryngologists being paid more than $600,000 and 10% being paid $108,000 or less. About 90% of payments were by FFS.

Plastic Surgery (exhibits 7.22 to 7.24)

The number of plastic surgeons practicing in Ontario increased by 29% from 1992/93 to 200 in 2009/10, with payments totaling nearly $64 million in that year. Mean and median payments to individuals remained fairly flat and only rose after 2004/05, by about 21%. Median payments to plastic surgeons were about 40% higher than median payments to all physicians in 1992/93, compared with 15% higher in 2009/10. Mean payments followed a similar trend. In 2009/00, 10% of plastic surgeons were paid over $550,000 and 10% were paid less than $100,000. Eighty-six percent of payments were from FFS and 14% from alternate payment sources.

Urology (exhibits 7.25 to 7.27)

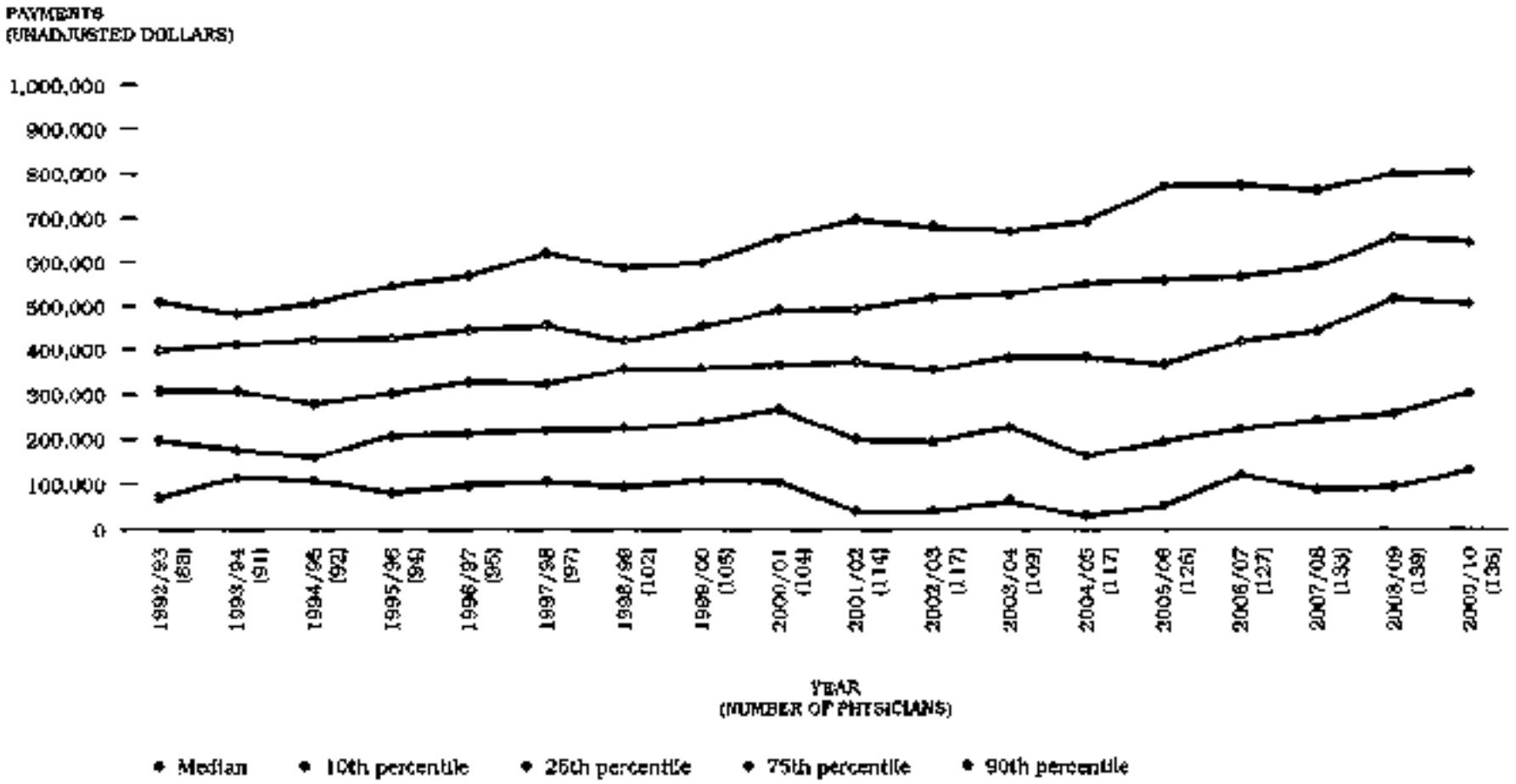
The number of practicing urologists increased by 31%, from 205 in 1992/93 to 268 in 2009/10. The total of all payments in 2009/10 was $106 million. Median and mean annual payments to individual urologists were similar and rose from about $300,000 in 1999/00 to around $400,000 in 2009/10. The mean payment for urologists was around $100,000, more than the average for all physicians during much of the period of observation. Ten percent of urologists were paid $665,000 or more in 2009/10, and 10% received less than $100,000. Ninety percent of payments were by FFS.

Vascular Surgery (exhibits 7.28 to 7.30)

This is a small specialty with 50 surgeons practicing in 1992/93 and 72 in 2009/10. Payments totalled $38 million in the latter year. The median payment to vascular surgeons was 75% higher than the median payment for all physicians, increasing by 22% between 2005/06 and 2009/10. Exhibit 7.28 does not include the 10th and 90th percentiles because they would be based on payments to a small number of physicians and therefore would be very unstable (e.g., the top and bottom 10% each included only five physicians in 1992/93 and only seven in 2009/10). Seventy-nine percent of payments reported for this specialty were from FFS and 21% from alternate payment sources.

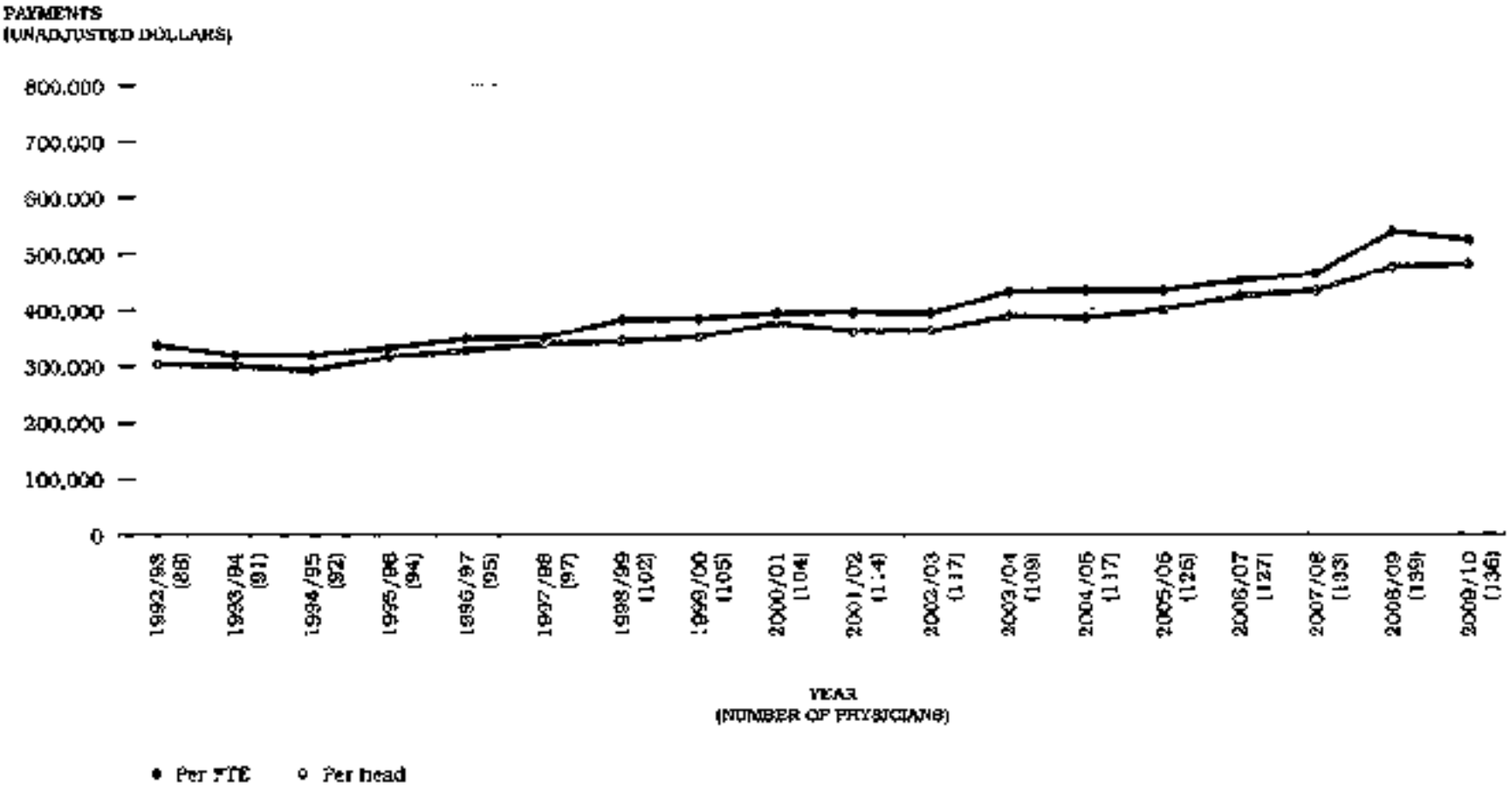
CARDIAC AND THORACIC SURGEONS

EXHIBIT 7.1 Median and percentiles of payments (in unadjusted dollars) to individual cardiac and thoracic surgeons, in Ontario, 1992/93 to 2009/10



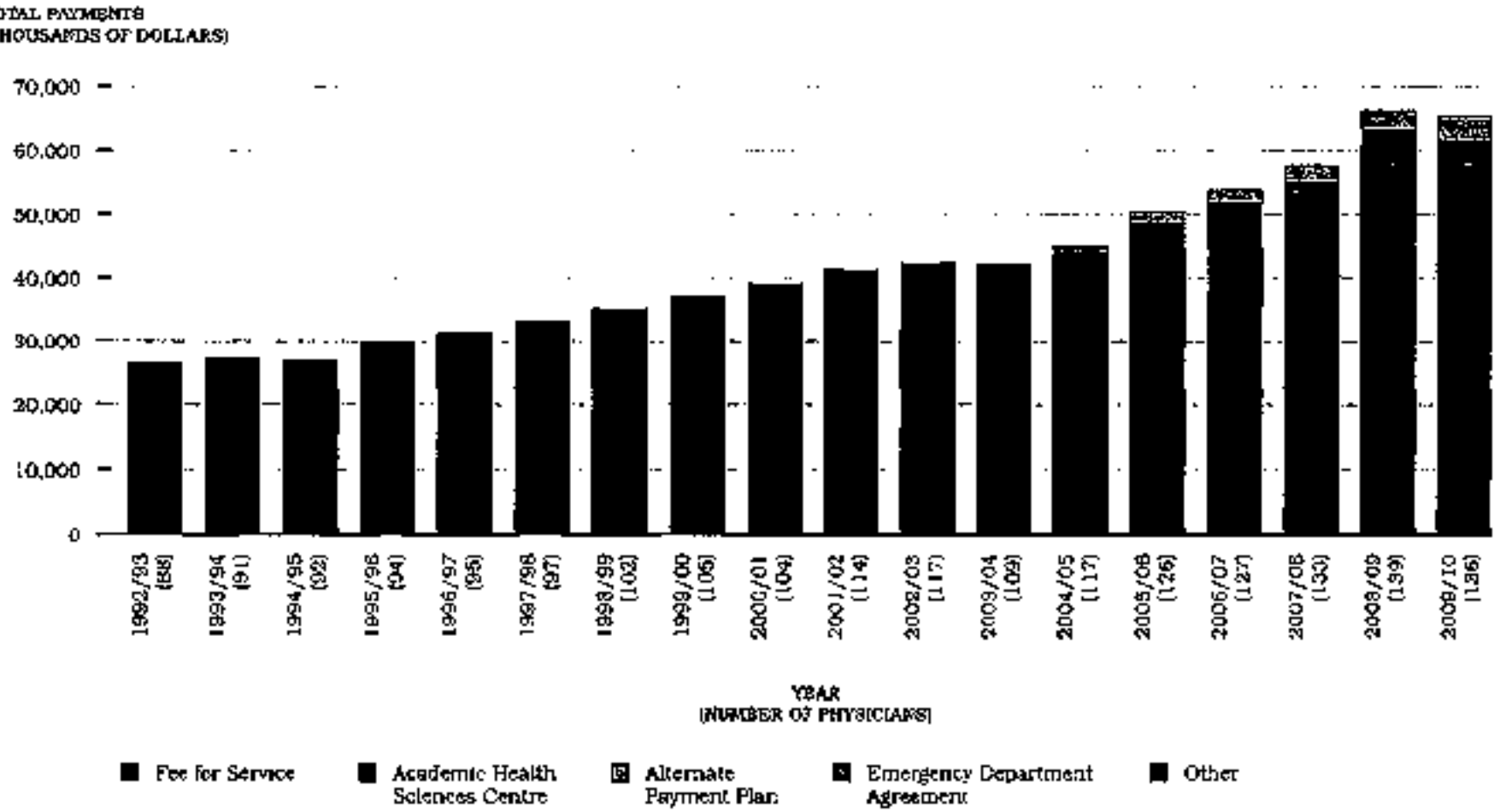
CARDIAC AND THORACIC SURGEONS

EXHIBIT 7.2 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to cardiac and thoracic surgeons, in Ontario, 1992/93 to 2009/10



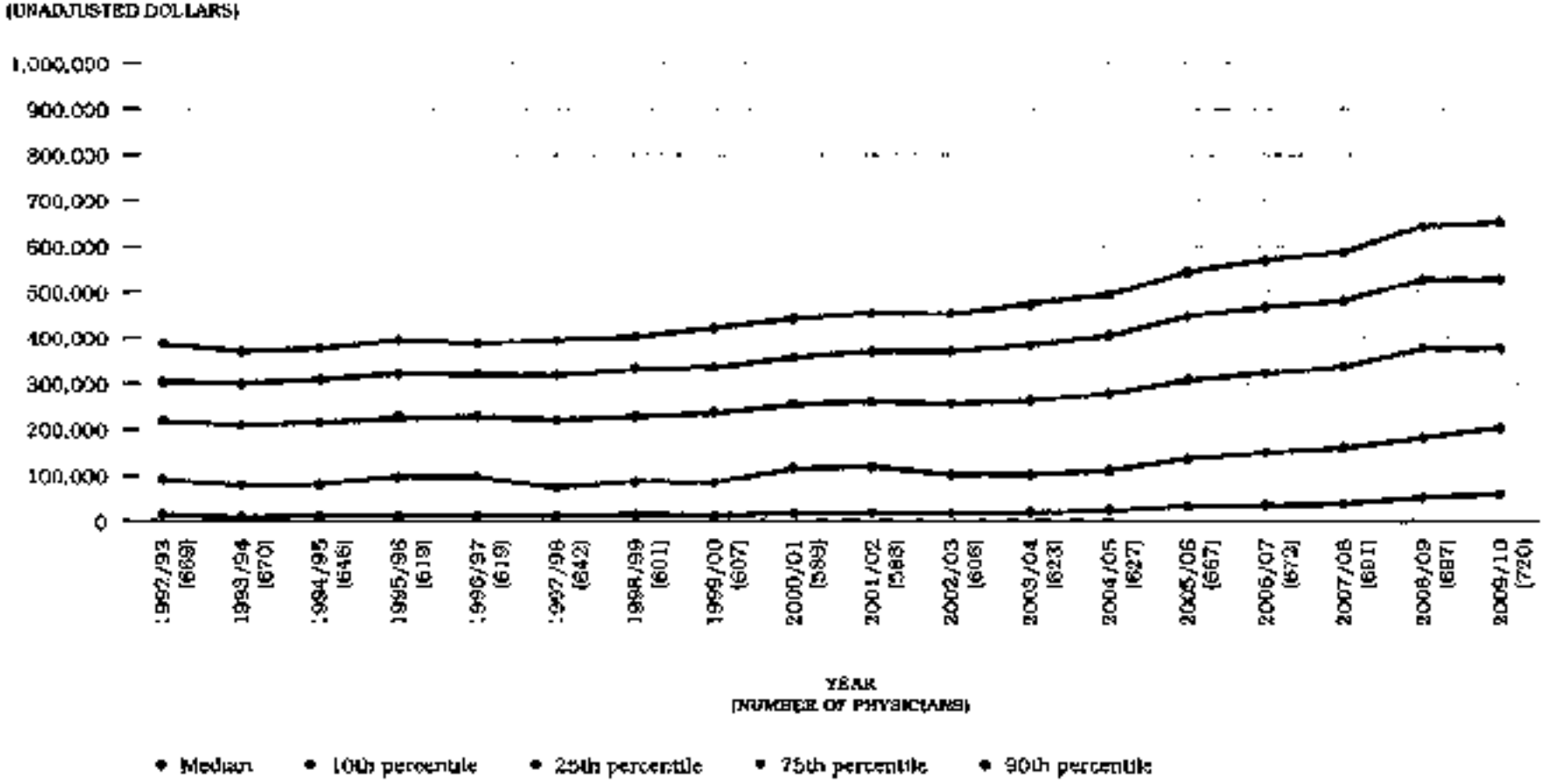
CARDIAC AND THORACIC SURGEONS

EXHIBIT 7.8 Total payments to cardiac and thoracic surgeons by payment source, in Ontario, 1992/93 to 2009/10



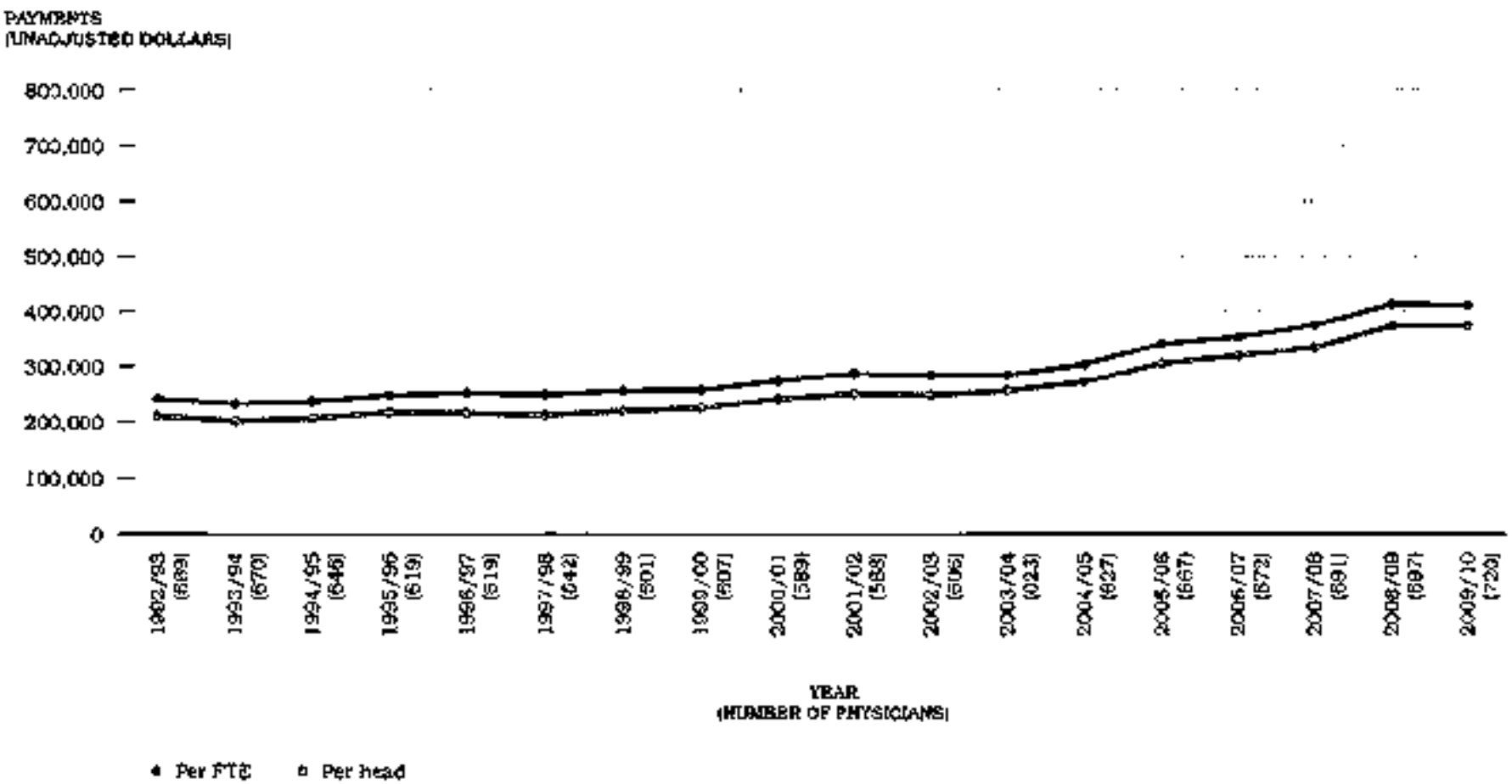
GENERAL SURGEONS

EXHIBIT 7.4 Median and percentiles of payments (in unadjusted dollars) to individual general surgeons, in Ontario, 1992/93 to 2009/10



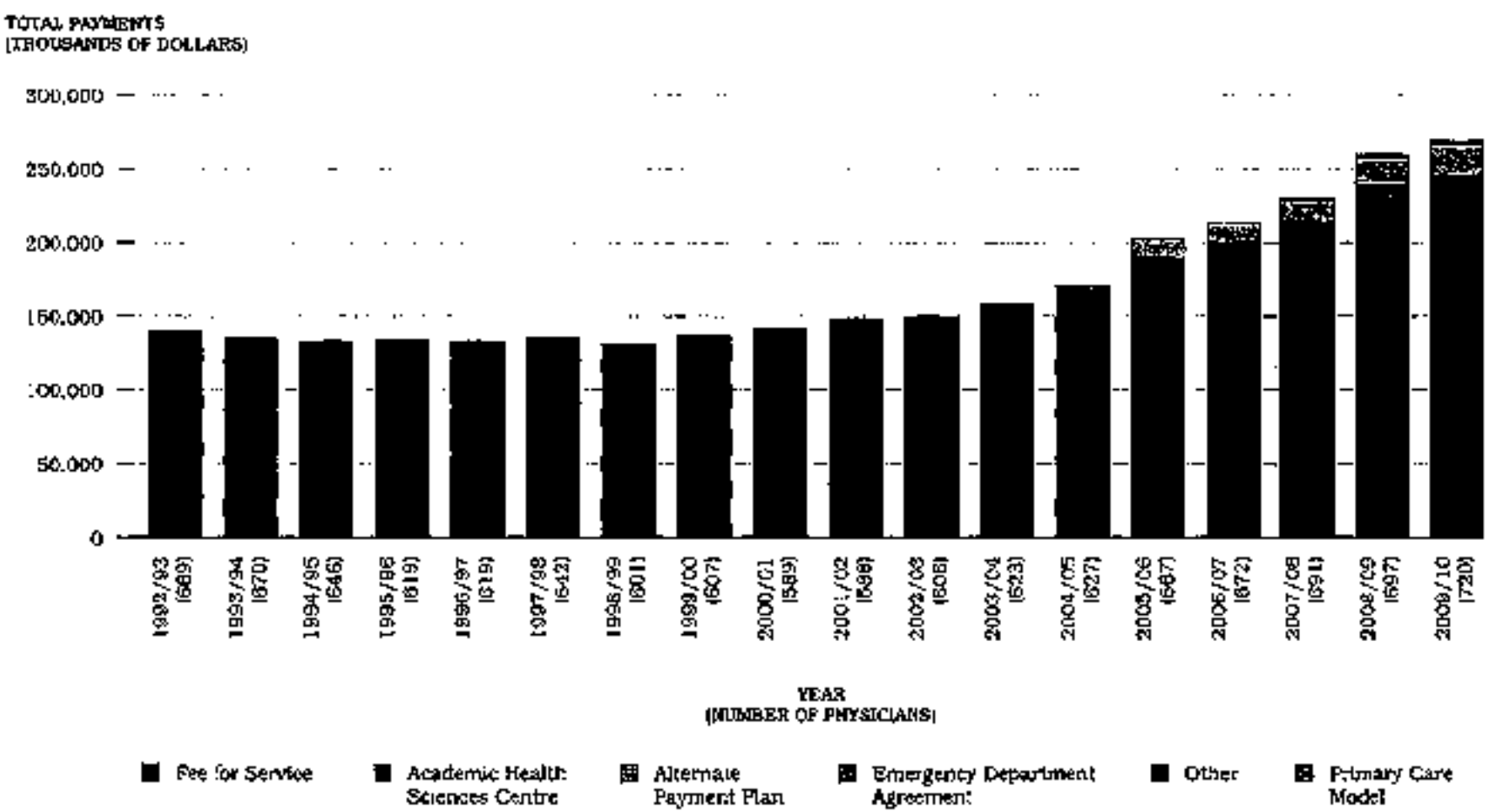
GENERAL SURGEONS

EXHIBIT 7.1 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE), to general surgeons, in Ontario, 1992/93 to 2009/10



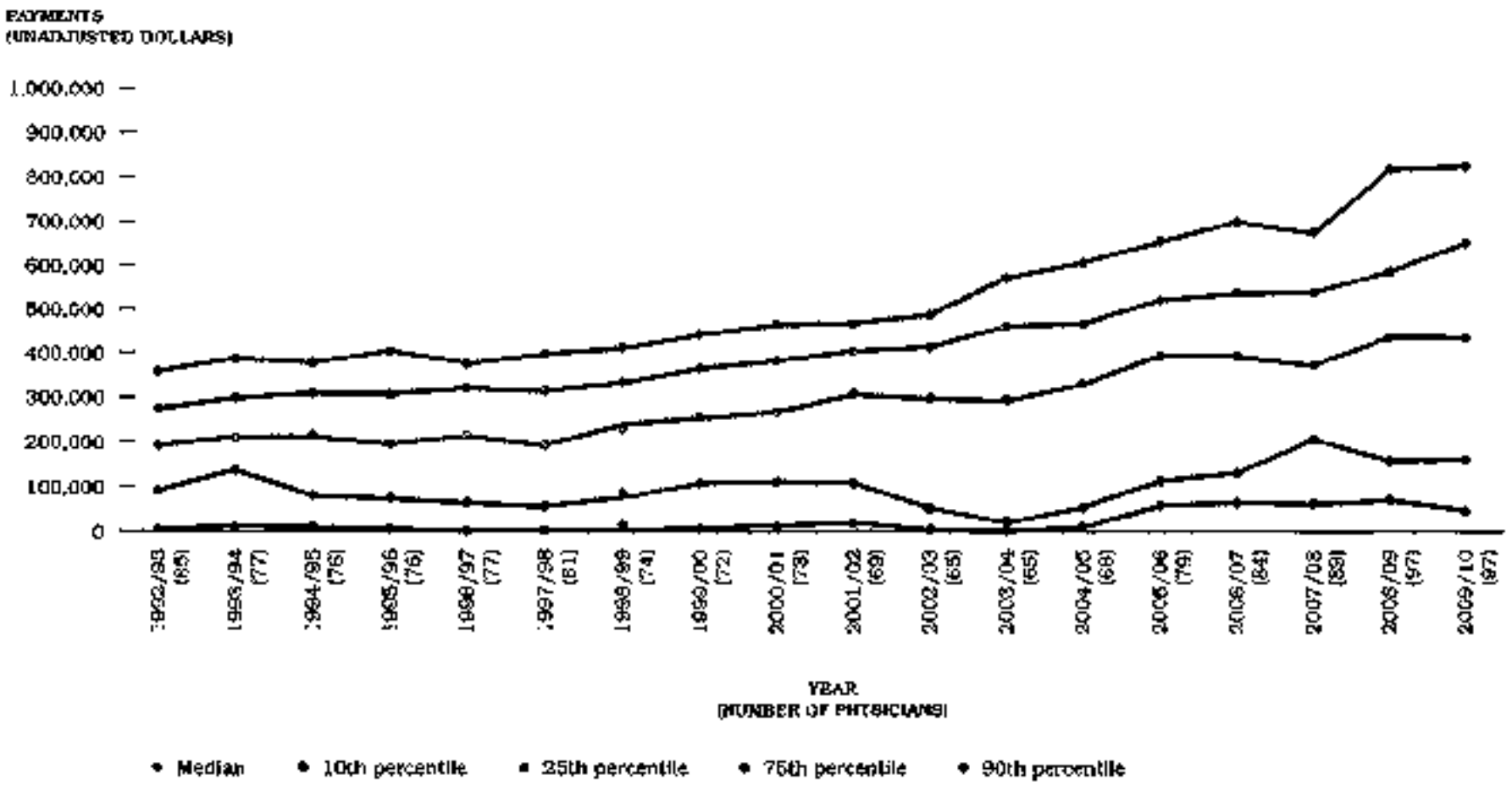
GENERAL SURGEONS

EXHIBIT 7.6 Total payments to general surgeons by payment source, in Ontario, 1992/93 to 2009/10



NEUROSURGEONS

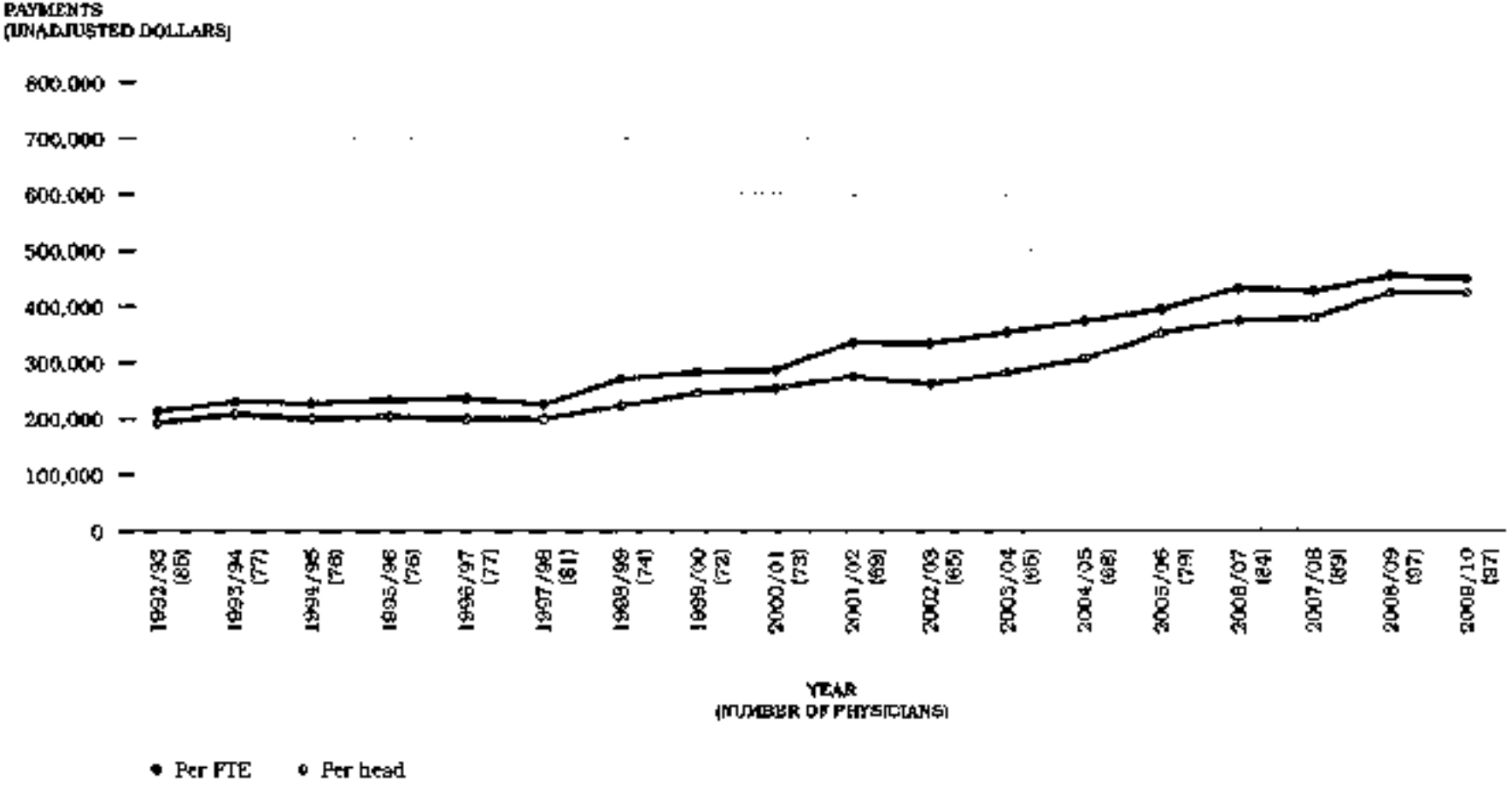
EXHIBIT 7.7 Median and percentiles of payments (in unadjusted dollars) to individual neurosurgeons. In Ontario, 1992/93 to 2009/10



Note: Data from 2002/03 to 2004/05 should be treated with caution due to missing AFP payment information

NEUROSURGEONS

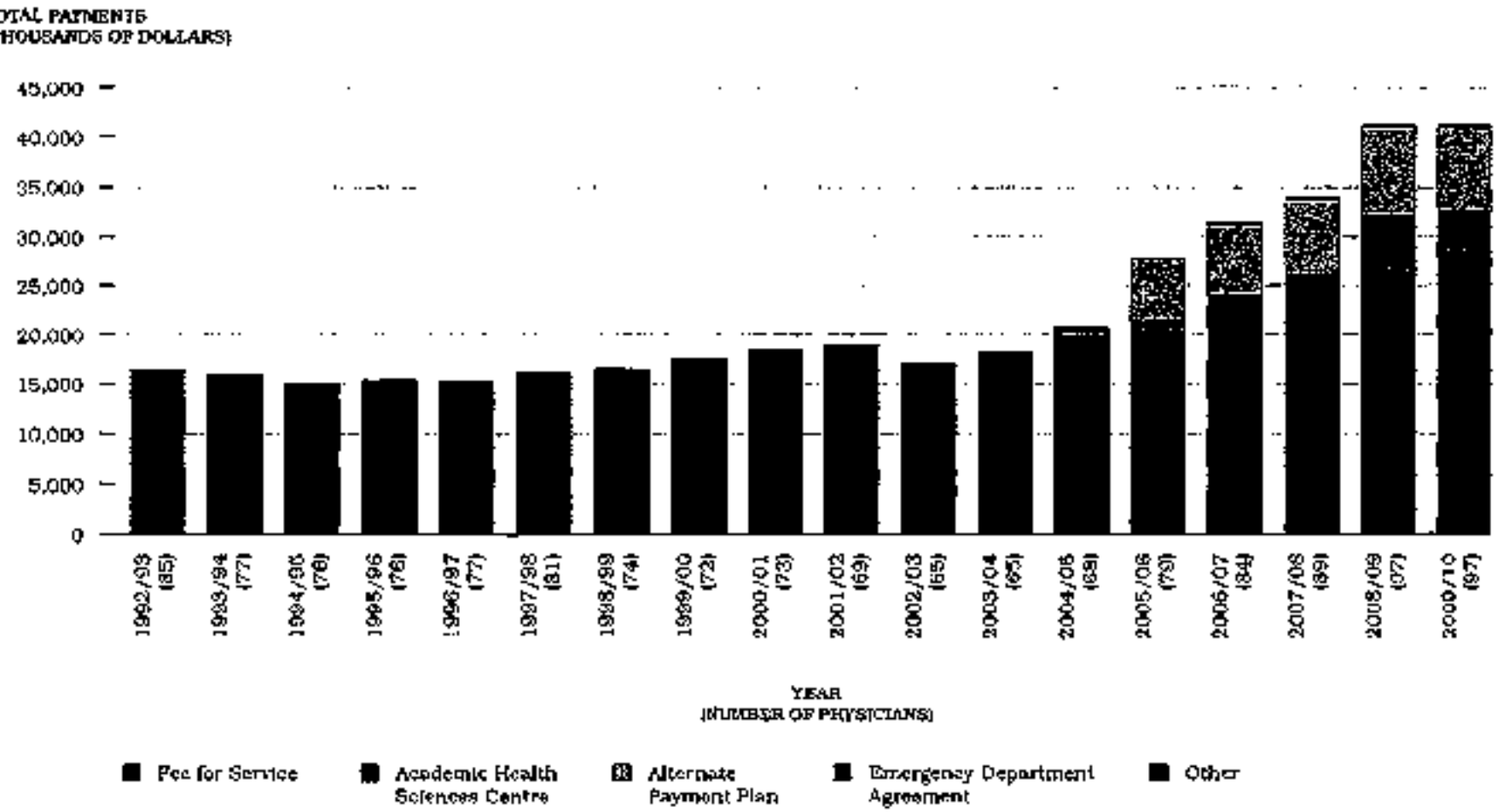
EXHIBIT 7.8 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to neurosurgeons, in Ontario, 1992/93 to 2009/10



Note: Data from 2002/03 to 2004/05 should be treated with caution due to missing OHIP payment information.

NEUROSURGEONS

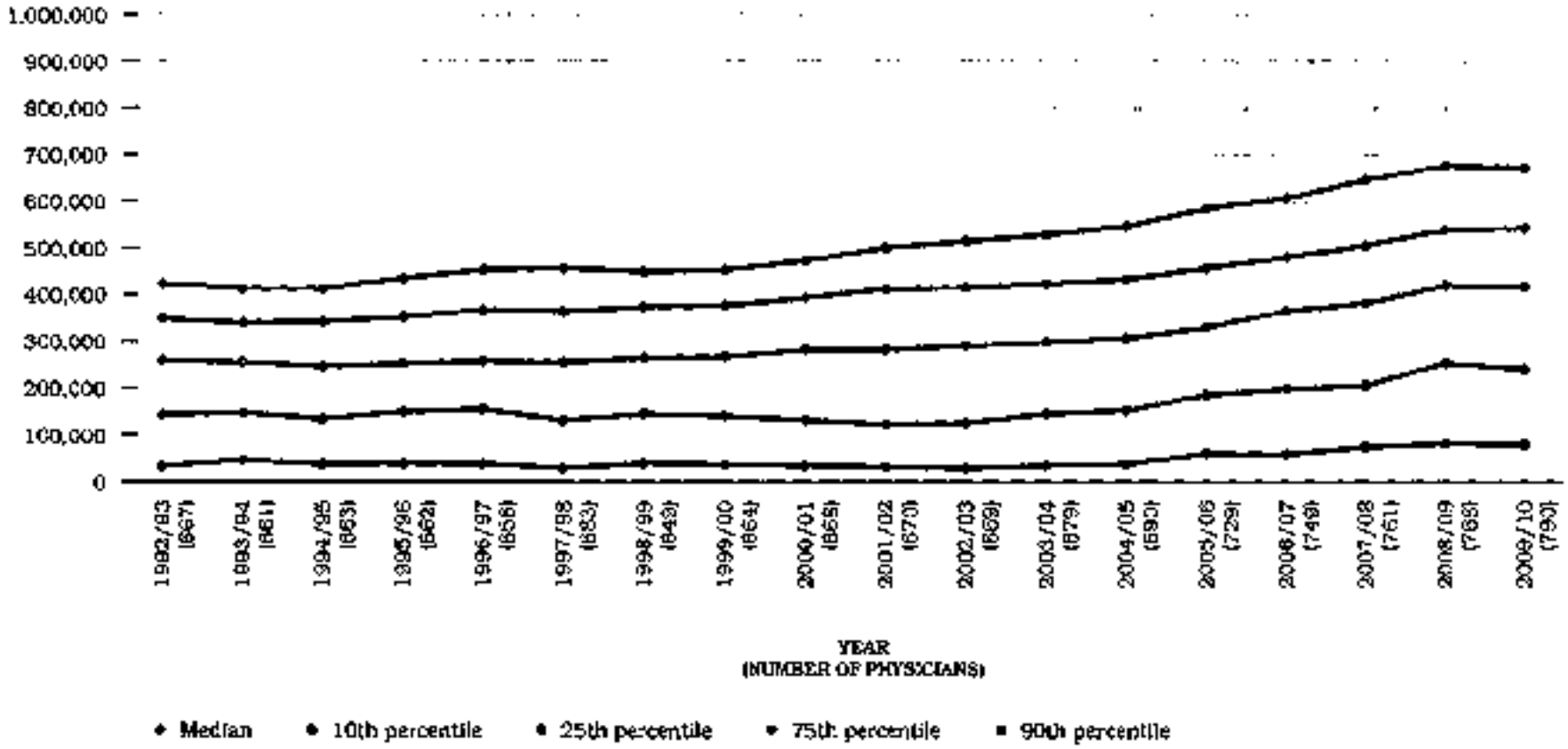
EXHIBIT 7.9 Total payments to neurosurgeons by payment source.
in Ontario, 1992/93 to 2009/10



Note: Data from 2002/03 to 2004/05 should be treated with caution due to missing APP payment information.

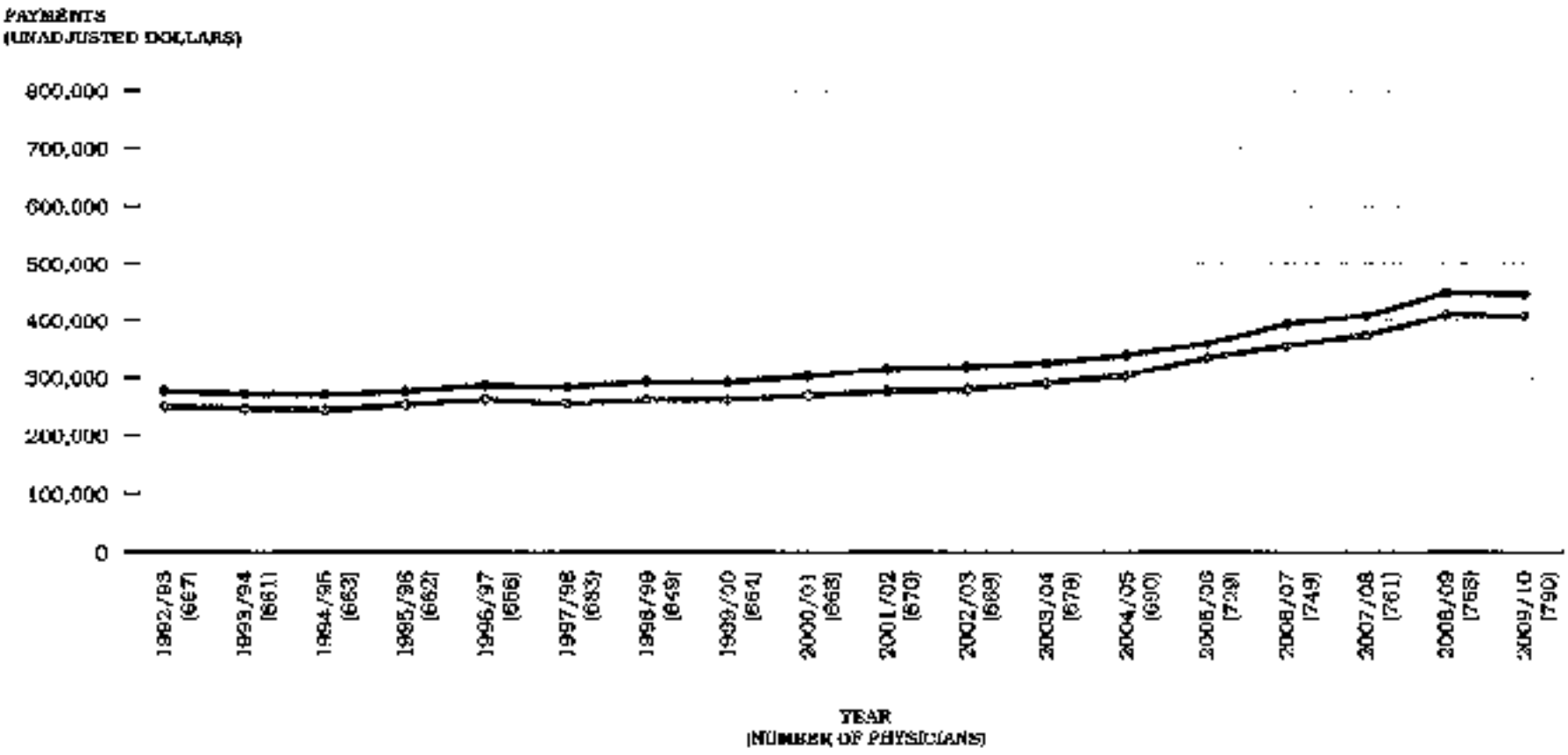
OBSTETRICIANS AND GYNECOLOGISTS

EXHIBIT 7.10 Median and percentiles of payments (in unadjusted dollars) to individual obstetricians and gynecologists, in Ontario, 1992/93 to 2009/10



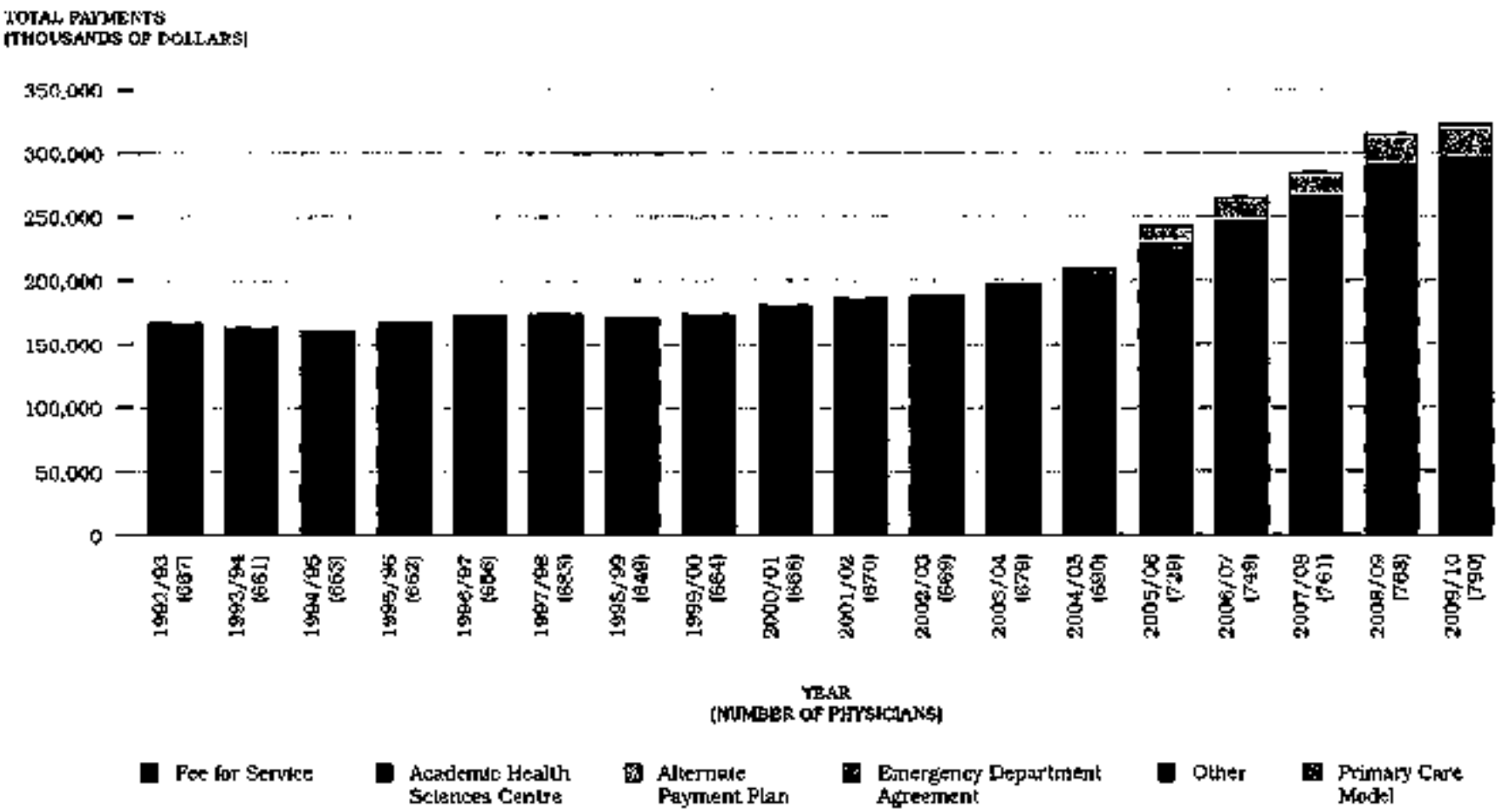
OBSTETRICIANS AND GYNECOLOGISTS

EXHIBIT 7.11 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to obstetricians and gynecologists. In Ontario, 1992/93 to 2009/10



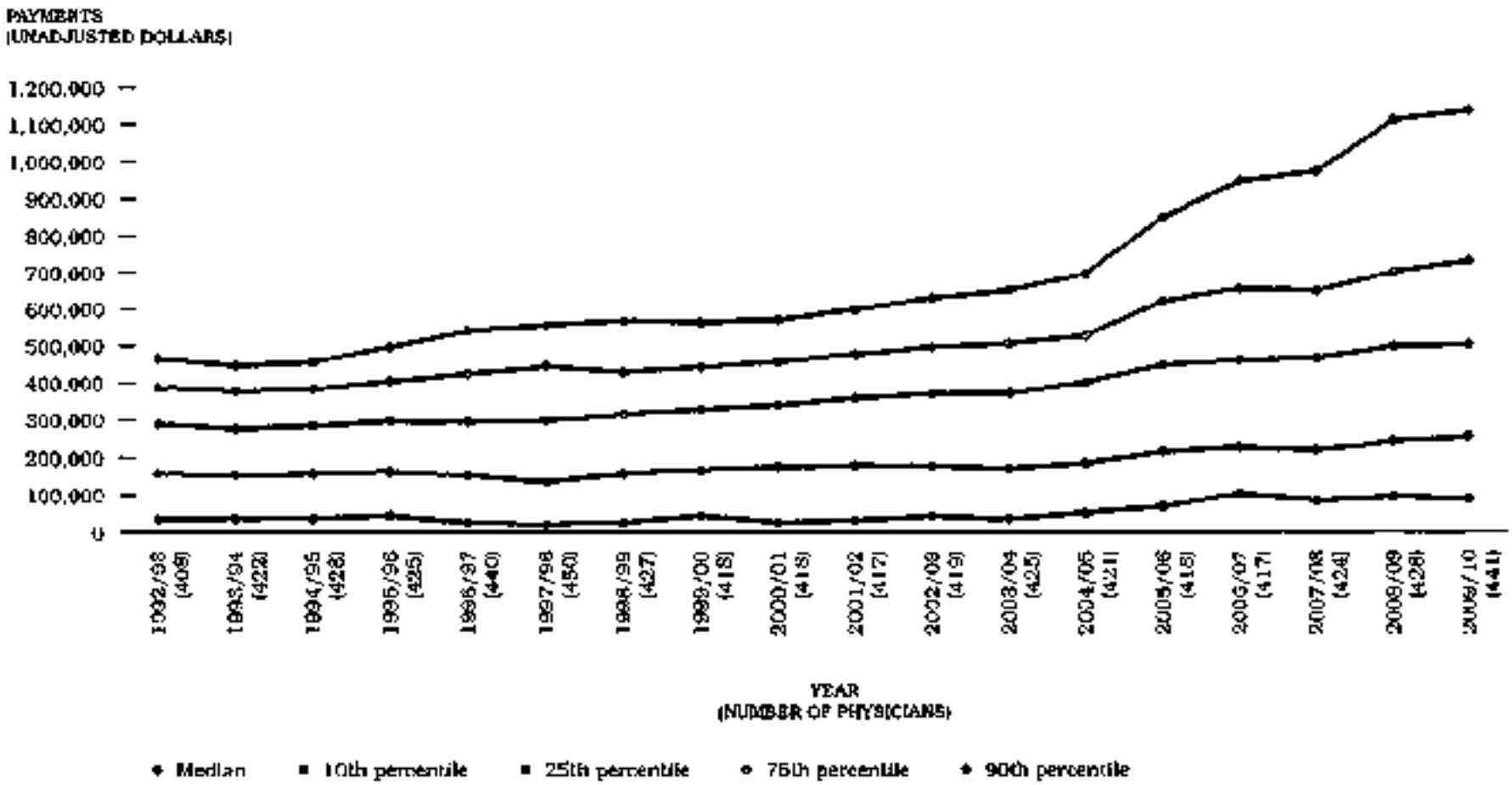
OBSTETRICIANS AND GYNECOLOGISTS

EXHIBIT 7.12 Total payments to obstetricians and gynecologists by payment source, in Ontario, 1992/93 to 2009/10



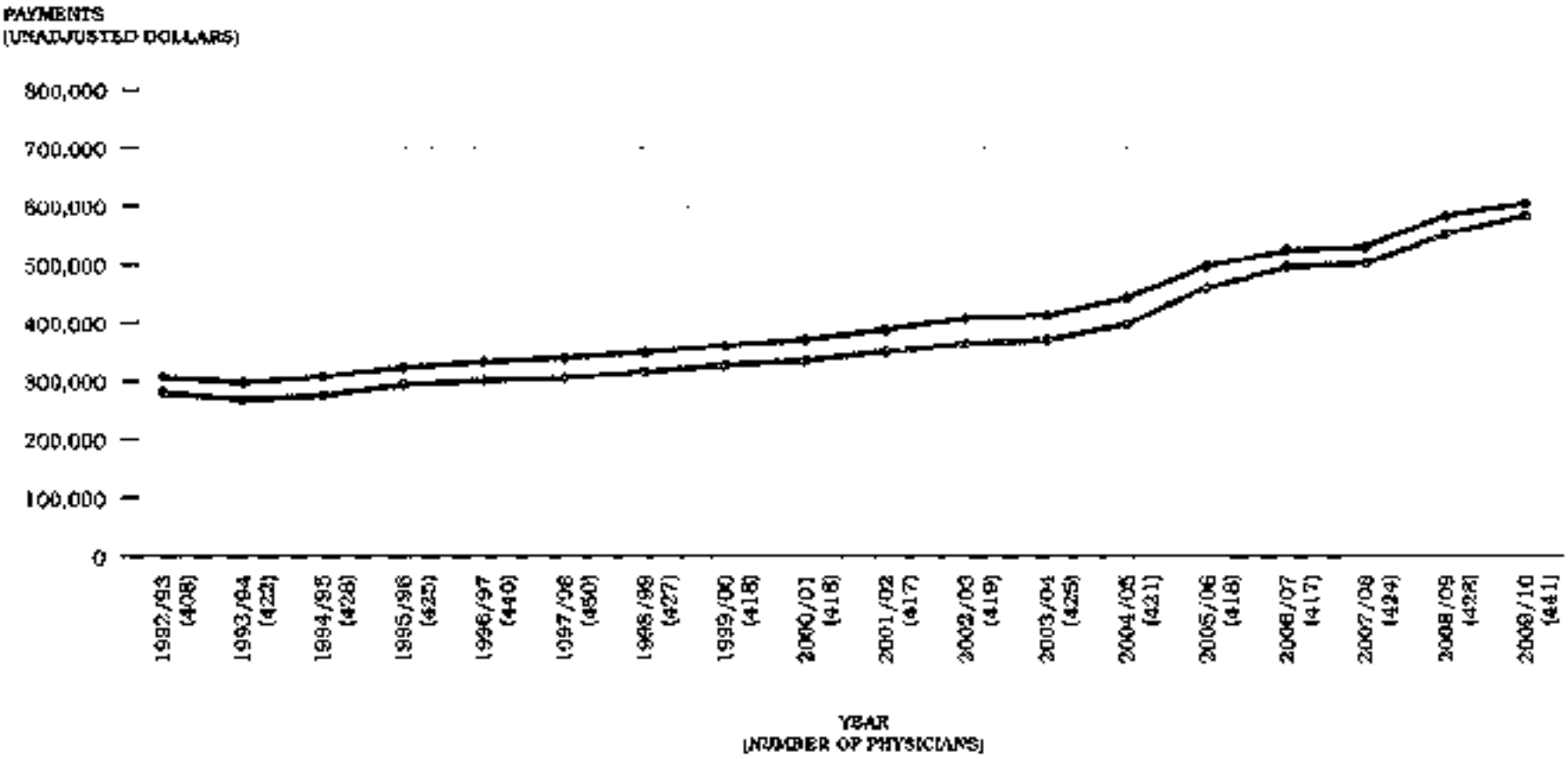
OPHTHALMOLOGISTS

EXHIBIT 7.13 Median and percentiles of payments (in unadjusted dollars) to individual ophthalmologists, in Ontario, 1992/93 to 2009/10



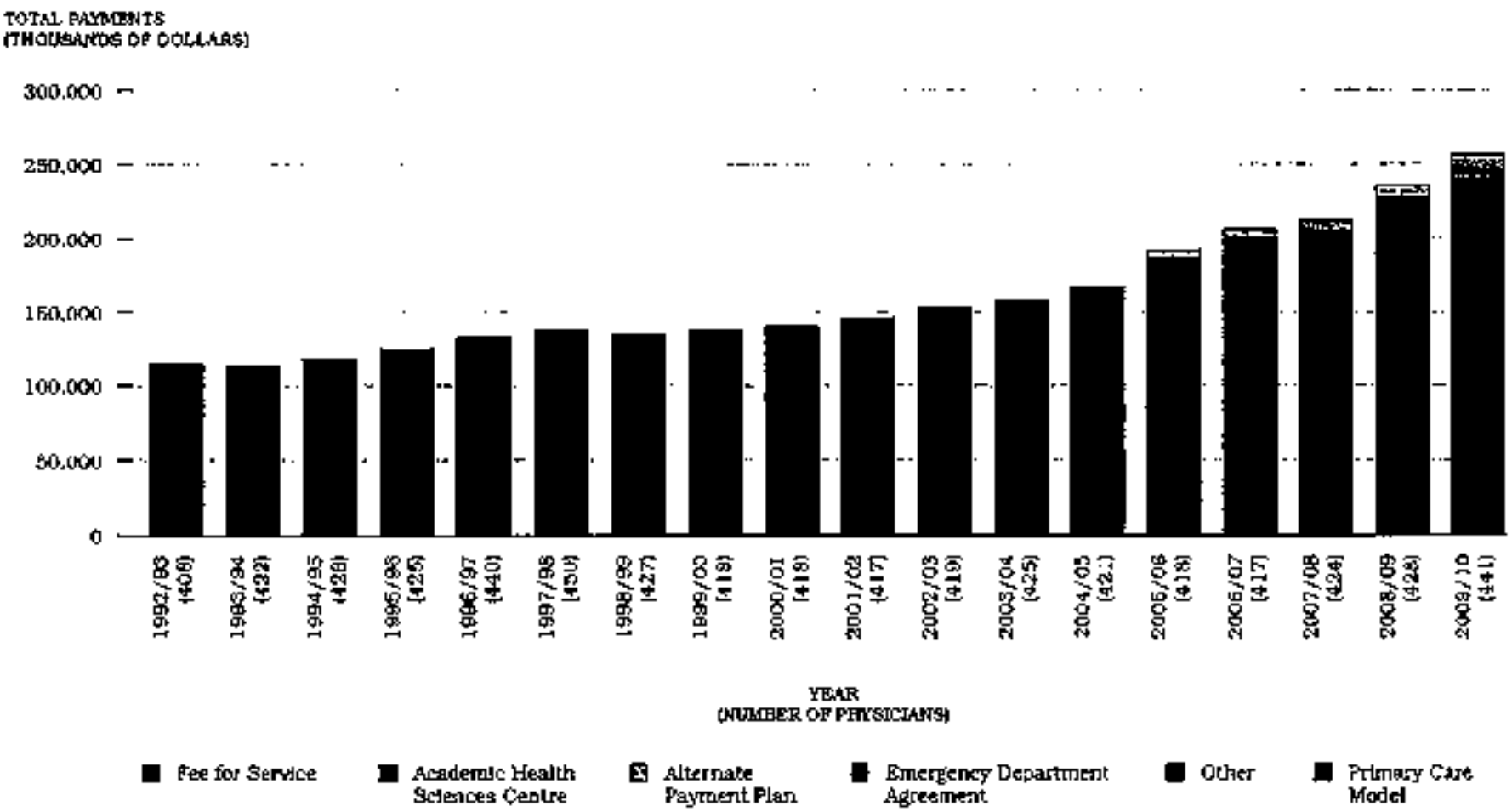
OPHTHALMOLOGISTS

EXHIBIT 7.14 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to ophthalmologists, in Ontario, 1992/93 to 2009/10



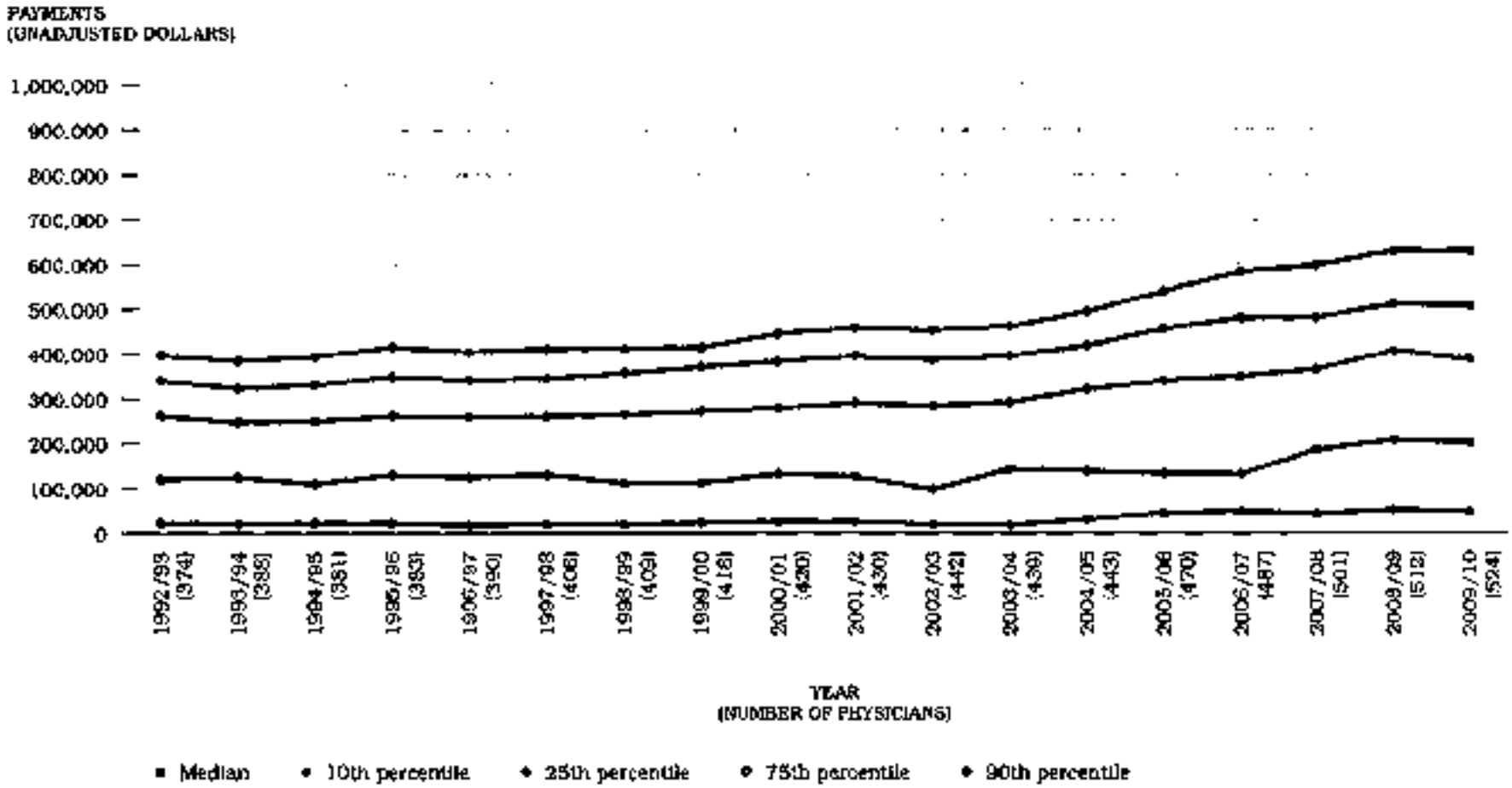
OPHTHALMOLOGISTS

EXHIBIT 7.18 Total payments to ophthalmologists by payment source, in Ontario, 1992/93 to 2009/10



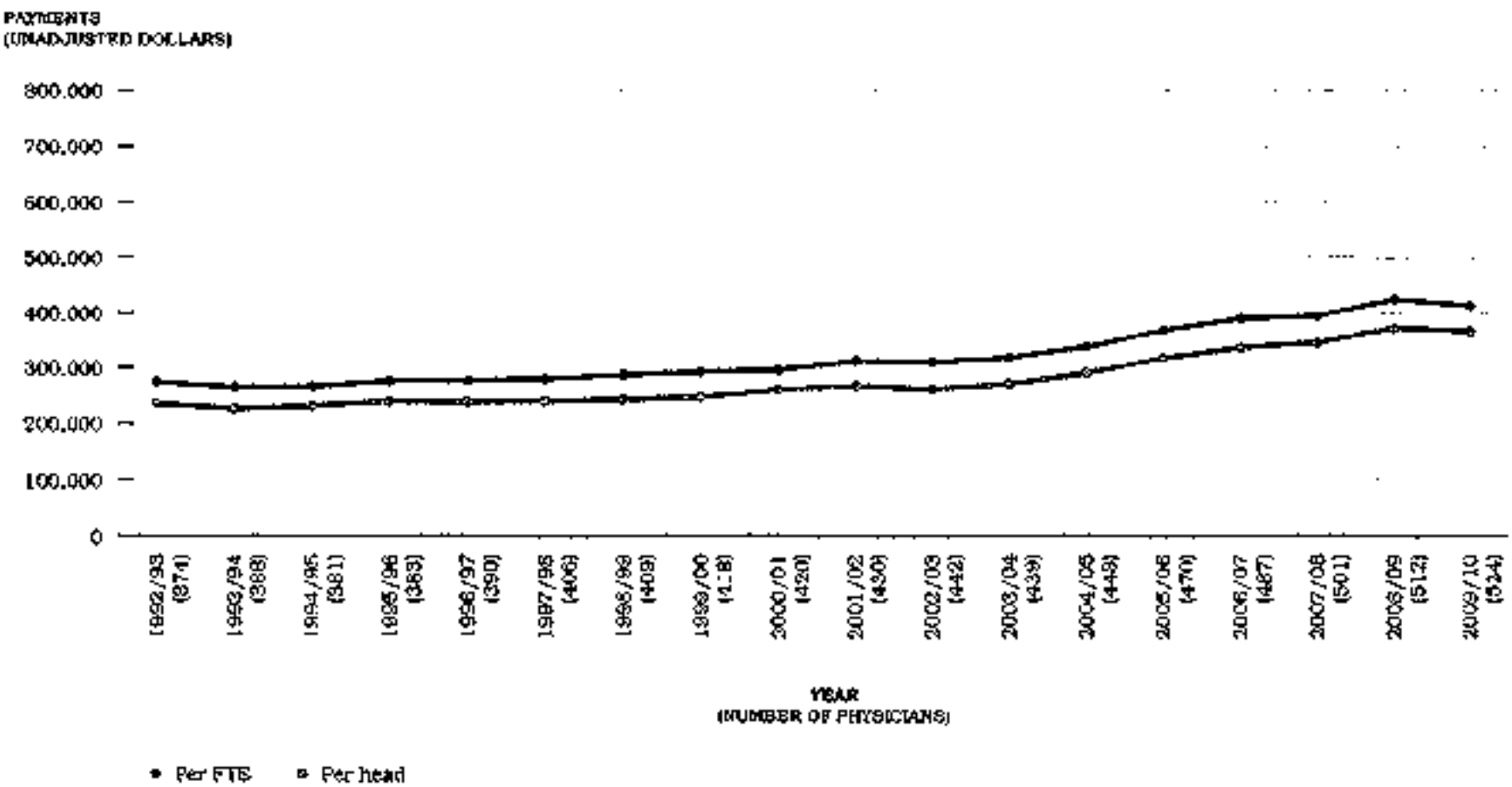
ORTHOPEDIC SURGEONS

EXHIBIT 7.10 Median and percentiles of payments (in unadjusted dollars) to individual orthopedic surgeons, in Ontario, 1992/93 to 2009/10



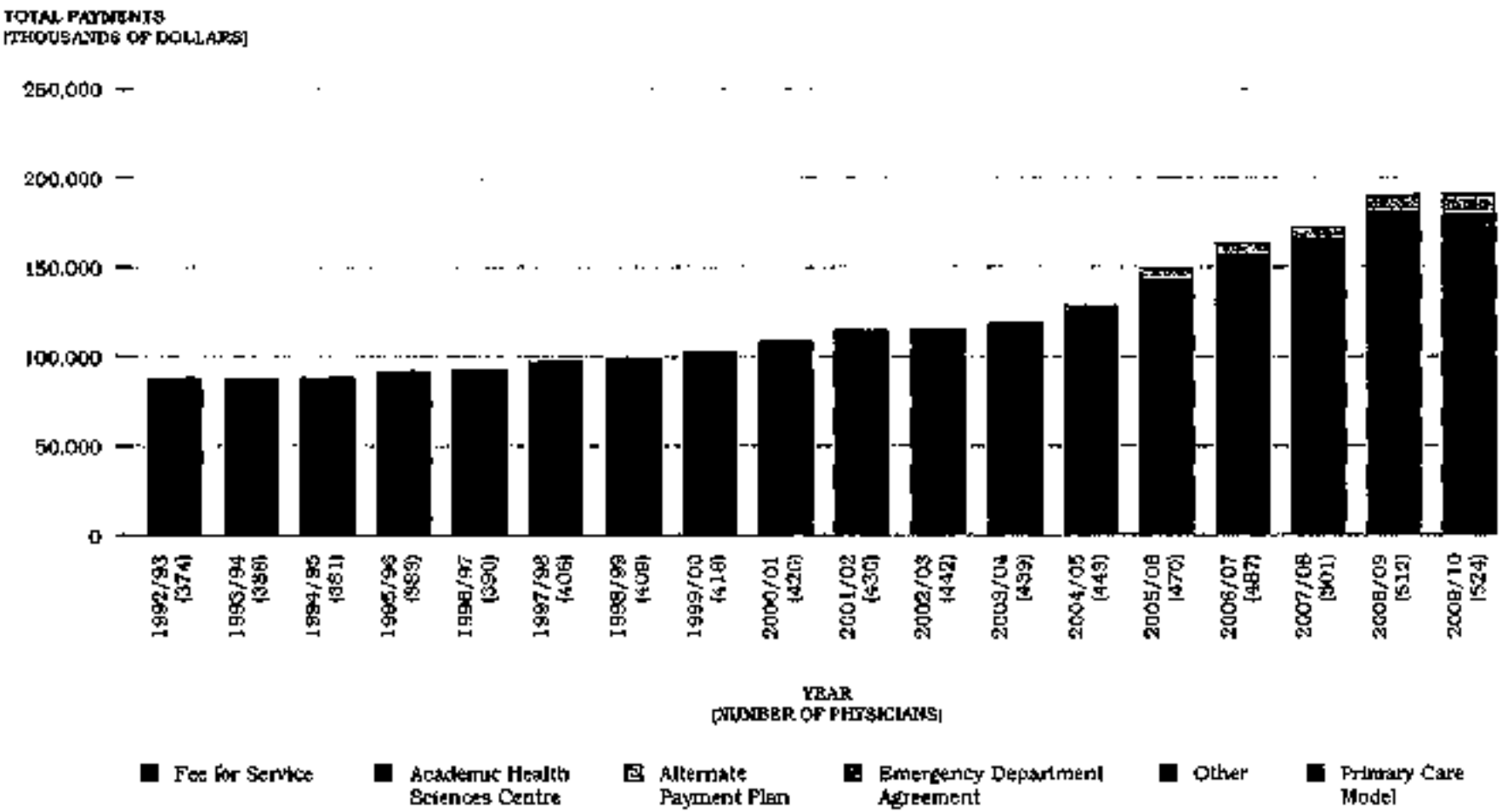
ORTHOPEDIC SURGEONS

EXHIBIT 7.17 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to orthopedic surgeons, in Ontario, 1992/93 to 2009/10



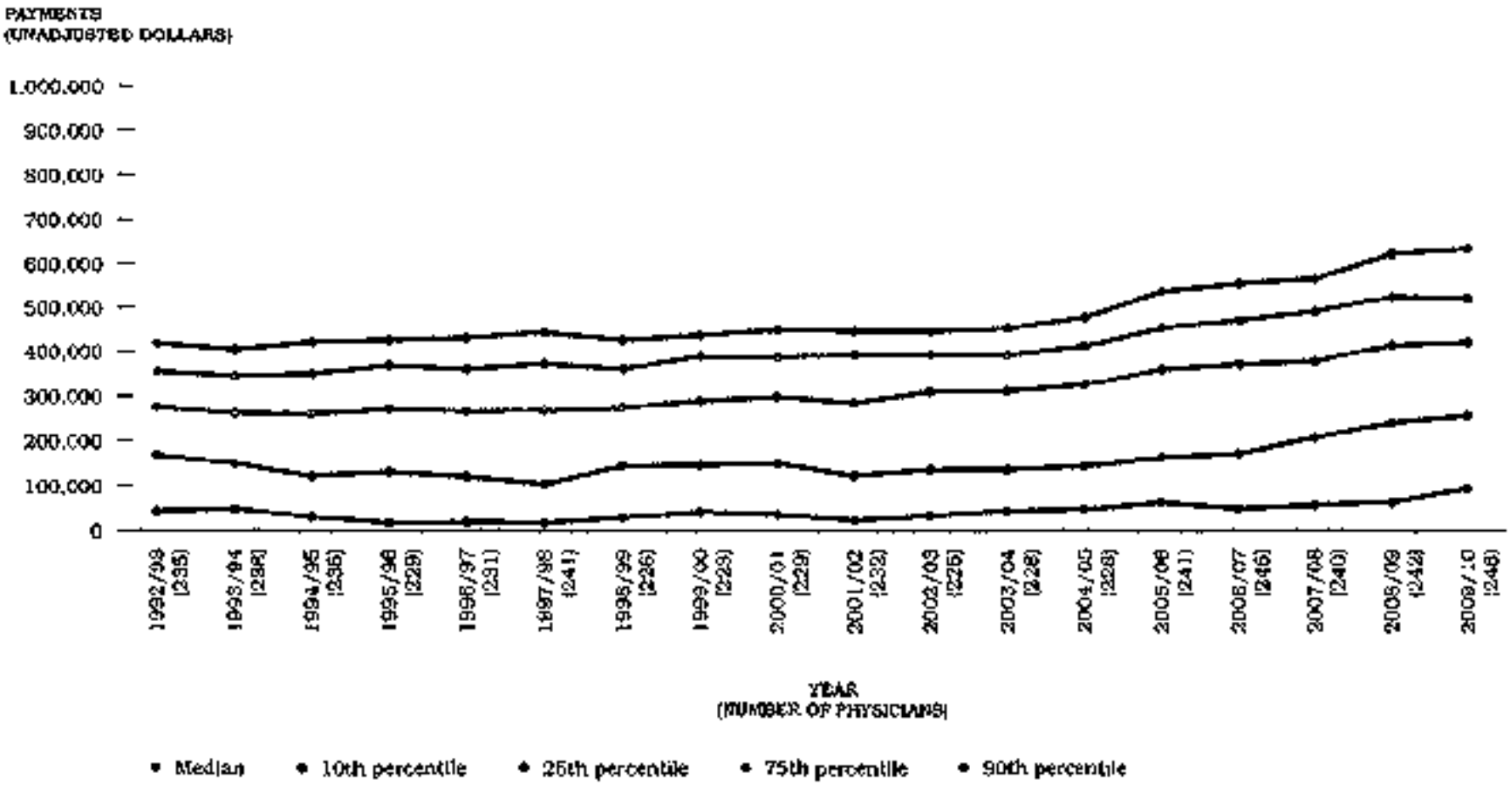
ORTHOPEDIC SURGEONS

EXHIBIT 7.18 Total payments to orthopedic surgeons by payment source, in Ontario, 1992/93 to 2009/10



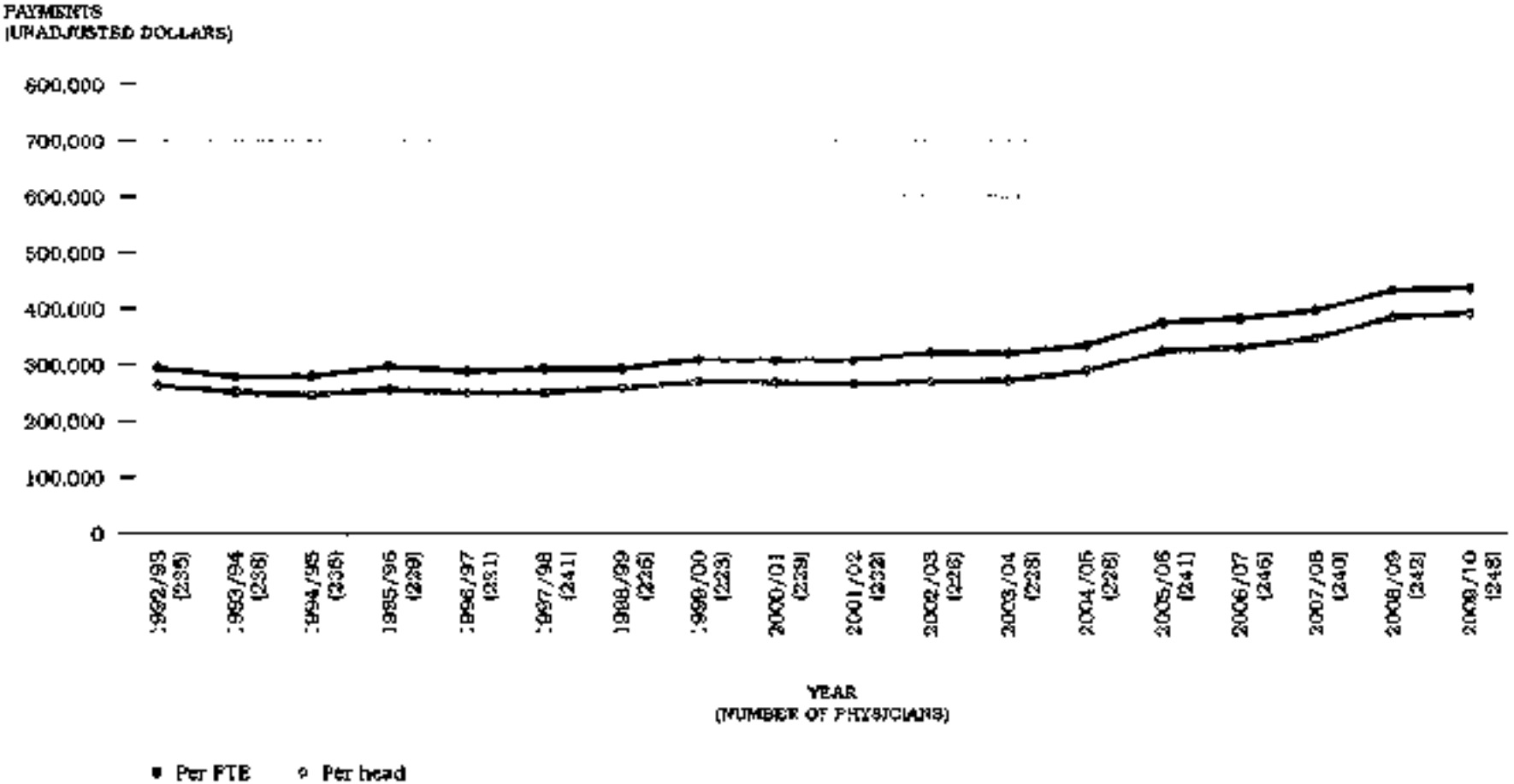
OTOLARYNGOLOGISTS

EXHIBIT 7.19 Median and percentiles of payments (in unadjusted dollars) to individual otolaryngologists, in Ontario, 1992/93 to 2009/10



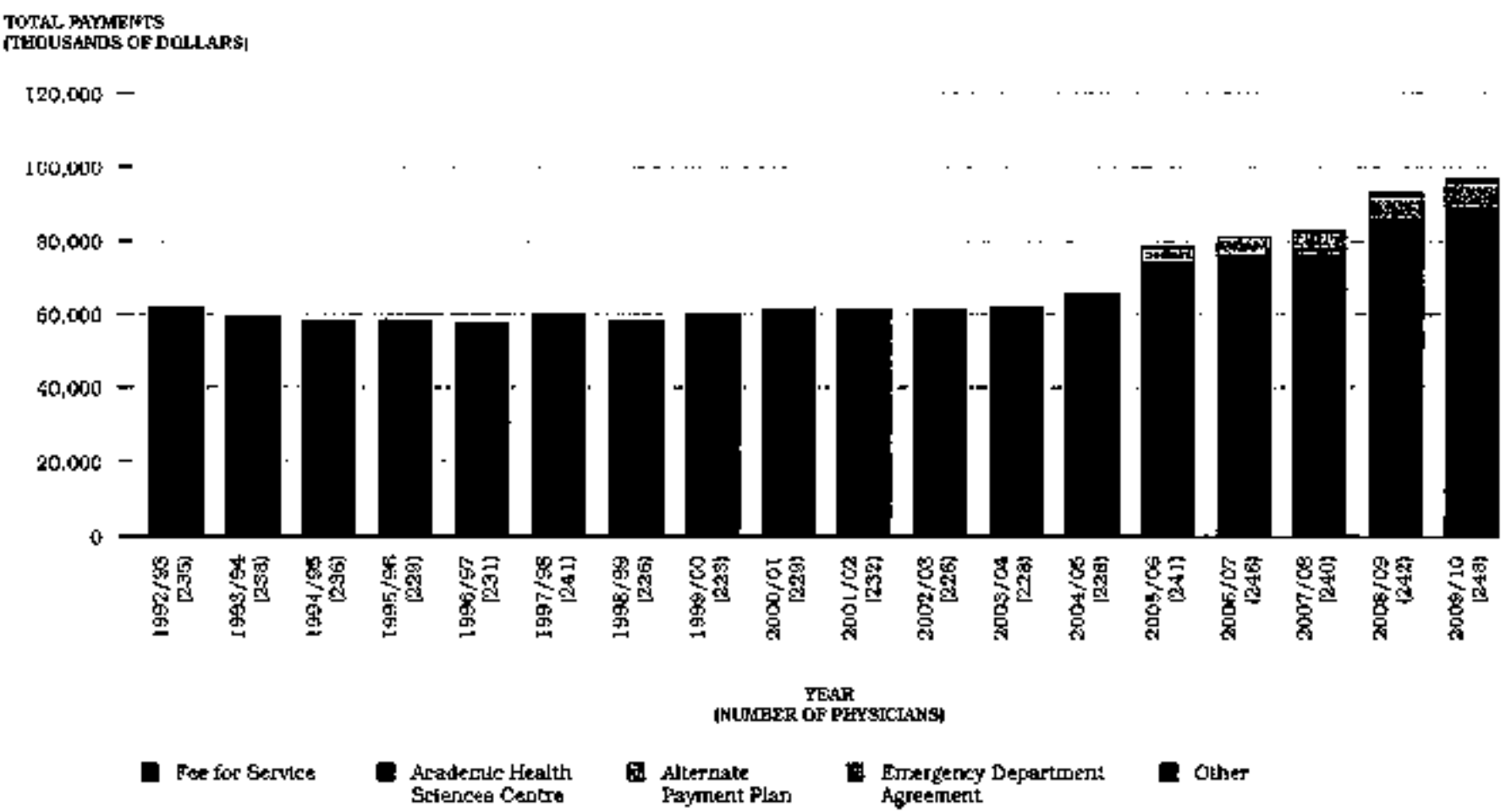
OTOLARYNGOLOGISTS

EXHIBIT 7.20 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to otolaryngologists, in Ontario, 1992/93 to 2009/10



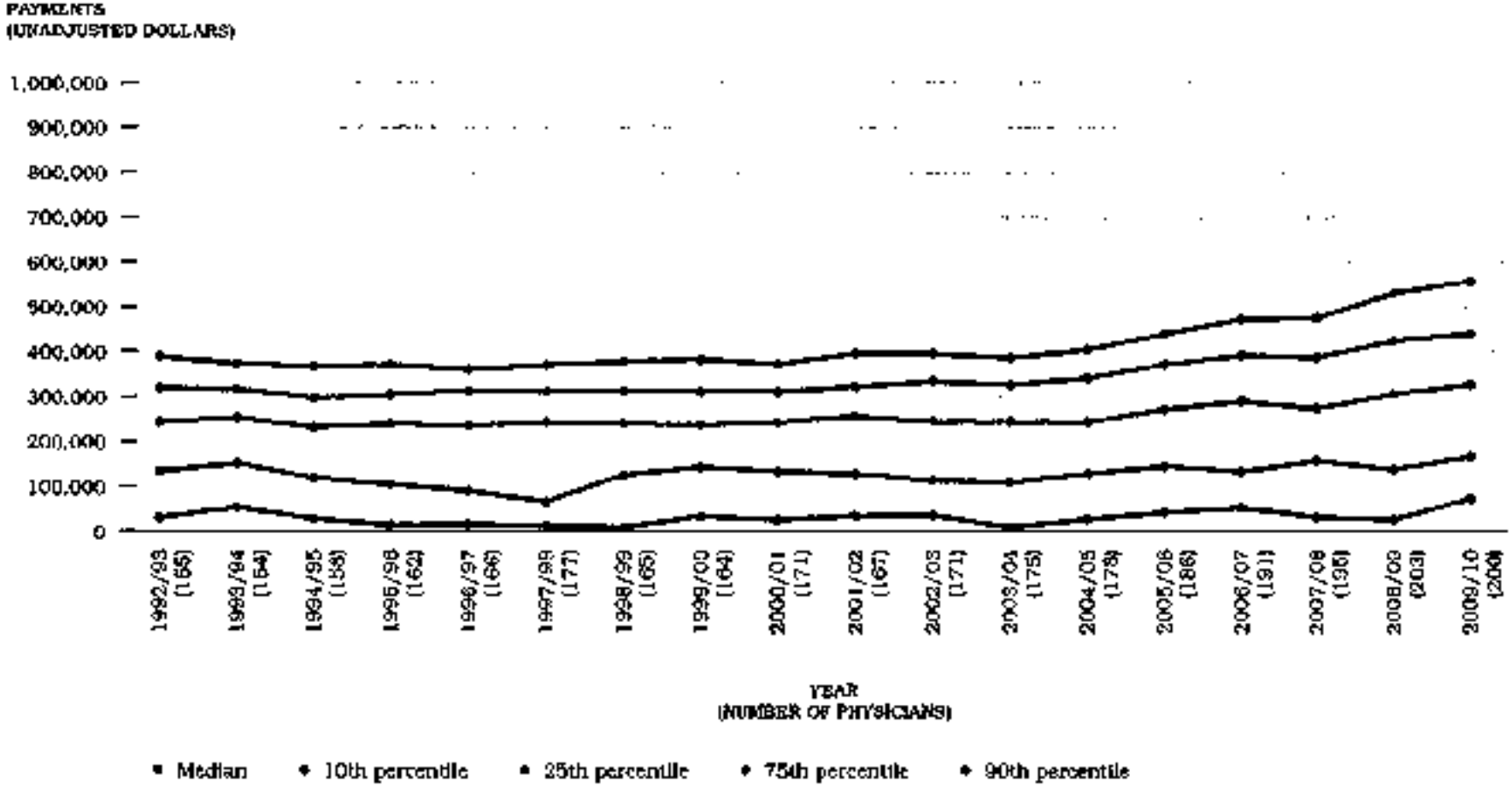
OTOLARYNGOLOGISTS

EXHIBIT 7.21 Total payments to otolaryngologists by payment source, in Ontario, 1992/93 to 2009/10



PLASTIC SURGEONS

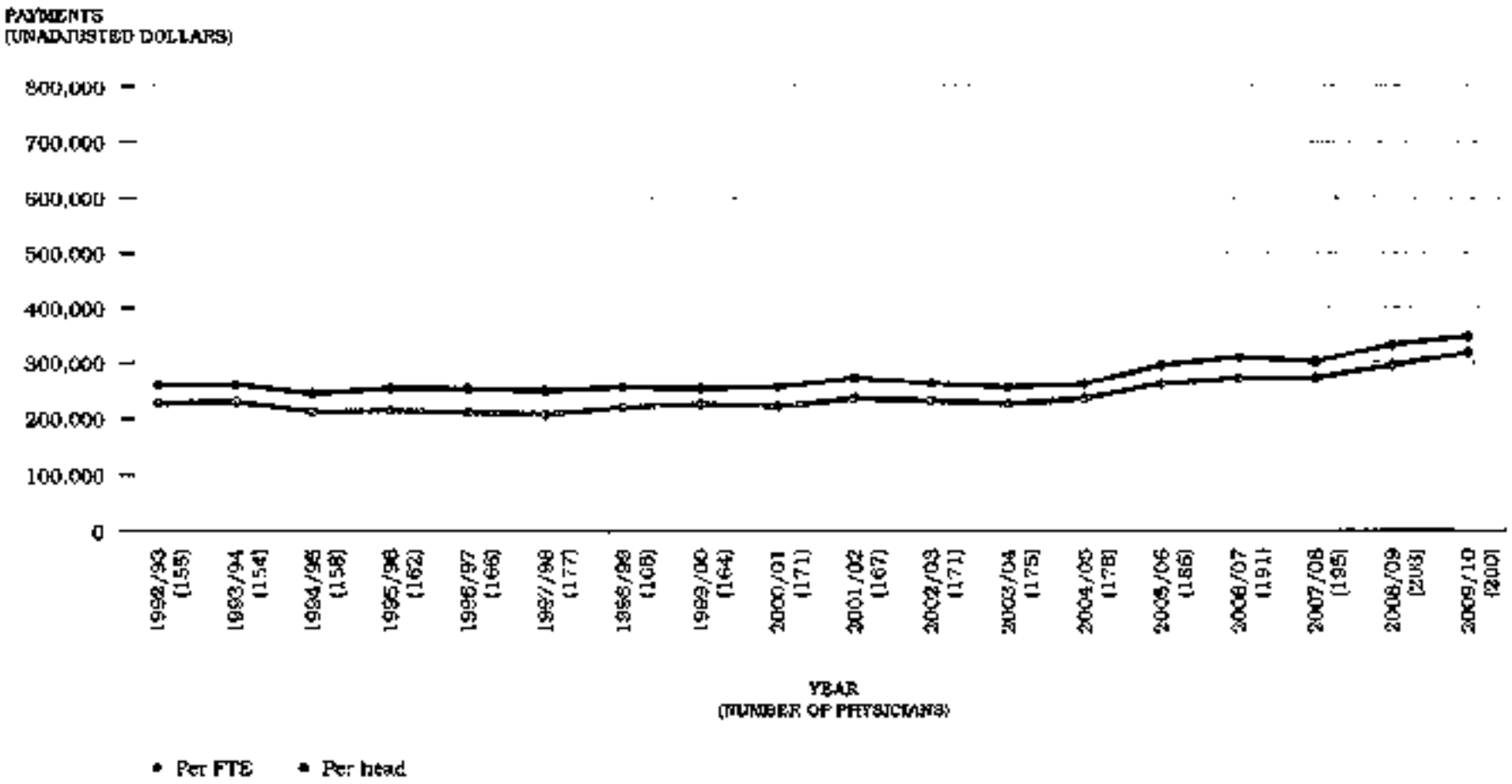
EXHIBIT 7.22 Median and percentiles of payments (in unadjusted dollars) to individual plastic surgeons, in Ontario, 1992/93 to 2009/10



Note: Data include payments for OHIP-insured services only and do not reflect payments for cosmetic surgery or other non-insured services.

PLASTIC SURGEONS

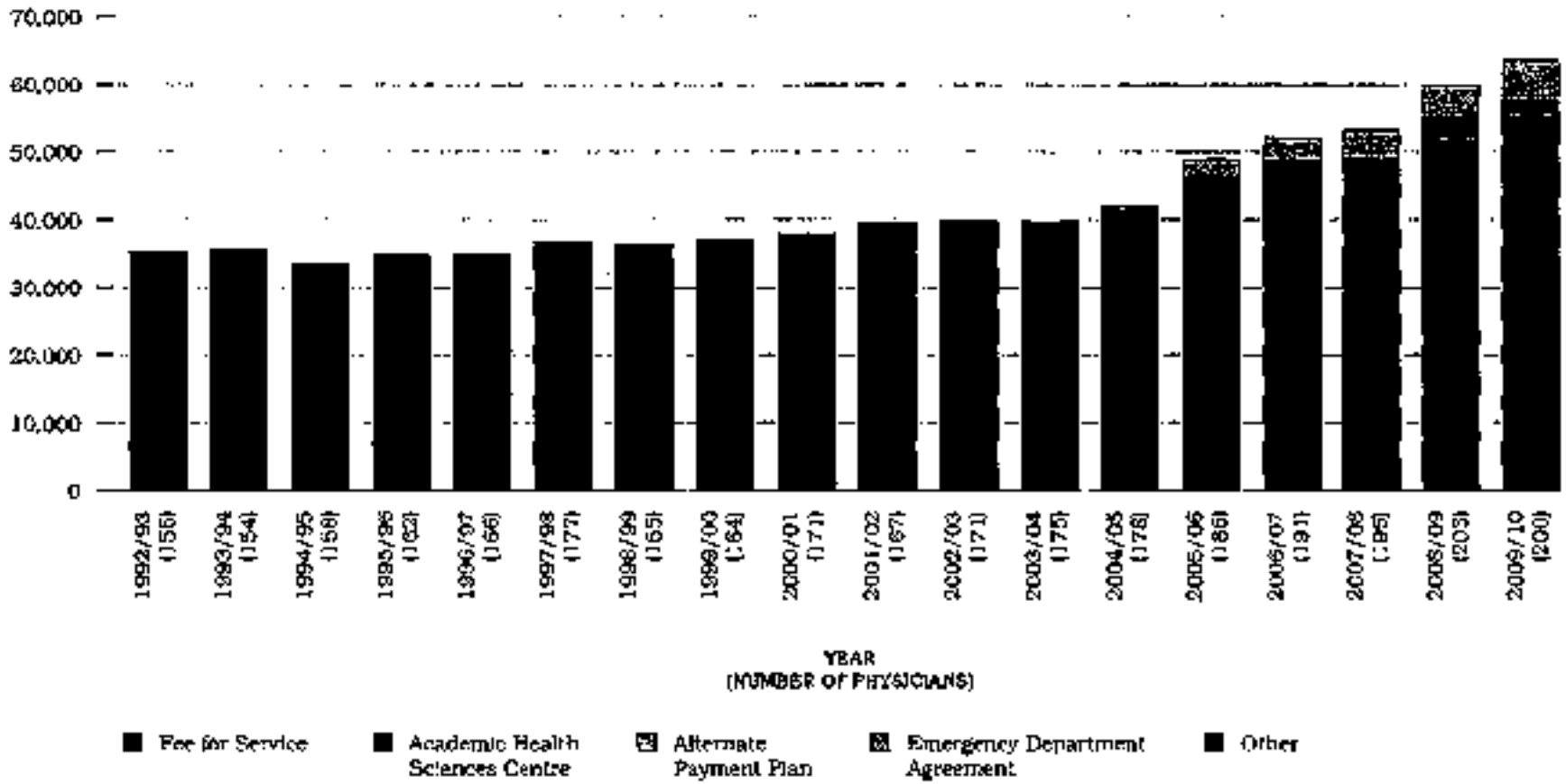
EXHIBIT 7.23 **Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to plastic surgeons, in Ontario, 1992/93 to 2009/10**



Note: Data include payments for OHIP-insured services only and do not reflect payments for cosmetic surgery or other non-insured services.

PLASTIC SURGEONS

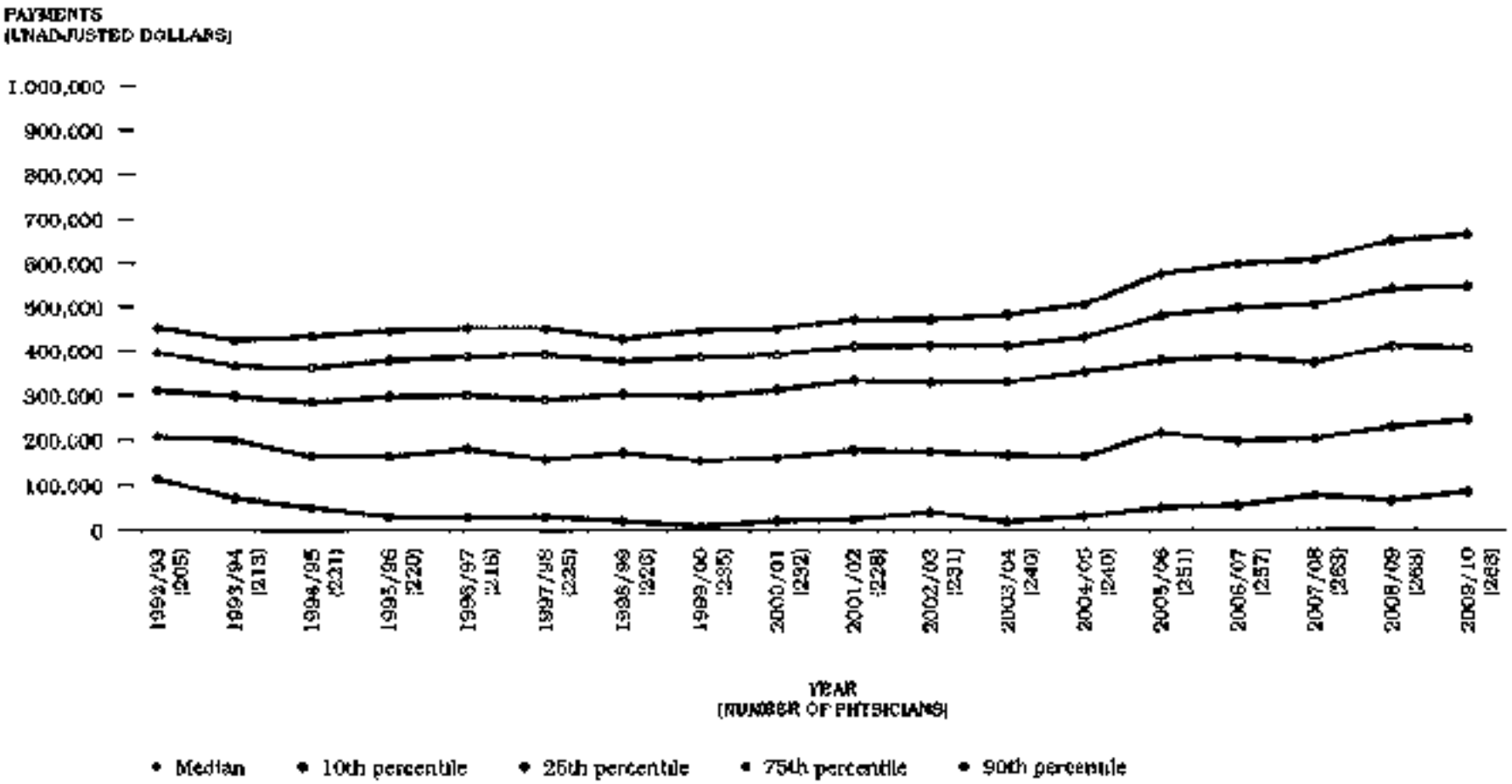
EXHIBIT 7.24 Total payments to plastic surgeons by payment source, in Ontario, 1992/93 to 2009/10



Note: Data include payments for OHIP-insured services only and do not reflect payments for cosmetic surgery or other non-insured services.

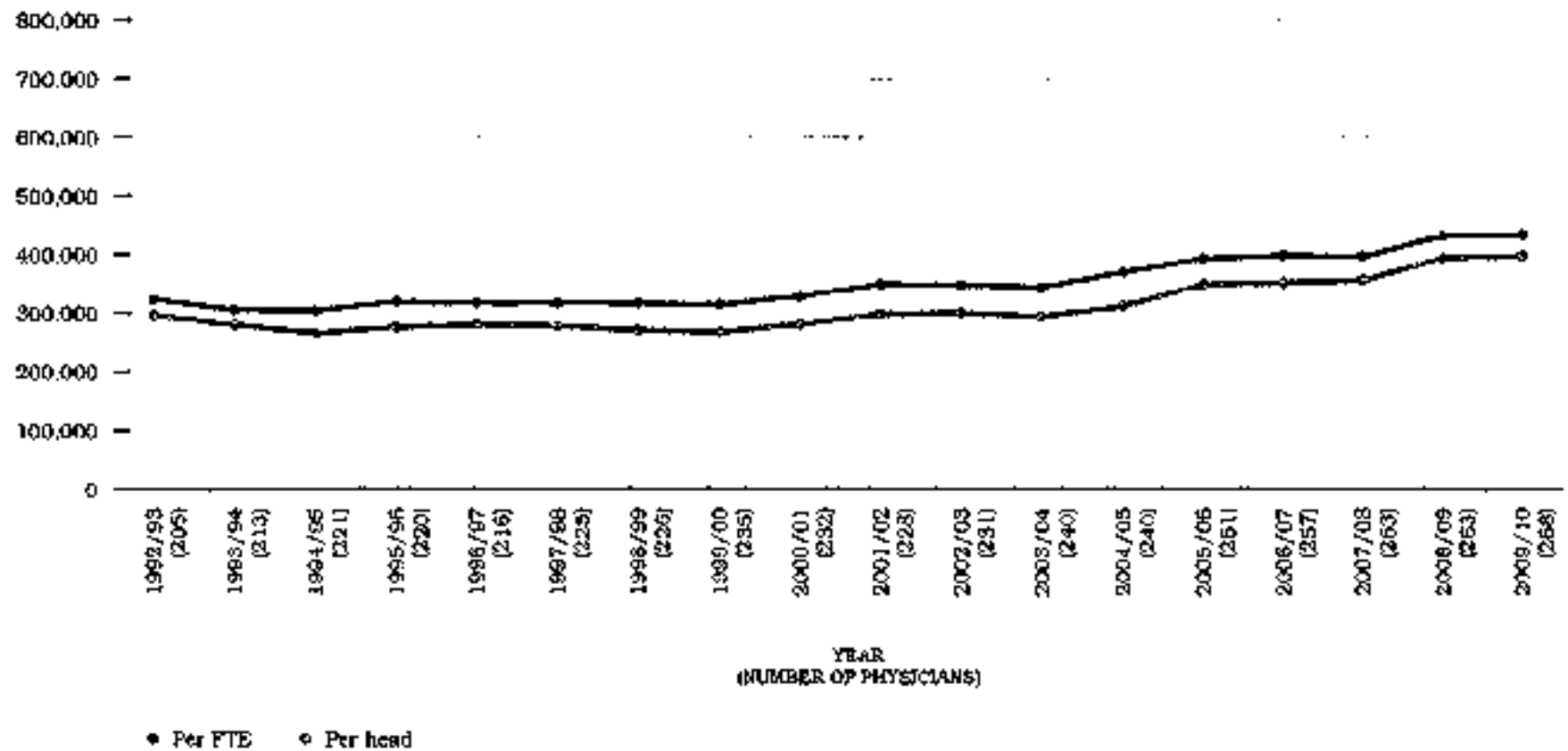
UROLOGISTS

EXHIBIT 7.25 Median and percentiles of payments (in unadjusted dollars) to individual urologists, in Ontario, 1992/93 to 2009/10



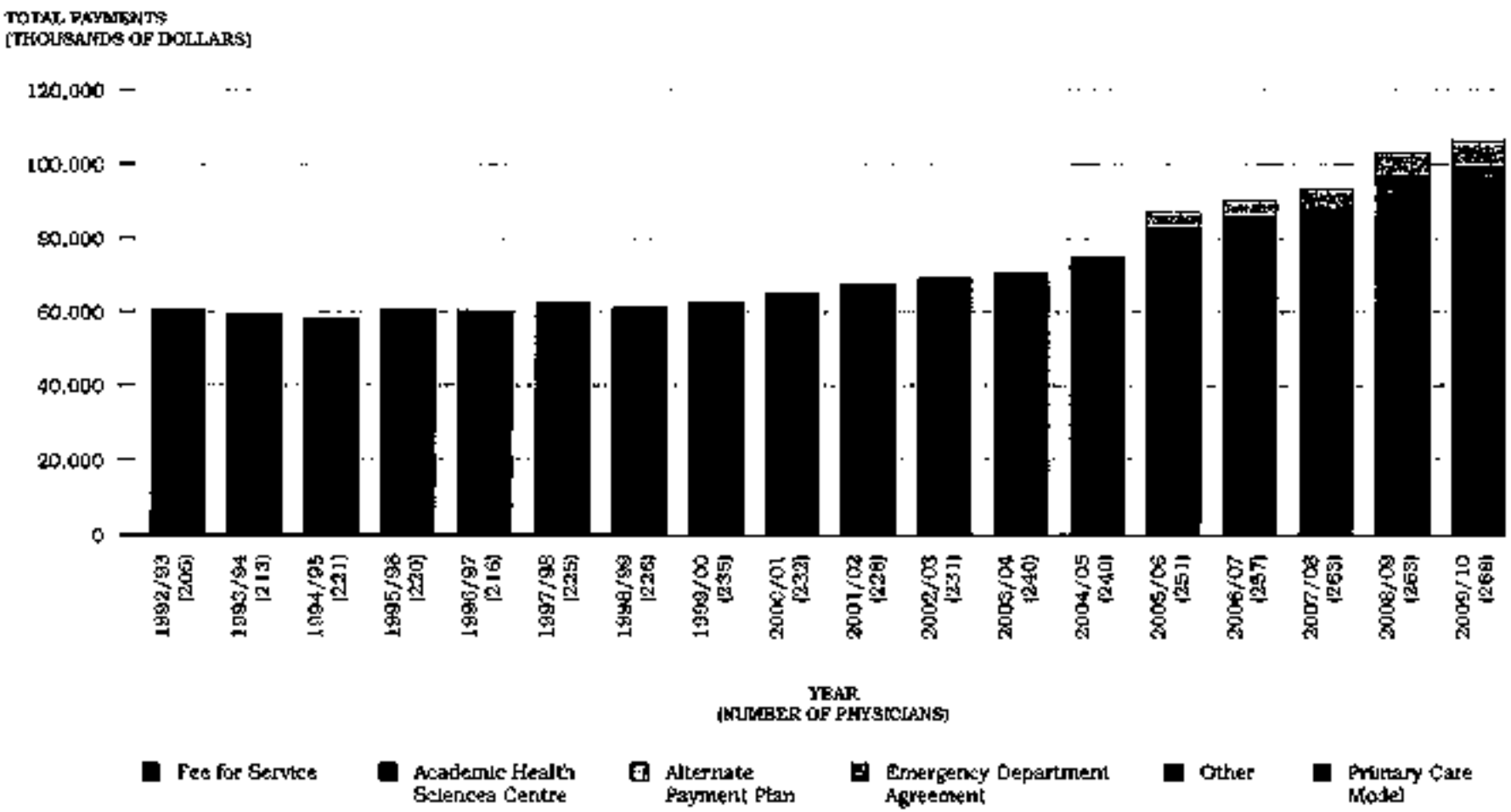
UROLOGISTS

EXHIBIT 7.25 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to urologists, in Ontario, 1992/93 to 2009/10



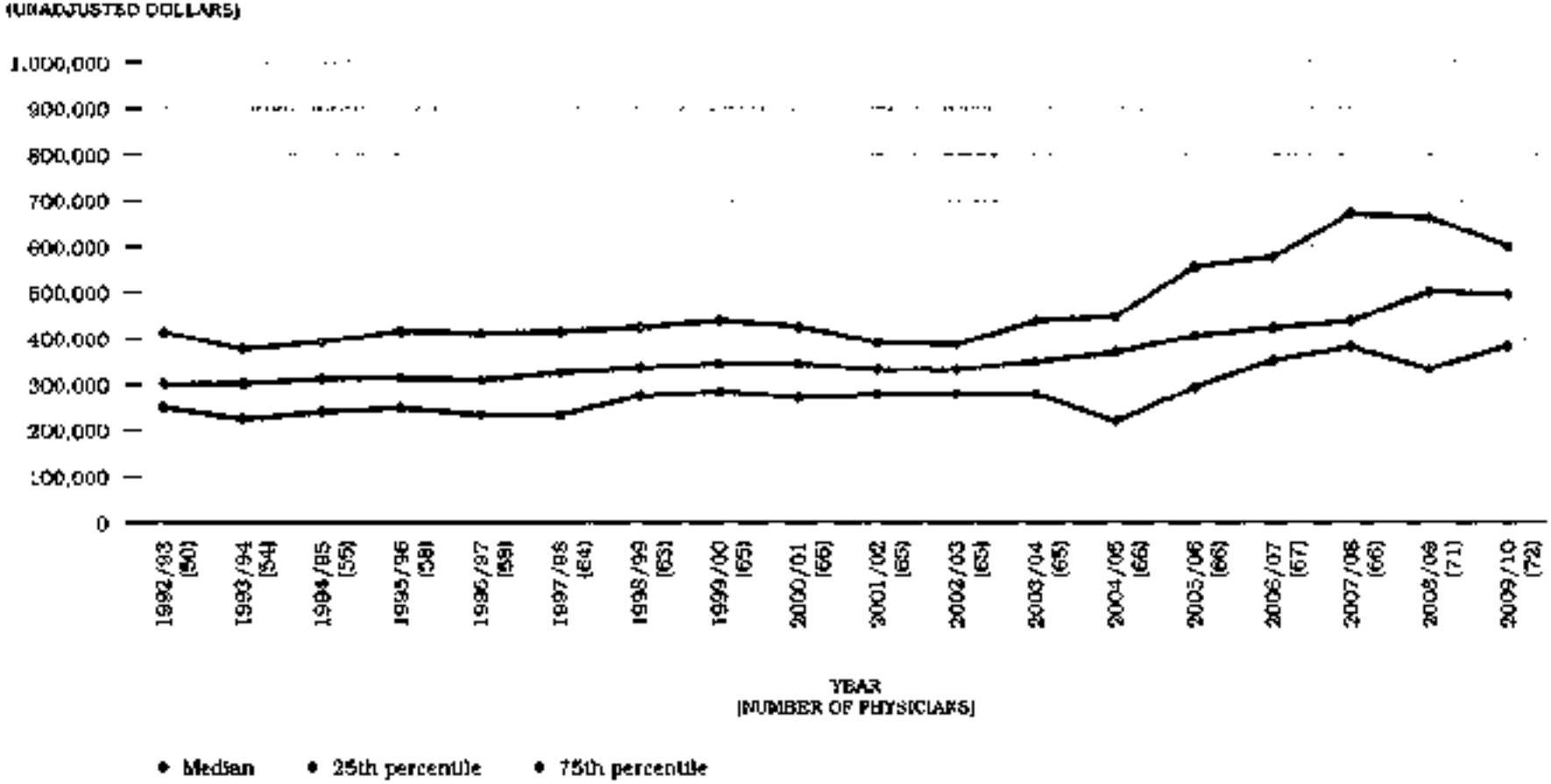
UROLOGISTS

EXHIBIT 7.27 Total payments to urologists by payment source, in Ontario, 1992/93 to 2009/10



VASCULAR SURGEONS

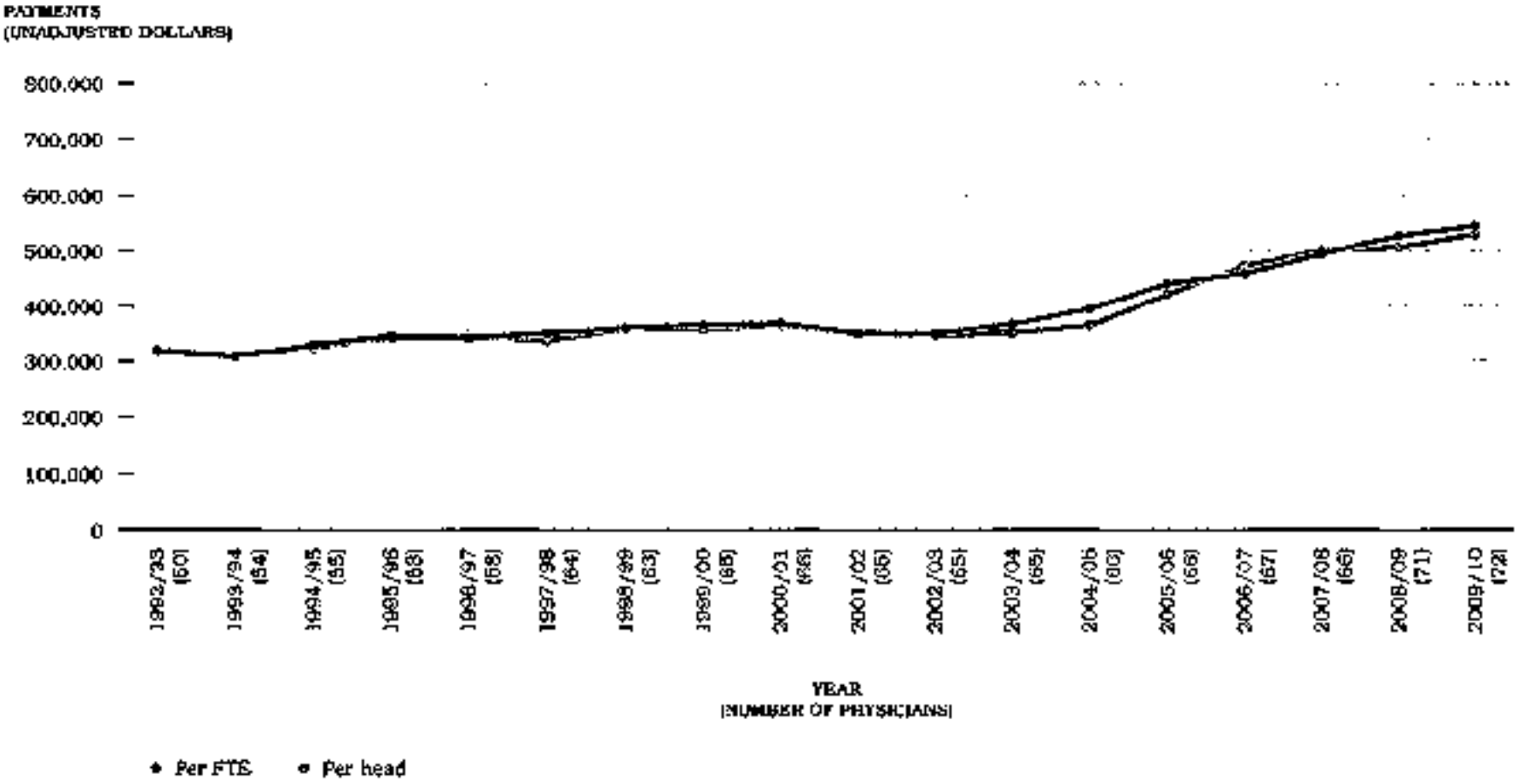
EXHIBIT 7.38 Median and percentiles of payments (in unadjusted dollars) to individual vascular surgeons in Ontario, 1992/93 to 2009/10



Note: The 10th and 90th percentiles are omitted due to the small number of physicians in the top and bottom 10%.

VASCULAR SURGEONS

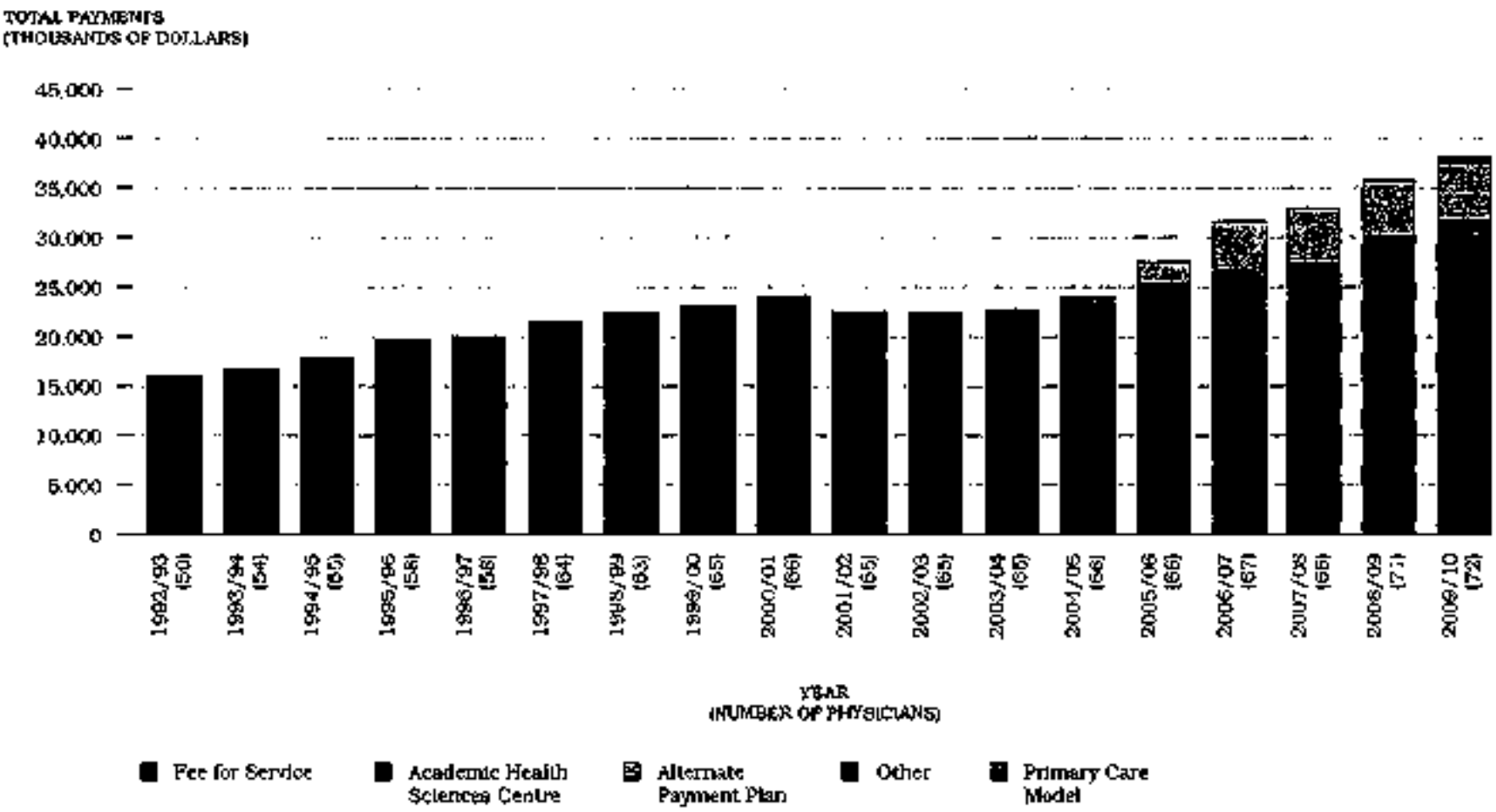
EXHIBIT 7.29 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to vascular surgeons, in Ontario, 1992/93 to 2009/10



Note: The 10th and 90th percentiles are omitted due to the small number of physicians in the top and bottom 10%.

VASCULAR SURGEONS

EXHIBIT 7.30 Total payments to vascular surgeons by payment source, in Ontario, 1992/93 to 2009/10



Note: The 10th and 90th percentiles are omitted due to the small number of physicians in the top and bottom 10%.

CHAPTER 8

Results for Imaging Specialists

INTRODUCTION

The imaging specialty group includes diagnostic radiologists and nuclear medicine specialists. Radiologists use a range of imaging modalities to aid in the diagnosis of disease. The range of imaging techniques has progressively widened to include traditional X-rays, computerized tomography (CT), ultrasound and magnetic resonance imaging (MRI). Radiologists use a variety of contrast agents to enhance definition of certain tissues. They provide imaging guidance for certain procedures (for instance, biopsies, placement of stents). Radiologists increasingly perform these procedures, and interventional radiology has developed as a discipline that uses minimally-invasive, image-guided procedures to diagnose and treat diseases in nearly every organ system. Modern radiologists perform a wide variety of diagnostic and some therapeutic procedures, and two of these, CT and MR, have been the subject of additional public funding to reduce wait times in Ontario.

Nuclear medicine is sometimes called radiology 'inside out' as this specialty records radiation emitting from within the body rather than radiation that is generated by external sources like X-rays. This is achieved by administering a range of radio-pharmaceuticals to the patient that localize to particular tissues, organs and cellular receptors. By doing this, nuclear medicine specialists can study disease through altered cellular function and physiology rather than relying on physical changes in the tissue anatomy. This can enable a better definition of the extent of disease. Nuclear medicine is a much smaller specialty than radiology, with a limited number of procedures. One of these, positron emission tomography, has been subject to an evaluation program in Ontario, which has restricted access to public funding. In October 2009, OHIP coverage was extended to a range of diseases where conventional imaging could not provide essential information.[1]

Historically, two fees have applied to diagnostic tests: a professional fee and a technical fee. Professional fees are paid to the physician who performs and interprets the test, whereas technical fees are paid to the imaging facility (e.g., the hospital) to offset the costs associated with providing the imaging services (including the costs of paying technicians, overhead expenditures, capital outlays and amortization).[2] In this report, we are concerned with the professional fees paid to radiologists and nuclear medicine specialists. As the footnotes to the exhibits indicate, payments before 2000 included some professional and technical fees and those after that did not, so data from the two periods should not be compared.

FINDINGS FOR INDIVIDUAL SPECIALTIES

Diagnostic Radiology (exhibits 8.1 to 8.3)

The supply of diagnostic radiologists increased steadily throughout the study period. In 2009/10, there were 975 radiologists, about 43% more than in 1992/93. Total payments to this specialty in 2009/10 were about $550 million, an increase of about $250 million (82%) compared with 2003. Radiologist numbers increased by 145 (approximately 18%) during this period. Diagnostic radiologists had the highest mean payments per FTE of any specialty in 2009/10 ($606,700), which was almost double the average paid to all physicians in the province in that year. The median payment was lower than this (about $555,000), and the variation in payments was very wide, with 10% of radiologists paid more than $945,000 and 25% paid more than $775,000. At the other end of the scale, 25% of radiologists were paid less than $300,000 and 10% were paid less than $132,000. This very wide variation in payments may indicate that a significant proportion of radiologists worked part-time. Almost all payments were by FFS.

Nuclear Medicine (exhibits 8.4 to 8.6)

By comparison with diagnostic radiology, nuclear medicine is a small specialty with only 54 practitioners in 1992/93, increasing to 88 in 2009/10. Total payments to this specialty in 2009/10 were approximately $46 million. The median payment to nuclear medicine specialists in 2009/10 was approximately $500,000, substantially more than the average payment to all physicians. The mean payment was slightly higher than the median. The great majority of payments (97%) were by FFS.

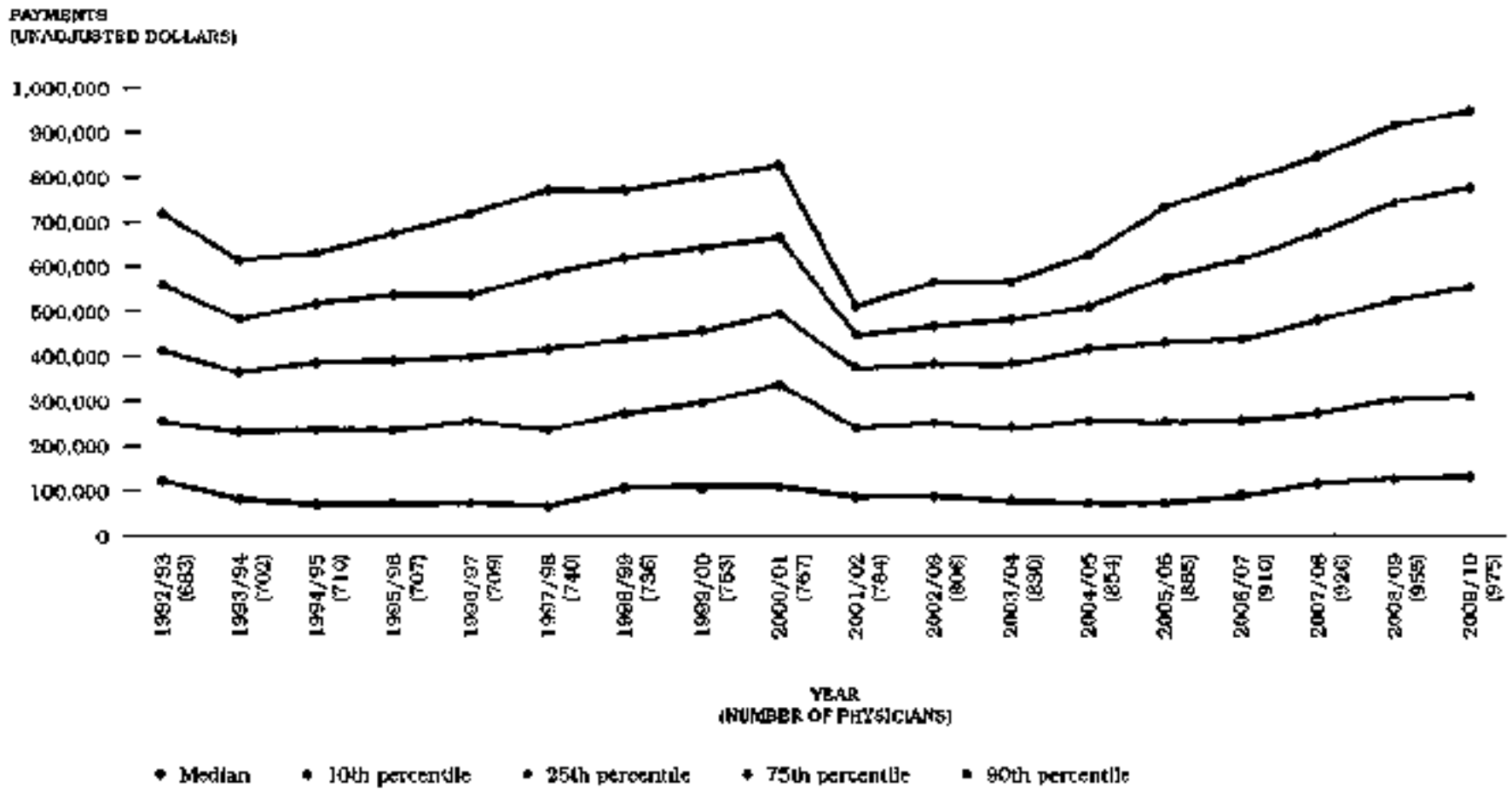
REFERENCES

1 Ontario Ministry of Health and Long-Term Care. OHIP Coverage for Positron Emission Tomography (PET) Scanning, Effective October 1, 2009. Accessed January 16, 2012 at http://health.gov.on.ca/en/public/publications/ohip/pet.aspx

2 Toronto Health Economics and Technology Assessment Collaborative. *The Relative Cost-effectiveness of Five Non-invasive Cardiac Imaging Technologies for Diagnosing Coronary Artery Disease in Ontario*. Toronto: THETA; 2010. Accessed January 16, 2012 at http://theta.utoronto.ca/papers/theta_report_007.pdf

DIAGNOSTIC RADIOLOGISTS

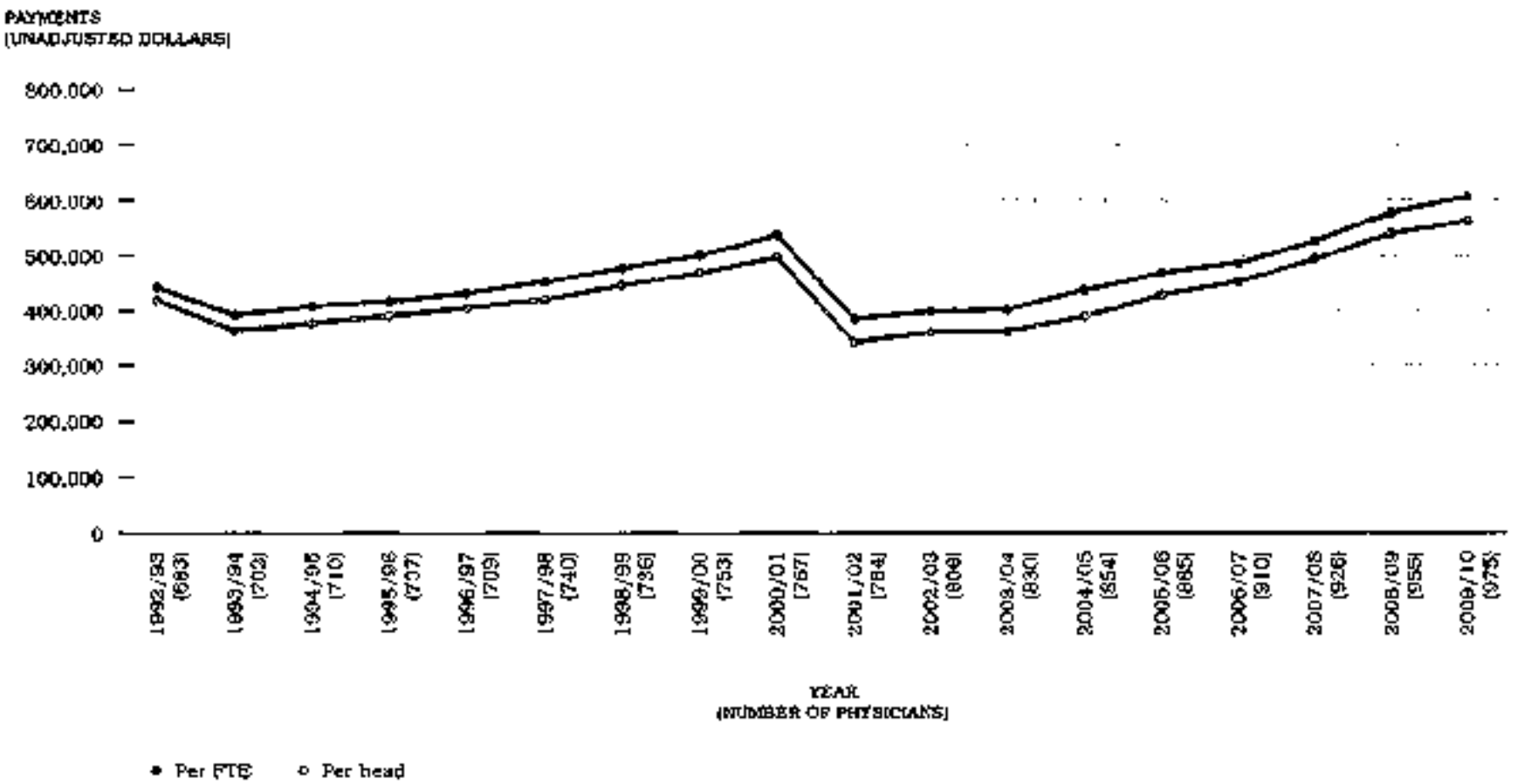
EXHIBIT 8.1 Median and percentiles of payments (in unadjusted dollars) to individual diagnostic radiologists, in Ontario, 1992/93 to 2009/10



Note: Data prior to 2001/02 include some fees that contained technical and professional fees. Such contained fees were discontinued in 2000/01.

DIAGNOSTIC RADIOLOGISTS

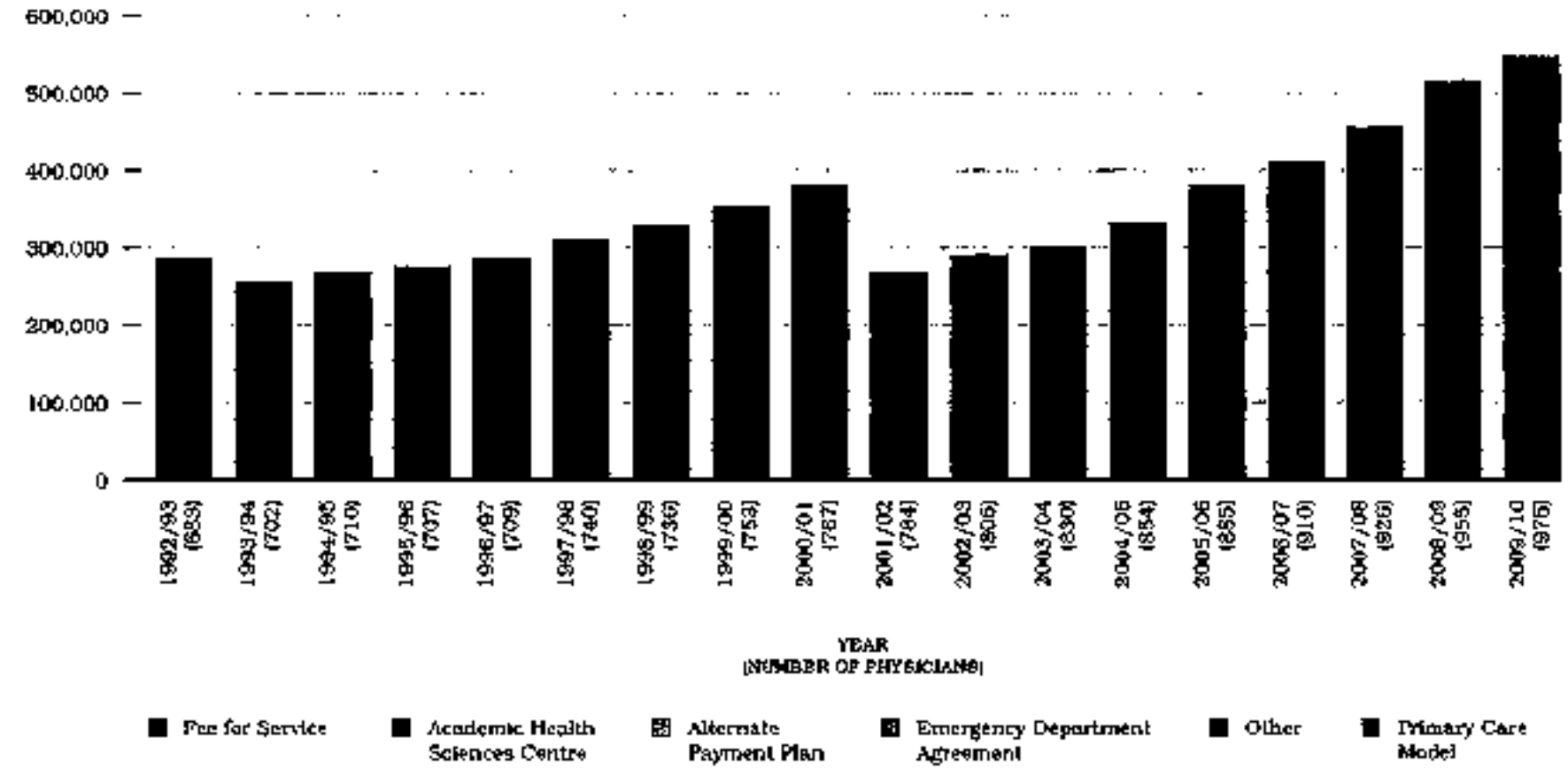
EXHIBIT 8.2 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to diagnostic radiologists, in Ontario, 1992/93 to 2009/10



Note: Data prior to 2001/02 include some fees that combined technical and professional fees. Such combined fees were discontinued in 2000/01.

DIAGNOSTIC RADIOLOGISTS

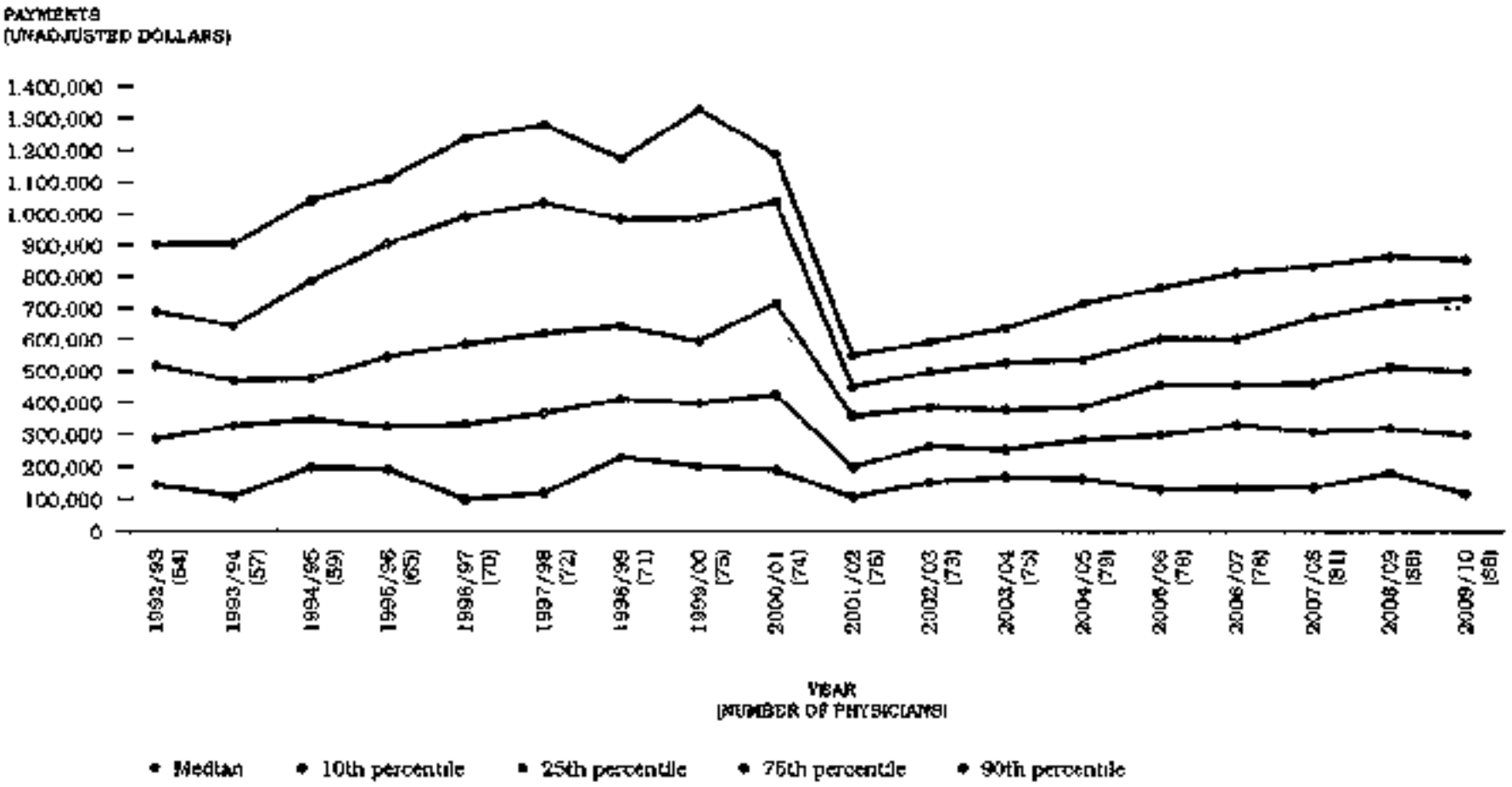
EXHIBIT 8.3 Total payments to diagnostic radiologists by payment source, in Ontario, 1992/93 to 2009/10



Note: Data prior to 2001/02 include some fees that contained technical and professional fees. Such combined fees were discontinued in 2000/01.

NUCLEAR MEDICINE SPECIALISTS

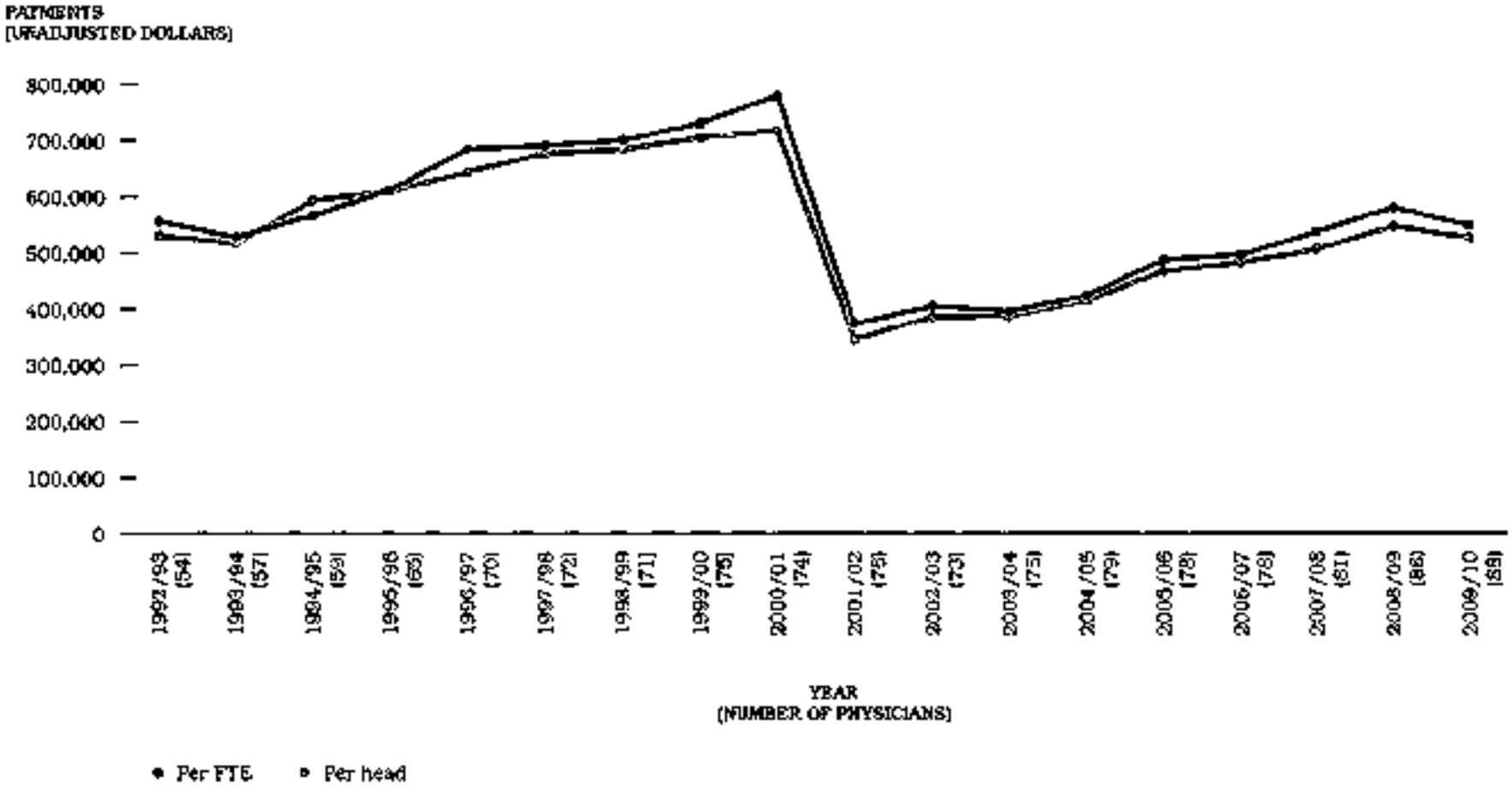
EXHIBIT 8.4 Median and percentiles of payments (in unadjusted dollars) to individual nuclear medicine specialists, in Ontario, 1992/93 to 2009/10



Note: Data prior to 2000/01 may include some technical and professional fees.

NUCLEAR MEDICINE SPECIALISTS

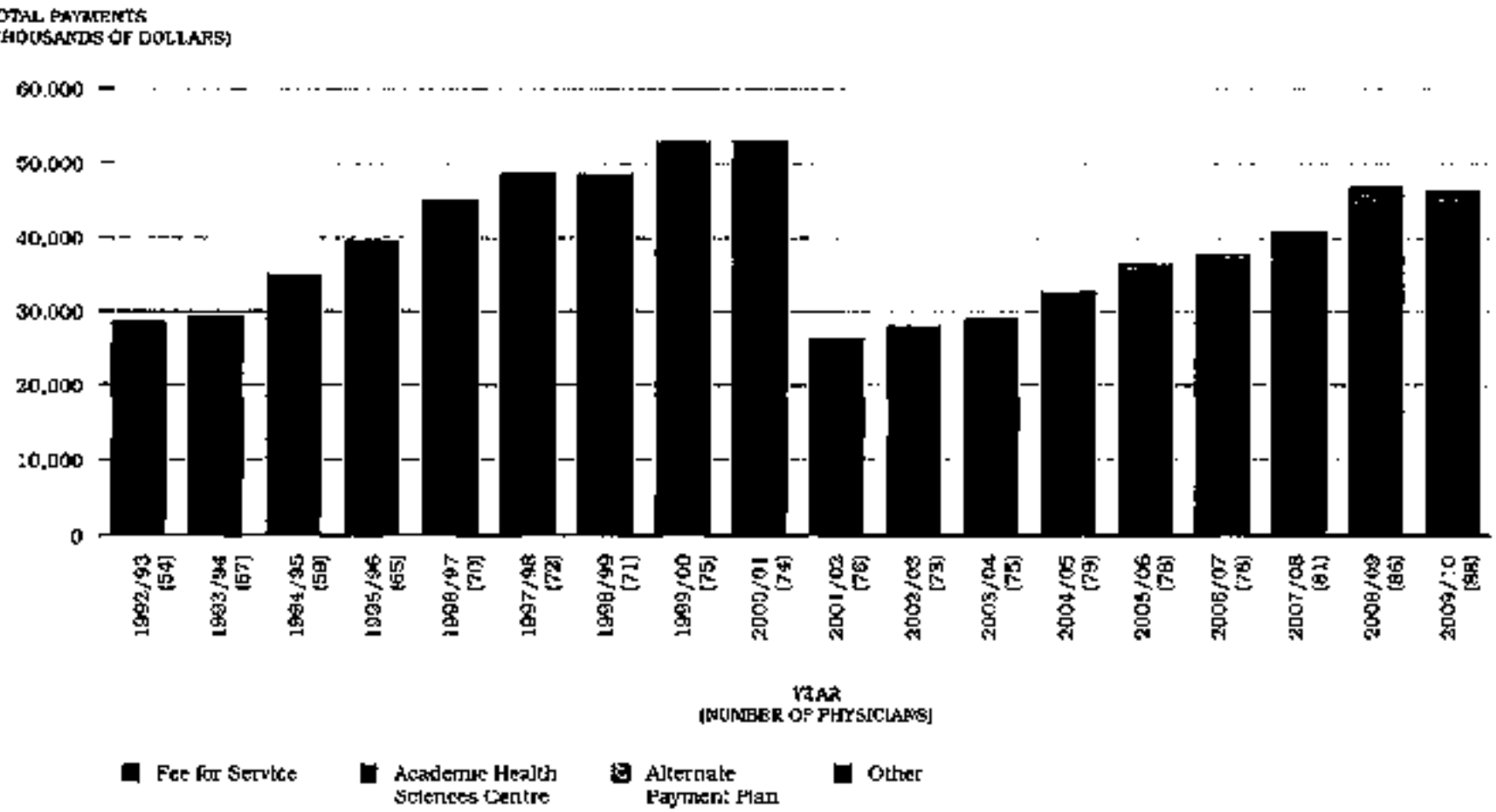
EXHIBIT 8.5 Mean payments (unadjusted dollars) per head and full-time equivalent (FTE) to nuclear medicine specialists, in Ontario, 1992/93 to 2009/10



Note: Data prior to 2001/02 may include some technical and professional fees.

NUCLEAR MEDICINE SPECIALISTS

EXHIBIT 8.6 Total payments to nuclear medicine specialists by payment source, in Ontario, 1992/93 to 2009/10



Note: Data prior to 2000/01 may include some technical and professional fees.

CHAPTER 9

Results for Anesthesiologists

INTRODUCTION

The administration of anesthesia is an important component of surgery and a number of other clinical procedures. Anesthesiologists play a key collaborative role with surgeons and physicians from a variety of clinical specialties and have provided important support to the wait times strategy in recent years. In this report, we have decided to present anesthesiologists separately from other specialties because of the diversity of their role in the health care system. Operating room time and the availability of anesthesiologists are two factors that can affect surgical wait times.

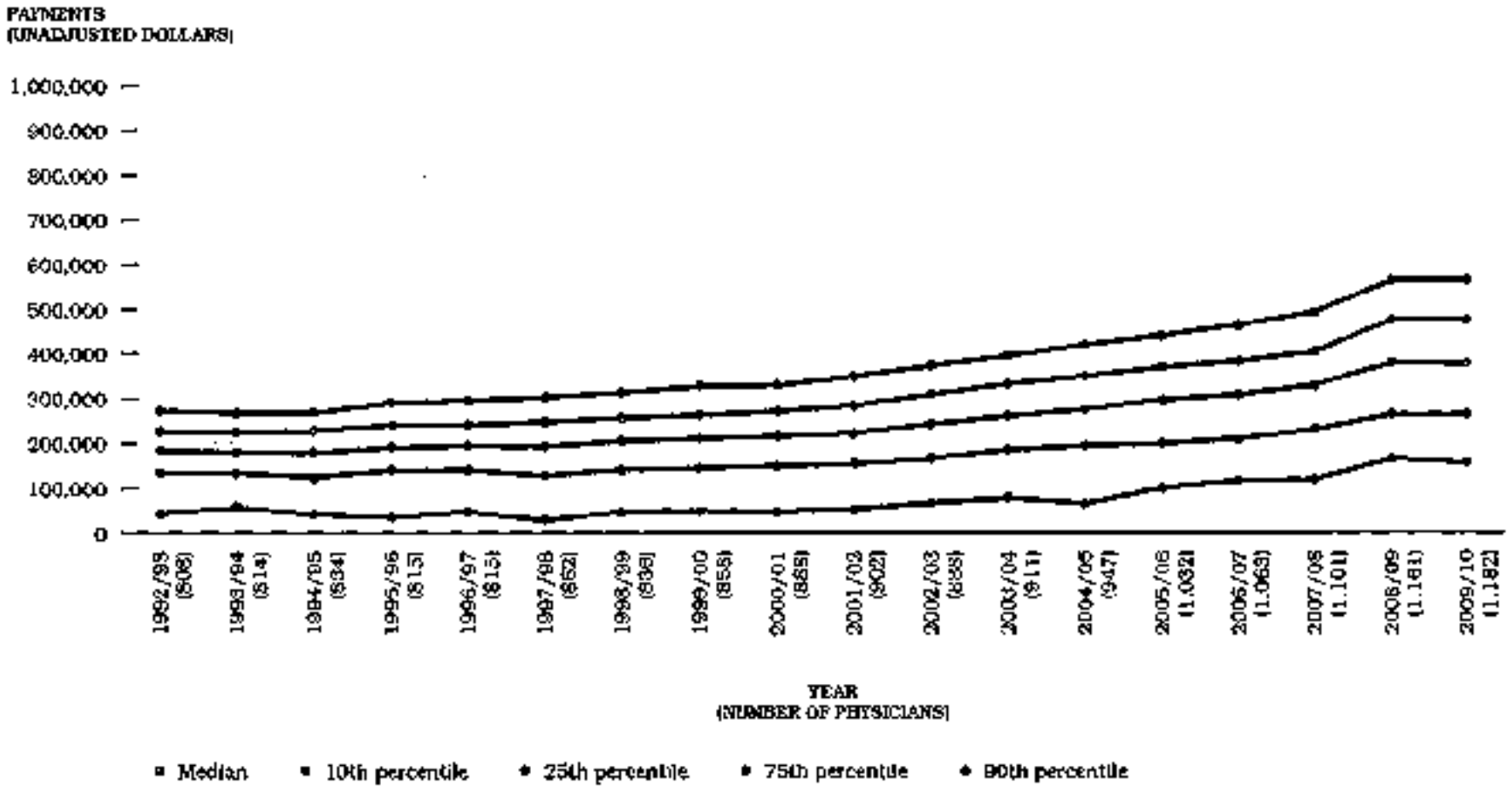
FINDINGS

Median, Mean and Total Payments [exhibits 9.1 to 9.3]

The number of anesthesiologists in Ontario rose from 808 in 1992/93 to 1,182 in 2009/10, an increase of 46%. Total payments to this specialty tripled in that period: from about $163 million to over $440 million (in unadjusted dollars). During the 1990s, the median payment to anesthesiologists was slightly higher than for all physicians; subsequently, the median payment rose 79% between 1999/00 and 2009/10. The mean payment doubled between 1992/93 and 2009/10, with most of the increase occurring after 1999/00. The distribution of payments was relatively narrow, with the 90th percentile being 50% higher than the median. In 2009/10, 85% of payments were from fee for service, 7% from academic health sciences centres, 6% from alternate payment plans, and the remainder from other non-FFS sources.

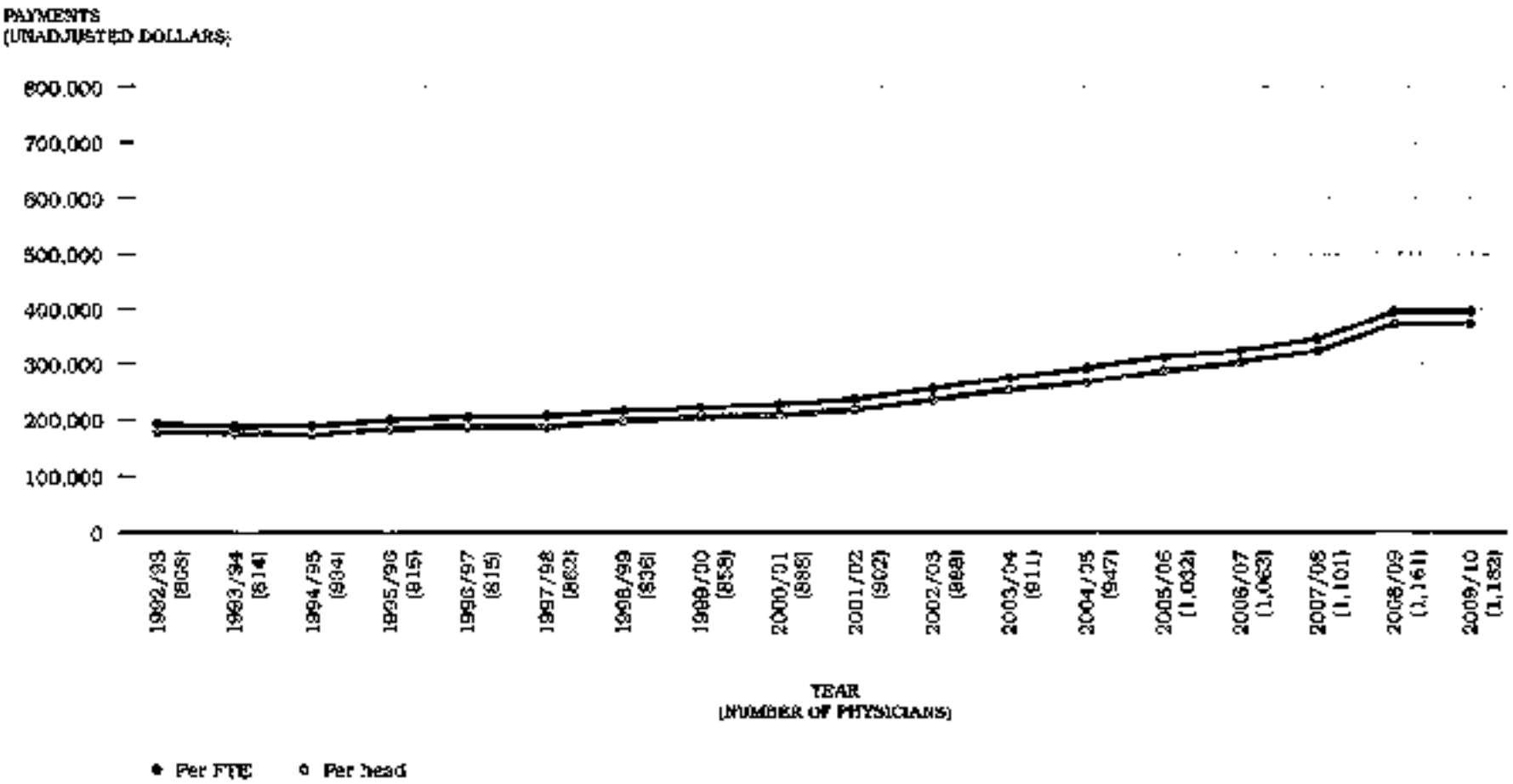
ANESTHESIOLOGISTS

EXHIBIT 9.1 Median and percentiles of payments (in unadjusted dollars) to individual anesthesiologists, in Ontario, 1992/93 to 2009/10



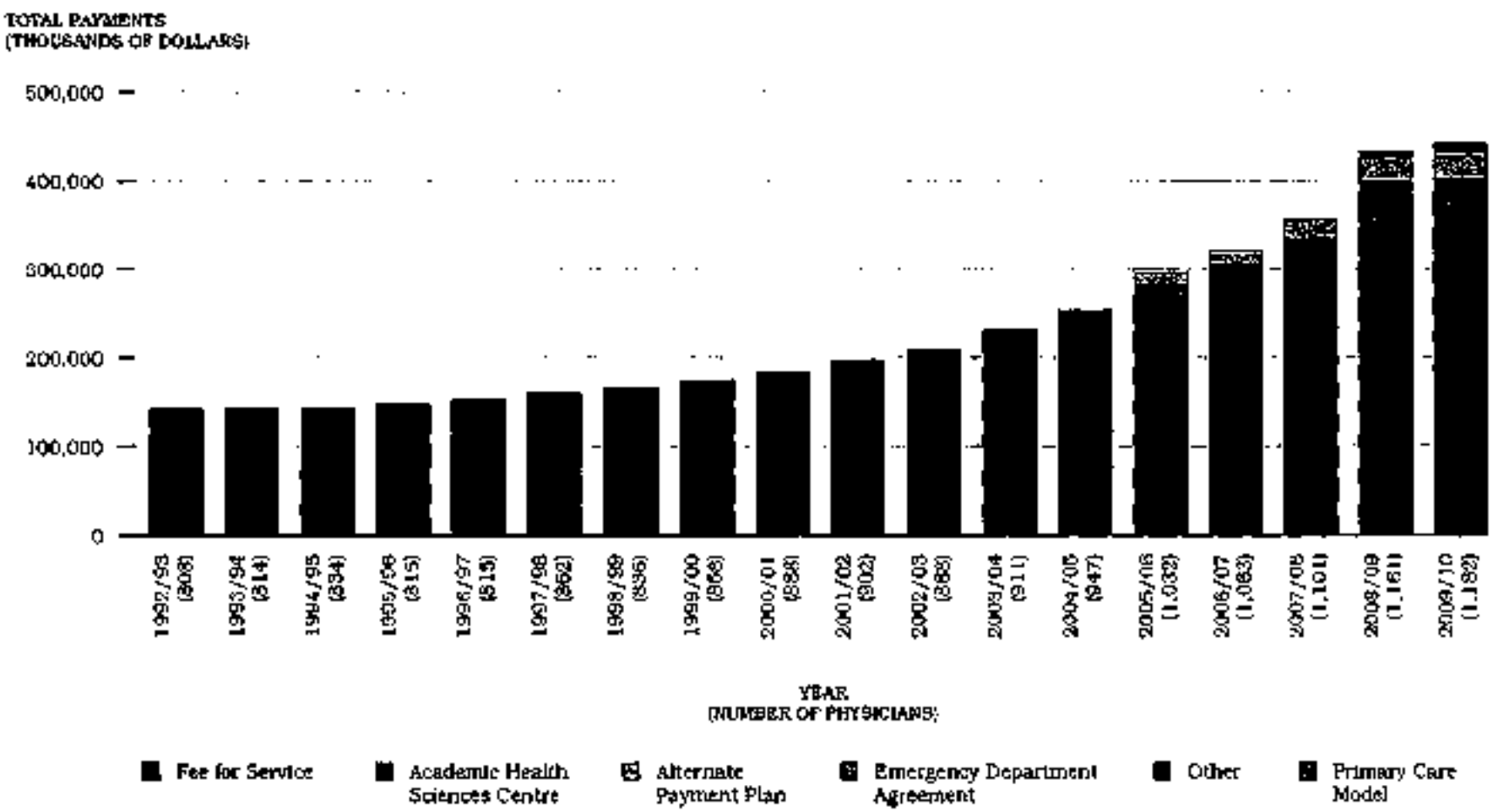
ANESTHESIOLOGISTS

EXHIBIT 9.2 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to anesthesiologists, in Ontario, 1992/93 to 2009/10



ANESTHESIOLOGISTS

EXHIBIT 9.3 Total payments to anesthesiologists by payment source, in Ontario, 1992/93 to 2009/10



CHAPTER 10

Results for Emergency Department Physicians

INTRODUCTION

Emergency departments (EDs) in Ontario hospitals may be staffed by:

- general practitioners/family physicians;
- family physicians with an additional year of training in emergency medicine and certification from the Canadian College of Family Physicians (CCFP(EM)s); or
- physicians who have completed a five-year residency and passed certifying exams to earn the designation of Fellow of the Royal College of Physicians and Surgeons of Canada (FRCPC EM specialists).

For the purposes of this report, an emergency medicine physician is any physician who has more than 50% of billings for services rendered in the ED. It includes physicians from all three groups listed above. In this chapter, we will refer to them collectively as ED physicians.

Staffing and funding EDs has long presented a challenge to health planners and policy makers. A 2001 ICES report found that the total number of physicians working in EDs declined from 2,525 in 1993/94 to 1,987 in 2000/01.[1] There were reports in the media from time to time of EDs having to close temporarily due to a lack of physician coverage. For this reason, EDs were one of the first physician sectors in the health care system to see the introduction of widespread alternate funding arrangements. As Chan et

at, reported, this began in 1996 with the introduction of sessional fees for after-hours and weekend coverage. In the same year, the MOHLTC began offering Alternate Funding Plans (AFPs) as a recruiting tool to physicians in rural Northern Ontario. In 1999, the MOHLTC implemented a new Alternate Funding Arrangement (AFA) that was intended to replace sessional fees, any existing AFPs and fee-for-service billings. It was offered to most EDs in the province, and introduced on an interim basis in three waves between September 1999 and November 2000. Permanent AFAs were introduced in 2002.

All of these funding changes have implications for the results presented in this chapter. No payment information was available for AFAs prior to 2005/06 or for the earlier AFPs (data were available for FFS payments and sessional fees). From 1996/97 to 1998/99, we are missing data on payments to Northern Ontario physicians who were part of AFPs. From 1999/00 to 2004/05, we are missing data for nearly all payments to ED physicians, which is why the results for these years have been suppressed. The data for 1992/93 to 1995/96 and 2005/06 to 2009/10 are complete.

FINDINGS

Median, Mean and Total Payments (exhibits 10.1 to 10.3)

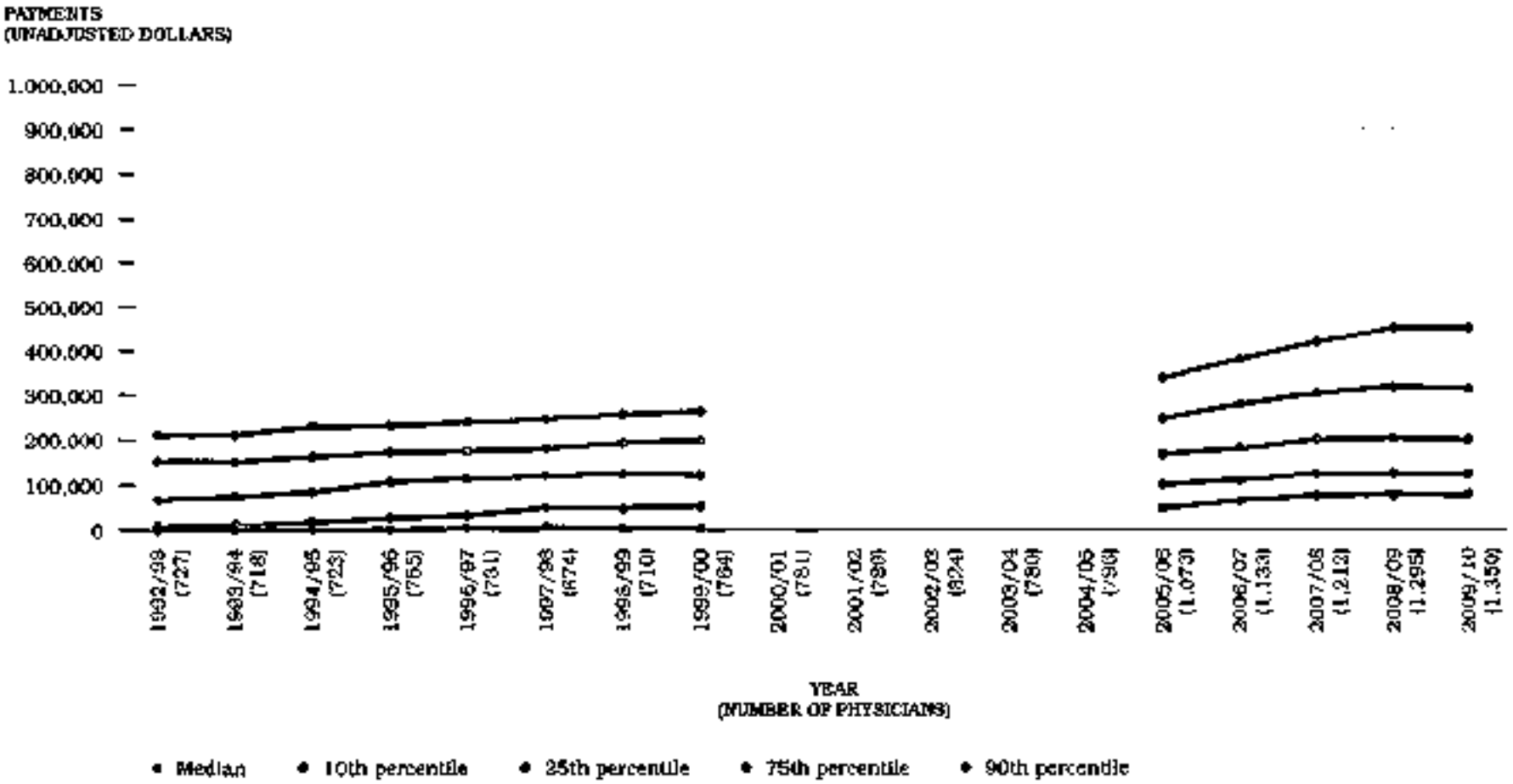
In 1992/93, there were 727 ED physicians in Ontario, 75% of whom were GP/FPs; the remainder were evenly split between 84 CCFP(EM)s and 85 FRCPC-EM specialists. By contrast, of the 1,350 ED physicians in 2009/10, 550 (41%) were GP/FPs, 43% (578) were CCFP(EM)s and 16% were EM specialists. In 2005/06, the median payment to ED physicians was just under $170,000, much lower than the $226,000 median for all physician in that year. The low median for ED physicians may reflect the fact that this group includes a significant proportion of newly graduated physicians who, not having started their own practices, chose to work part-time or do locums in the ED. ED physicians in the top 10% earned more than $338,000, while those in the lowest 10% earned less than $50,000. The mean payment per full-time equivalent (FTE) increased by about 24% between 2005/06 and 2009/10, from approximately $190,000 to $235,000. Payments to ED physicians totalled about $323 million in 2009/10, with only 27% coming from FFS billings.

REFERENCE

1 Chan BTB, Schull MJ, Schultz SE. *Emergency Department Services in Ontario*. Toronto: Institute for Clinical Evaluative Sciences; 2001. Accessed January 13, 2012 at http://www.ices.on.ca/file/Emergency_department_services_in_Ontario.pdf.

EMERGENCY DEPARTMENT PHYSICIANS

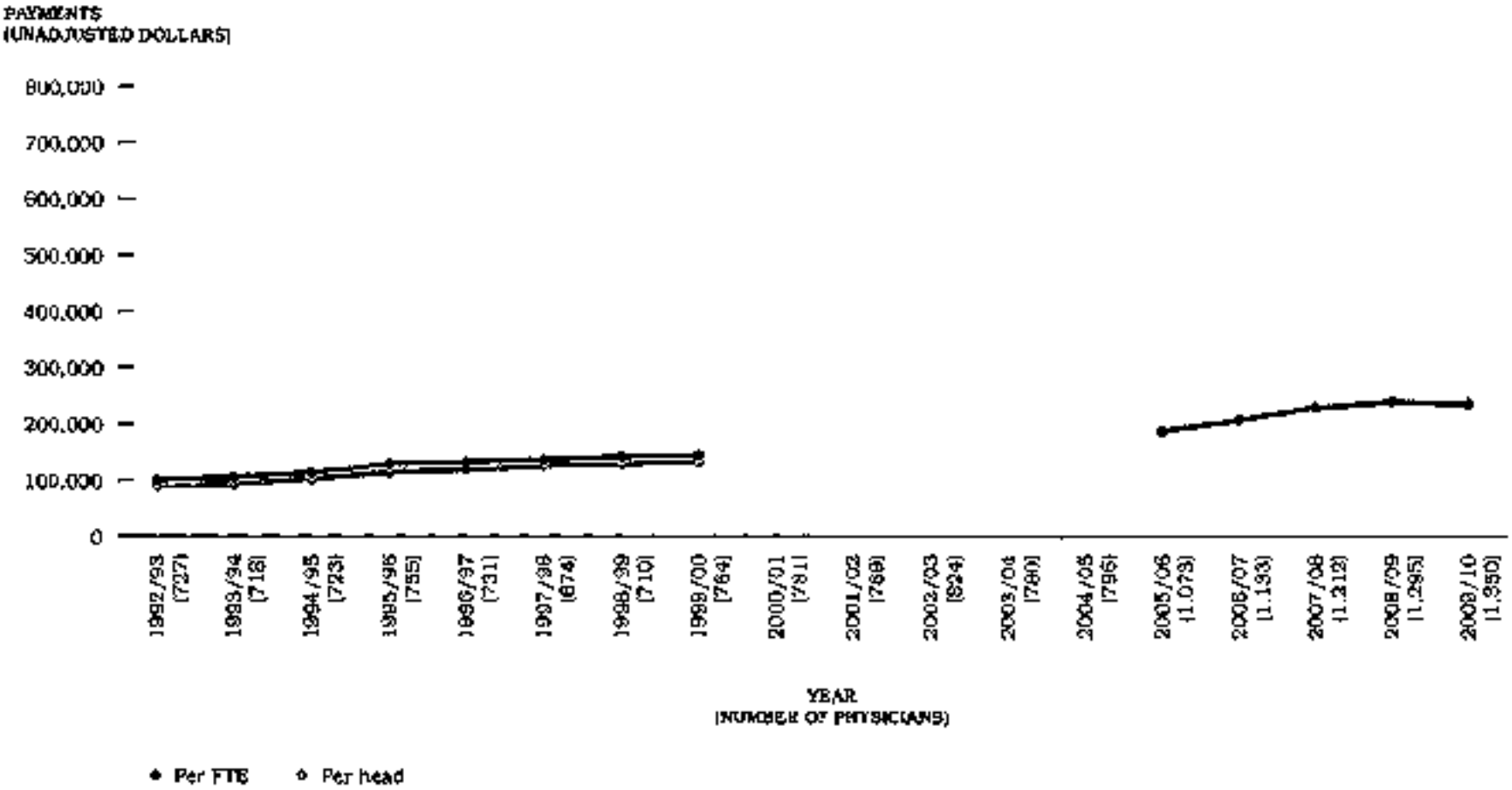
EXHIBIT 10.1 Median and percentiles of payments (in unadjusted dollars) to individual emergency department physicians. In Ontario, 1992/93 to 2009/10



Note. Results for 2000/01 to 2004/05 have been suppressed due to missing data.

EMERGENCY DEPARTMENT PHYSICIANS

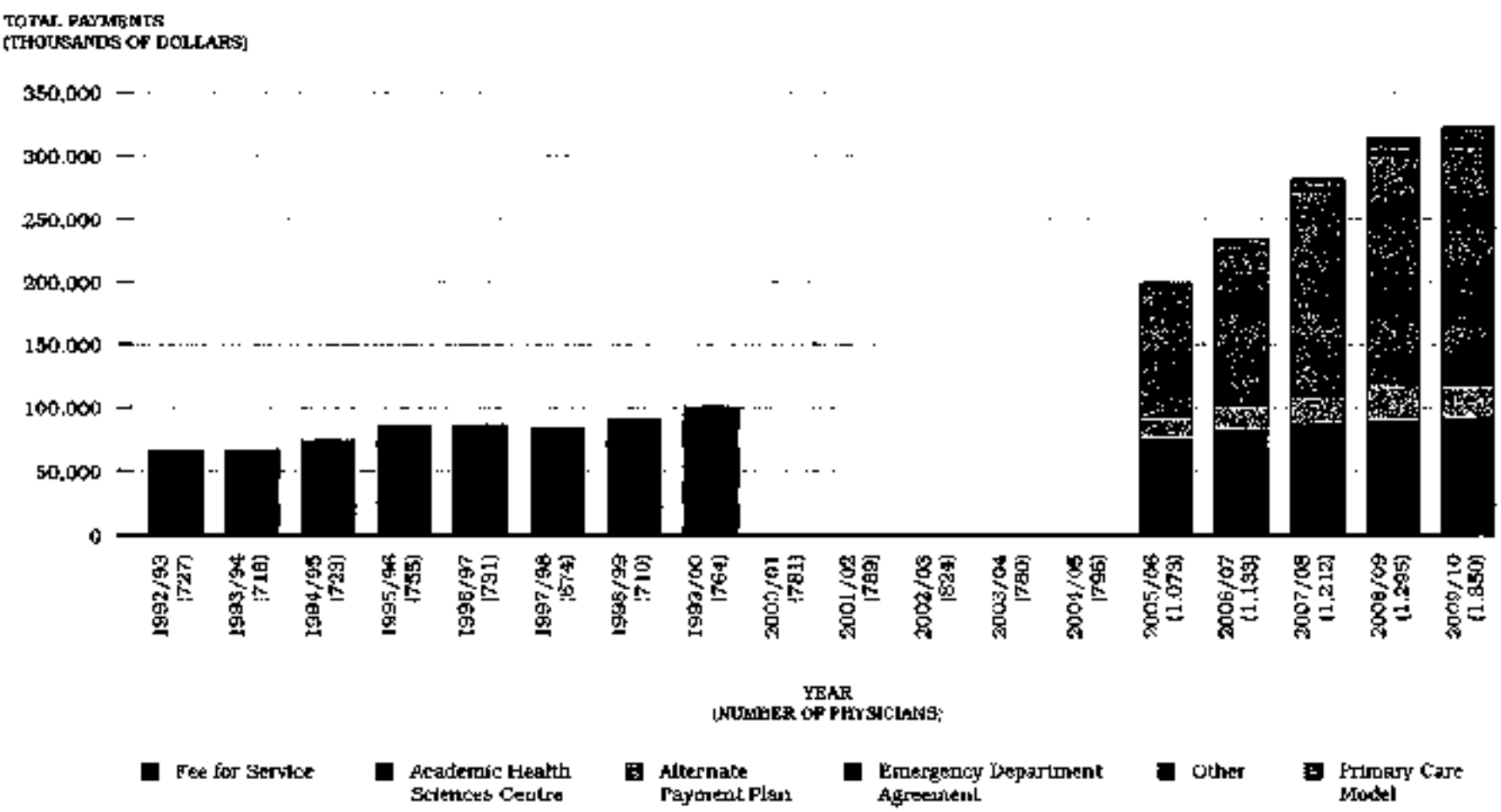
EXHIBIT 10.2 Mean payments (in unadjusted dollars) per head and full-time equivalent (FTE) to emergency department physicians, in Ontario, 1992/93 to 2009/10



Note: Results for 2000/01 to 2004/05 have been suppressed due to missing data.

EMERGENCY DEPARTMENT PHYSICIANS

EXHIBIT 10.3 Total payments to emergency department physicians by payment source, in Ontario, 1992/93 to 2009/10



Note: Results for 2000/01 to 2004/05 have been suppressed due to missing data.

CHAPTER 11

Summary

Chapters 4 to 10 reported payments to physicians in individual specialties separately. In this chapter we bring the results together to show how physician supply and payments and the changes within them varied among specialties between 1992/93 and 2009/10.

Physician Supply (exhibits 11.1 and 11.2)

The overall number of physicians for whom we had payment information increased by 4,811 (24%) between 1992/93 and 2009/10. This is slightly higher than Ontario's overall population growth (20%) in this period. Growth was not constant over time; in fact, there was a slight contraction in the number of doctors between 1993/94 and 1999/00. Growth was greatest between 2005/06 and 2009/10 (2.3% per year).

Growth in physician supply was variable across specialty groups. Proportionally, the greatest increases were seen in emergency medicine and the medical procedural specialties. As a group, the procedural specialties showed the largest increase, with the number of physicians in this group growing by 58% between 1992/93 and 2009/10. The smallest overall proportional increase (4.5% between 1992/93 and 2009/10) was among GP/FPs. However, this overall figure disguises a decline of almost 8% between 1993/94 and 1999/00, which then reversed. Significantly, the numbers of GP/FPs grew substantially between 1999/00 and

2009/10 (the largest growth in any specialty seen during this period). These growth periods compensated for the loss of GP/FPs between 1992/93 and 1999/00.

Among specialist groups, the combined surgical specialties grew the least, with overall growth of only 18% between 1992/93 and 2009/10. Within a number of specialties in this group, supply remained flat or contracted between 1992/93 and 1999/00. Overall, specialist numbers increased to a proportionally greater extent than did the numbers of GP/FPs.

We estimate that the density of physicians in Ontario in 2009/10 was 1.9 per 1,000 population. An analysis of the situation in Canada prepared by the Canadian Institute for Health Information found that Canada has an overall physician supply of 2.2 per 1,000 population, which is lower than other OECD countries such as Australia (3.2 per 1,000), the United Kingdom (2.5 per 1,000) and the United States (2.6 per 1,000).[1]

Overall Payments to Physicians (exhibits 11.3 to 11.7)

We identified payments of almost $8 billion to doctors in Ontario in 2009/10, $4.3 billion more than they were paid in 1992/93. These estimates are in unadjusted dollars. Exhibit 11.3 presents a breakdown of the total payments by physician groups in 2009/10. Thirty-nine percent of the expenditure went to GP/FPs, with 18% and 17% going to surgical and medical non-procedural specialist groups, respectively. Comparing this with physician supply, GP/FPs comprise 43% of the physician population, medical non-procedural specialists 22%, and surgical specialists only 14%.

Exhibits 11.4 to 11.6 present the distribution of overall payments within the large multispecialty groups. With respect to the non-medical procedural specialists, 22% of payments in 2009/10 went to pediatricians. This is commensurate with the fact that they make up 21% of all non-procedural specialists. Psychiatrists, on the other hand, received the largest proportion of payments, 26%, but they make up 35% of all non-procedural specialists. The discrepancy is due, in part, to the fact that we are missing mental health sessional fees and other payments to psychiatrists. Within the procedural specialty group, cardiologists received 45% of payments followed by gastroenterologists at 20%. Among the surgical specialist group, obstetricians/gynecologists received the largest proportion (29%), followed by general surgeons (19%) and ophthalmologists (18%). These specialties comprised 23%, 21% and 13% of the surgical specialty group, respectively.

By far the largest increase in total payments was to family physicians—an increase of more than $1.5 billion between 1993 and 2009 (exhibit 11.7). Next in rank order were anesthesiologists ($298 million), diagnostic radiologists ($294 million), emergency department physicians ($256 million), cardiologists ($223 million) and pediatricians ($193 million). Four of these are in the top five specialties ranked by increase in numbers of active physicians. The list also includes specialties that have been key to the wait times strategy.

Payments per Physician (exhibit 11.8 and 11.9)

Average payments per full-time equivalent (FTE) are summarized in exhibit 11.8. Diagnostic radiologists had the highest payments per FTE, with ophthalmologists, nephrologists, nuclear medicine specialists and vascular surgeons rounding out the top five. Among the multispecialty groups, imaging specialties had the highest payments per FTE, followed by procedural and surgical specialties. All of these groups rank higher than the mean for all physicians combined.

When we looked at the change in mean payments to physician specialties since 2005/06, GP/FPs came out on top with a 31% increase in four years (exhibit 11.9). This is related to the introduction and uptake of new models of funding primary care. The most lucrative of the models, the Family Health Organization, was also the most popular as at the end of 2009/10.

Other specialties that experienced relatively large increases in the past four years include diagnostic radiology (29%), clinical immunology (29%), geriatric medicine (29%) and pediatrics (28%). However, although the rate of increase might be the same, the average payments per physician were not. Pediatricians, for example, ranked 29th out of 32 specialties in their mean payments per FTE. Geriatricians ranked 28th and clinical immunologists 18th, diagnostic radiologists were first overall. Pediatricians with an average payment per physician of $260,000 ranked far below diagnostic radiologists and ophthalmologists at over $600,000 each.

REFERENCE

1 Canadian Institute for Health Information. *Health Care Cost Drivers: The Facts*. Ottawa: CIHI; 2011. Accessed January 13, 2012 at http://secure.cihi.ca/cihiweb/products/health_care_cost_drivers_the_facts_en.pdf.

ALL PHYSICIANS

EXHIBIT 11.1 Total and percent change in number of active physicians by specialty and specialty group, in Ontario, 1993/94, 1999/00, 2005/06 and 2009/10

	NUMBER OF ACTIVE PHYSICIANS				PERCENT CHANGE IN PHYSICIAN SUPPLY				
Specialty/Specialty Group	1993/94	1999/00	2005/06	2009/10	1993/94-1999/00	1999/00-2005/06	2005/06-2009/10	1993/94-2009/10	Rank, 1993/94-2009/10
Anesthesiology	814	858	1,032	1,182	5.9	19.7	14.5	45.2	13
Emergency department physicians	718	764	1,073	1,350	7.2	39.4	25.8	88.0	4
General practice/family medicine	10,329	9,529	10,236	10,799	-7.5	7.3	5.4	4.5	29
IMAGING SPECIALTIES									
Diagnostic radiology	702	753	885	975	7.3	17.5	10.2	38.9	16
Nuclear medicine	57	75	78	88	31.6	4.0	12.8	54.4	11
Group Total	759	828	963	1,063	9.1	16.3	10.4	40.1	
MEDICAL NON-PROCEDURAL SPECIALTIES AND SUBSPECIALTIES									
Clinical immunology	49	60	63	62	22.4	5.0	-1.6	26.5	23
Dermatology	207	207	188	200	0.0	-9.2	6.4	-3.4	32
Endocrinology	112	139	151	174	25.9	7.1	15.2	55.4	10
Geriatric medicine	53	83	90	102	58.5	7.1	13.3	92.5	3
Hematology	111	117	135	152	5.8	9.8	12.6	34.5	19
Internal medicine	671	517	827	966	-22.9	60.0	16.5	43.8	14
Medical oncology	94	130	149	187	38.4	13.7	25.5	98.9	2
Neurology	208	231	261	295	13.4	10.1	13.0	41.1	15
Pediatrics	680	725	1,015	1,165	10.3	26.2	14.8	59.8	9
Physical medicine and rehabilitation	119	136	158	164	15.0	14.5	3.8	36.7	17
Psychiatry	1,643	1,768	1,857	1,979	8.1	4.6	6.6	20.5	26

Note: Totals include only physicians for whom payment information was available.

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EXHIBIT 11 CONTINUED...

Specialty/Specialty Group	NUMBER OF ACTIVE PHYSICIANS				PERCENT CHANGE IN PHYSICIAN SUPPLY				
	1993/94	1999/00	2005/06	2009/10	1993/94-1999/00	1999/00-2005/06	2005/06-2009/10	1993/94-2009/10	Rank, 1993/94-2009/10
Rheumatology	119	149	151	160	25.4	1.9	6.0	34.5	20
Group Total	4,066	4,262	5,045	5,606	6.5	15.6	11.3	38.2	
MEDICAL PROCEDURAL SPECIALTIES AND SUBSPECIALTIES									
Cardiology	375	479	539	625	27.9	11.6	16.0	66.8	7
Gastroenterology	163	211	230	289	27.5	8.0	25.7	73.1	6
Nephrology	88	125	155	191	41.6	23.0	23.2	114.6	1
Radiation oncology	104	127	154	182	22.1	21.3	18.2	75.0	5
Respirology	145	166	212	236	30.8	11.0	11.3	61.6	8
Group Total	875	1,128	1,290	1,523	23.5	9.6	16.6	58.1	
SURGICAL SPECIALTIES									
Cardiac and thoracic surgery	91	105	126	136	16.5	18.9	7.9	49.5	12
General surgery	670	607	667	720	-9.0	9.3	7.9	7.5	28
Neurosurgery	77	72	79	97	0.0	2.6	22.8	26.0	24
Obstetrics/gynecology	661	664	729	790	0.5	9.6	8.4	19.5	27
Ophthalmology	422	418	418	441	-0.9	0.0	5.5	4.5	30
Orthopedic surgery	388	418	470	524	7.7	12.4	11.5	35.1	18
Otolaryngology	209	223	241	246	-5.5	7.1	2.9	4.2	31
Plastic surgery	154	164	186	200	6.5	13.4	7.5	29.9	22
Urology	213	236	251	268	10.3	6.8	6.8	25.8	25
Vascular surgery	54	65	66	72	20.4	1.5	9.1	33.3	21
Group Total	2,965	2,971	3,233	3,496	0.5	8.4	8.1	17.8	
ONTARIO	20,529	20,340	22,874	25,019	-0.9	12.5	9.4	21.9	

Note: Totals include only physicians for whom payment information was available.

ALL PHYSICIANS

EXHIBIT 11.2 Total and percent change in number of physician full-time equivalents (FTES) by specialty and specialty group, in Ontario, 1993/94, 1999/00, 2005/06 and 2009/10

	NUMBER OF FTES				PERCENT CHANGE IN FTES		
Specialty/Specialty Group	1993/94	1999/00	2005/06	2009/10	1993/94-1999/00	1999/00-2005/06	2005/06-2009/10
Anesthesiology	758	791	950	1,115	4	20	17
Emergency department physicians	634	703	1,057	1,375	11	50	30
General practice/family medicine	9,105	8,657	9,500	10,220	-5	10	8
IMAGING SPECIALTIES							
Diagnostic radiology	651	705	810	906	8	15	12
Nuclear medicine	56	72	75	85	30	3	13
Group Total	707	777	885	990	10	14	12
MEDICAL NON-PROCEDURAL SPECIALTIES AND SUBSPECIALTIES							
Clinical immunology	46	55	60	60	19	10	-1
Dermatology	186	185	173	198	0	-7	15
Endocrinology	117	136	150	174	17	10	16
Geriatric medicine	56	80	87	100	45	8	15
Hematology	105	107	120	137	2	13	13
Internal medicine	635	491	753	887	-23	53	18
Medical oncology	94	129	143	177	38	11	24
Neurology	193	223	263	289	15	18	10
Pediatrics	817	842	1,043	1,187	4	63	14
Physical medicine and rehabilitation	121	130	143	157	7	10	10
Psychiatry	1,525	1,640	1,763	1,905	8	8	8

Note: Totals include only physicians for whom payment information was available.

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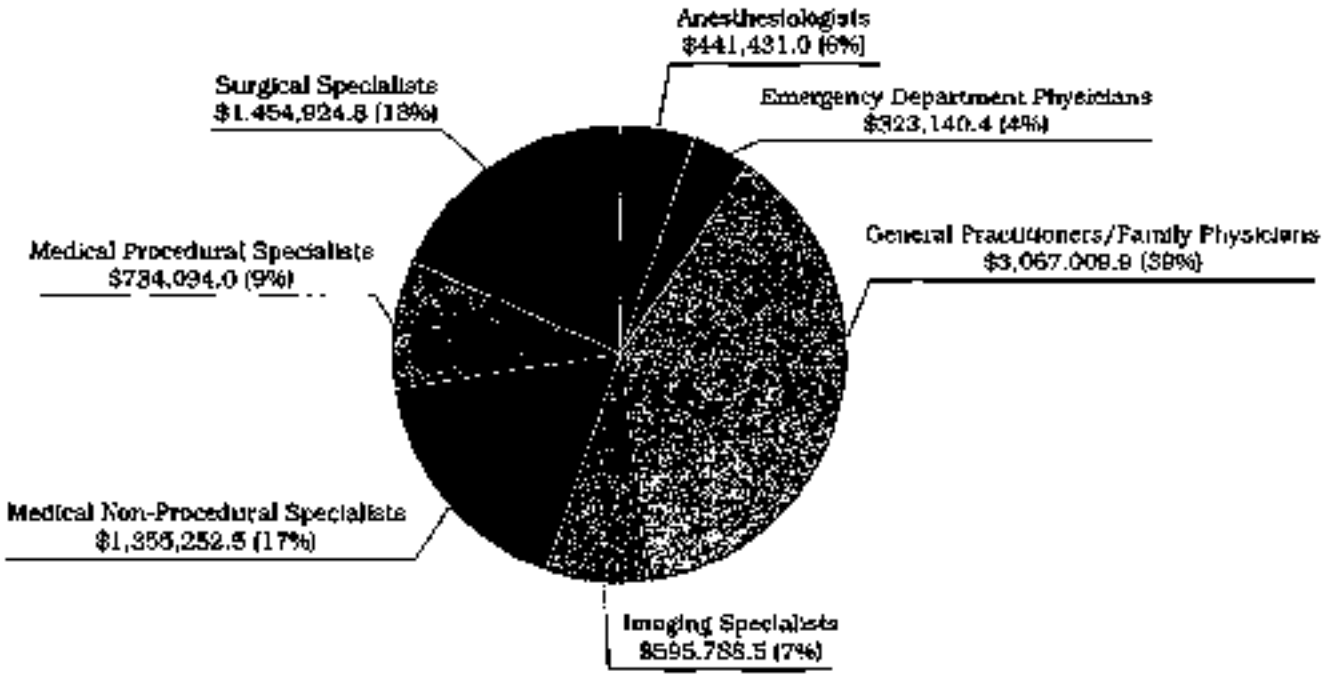
EXHIBIT 11.2 CONTINUED .

Specialty/Specialty Group	NUMBER OF FTES				PERCENT CHANGE IN FTES		
	1993/94	1999/00	2005/06	2009/10	1993/94-1999/00	1999/00-2005/06	2005/06-2009/10
Rheumatology	120	148	153	164	23	3	7
Group Total	3,818	3,986	4,851	5,425	4	24	12
MEDICAL PROCEDURAL SPECIALTIES AND SUBSPECIALTIES							
Cardiology	344	442	521	617	28	18	18
Gastroenterology	152	192	220	278	27	15	26
Nephrology	81	115	142	183	41	24	29
Radiation oncology	102	120	149	176	19	24	18
Respirology	136	181	200	228	33	10	14
Group Total	815	1,050	1,232	1,482	23	14	20
SURGICAL SPECIALTIES							
Cardiac and thoracic surgery	85	96	116	125	13	21	8
General surgery	582	531	598	656	-9	13	10
Neurosurgery	70	62	71	92	-10	13	30
Obstetrics/gynecology	597	596	677	725	0	14	7
Ophthalmology	381	380	387	426	0	2	10
Orthopedic surgery	331	353	405	465	7	15	15
Otolaryngology	214	194	209	223	-9	7	7
Plastic surgery	196	146	165	183	7	13	11
Urology	195	199	223	246	2	12	10
Vascular surgery	55	53	63	70	16	-1	11
Group Total	2,646	2,621	2,914	3,210	-1	11	10
ONTARIO	18,491	18,665	21,389	23,818	1	15	11

Note: Totals include only physicians for whom payment information was available.

ALL PHYSICIANS

EXHIBIT 11.3 Distribution of all payments (in thousands of dollars) to physicians by specialty group, in Ontario, 2009/10

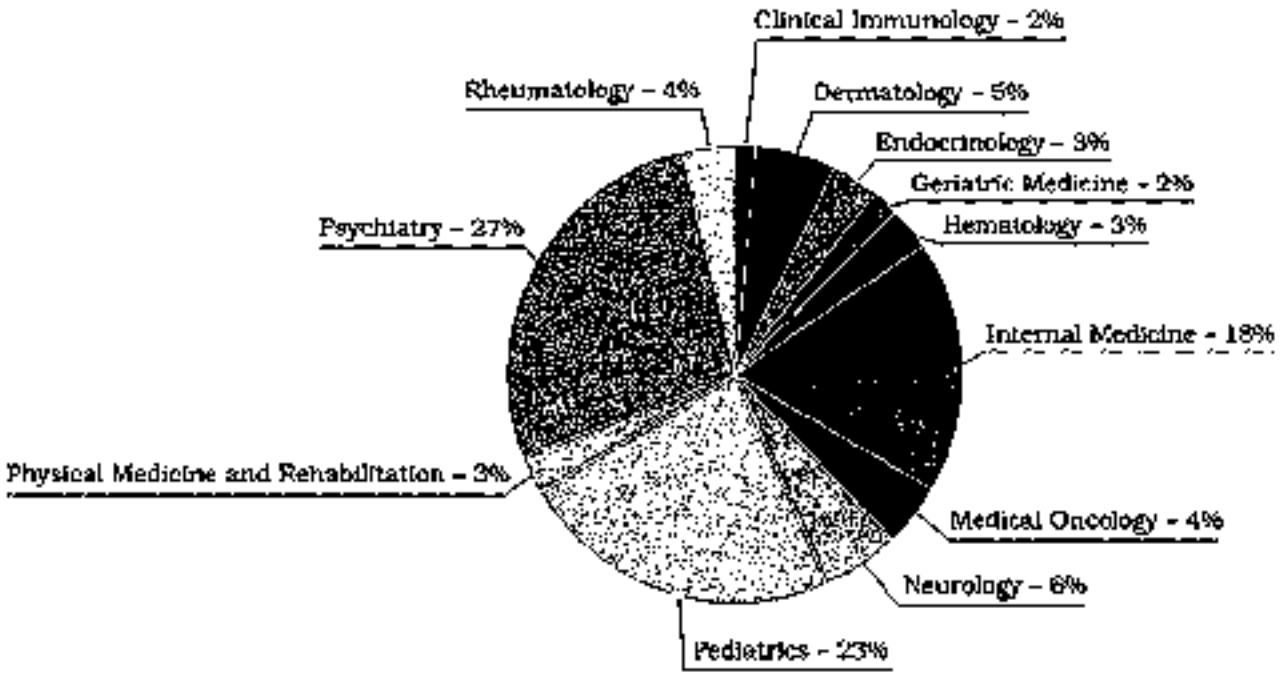


Total: $7,971,641.2

Note: All payment estimates are rounded to the nearest hundred and presented in thousands of dollars. Percents are calculated on unrounded numbers and rounded to the nearest integer.

MEDICAL NON-PROCEDURAL SPECIALISTS

EXHIBIT 11.4 Distribution of payments to medical non-procedural specialists, in Ontario, 2009/10

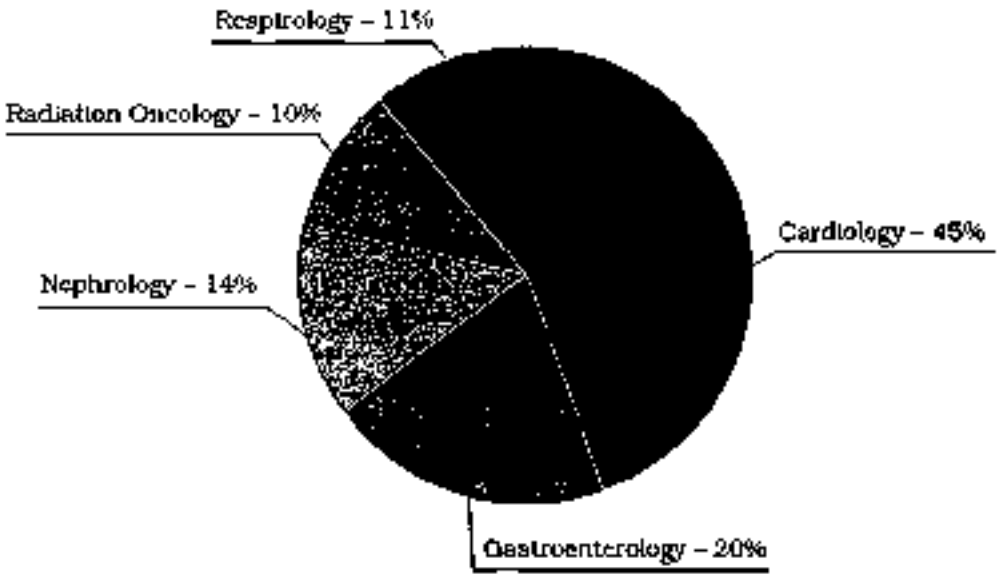


Total (in thousands of dollars): $1,356,252.5

Note: Payment estimates are rounded to the nearest hundred and presented in thousands of dollars. Percents are calculated on unrounded numbers and rounded to the nearest integer.

MEDICAL PROCEDURAL SPECIALISTS

EXHIBIT 11.5 Distribution of payments to medical procedural specialists, in Ontario, 2009/10

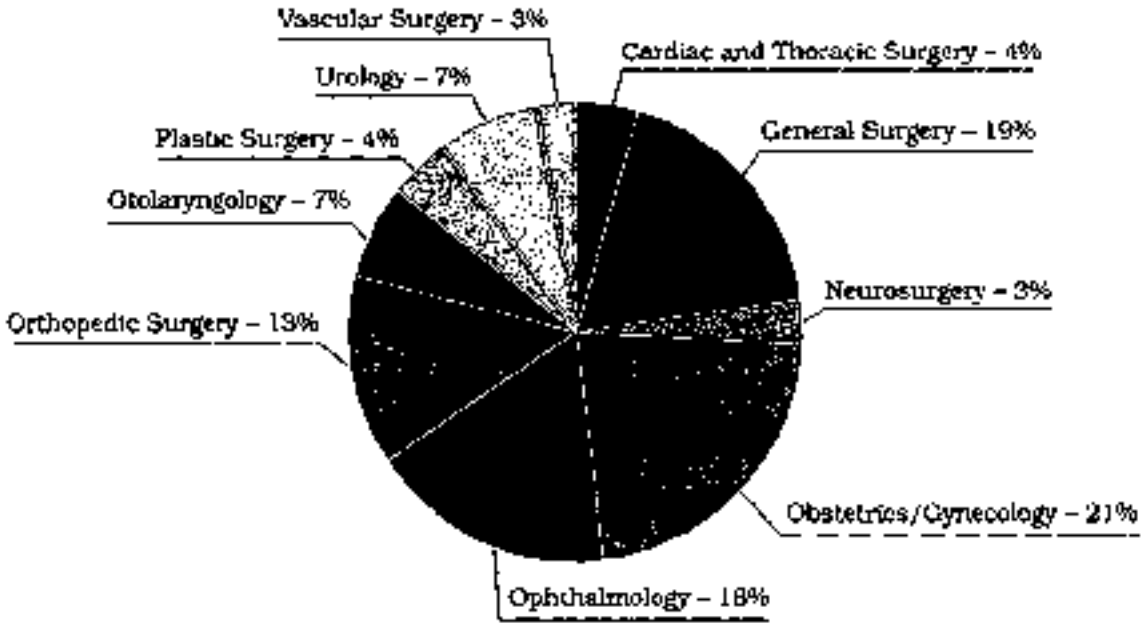


Total (in thousands of dollars): 6734,094.0

Note: Payment estimates are rounded to the nearest hundred and presented in thousands of dollars. Percents are calculated on unrounded numbers and rounded to the nearest integer.

SURGICAL SPECIALISTS

EXHIBIT 11.6 Distribution of payments to surgical specialists, in Ontario, 2009/10



Total (in thousands of dollars): $1,454,924.8

Note: Payments estimates are rounded to the nearest hundred and presented in thousands of dollars. Percents are calculated on unrounded numbers and rounded to the nearest integer.

ALL PHYSICIANS

EXHIBIT 11.7 Total and percent change in payments from all MOHLTC sources to physicians by specialty and specialty group, in Ontario, 1993/94, 1999/00, 2005/06 and 2009/10

	PAYMENTS FROM ALL SOURCES, IN THOUSANDS OF DOLLARS				CHANGE IN TOTAL PAYMENTS, IN THOUSANDS OF DOLLARS (% CHANGE)			
Specialty/Specialty Group	1993/94	1999/00	2005/06	2009/10	1993/94-1999/00	1999/00-2005/06	2005/06-2009/10	1993/94-2009/10
Anesthesiology	143,531.7	175,534.0	296,667.6	441,431	32,002.3 (22)	121,133.6 (69)	144,763.4 (49)	297,899.3 (208)
Emergency department physicians	67,077.6	101,464.7	199,660.8	323,140.4	34,387.1 (51)	98,195.9 (97)	123,479.8 (62)	256,062.8 (382)
General practice/family medicine	1,513,228.0	1,612,869.7	2,176,527.5	3,067,009.9	99,641.7 (7)	563,657.4 (35)	890,482.3 (41)	1,553,781.9 (103)
IMAGING SPECIALTIES								
Diagnostic radiology	255,123.2	353,764.1	379,946.2	549,480.9	98,640.9 (39)	26,182.1 (7)	169,534.7 (45)	294,357.7 (115)
Nuclear medicine	29,485.4	52,853.4	36,445.2	46,307.7	23,368.0 (79)	-16,408.2 (-31)	9,862.5 (27)	16,822.3 (57)
Group Total	284,608.6	406,617.5	416,391.3	595,788.5	122,008.9 (43)	9,773.8 (2)	179,397.2 (43)	311,179.9 (109)
MEDICAL NON-PROCEDURAL SPECIALTIES AND SUBSPECIALTIES								
Clinical immunology	10,545.6	13,445.9	17,504.2	22,407.7	2,900.3 (28)	4,058.3 (30)	4,903.5 (28)	11,862.1 (112)
Dermatology	53,120.8	59,191.2	55,354.6	76,090.8	70.4 (0)	2,163.6 (4)	20,736.0 (37)	22,970.0 (43)
Endocrinology	21,738.5	26,377.8	32,463.8	47,854.8	4,639.3 (21)	6,086.0 (23)	15,391.0 (47)	26,116.3 (120)
Geriatric medicine	5,027.7	11,120.0	17,801.1	26,365.6	6,092.3 (121)	6,681.1 (60)	8,564.5 (48)	21,337.9 (424)
Hematology	15,222.1	16,971.6	30,442.7	39,628.8	1,749.5 (11)	13,471.1 (79)	9,186.1 (31)	24,606.7 (162)
Internal medicine	103,324.3	78,499.2	168,113.7	240,669.8	-24,825.1 (-24)	89,614.5 (114)	72,756.1 (43)	137,345.5 (133)
Medical oncology	12,732.1	22,456.3	38,189.5	58,043.2	9,706.2 (76)	15,731.2 (70)	19,453.7 (50)	45,891.1 (360)
Neurology	38,732.5	44,827.3	57,355.2	78,650.2	6,094.8 (16)	12,527.9 (28)	21,295.0 (37)	39,917.7 (103)
Pediatrics	117,090.4	124,729.9	212,546.3	310,240.7	7,680.5 (7)	87,816.4 (70)	97,694.4 (46)	193,150.3 (165)
Physical medicine and rehabilitation	18,366.7	21,172.3	29,794.2	39,413.2	2,805.6 (15)	8,621.9 (41)	9,619.0 (32)	21,046.6 (115)
Psychiatry	231,716.3	254,314.3	296,987.6	365,840.1	22,598.0 (10)	42,673.3 (17)	68,852.5 (23)	134,123.8 (58)

Note: Payment estimates are rounded to the nearest hundred and presented in thousands of dollars.
Percentages are calculated on unrounded numbers and rounded to the nearest integer.

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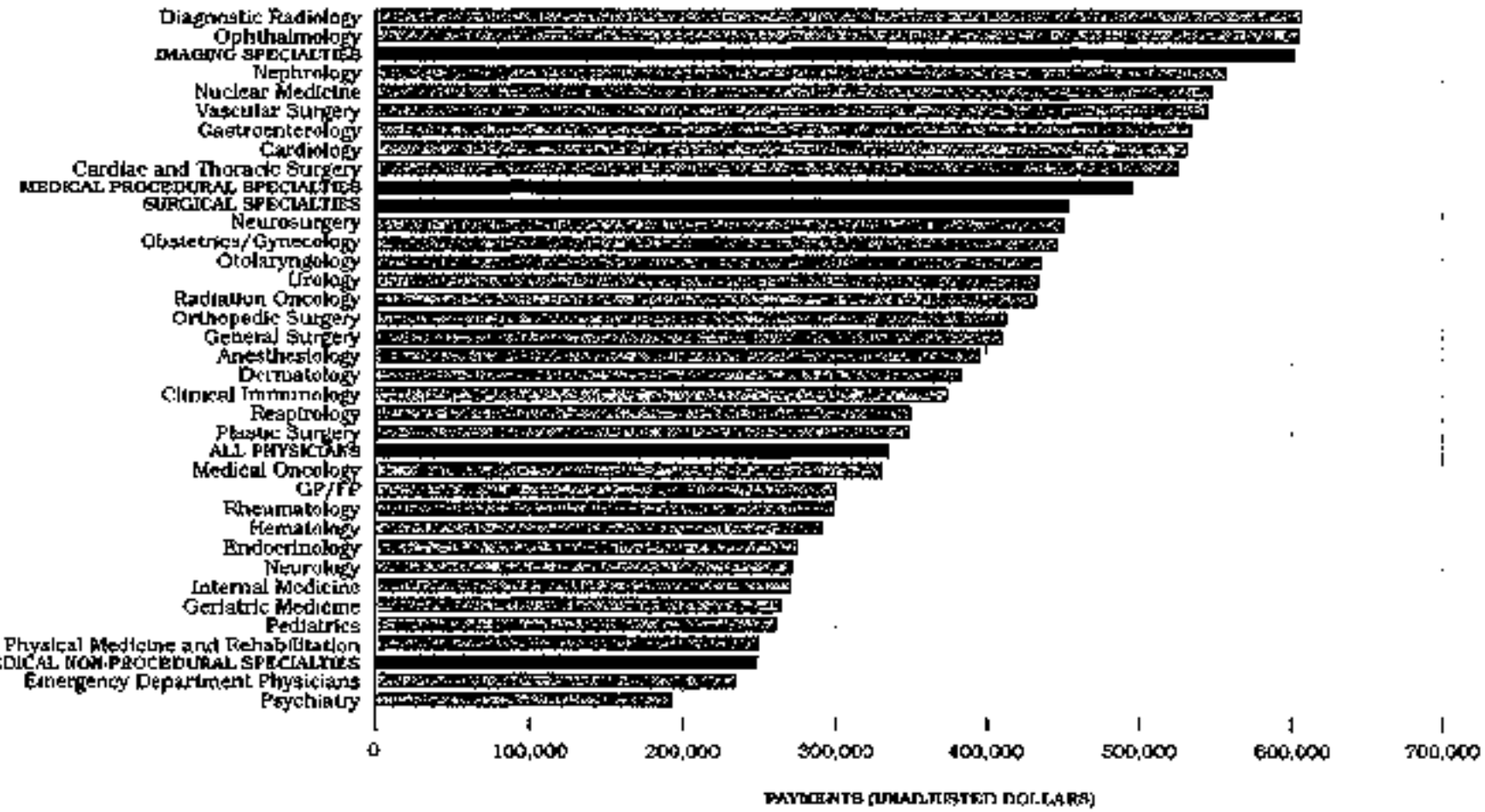
EXHIBIT 11./ Continued...

Specialty/Specialty Group	PAYMENTS FROM ALL SOURCES, IN THOUSANDS OF DOLLARS				CHANGE IN TOTAL PAYMENTS, IN THOUSANDS OF DOLLARS (% CHANGE)			
	1993/94	1999/00	2005/06	2009/10	1993/94-1999/00	1999/00-2005/06	2005/06-2009/10	1993/94-2009/10
Rheumatology	23,721.9	31,185.3	36,933.2	49,047.6	7,463.4 (31)	5,747.9 (18)	12,114.4 (33)	25,325.7 (107)
Group Total	651,358.9	698,293.1	994,486.3	1,355,252.5	46,934.2 (7)	296,193.2 (42)	360,766.2 (36)	703,893.6 (108)
MEDICAL PROCEDURAL SPECIALTIES AND SUBSPECIALTIES								
Cardiology	104,288.7	155,158.6	221,417.7	327,642.4	50,869.9 (49)	66,259.1 (43)	106,224.7 (48)	223,353.7 (214)
Gastroenterology	46,515.8	65,447.6	98,168.9	148,718.1	18,931.8 (41)	32,721.3 (50)	50,549.2 (51)	102,202.3 (220)
Nephrology	23,093.8	46,081.9	76,294.8	102,022.3	22,988.3 (100)	30,212.9 (66)	25,727.5 (34)	78,928.7 (342)
Radiation oncology	10,779.6	12,626.1	55,399.5	76,050.0	1,846.5 (17)	42,773.4 (339)	20,650.5 (37)	65,270.4 (605)
Respirology	34,438.2	55,269.1	60,186.8	79,661.2	20,830.9 (60)	4,917.7 (9)	19,474.4 (32)	45,223.0 (131)
Group Total	219,115.9	334,583.4	511,467.7	734,094	115,467.5 (53)	176,884.3 (53)	222,626.3 (44)	514,978.1 (235)
SURGICAL SPECIALTIES								
Cardiac and thoracic surgery	27,404.1	37,042.6	50,525.1	65,534.8	9,693.5 (35)	13,482.5 (36)	15,009.7 (30)	38,130.7 (139)
General surgery	135,125.0	136,705.7	203,194.2	269,461.2	1,580.7 (1)	66,488.5 (49)	66,267.0 (33)	134,336.2 (99)
Neurosurgery	16,029.9	17,678.7	27,667.3	41,302.8	1,648.8 (10)	10,188.6 (58)	13,635.5 (49)	25,272.9 (158)
Obstetrics/gynecology	163,179.5	174,001.8	243,598.4	323,594.1	10,822.3 (7)	69,596.6 (40)	79,995.7 (33)	160,414.6 (98)
Ophthalmology	113,782.2	137,503.4	192,750	257,465.6	23,721.2 (21)	55,246.6 (40)	64,715.6 (34)	143,683.4 (126)
Orthopedic surgery	88,001.4	103,339.3	149,319	191,847.5	15,337.9 (17)	45,979.7 (44)	42,528.6 (28)	103,846.2 (118)
Otolaryngology	59,740.1	60,256.6	78,476.7	97,196.9	516.5 (1)	18,220.1 (30)	18,720.2 (24)	37,456.8 (63)
Plastic surgery	35,679.4	37,171.5	48,960.3	63,792.0	1,492.1 (4)	11,788.8 (32)	14,831.7 (30)	28,112.6 (79)
Urology	59,594.7	62,809.8	87,566.6	106,580.4	3,215.1 (5)	24,756.8 (39)	19,013.8 (22)	46,985.7 (79)
Vascular surgery	16,799.7	23,196.7	27,696.6	38,149.4	6,397.0 (38)	4,501.9 (19)	10,450.8 (38)	21,349.7 (127)
Group Total	715,336.1	789,706.1	1,109,956.1	1,454,924.8	74,370.0 (10)	320,250.0 (41)	344,968.7 (31)	739,588.7 (103)
ONTARIO	3,594,258.8	4,119,068.5	5,705,156.7	7,971,641.2	524,811.7 (15)	1,586,088.2 (39)	2,266,484.5 (40)	4,377,384.4 (122)

Note: Payment estimates are rounded to the nearest hundred and presented in thousands of dollars. Percentages are calculated on unrounded numbers and rounded to the nearest integer.

ALL PHYSICIANS

EXHIBIT 11.8 Mean payments per full-time equivalent (FTE) by specialty and specialty group, in Ontario, 2009/10



ALL PHYSICIANS

EXHIBIT 11.9 Mean payments per full-time equivalent (FTE) and percent change in payments by specialty and specialty group, in Ontario, 1993/94, 1999/00, 2005/06 and 2009/10

	MEAN PAYMENTS PER FTE					CHANGE IN MEAN PAYMENTS PER FTE (% CHANGE)				
	1993/94	1999/00	2005/06	2009/10	Rank, 2009	1993/94-1999/00	1999/00-2005/06	2005/06-2009/10	Rank of % change, 2005/06-2009/10	1993/94-2009/10
Anesthesiology	189,200	221,900	312,900	395,900	16	32,700 (17)	90,400 (41)	83,600 (27)	6	206,700 (109)
Emergency department physicians	105,700	144,400	188,900	235,000	31	38,700 (37)	44,500 (31)	46,100 (24)	10	129,300 (122)
General practice/family medicine	166,200	186,300	229,100	300,100	22	20,100 (12)	42,800 (23)	71,000 (31)	1	133,900 (81)
IMAGING SPECIALTIES										
Diagnostic radiology	391,800	501,800	468,800	606,700	1	109,800 (28)	-33,000 (-7)	137,900 (29)	2	214,800 (55)
Nuclear medicine	529,000	780,800	487,800	547,700	4	201,800 (38)	-243,000 (-33)	59,900 (12)	29	18,700 (4)
Group Total	402,700	523,100	470,400	601,700		120,400 (30)	-52,700 (-10)	131,300 (28)		199,000 (49)
MEDICAL NON-PROCEDURAL SPECIALTIES AND SUBSPECIALTIES										
Clinical immunology	229,000	244,500	290,600	374,400	19	15,500 (7)	46,100 (19)	83,800 (29)	3	145,400 (63)
Dermatology	285,400	287,000	320,000	383,400	17	1,600 (1)	33,000 (11)	63,400 (20)	19	98,000 (34)
Endocrinology	186,300	193,500	216,600	275,600	25	7,200 (4)	23,100 (12)	59,000 (27)	7	89,300 (48)
Geriatric medicine	90,400	138,200	205,000	264,100	28	47,800 (53)	66,800 (48)	59,100 (29)	4	173,700 (192)
Hematology	145,200	159,700	252,700	291,500	24	13,500 (9)	94,000 (59)	38,800 (15)	26	146,300 (101)
Internal medicine	162,600	159,800	223,400	271,500	27	-2,800 (-2)	63,600 (40)	48,100 (22)	14	108,900 (67)
Medical oncology	135,000	174,500	274,200	330,600	21	39,500 (29)	99,700 (57)	56,400 (21)	15	195,600 (145)
Neurology	200,200	201,200	217,800	271,900	26	1,000 (0)	16,600 (8)	54,100 (25)	8	71,700 (36)
Pediatrics	189,600	194,400	203,800	261,300	29	4,800 (3)	9,400 (5)	57,500 (28)	5	71,700 (38)
Physical medicine and rehabilitation	151,900	163,000	208,600	251,000	30	11,100 (7)	45,600 (28)	42,400 (20)	20	99,100 (65)
Psychiatry	152,000	155,100	168,400	193,000	32	3,100 (2)	13,300 (9)	24,600 (15)	27	41,000 (27)

Note: Payment estimates are rounded to the nearest hundred. Percentages are calculated on unrounded numbers and rounded to the nearest integer

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EXHIBIT 11.9 CONTINUED...

	MEAN PAYMENTS PER FTE					CHANGE IN MEAN PAYMENTS PER FTE (% CHANGE)				
	1993/94	1999/00	2005/06	2009/10	Rank, 2009	1993/94-1999/00	1999/00-2005/06	2005/06-2009/10	Rank of % change, 2005/06-2009/10	1993/94-2009/10
Rheumatology	197,400	210,500	241,600	299,200	23	13,100 (7)	31,100 (15)	57,600 (24)	11	101,800 (52)
Group Total	170,700	176,100	205,000	249,800		5,400 (3)	28,900 (16)	44,800 (22)		79,100 (46)
MEDICAL PROCEDURAL SPECIALTIES AND SUBSPECIALTIES										
Cardiology	302,800	951,400	424,700	531,000	7	48,600 (16)	73,300 (21)	106,300 (25)	9	228,200 (75)
Gastroenterology	306,900	341,000	446,000	534,400	6	34,100 (11)	105,000 (31)	88,400 (20)	21	227,500 (74)
Nephrology	283,500	402,500	536,400	557,200	3	119,000 (42)	135,900 (34)	18,800 (3)	32	273,700 (97)
Radiation oncology	106,100	104,800	371,200	432,400	13	-1,300 (-1)	266,400 (254)	61,200 (16)	23	326,300 (307)
Respirology	253,200	305,200	301,500	349,300	19	52,000 (21)	-3,700 (-1)	47,800 (16)	24	961,00 (38)
Group Total	268,800	318,800	415,100	495,200		50,000 (19)	96,300 (30)	80,100 (19)		226,400 (84)
SURGICAL SPECIALTIES										
Cardiac and thoracic surgery	320,800	384,700	435,500	525,400	8	63,900 (20)	50,800 (13)	89,900 (21)	16	204,600 (64)
General surgery	232,400	257,600	339,600	410,500	15	25,200 (11)	82,000 (32)	70,900 (21)	17	178,100 (77)
Neurosurgery	230,600	293,900	395,200	450,300	9	52,700 (23)	111,900 (39)	55,100 (14)	28	219,700 (95)
Obstetrics/gynecology	273,200	292,200	359,700	446,100	10	19,000 (7)	67,500 (23)	86,400 (24)	12	172,900 (63)
Ophthalmology	298,300	361,700	498,300	604,600	2	63,400 (21)	136,600 (38)	106,300 (21)	18	306,300 (103)
Orthopedic surgery	266,500	292,800	369,500	412,900	14	27,300 (10)	76,700 (26)	44,400 (12)	30	147,400 (56)
Otolaryngology	279,400	309,800	376,000	436,400	11	30,400 (11)	66,200 (21)	60,400 (16)	25	157,000 (56)
Plastic surgery	262,100	254,300	296,100	348,500	20	-7,800 (-3)	41,800 (16)	52,400 (18)	22	86,400 (33)
Urology	306,000	315,000	393,100	433,900	12	9,000 (3)	78,100 (25)	40,800 (10)	31	127,900 (42)
Vascular surgery	306,000	366,500	440,200	545,000	5	58,500 (19)	73,700 (20)	104,900 (24)	13	237,000 (77)
Group Total	270,400	301,300	380,900	453,200		30,900 (11)	79,600 (26)	72,300 (19)		182,800 (68)
ONTARIO	194,500	221,000	266,700	334,700		27,400 (14)	44,800 (20)	68,000 (25)		140,200 (72)

Note: Payment summaries are rounded to the nearest hundred. Percentages are calculated on unrounded numbers and rounded to the nearest integer.

CHAPTER 12

Discussion and Conclusion

DISCUSSION

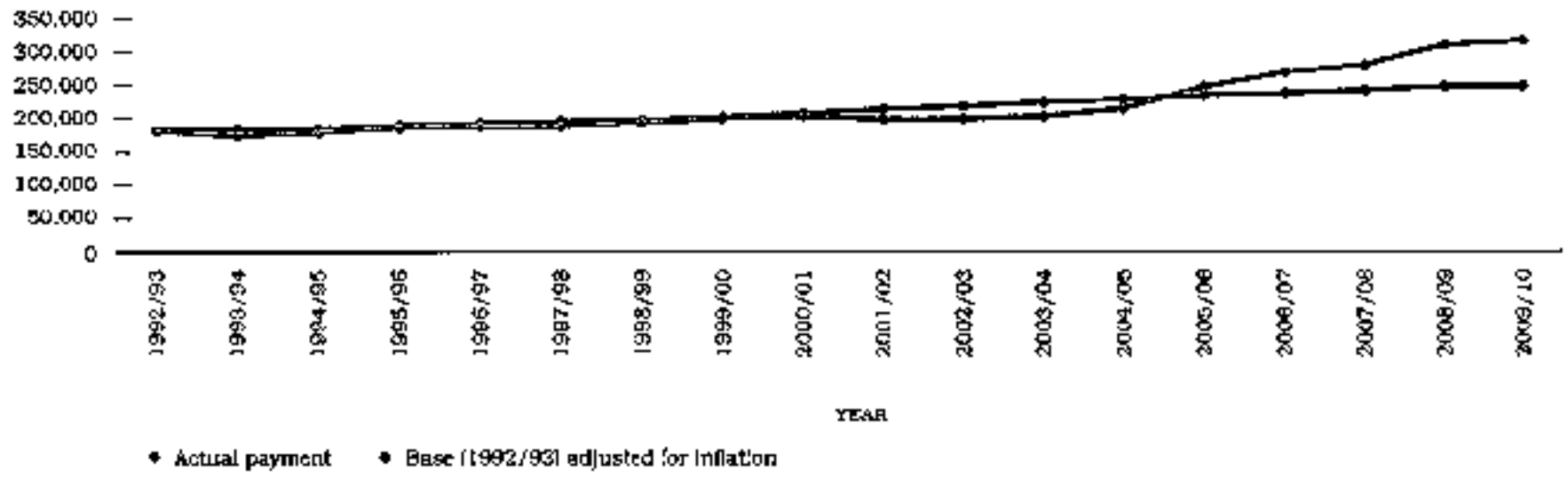
This report has documented payments to physicians during two different policy environments. The first phase included the period up to 1998 when, in common with other provinces, Ontario capped payments to physicians and restricted the numbers of physicians who could receive full payment of fees under the Ontario Health Insurance Plan (OHIP). Most payments during this period were made under fee-for-service (FFS) arrangements. The second period from 1998 onward represented a sharp change in policies with a shift to alternate payment plans (including capitation) to bolster recruitment and retention in certain specialties and in general/family medicine in particular. This period also coincided with the implementation of a range of interventions designed to reduce wait times for certain surgical procedures and diagnostic tests.

There were many other factors in play during this second period, examples include the promotion of screening tests for colorectal and breast cancer and major changes in the treatment of coronary heart disease, with increasing use of angioplasty and stents rather than open heart surgery. The period also coincides with a better appreciation of the importance of chronic diseases, including diabetes, congestive heart failure and chronic pulmonary disease in an aging population. It is to be expected that these trends would be reflected in payments for services provided by particular groups of physicians.

The two policy environments had different impacts on the trajectory of payments, as exhibit 12.1 illustrates.

The average per capita payment to Ontario physicians remained at or below the rate of inflation until 2004/05, after which it increased sharply and exceeded inflation (using Ontario's consumer price index) until the end of the study period. This finding is consistent with a 2011 CIHI study that found that across Canada the rates of increase in physician compensation followed rates of increase in the Government Current Expenditure Implicit Price Index (GCEIPI) prior to 1998.[1] Since 1998, rates of increase in physician compensation have exceeded rates of increase in the GCEIPI. CIHI reported that physician compensation grew faster than wages for other health and social services workers. There are a number of theoretical reasons for this recent increase, including a rise in the number of patients treated since 2004/05, an increase in services received by each patient, a rise in fees, and a shift to more expensive services.

EXHIBIT 12.1 **Mean annual payments per head to all Ontario physicians and inflation-adjusted base (1992/93) payment, 1992/93 to 2009/10**



A full evaluation of these potential explanations is beyond the scope of this report as it would require that analyses be performed at the level of individual patients. However, to get a lead on the main drivers of the increase in payments we performed some additional analyses at the physician level. Approximately 63% of the $4.3 billion increase in total payments was related to an increase in average payments per physician. The other 37% was a result of the increase in physician supply. Between 2004/05 and 2009/10, the substantial increases in OHIP payments to radiologists, nephrologists and ophthalmologists were due almost exclusively due to an increase in the average number of services provided by each specialist.

In its report, CIHI concluded that fee increases were the major cost driver for physician expenditure during the last 10 years. Per capita utilization (adjusted for aging) was the second major cost driver, and population growth and aging were the third and fourth most important.[1] Our data suggest that for key growth specialties, fee increases per se were not the main factor, and utilization (as reflected in services provided per physician) was more important, at least during the all-important period between 2005 and 2009. CIHI also reported that for both medical and surgical specialties a rise in the use of diagnostic and therapeutic services has been a significant cost driver. Population aging on its own was responsible for a relatively modest rate of growth in expenditure: 0.6% per year.[1] Further elucidation of these trends will require a patient-level analysis of the types of services provided and how these have changed over time. This is beyond the scope of the present analysis.

Payments to Specialists

As noted earlier, the policy initiatives directed at specialists have included a wide variety of alternate payment plans. The analyses presented here indicate that they have become significant payment programs for geriatrics, pediatrics, medical oncology, radiation oncology, hematology, and emergency medicine. Doubtless these payment models, as an alternative to FFS, have helped to retain practitioners in these specialties all of which have seen an increase in physician supply in recent years. However, with the exception of radiation oncology, payments to these specialties remain below the average for all specialist physicians. Those that rank highest include specialties that have had a key role in the government's wait times strategy. Those specialties, for instance ophthalmology and radiology, continue to have a high dependence on payments under FFS. As noted earlier the increased number of services provided by them in recent years has been the main cost driver rather than an increase in the scheduled fees. This increase in productivity may have resulted from longer working hours, but it is also likely that these specialties have benefitted from improvements in technology, and access to hospital facilities, which have allowed them to manage increased numbers of patients in a working day.

Under fee-for-service arrangements, more treated patients translates directly into more money. Doubtless, patients have been beneficiaries, but we undertook no patient-level analysis in this work and are not able to comment on clinical outcomes.

Payments to General Practitioners/ Family Physicians

We found that the numbers of GP/FPs have increased significantly since reaching a nadir in 2001/02. Their payments have increased, and the majority have enrolled in an alternative funding model. Arguably, these are the most important findings in this report. GP/FPs are the first point of contact for many patients, provide consultation and care for common problems and have a key role in disease prevention (through immunization, screening and risk factor reduction). They are the largest group of physicians in Ontario, and therefore, changes in their payments have a large financial impact.

Alternatives to FFS in general/family practice are not new. Before the start of our observation period, Ontario had a number of health service organizations that paid physicians on a capitation basis, and Community Health Centres, where physicians were (and still are)

salaried employees. However, prior to 2000 the number of physicians being paid primarily through non-FFS sources was quite low, estimated at 2–5% of the total physician pool.[2] The process of deliberately moving GP/FPs away from a purely FFS model began in earnest in 1999/00. In that year, several primary care capitation pilot projects (called Primary Care Networks) began. A major expansion of primary care models began in 2001/02 with blended capitation Family Health Networks (FHNs), in 2003 with blended fee-for-service Family Health Groups (FHGs) and Comprehensive Care Models (CCMs, similar to FHGs but for solo-practice physicians), in 2004 with the group payment-based Rural-Northern Physician Group Agreement (RNPGA), and in 2006 with blended capitation Family Health Organizations (FHOs), into which the old HSOs and PCNs were integrated. By 2010, more than two-thirds of Ontario's primary care physicians belonged to one of these models, with FHOs being the most popular.

The financial results of this reform program are seen here. Total payments to GP/FPs in 2009/10 were $3.1 billion, an increase of $1.3 billion (77%) from 2003/04, or 58% after adjustment for inflation. Fee-for-service payments remained relatively flat over the whole time period. Payments specific to primary care models, the majority of which was capitation, rose very rapidly after 2004/05 and accounted for a large proportion of the increase in payments. Payments to physicians outside of patient enrolment models decreased after 2005/06 and payments in other models remained relatively flat between 2005/06 and 2009/10. Average payments per active GP/FP were highest among those in FHOs, followed by FHNs and FHGs. Payments in all these models showed a general increase between 2005/06 and 2009/10.

It appears clear that more GP/FPs were recruited and retained as a result of the new funding models. What is unclear at this time is the extent to which this has translated into better access and better services for patients. Two recent reviews have found mixed results.

In a 2011 report, the Auditor General for Ontario noted that the MOHLTC had not yet conducted any formal analysis of whether the expected benefits of these alternate payment plans have materialized.[3] The Auditor General reported: "Although many more Ontarians are enrolled with multi-physician practices under the new alternate funding arrangements than in the 2006/07 fiscal year, the wait time to see a family physician if they become sick has not changed as a result. Based on ministry survey results, while more than 40% of patients got in to see their physician within a day, the rest indicated that they had to wait up to a week or longer."

Health Quality Ontario in its 2011 annual report observed that the number of individuals without a regular family doctor has dropped in recent years and is on a par with the best results of 11 countries that were surveyed.[4] However, fewer than 50% are able to see their doctor on the same day when they are sick and in that regard Ontario (and the rest of Canada) lags behind other countries.[4]

Report Limitations

It is important to recognize a number of limitations to this work, most of which relate to incomplete capture of payments and as a result may hamper the interpretation of some of the data. At the outset we will make the point that these errors will have tended to underestimate the payments to physicians, meaning that the numbers given here are probably conservative. A few doctors are salaried and their payments come from hospital budgets and are not tracked here. Some physicians may work in more than one specialty; usually this will be general internal medicine combined with another (e.g., diabetes/endocrinology). For some years of observation, data were missing and we have highlighted these in the relevant exhibits. The analyses are fairly high level and cannot capture all the details and intricacies of alternate payment plans that apply to individual specialties. When a block grant was provided to a specialist group under an alternate payment plan, we allocated this equally across all members of that plan, which will have led to some inaccuracies at the individual level.

With the exception of the exhibit in this chapter which explicitly compares the overall increase in physician payments with inflation, none of the figures in this report have been adjusted for inflation. No adjustments were made for the overhead costs of running a medical practice. These are widely believed to average around 30% but vary among specialties. It is unclear to what extent overhead costs rise with increased numbers of services. There is likely to be both a fixed and a variable component, and we did not have data to inform this question.

We did not investigate the very wide variation in payments among some specialty groups. In some cases (e.g., ophthalmologists, radiologists, cardiologists and nephrologists), these variations increased substantially over time. It is not clear if the highest paid physicians in a specialty are seeing more patients, doing more procedures, or both. It is also unclear if the lowest paid physicians are working part-time. This is an important issue that we flag here as needing further investigation.

CONCLUSION

Physician payments comprise approximately 20% of total health care costs in Ontario. Although overall physician supply rose in line with population growth, it varied substantially among specialties. The rise in physician payments since the turn of the century was considerably greater than the overall growth in physician numbers and has been growing significantly above the average rate of inflation since 2004/05. Directed increases in physician payments through negotiated agreements with the OMA in 2004 and 2008 were aimed primarily at improving patient access to primary care and reducing wait times.

Primary care-related policies represent the largest financial investment in doctors that has been made by the provincial government. The most important positive change resulting from these policies has been the reversal of the decline in numbers of GP/FPs seen in the 1990s. Much of this impact appears to have been related to the change in financial models, with a shift from fee for service to capitation-based payments.

Efforts to reduce wait times in a fee-for-service environment have disproportionately benefited key surgical, medical procedural and diagnostic specialties. These groups have also gained financially from demographic changes, technological advances and increased health system capacity (i.e., increased hospital funding) that have enabled larger numbers of services to be provided by certain specialists in recent years.

The government of Ontario spent $8 billion on physician services in 2009, $4.3 billion more than in 1992. This investment has resulted in more practising physicians and an increase in services, particularly in areas targeted by certain policies. Alternative payment plans have supported certain government priorities and policy directions, particularly in general/family practice and the non-procedural medical specialties. This report cannot answer whether increased investment has led to better patient outcomes or improved functioning of the health care system. To our knowledge, no such impact analysis has been undertaken. We believe this subsequent work is critical to ensuring that taxpayer dollars invested in the health care system provide maximal benefits for the patients of Ontario.

REFERENCES

1 Canadian Institute for Health Information. *Health Care Cost Drivers: The Facts*. Ottawa: CIHI; 2011. Accessed January 13, 2012 at: http://secure.cihi.ca/cihiweb/products/health_care_cost_drivers_the_facts_en.pdf.

2 Chan B. *Supply of Physician's Services in Ontario, Research Atlas*. Toronto: Institute for Clinical Evaluative Sciences; 2004. Accessed January 13, 2012 at http://www.ices.on.ca/file/mod2rp1.pdf.

3 Office of the Auditor General of Ontario *2011 Annual Report of the Office of the Auditor General of Ontario*. Toronto: Queen's Printer; 2011. Accessed January 13, 2012 at http://www.auditor.on.ca/en/reports_en/en11/306en11.pdf.

4 Health Quality Ontario. *Quality Monitor: 2011 Report on Ontario's Health System*. Toronto: Queen's Printer; 2011. Accessed January 13, 2012 at http://www.ohqc.ca/pdfs/2011_report_-_english.pdf. Toronto: Queen's Printer; 2011.

Institute for Clinical
Evaluative Sciences (ICES)

G1 06, 2075 Bayview Avenue
Toronto, Ontario M4N 3M5

Email: info@ices.on.ca
416.480.4055

www.ices.on.ca

ICES Institute for Clinical Evaluative Sciences

TAB 48

MEMORANDUM OF AGREEMENT

B E T W E E N:

THE ONTARIO MEDICAL ASSOCIATION

(The "OMA")

-and-

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO,

AS REPRESENTED BY THE MINISTER OF HEALTH

AND LONG -TERM CARE

(The "MOHLTC")

WHEREAS the OMA and the MOHLTC are the parties (the "Parties") to a Physician Services Agreement dated April 26, 2000 in effect until March 31, 2004 which includes the Memorandum of Agreement between the Parties dated April 8, 2003 (the "2000 Framework Agreement");

AND WHEREAS during the term of the 2000 Framework Agreement the Parties have agreed to various changes to the Agreement which were implemented;

AND WHEREAS the Parties have agreed to extend the term of the 2000 Framework Agreement until the ratification of this Memorandum of Agreement, or until notice is given to discontinue the 2000 Framework Agreement;

AND WHEREAS the Government of Ontario consults and negotiates with the OMA as the representative of the medical profession in Ontario;

AND WHEREAS the MOHLTC is charged with the responsibility for health care in the Province of Ontario;

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

NOW the Parties have come to the following 2004 Physician Services Framework Agreement (the "Agreement")

1. RELATIONSHIP

1.1 As stated in the recitals, the Parties acknowledge the importance of our on-going relationship based on mutual respect, trust, consultation and co-operation. The MOHLTC acknowledges that the OMA is the representative of physicians in Ontario for the purpose of this relationship, these negotiations and this Agreement.

1.2 The Parties understand that major and rapid change is continuing to occur in the way health care is delivered in Ontario. The Parties appreciate that this change will require the development of stronger relationships with hospitals, long-term care facilities and other health care providers. The Parties also acknowledge that improved funding is essential to help achieve change, both in amount and in the way the funds are applied.

1.3 For this purpose, the MOHLTC has made a wide range of investments in this Agreement intending to increase access to physician services, improve and extend comprehensive primary care, provide integrated in-hospital and after hospital care, increase long-term care services and improve academic medicine in our valuable academic health science centres. In addition, these investments allow us to address important issues of physician human resources, physician compensation and practice work loads and styles, all of which have significant impact on the effectiveness and efficiency of the health care system. These issues will be dealt with elsewhere in this Agreement.

1.4 The Parties also acknowledge that the results achieved from these investments will need to be measured and evaluated at regular intervals during the term of this Agreement. It is difficult to predict the investment outcomes over a four year period and the Parties will require a re-assessment of their work to provide the Parties with the opportunity to review and evaluate investments where appropriate.

2. THE PHYSICIAN SERVICES COMMITTEE

2.1 The Parties agree to continue the Physician Services Committee ("PSC"). The Parties agree that matters arising from this Agreement and the continuing development and strengthening of our relationship will be considered at the PSC. The PSC will continue to provide a broad and structured process for regular liaison and communication between the MOHLTC and the medical profession through its representation by the OMA. The mandate and terms of reference for the PSC are more completely set out in **Appendix "A"** of this Agreement.

2.2 It has become apparent that the complexity of our work and this Agreement requires the creation of at least two new committees, the Primary and Community Care Committee ("PCCC") and the Physician Hospital Care Committee ("PHCC"). The mandate and terms of reference for the former are in **Appendix "B"** and in **Appendix "C"** for the latter. The PHCC is more fully described in Section 25 of this Agreement.

3. DISPUTE RESOLUTION

3.1 The Parties believe that a clear dispute resolution process is important both with regard to disagreements between the Parties concerning the interpretation and application of this Agreement and issues of fair representation that may arise as a result of actions taken by the Parties during the term of this Agreement. The appropriate dispute resolution processes are contained in **Appendix "D".**

4. INVESTMENTS IN HEALTH CARE

4.1 The Parties have made substantial investments in health care that are set out in Sections 5 to 28. Where appropriate, the Section will only provide a brief introduction to the subject matter and the details will be set out in an accompanying appendix.

4.A GENERAL FEE INCREASES

4.A.1 The Parties agree to the following revisions to the Schedule of Benefits:

a) Effective April 1, 2004, a 2.5% increase to all family practice professional fees,
b) Effective April 1, 2004, a 2.0% increase to all specialist professional fees, and
c) Effective April 1, 2005, a 1.0% increase to all technical fees.

These across-the-board fee increases will be applied to all fee codes in the Schedule of Benefits including those targeted fee codes with targeted increases elsewhere in this Agreement.

4.A.2 The Parties agree that the across-the-board fee increases in s.4.A.1 a) and b) shall flow through to Physicians in all primary care and alternate payment plans, alternate funding plans, alternate funding agreements and all other non-fee-for-service funding agreements except the AHSC Phase I AFP. Any issues that arise from the application of this section 4.A.2 will be dealt with by the Medical Services Payment Committee

4.A.3 The Parties agree that effective April 1, 2004, thresholds shall increase to $466,375.

5. PRIMARY HEALTH CARE

5.1 The Parties are committed to continuing the reform and renewal of primary health care in Ontario. All primary health care models are continued and improved as described in **Appendix "E".**

5.2 The Parties understand that the relationship between a patient and his/her family physician has been a historic foundation in the delivery of primary care and continues to be pivotal in today's collaborative network of care providers. For this reason the Parties agree that every person in the province should have the opportunity to enter into a relationship with a family physician who commits to the ongoing provision of primary care to that person. Rostering reinforces the mutual commitment inherent in this relationship.

5.3 The Government of Ontario has made an investment in information technology for physicians in certain primary health care models and has engaged the OMA to implement that investment pursuant to their letter of commitment dated March 29, 2004.

6. HOSPITAL CARE

6.1 The Parties are committed to continue and improve initiatives designed to enhance the delivery of health care in hospitals. The details of our agreements are set out in **Appendix "F".**

7. ACADEMIC HEALTH SCIENCES CENTRES

7.1 The Parties recognize the need to complete the initiative begun under the 2000 Framework Agreement to stabilize and enhance the Academic Health Sciences Centres ("AHSCs") so that these institutions and their physicians may better fulfill their roles as providers of clinical services to patients, educators of future health care professionals and sources of research and innovation and advances in health care. Accordingly, the Parties have increased the funding for AHSC alternate funding plans (AFPs) as more particularly set out in **Appendix "G"**. In addition, the details of entitlement, allocation and distribution are also contained in Appendix "G".

7.2 The Parties agree to develop and implement a new method of tracking physician services provided by physicians in AHSCs in order to allow the Parties to measure and evaluate appropriately the performance of these AHSC AFPs.

7.3 To accomplish these goals, the Parties agree that the interests of the affected physicians, hospitals, universities, the OMA and MOHLTC must be appropriately represented.

7.4 The Parties agree that subject to appropriate local circumstances, a common template will be offered to each of the eligible AHSCs.

7.5 The Parties further agree that the funding already allocated to the AHSC initiative during the term of the 2000 Framework Agreement shall continue during the term of this Agreement.

8. COMMUNITY CARE

8.1 The Parties agree to improve the level of patient care provided in the community by the introduction of a number of new and enhanced investments as described in detail in **Appendix "H"**.

8.2 The Parties recognize the potential for improved patient care in chronic disease management if there is shared care between the specialist and the family physician. Accordingly, the Parties will develop recommendations for patient care models designed to achieve shared care in chronic disease management.

9. LONG-TERM CARE AND CHRONIC CARE

9.1 The Parties acknowledge the importance of significantly improving long-term care services to Ontarians by providing residents with increased access to physicians in long-term care facilities. For that reason, the Parties have established a new monthly patient care incentive and a special on-call program for long-term care facilities and chronic care hospitals. The details of these initiatives are in **Appendix "I"**.

10. MENTAL HEALTH

10.1 The Parties agree that there is a need to improve patient access to hospital psychiatric care services including emergency and in-patient services. To achieve this, the Parties have increased the rate for sessional payments and created a new stipend for hospital psychiatric services. The details are set out in **Appendix "J"**.

10.2 The Mental Health Funding Working Group will be established to develop options and make recommendations concerning the appropriate payment mechanisms for direct and indirect psychiatric services in hospital and community settings.

11. CONVERSION

11.1 The Parties agree that conversion of the actual value of services provided by physicians paid on a fee-for-service basis and other appropriate payments which may be made will take place in all cases where alternate funding arrangements are put in place during the term of this Agreement. The Parties also agree that reverse conversion will occur when a physician reverts to fee-for-service from an alternate funding arrangement during the term of this Agreement. The manner in which the conversions will be calculated will be agreed to by the Parties prior to each conversion.

12. THRESHOLDS

12.1 To improve access to services, the Parties agree that all physician payment thresholds will be eliminated, no later than April 1, 2005.

13. MEDICAL SERVICES PAYMENTS

13.1 The Parties recognize the importance of having a fee schedule that reflects the needs and economics of modern health care, promotes patient access to appropriate medical care and remunerates physicians in a manner that reflects relativity and competitiveness. With that in mind, the Parties have established the Medical Services Payment Committee ("MSPC") as a committee with the responsibility for making recommendations to the Parties regarding changes to the Schedule of Benefits and other payment mechanisms and their associated impact. The structure and mandate of the MSPC is contained in **Appendix "K"**.

13.2 The Schedule of Benefits will be amended as more particularly described in **Appendix "L"**. In addition, there are other changes in payments which are set out in Appendix "L" and in other appendices. These amendments and changes take into consideration the importance of continuing to provide improvements in patient care and the need to further address issues of relativity.

13.3 The Parties agree to continue our work to simplify the preamble to the Schedule of Benefits and intend to implement the first set of improvements by October 1, 2005.

13.4 The Parties agree to refer the definitions of a minor assessment (A001) and an intermediate assessment (A007) to the Medical Services Payment Committee to ensure that such definitions reflect modern practice. The Committee will report to the Parties by October 1, 2006.

14. PHYSICIAN BENEFITS

14.1 The MOHLTC agrees to make a contribution to an initiative to assist eligible physicians practicing in Ontario to secure health related benefits such as critical illness insurance. This initiative will require participating physicians to contribute to its cost. To ensure this initiative is of maximum benefit to physicians, the Parties agree to jointly design this initiative. It will be administered by the OMA pursuant to a memorandum of agreement between the Parties which will outline the details of the initiative and its implementation, to be developed no later than July, 2007. The MOHLTC agrees to contribute the sum of $25 million annually commencing January 1, 2008 in this regard.

15. PREGNANCY/PARENTAL LEAVE BENEFIT PROGRAM

15.1 The Parties will be continuing the existing Maternity Leave Benefits Program on the same terms and conditions until March 31, 2005. It will pay 50% of the average fee-for-service billings or alternate payment plan remuneration up to a new maximum of $1000 per week effective April 1, 2005.

15.2 Starting April 1, 2005 the Parties agree to replace the existing Maternity Leave Benefits Program with a new Pregnancy/Parental Leave Benefit Program. It will also pay 50% of the average fee-for-service billings or alternate payment plan remuneration up to a maximum of $1000 per week. This Program, funded by the MOHLTC, will provide eligible physicians a pregnancy leave benefit of 9 consecutive weeks and a separate parental leave benefit of 8 consecutive weeks. The details of the Program will be developed by the PSC and will be incorporated into a memorandum of understanding between the Parties.

16. NORTHERN PHYSICIAN RETENTION INITIATIVE

16.1 The Parties agree to continue the Northern Physician Retention Initiative and the MOHLTC will provide funding of up to $7 million for 2005-06. The Parties agree to a joint evaluation of the Initiative before March 31, 2006 to determine continuation of the Initiative

17. FORMS

17.1 The Parties agree to continue to make every reasonable effort to reduce the amount of administrative work being done by physicians in order to increase patient access to care.

17.2 The Parties will continue our Forms Committee to report recommendations to the PSC. The mandate for the Forms Committee is as follows:

a) to review all new forms intended to be completed by physicians and originating with the Government of Ontario, prior to introduction or implementation;

b) to review other new forms submitted to it;

c) to consider the significance of the evolving electronic health record;

d) to review the need for a fee for appropriate forms; and

e) to review the need for changes to content of existing forms.

17.3 In keeping with the Parties' commitment to maximize physician availability for service delivery by reducing administrative burden, the Parties agree to undertake an examination of third party use of physician services to monitor employee illness and absenteeism.

17.4 The Parties, in consultation with representatives from appropriate stakeholders, agree to develop options and recommendations, including a legal framework, for attributing the costs of third party requests for physician services back to the requesting third party. Recommendations will be provided by April 1, 2006.

18. CONTINUING MEDICAL EDUCATION PROGRAM/LOCUM PROGRAM

18.1 The Parties agree to continue both of the Continuing Medical Education ("CME") Program for physicians working in isolated and rural communities and the Locum Program. "The MOHLTC will increase the total funding for these Programs by an additional annual amount of $2.5 million beginning April 1, 2005.Allocation of these funds will be agreed to by the Parties. The Programs will be administered by the OMA, at no additional cost to the MOHLTC, pursuant to an agreement setting out the appropriate operational, administrative, financial, auditing and reporting arrangements.

19. CLERKSHIPS

19.1 The Parties agree to establish a Clerkship Stipend Program that provides a payment of $500 a month to undergraduate medical students in Ontario medical schools for the 12 months in their final year of medical school, effective July 1, 2004. The Program will be administered by the OMA, at no additional cost to the MOHLTC, pursuant to an agreement setting out the appropriate operational, administrative, financial, auditing and reporting arrangements.

19.2 The MOHLTC will continue the existing program which provides funding to encourage students to perform clinical rotations in a northern or rural areas during their clerkship. This program provides a maximum of $1500 per month per eligible student for transportation and accommodation for a minimum of 4 weeks to a maximum of 12 weeks.

20. DIAGNOSTIC SERVICES

20.1 The Parties recognize the fundamental importance of having diagnostic services planned and coordinated on a province-wide basis with all stakeholders working together. The Diagnostic Services Committee ("DSC") established during the term of the 2000 Framework Agreement will assist the Parties in achieving this goal. The Parties agree to activate the Diagnostic Services Committee within three months of the ratification of the 2004 Physician Services Agreement.

20.2 Based on the report of the DSC Development Team, the Parties agree to do the following:

a) The professional fee component for in-patient diagnostic services will be billed to the OHIP fee-for-service pool effective to a date to be determined by the DSC no later than April 1, 2006. Such services shall not be included in threshold calculations; and

b) Effective to a date to be determined by the DSC no later than April 1, 2006, there will be real time conversion of professional fees to the OHIP pool of the appropriate amounts from the hospital global budgets with offsetting adjustments to hospital transfer payments. This will occur as soon as possible, taking into consideration existing agreements between hospitals and their physicians.

20.3 The MOHLTC will provide $40 million in 2005-06 from the Diagnostic and Medical Equipment Fund to purchase equipment in support of physician-based diagnostic services and the DSC will provide the MOHLTC with its recommendations on or before October 1, 2005.

20.4 The performance of the DSC will be evaluated during the Re-Assessment process.

21. ALTERNATE FUNDING PLANS AND OTHER PAYMENT MECHANISMS

21.1 The OMA will be notified of all expressions of interest made to the MOHLTC to establish an Alternate Funding Plan ("AFP") or any other type of non-fee-for-service delivery model as well as the intention to commence any negotiations or re-negotiations for non-fee-for-service delivery models.

21.2 The MOHLTC recognizes the OMA as the representative of physicians in Ontario for the following purposes:

a. the negotiation of template agreements for the AHSCs initiative described in Section 7 of this Agreement;

b. the negotiation of template agreements for Family Health Networks ("FHNs") and Family Health Groups ("FHGs");

c. the negotiation of physician interests with respect to their participation in Family Health Teams ("FHTs") in whatever form FHTs may take;

d. the negotiation of template agreements for primary care Harmonized Models ("HMs" as defined in Appendix E). This negotiation shall be done in one coordinated negotiation between the Parties;

e. the negotiation of physician AFPs in all cases where requested by the participating physicians; and

f. the negotiation of the long-term agreement to fund laboratory physicians in Ontario.

21.3 All agreements that the MOHLTC enters into, amends or renews with any third party that provide for or fund, in whole or in part, the compensation of physicians, shall contain a provision requiring those physicians to pay the dues and assessments that the OMA would charge if the physician was a member and requiring the third party to deduct and remit to the OMA these amounts from the compensation owed to the physician. The MOHLTC further agrees that it shall require that the OMA be made a party to all such agreements with third parties with respect to the provisions regarding enforcement of OMA dues and assessments.

22. NORTHERN SPECIALISTS AFP

22.1 The Parties agree to develop an Alternate Funding Plan by April 1, 2006, for specialists located in Northern Ontario and performing hospital-based services in the Districts of Algoma, Cochrane,

Nipissing, Sudbury DM, Sudbury RM, Thunder Bay and such other Districts as may be agreed upon by the Parties. The MOHLTC will provide new retention funding for specialists on an incremental basis to a total on-going annual amount of $20 million, of which $5 million to be provided effective April 1, 2006 and the additional $15 million effective April 1, 2007. A working group will be established to develop a template approach for approval by the Parties.

23. LABORATORY MEDICINE

23.1 The Parties are committed to the on-going negotiations, to be completed by March 31, 2005, for a long-term agreement to fund laboratory physicians in Ontario.

23.2 The Parties agree to modernization and review of professional fees relating to laboratory medicine contained in the Schedule of Benefits.

24. TELEMEDICINE

24.1 The Parties recognize that telemedicine has a significant role in improving patient access to services, especially in northern and rural locations. The Parties also recognize the need to first establish appropriate policies and practice rules before proceeding to consider payment issues. With this in mind, the Parties will establish a Telemedicine Advisory Team to investigate the issues and make recommendations to the PSC by October 1, 2005.

25. THE PHYSICIAN HOSPITAL CARE COMMITTEE

25.1 The Parties agree that further integration of the health care system requires greater co-operation and collaboration between physicians and hospitals. Accordingly, subject to the agreement of the Ontario Hospital Association ("OHA"), the Parties will establish, with the OHA, the Physician Hospital Care Committee ("PHCC"), consisting of representatives of physicians, hospitals and the MOHLTC, as soon as possible following the date of this Agreement. The PHCC will advise the MOHLTC, the OMA and the OHA for the purpose of strategic planning and coordination of effective and efficient physician hospital care in Ontario. Its composition and mandate are described in Appendix "C".

26. HOSPITAL STANDARDIZATION INITIATIVE

26.1 The Parties believe that the quality and efficiency of health care services can be significantly improved through the introduction of appropriate comprehensive standardization of procedures and products in hospitals and institutions. The Parties will establish in this fiscal year, the Standardization Task Force as a working group reporting its recommendations through both the PHCC and the PSC to the Parties and the OHA and having appropriate representation from the three interested parties. The Parties also recognize the importance of working with other health care professions where appropriate.

26.2 The Task Force will include in its work plan as priorities, the following:

a) the development and use of a common provincial drug formulary for hospitals with standard prescribing protocols;

b) the selection and use of surgical devices; and

c) the development and implementation of standardized processes to enhance patient safety, improve efficiencies and effectiveness of patient care.

26.3 Cost reductions achieved through the introduction and operation of these matters will be to the benefit of the public and other involved stakeholders. In anticipation of results from this initiative, the MOHLTC will invest a total of $40 million during the 2005-06 and 2006-07 fiscal years to help fund the initiatives contained in Appendix "F" for those two years. The Parties agree to evaluate this initiative and determine the future level of support as part of the Re-Assessment process.

27. COLLABORATIVE PRACTICE

27.1 The Parties recognize that collaboration between physicians and other qualified health professionals will improve access to good heath care in the areas of primary health care, community care and hospital care. The Parties also acknowledge the need to establish appropriate payment mechanisms for collaborative practice.

27.2 The PCCC, in consultation with other health professions as required, will develop recommendations to the PSC byMarch 31, 2005, for establishing project sites that will allow the Parties to measure and evaluate the effectiveness and cost of both a fee-for-service based model and a salary based model of delegation and collaborative practice. The MOHLTC will invest $11.3 million during this Agreement for these project sites.

27.3 The Parties agree that there is an urgent need to address the challenges facing operative anaesthesia in Ontario's hospitals. Accordingly, the Parties agree to establish a committee with representation from the OMA and MOHLTC to develop recommendations for addressing this issue in a timely fashion including opportunities for Schedule of Benefits redefinition, other physician payment strategies and the use of anaesthesia extenders. This committee will consult with the OHA as appropriate. The MOHLTC agrees to provide physician funding beginning October 1, 2005.

28. HOSPITAL ON-CALL COVERAGE PROGRAM

28.1 The Parties agree to continue and improve the Hospital On-Call Coverage Program for the term of this Agreement in accordance with the details contained in **Appendix "N"**.

28.2 The Parties further agree to continue the Hospital On-Call Coverage Committee ("HOCC"). This Committee will assist the Parties in the development of a new template agreement, to be implemented on October 1, 2005. Further the Hospital On-Call Coverage Committee, as part of its ongoing initiative, will work to develop and implement solutions to ensure consistency in regional on-call arrangements.

28.3 The Parties agree that prior to, October 1, 2005 the HOCC program and the agreed upon funding for same under this Agreement will be transferred to the OMA, for the term of this Agreement, with appropriate administrative costs, provided that the Parties have entered into a memorandum of understanding setting out the appropriate operational, administrative, financial, auditing and reporting arrangements.

29. SYSTEM MANAGEMENT

29.1 Our history of system management shows the Parties that utilization costs do not grow evenly across the system. The Parties have also discovered that the reasons for the differences are complex and far from obvious, both in terms of health care needs and good health care outcomes. However, the Parties agree that there is an on-going need to manage both:

a) the growth in the cost of the physician services system caused by factors such as an aging and increasing population, the addition of new physicians to the system, new technology and physician and patient behaviour; and

b) the investments in the physician services system provided for in the preceding sections of this Agreement.

29.2 The Parties will continue a sub-committee of the PSC, the System Management Committee ("SMC"), to advise the PSC and the Parties in connection with the broad requirements of system management and the options and action plans that may be required.

29.3 The MOHLTC acknowledges that resources separate and apart from any investments provided for under this Agreement will be required to address the system management factors described above. In addition, the Parties both acknowledge that resources are limited and that the Government of Ontario requires reasonable predictability in the cost associated with system management. For that reason, the MOHLTC has set utilization cost targets for system management purposes. The Parties understand that the creation of new health care initiatives may have the effect of increasing the volume and the cost of future physician services and that those utilization costs are not included in any targets except for the initiatives contemplated in this Agreement. The PSC may make recommendations to the Parties regarding the need for these additional system management resources.

29.4 The Parties agree that the performance of the investments provided for in this Agreement will be managed through a process of measurement and evaluation as determined by the Parties with advice from the SMC. This process must begin immediately and the SMC will develop an appropriate measurement and evaluation template, or templates, as soon as possible. The on-going process of performance measurement and evaluation will be carried out by the SMC. The results of the investment performance management process will be reported regularly to the PSC and it may, based on the information, make recommendations to the Parties through the PSC regarding the need for any appropriate changes in the investments.

29.5 The Parties agree to work together to increase volumes in targeted wait time areas as identified in the provincial government budget for 2004-05 or during the term of this Agreement. The Ministry may propose changes to facilitate wait list reduction by providing additional financial resources for all applicable physician services. The Parties agree, through the Physician Services Committee, to monitor the effects of the initiative on access to other clinical services.

29.6 For the purpose of system management, the MOHLTC agrees that it will not introduce any clawbacks from payments during the term of this Agreement with respect to services rendered either before or during the term of this Agreement. No changes will be made to the Schedule of Benefits or other payment mechanisms outlined in this Agreement without prior consultation between the Parties. In urgent circumstances the Parties will conduct such consultation expeditiously.

29.7 The Parties will develop a work plan outlining specific steps which will address:

a) the provision of information and advice regarding reasons for utilization changes;

b) the use of utilization trends to provide estimates of future physician service expenditures and their potential impact on utilization targets in order to allow for the early development of practical options and responsive action plans;

c) a review of the changes of volume and mix of medical services;

d) the ongoing measurement of utilization both system wide and, in the following distinct areas of focus: Professional fees (P-fees) Diagnostic Professional fees, Technical fees (T-fees), Primary Health Care, AHSCs and all other AFPs;

e) changes to the Schedule of Benefits that have a positive strategic impact on utilization for recommendation to the PSC and subsequent action by the MSPC; and

f) the ongoing measurement and evaluation of the investments provided for in this Agreement.

29.8 The Parties have agreed to share data as set out in **Appendix "M".**

30. RE-ASSESSMENT

30.1 The Parties recognize that, given the highly complex nature of this Agreement, its length of operation, the difficulty in accurately predicting the consequences and costs of many of the investment initiatives, the degree of current and future change the health care system is experiencing and the uncertainty of Federal funding for health, it is appropriate that the Parties re-assess its performance at the mid-point of its operation.

30.2 Unless the Parties agree otherwise, the Re-Assessment will be done by the PSC starting in April 1, 2007, and it will make its recommendations to the Parties by October 1, 2007. It will take the following into consideration:

a) the degree to which the investments are accomplishing our objectives;

b) whether the appropriate incentives are in place;

c) any new developments in health care initiatives and funding;

d) the success of cost reduction outcomes from the Hospital Standardization Initiative;

e) any changes in physician retention and recruitment;

f) the need for any changes in AFP funding;

g) the results of our system management processes regarding both utilization and performance management;

h) unforeseen events; and

i) the need for innovation, access, integration and competitiveness.

30.3 The Parties have agreed to reserve $7.5 million effective October 1, 2007 ($15M annualized for 2008-2009) for this Re-Assessment process to assist with issues identified during this process.

30.A EVIDENCE-BASED BEST PRESCRIBING PRACTICES

30.A.1 The Parties agree that evidence-based best prescribing practices have the opportunity to improve the quality and safety of care thereby improving patient health outcomes.

30.A.2 The Parties agree to develop and release a series of these evidence-based best prescribing practices guidelines that they will recommend to Ontario physicians.

31. PHYSICIAN HUMAN RESOURCES

31.1 The Parties agree to continue the Physician Human Resources Committee to report to and advise the Parties in accordance with the following mandate:

a) to monitor programs that have been established or are established during the operation of this Agreement to deal with problems of physician supply;

b) to continue its work in connection with the Locum Program and to work with the Telemedicine Advisory Team in the preparation of its recommendations;

c) to review the need for physician recruitment and retention in under-serviced areas; and

d) to perform any additional physician human resources work assigned by the Parties or requested by the PSC.

32. COMMITMENT TO THE FUTURE OF MEDICARE ACT, 2004

32.1 The Parties agree that a working group will be established with representatives from the Parties to discuss matters arising from the implementation of the *Commitment to the Future of Medicare Act, 2004*.

33. STATUTORY AND CONSTITUTIONAL AUTHORITY

33.1 Nothing in this Agreement affects the underlying statutory or constitutional rights of the Government of Ontario.

34. TERM AND RENEWAL

34.1 This Agreement will begin on April 1, 2004, and will terminate at the end of March 31, 2008. Negotiations to establish the next Physician Services Framework Agreement will begin no later than January 10, 2008. The MOHLTC recognizes the OMA as the representative of the medical profession for the purposes of these negotiations. The Parties may mutually agree to utilize the services of the "Independent Facilitator" set out in Appendix "A" Physician Services Committee to assist the Parties in negotiations for a new agreement in 2008.

The undersigned representatives of the Parties hereby agree to unanimously recommend acceptance of this Agreement to their respective principals.

DATED AT TORONTO, ONTARIO THIS DAY OF SEPTEMBER, 2004

FOR THE OMA	FOR THE MOHLTC
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

APPENDIX "A"

PHYSICIAN SERVICES COMMITTEE

1. The Physician Services Committee ("PSC") will consist of five members appointed by the OMA and five members appointed by the MOHLTC, all of whom will be expected to remain on the Committee for a minimum of two years and adopt roles of leadership in the performance of the PSC mandate.

2. Each of the Parties will appoint a co-chair from its five members.

3. The PSC will have an independent facilitator chosen by the Parties and subject to an annual review or a review at the request of either Party.

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

5. The agenda of the PSC will be set by the co-chairs appointed by the Parties, in consultation with the facilitator. In the event of dispute, the facilitator will set the agenda.

6. Each Party will fund its own members and the MOHLTC will fund the administration costs of the Committee and the facilitator.

7. The PSC will normally meet at least twice a month.

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

    a) to build and sustain a strong positive working relationship between the Government of Ontario and the medical profession;

    b) to receive and consider reports and recommendations as set out in this Agreement;

    c) to advise the Parties in connection with the changing role of physicians within the health care system, including possible improved models of delivery of and compensation for services;

    d) to develop recommendations, either on its own initiative or as a result of reports and recommendations received from committees reporting to it, to the MOHLTC and the OMA leading to the enhancement of the quality and effectiveness of medical care in Ontario;

    e) to identify efficiencies and maximize return on the funding provided under this Agreement;

    f) to review utilization and other reports from the SMC on a monthly basis and work with the SMC in the fulfillment of its mandate;

    g) to recommend to the Parties appropriate and effective steps to be taken to deal with system management issues;

h) to develop and recommend patient education programs;

i) to participate in the Dispute Resolution Process in accordance with its requirements as described elsewhere in this Agreement;

j) to continue to monitor the impact of health services restructuring on system management and the cost of physician services; and

k) to consider matters referred to it by either Party.

9. The PSC is committed to giving appropriate opportunity to affected parties to provide timely input to the PSC before making recommendations to the MOHLTC and the OMA.

APPENDIX "B"

THE PRIMARY AND COMMUNITY CARE COMMITTEE

1. The Primary and Community Care Committee ("PCCC") will consist of four members appointed by each of the Parties, all of whom will be expected to remain on the Committee for a minimum of two years and adopt roles of leadership in the fulfillment of the PCCC mandate. At least one of each Parties' representatives will also sit on the Physician Services Committee ("PSC").

2. Each of the Parties will appoint a co-chair from its four members.

3. The PCCC will have an independent facilitator chosen by the Parties and subject to an annual review or a review at the request of either Party.

4. The PCCC will have training in relationship-building and conflict resolution as the Parties consider necessary.

5. The agenda of the PCCC will be set by the co-chairs in consultation with the facilitator. In the event of dispute, the facilitator will set the agenda.

6. Each Party will fund its own members and the MOHLTC will fund the administration costs of the Committee and the facilitator.

7. The PCCC will meet at least once a month and will report regularly to the Parties and to PSC as requested by the PSC.

8. The mandate of the PCCC is as follows:

    a. to review and evaluate the primary care initiatives outlined in this Agreement including the provisions in the current primary care templates and initiatives that support interdisciplinary care;

    b. to develop recommendations to facilitate the integration of interdisciplinary teams and collaborative team practice;

    c. to develop recommendations regarding financial support for infrastructure and overhead expenses to facilitate interdisciplinary practices;

    d. to review the requirements of each of the preventive care bonuses and the existing payments and make recommendations to the PSC prior to the date of the Re-Assessment under this Agreement;

    e. to develop recommendations for a chronic disease and health promotion and disease prevention management strategy which includes support for:

        i. collaborative chronic disease guidelines and tools development and implementation;

ii. appropriate incentives and rewards; and

iii. facilitating the integration and coordination of health promotion strategies.

f. to make recommendations to the Parties concerning implementation of a second Chronic Disease Management (CDM) program as part of the Re-Assessment;

g. to assist the Systems Management Committee ("SMC") in the fulfillment of its mandate insofar as it relates to primary and community care by working with the SMC under the guidance and direction of the PSC;

h. to develop recommendations for patient care models designed to achieve shared care in chronic disease management;

i. to perform all other duties assigned to the PCCC by the Parties or elsewhere in this Agreement;

j. to assist the Parties, through the use of the facilitator, to resolve any disputes arising under a FHG contract; and

k. to consider matters referred to it by either Party.

APPENDIX "C"

THE PHYSICIAN HOSPITAL CARE COMMITTEE

1. The Physician Hospital Care Committee ("PHCC") will consist of four members appointed by each of the Ontario Hospital Association ("OHA"), the OMA and the MOHLTC, all of whom will be expected to remain on the Committee for a minimum of two years and adopt roles of leadership in the fulfillment of the PHCC mandate. At least one of the MOHLTC and OMA representatives will also sit on PSC.

2. Each of the MOHLTC, OMA and OHA will appoint a co-chair from its four members.

3. The PHCC will have an independent facilitator chosen by the MOHLTC, OMA, and OHA and subject to an annual review or a review at the request of any party.

4. The PHCC will have training in relationship-building and conflict resolution as the Parties consider necessary.

5. The agenda of the PHCC will be set by the co-chairs in consultation with the facilitator. In the event of dispute, the facilitator will set the agenda.

6. Each party will fund its own members and the MOHLTC will fund the administration costs of the Committee and the facilitator.

7. The PHCC will meet at least once a month and will report regularly to the Parties and to PSC and to the Joint Policy and Planning Committee (JPPC) at such times as may be requested by them.

8. The mandate for the PHCC is as follows:

    a. to function generally as an advisory body to the MOHLTC for the purpose of strategic planning for the effective and efficient delivery of hospital-based care in the Province of Ontario;

    b. to develop and recommend options for the coordination and alignment of services between physicians and hospitals;

    c. to receive and review the recommendations of the Standardization Task Force and consult with the Task Force to finalize the recommendations made to the Parties;

    d. to develop and recommend options for a planning process to identify patient volumes and strategies for wait time reductions for designated services;

    e. to develop recommendations for the enhancement of patient safety in connection with in hospital services;

    f. to develop recommendations for establishing project sites for delegation and collaborative practice models, as provided for in Section 27.2 of the Agreement;

g. to develop recommendations in connection with the following issues in the current hospital practice environment:

    i. the communication of appropriate patient information to hospital physicians from community physicians and nurses;

    ii. the availability to hospital physicians of patient histories from family physicians in order to improve efficiency and timely patient care;

    iii. the speedy provision of discharge information to the family physician; and

    iv. the reduction in the burden of paperwork.

h. to assist the Systems Management Committee ("SMC") in the fulfillment of its mandate insofar as it relates to hospital care; and,

i. to consider matters referred to it by any party.

APPENDIX "D"

DISPUTE RESOLUTION

1) If the OMA and the MOHLTC have a disagreement regarding the interpretation and/ or the application of this Agreement, the matter will first be referred to the PSC for consideration. The PSC will make recommendations to the Parties regarding the resolution of the disagreement and may enlist the support of an agreed upon mediator to assist it. Failing settlement of the matter, either Party may then use any other available dispute resolution process.

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

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

APPENDIX "E"

PRIMARY CARE INITIATIVES

The Parties have established the principles and goals set out in this Appendix to help guide development, implementation and evaluation of our primary health care initiatives. Using these goals and principles the Parties have agreed to the following.

1. COMPREHENSIVE CARE FEES (Implementation date: October 1/05)

Principles and Goals:

- comprehensive primary health care physicians should be appropriately compensated and rewarded for providing services to their patients;

- the blended compensation mechanisms should focus on providing special premiums, incentives and payments for comprehensive care, after hours and extended access, preventive care services, team consultation and, where applicable, the provision of hospital based services;

- in practices that include nurse practitioners ("NPs") or other interdisciplinary team members, the contribution of these members toward the achievement of the care goals and outcomes, should be, as appropriate, counted toward the achievement of targets and bonuses; and

- solo comprehensive care family physicians must be valued for their contribution and commitment to their patients.

1.1 Comprehensive Care Payments ("The Comprehensive Care Model" or "CCM")

The CCM Agreement (attached as Schedule 1) is available to all family physicians. Physicians choosing to provide comprehensive care (as defined in Schedule "A" of the CCM Agreement) to their rostered patients will be entitled to bill fee-for-service ("FFS") for all services and will be paid the FFS premiums and the average capitation rates set out in Schedule "B" of the CCM Agreement beginning on the date that the MOHLTC receives a copy of the CCM Agreement signed by the physician, or October 1, 2005, whichever is later.

1.2 Flow Through to Existing Models

For the purposes of this Schedule, "Harmonized Models" shall be deemed to include: Family Health Networks ("FHNs"); Group Health Centre ("GHC"); Northern Group Funding Plans ("NGFP"); Community Sponsored Contracts ("CSCs"); Health Service Organizations ("HSOs"); Primary Care Networks ("PCNs"); St. Joseph's Family Practice Unit; Weeneebayko Health Ahtvskaywin ("WHA"); Community Health Centres ("CHC"); and all variations or amendments to such models; as well as any future models introduced and agreed to by the Parties, as "Harmonized".

Family Health Group ("FHG") agreements will be amended October 1, 2005 to provide payment at an average monthly capitation rate per rostered person of $1.42 for the first 12 months and then $1.80 there after. On January 1, 2008 the average monthly capitation rate per rostered person will be revised to reflect the increase set out in section 1(4) in Schedule "B" of the CCM Agreement.

In capitated Harmonized Models including FHNs, GHC, HSOs, and PCNs, the above payments will be added to capitation rates.

In non-capitated Harmonized Models including NGFP, CSCs, CHCs, St Joseph's Family Practice Unit and the WHA, an appropriate equivalent value to compensation will be determined by the Parties. The Parties agree to provide for the appropriate equivalent "flow through" of increases in FFS billing codes to primary care physicians practicing in the Harmonized Models. This "flow through" will allow funding to be made available to the Harmonized Model physicians for increases to their capitation or complement based payments appropriate to the services included under these agreements. These funding adjustments will be made at the same time as FFS increases throughout the term of this Agreement. The movement of this funding to the Harmonized Models will be monitored and reported on regularly to the PSC. Similarly, should a physician move from a Harmonized Model back to FFS or a FFS based funding model the funding associated with this physician's services (excluding specific Harmonized Model incentives) will be returned to the FFS pool.

The "flow through" methodology will be determined and regularly reviewed by the PSC. The Ministry agrees to ensure that the appropriate flow through value goes directly to the CHC physicians.

1.3 After Hours Premium Increase (Implementation date: April 1/05)

The existing after-hours premium will be increased from 10% to 20% for FHGs and Harmonized Models in two phases:

1. On April 1, 2005 increase to 15%; and

2. On April 1, 2006 increase to 20%.

K005, K013 and K017 will be added to the menu of codes applying to this premium on April 1, 2005.

1.4 After Hours and Obstetrical Services (Implementation date: April 1/05)

The Harmonized Model templates will be amended to allow that the provision of obstetrical deliveries outside of regular office hours, be counted toward the exemption from after hours service requirements**.**

1.5 Template Amendments (Implementation date: April 1/05)

The FHG and Harmonized Models templates will be amended:

1. to allow services delivered on Sundays to count towards achievement of the requirement for weekend after hours coverage and if both Saturday and Sunday are provided, 3 hours of weekday after hours time would be met;

2. unless otherwise agreed to by the MOHLTC in writing, for the purposes of the payment of this premium, After Hours will be defined as a three hour block of time per day, for the number of days required in the applicable model outside of regular office hours;

3. to allow the payment of after hours premiums for services provided on statutory holidays;

4. to require the offering of both scheduled and unscheduled visits during after hours; and

5. the Parties agree to communicate to physicians providing student health medical services that they are eligible to participate in any of the primary care models.

1.6 Access To Premiums (Implementation date: April 1/05)

Physicians in Harmonized Models shall be allowed to access all premiums for which they meet the stated requirements.

1.7 Seniors Care Premium (Implementation date: October 1/05)

A new complex care premium on comprehensive care capitation payments of 15% for patients 70 years of age and older. This premium will replace the existing Q065 premium in FHGs and Harmonized Models.

As of January 1, 2008, the Complex Care premium on comprehensive care capitation payments will apply to patients 65 years of age and older.

The E075 code will be discontinued.

2. FAMILY HEALTH TEAMS

The Parties agree to work together to provide advice on the development and implementation of Family Health Teams and the OMA shall negotiate the terms of physician interests with respect to their participation in FHTs in whatever form FHTs may take, as set out in Section 21.2(c) of this Agreement.

3. CHRONIC DISEASE MANAGEMENT

Principles and Goals:

- to sponsor and support the development of collaborative chronic disease management;
- develop and implement chronic disease management guidelines and tools for medical practice and interdisciplinary collaborative team practice; and
- recognize the leadership role of family physicians in collaborative chronic disease management programs and the critical importance of information technology to the development of CDM tools.

The OMA will encourage and support the leadership role of local family physicians in community integrated chronic disease management initiatives and programs.

3.1 Diabetes Management Incentive (Implementation date: April 1/06)

Physicians in Patient Enrolment Models ("PEMs"), will receive an annual fee of $60 per rostered person for coordinating, providing, and documenting all required elements of care for diabetic patients according to guidelines recommended by the Primary and Community Care Committee ("PCCC") and agreed to by the Parties.

3.2 New Chronic Disease Management Incentive (Implementation date: January 1/08)

An additional CDM initiative will be determined during the Re-Assessment period with implementation targeted for January 1, 2008. The Parties agree that at least $2.5 million of the monies reserved for the Re-Assessment process will be available to implement a second CDM in congestive heart failure.

4. HEALTH PROMOTION AND DISEASE PREVENTION

Principles and Goals:

- facilitate the integration and coordination of health promotion strategies – including collaboration with public health units – to avoid duplication of preventive care services, enhance public education and achieve healthy outcomes.

4.1 Add-on Initial Smoking Cessation Fee (Implementation date: April 1/06)

PEM physicians will be entitled to receive an annual incentive fee of $15 added on to the normal visit fee for dialogue with patients who smoke. The specific requirements for the billing of this fee will be based on the recommendations from the Clinical Tobacco Intervention Task Force and will be recommended by the PCCC. On January 1/08, this fee will be made available to all family physicians.

4.2 Smoking Cessation Counseling Fee (Implementation date: April 1/06)

PEM physicians, will be entitled to bill a fee code for each of a maximum of 2 follow-up counselling sessions in the 12 months following the date of the first service for each patient who has committed to quit smoking. This fee will be equal to the adjusted value of A007 over the term of this Agreement plus $1.50. To receive this payment physicians must utilize flow sheets and guidelines developed by the PCCC. On January 1/08, this fee will be made available to all family physicians.

4.3 Colorectal Screening Bonus (Implementation date: April 1/06)

PEM Physicians will receive a new preventive care bonus fee for colorectal screening by Fecal Occult Blood Testing (FOBT) based on the following criteria:

- Target age group: 50 to 74 years of age (inclusive);
- Frequency: every 30 months;
- Application of current Cancer Care Ontario guidelines for ambiguous or positive results; and
- Evaluation to include review of family history and FOBT where appropriate.

Bonus thresholds of rostered qualifying patients:

15% > $220

20% > $440

40% > $1,100

50% > $2,200

The following patients are excluded from the target population for screening:

- Patients with known cancer being followed a physician;
- Patients with known inflammatory bowel disease;
- Patients who have had colonoscopies within 5 years;
- Patients with a history of malignant bowel disease; and
- Patients with any disease requiring regular colonoscopies for surveillance purposes.

4.4 Service Enhancement Codes and Bonuses

The FHG and CCM contracts shall be amended to allow FHG and CCM physicians to bill all the Cumulative Preventive Care Management Service Enhancement codes listed in s.2.3 Appendix I of the FHN Agreement effective April 1, 2007. The PCCC will establish minimum rostering size and other program details prior to implementation.

4.5 Bonus and Premium Review

The Parties shall create a special time limited consultation group to review the requirements of each of the preventive care bonuses and the existing payments and make recommendations to the PCCC prior to the date of the Re-assessment under this Agreement.

5. SELF CARE

Principles and Goals:

- that patients are key members of the care team and should be encouraged to take an active role in their own care.

5.1 Self-Help Materials (Implementation date: April 1/06)

As part of the rostering process, patients will be offered a self-help, patient education manual. The PCCC will recommend materials for distribution by the MOHLTC.

5.2 Electronic Information Access For Patients

Subject to available funding, the Parties shall establish a working group to identify, develop and recommend on-line self care and self help information for patients.

6. NEW GRADUATE INITIATIVES

Principles and Goals

- to increase the attractiveness of comprehensive family medicine through a combination of incentives, supports, communications, and opportunities that will encourage medical students to choose family medicine as a career.

6.1 Medical Student Outreach/Consultation (Implementation date: 2004/05)

The Parties agree to undertake a consultation process with medical students, new graduates, AHSCs, Professional Association of Interns and Residents of Ontario and the Ontario College of Family Physicians with respect to issues pertaining to enhancing the attractiveness of comprehensive family practice.

A report will be provided to the PCCC for consideration of potential measures to enhance activities, communications and models to achieve the stated goal prior to the Re-Assessment process.

6.2 Collaborative Practice Training Sites (Implementation date: April 1/07)

Collaborative team practice sites will be identified and funded to provide educational opportunities for family medicine trainees and other interdisciplinary team members. $250,000 dollars will be made available annually to implement this initiative.

The criteria for site selection and development of opportunities will be recommended by the PCCC in consultation with AHSCs and universities.

6.3 New Graduate–New Patient Incentives (Implementation date: July 1/05)

During their first year of comprehensive primary care practice in a PEM (commenced within three years following their graduation), new graduates will be allowed to bill the new patient declaration fee of $100.00. This per patient fee will be available to the physician for the rostering of up to 150 persons who quality as new patients and have completed the MOHLTC prescribed "New Patient Declaration Form".

"New graduates" include International Medical Graduates (IMGs).

7. INTERDISCIPLINARY TEAM CARE

Principles and Goals:

- interdisciplinary Team practice presents opportunities for improved patient access to services and care, as well as potential to improve physician workload and lifestyle; and

- nothing shall take away from other health care providers being full participants in the provision of care within their scope of practice.

7.1 Nurse Practitioner (NP) Consultation Pilot Project (Implementation date: April 1/05)

A pilot project in which funding is provided on a per NP basis ($800 per month for FFS or FHG physicians or physicians in Harmonized Models who consult with NPs about patients who are not rostered to the physician, or any other physician in the FHG or Harmonized Model, and $150 per month for physicians in Harmonized Models who consult with NPs about the physician's rostered patients) shall be implemented. Reporting requirements will enable the MOHLTC to collect reliable information on the amount of physician time spent in consultation with a NP. In addition, the MOHLTC will attempt to obtain further information from existing collaborative sites on time spent collaborating with a NP as well as the associated benefits of this collaboration. Evaluation of results will be conducted by the PCCC and reported by the time of Re-assessment.

7.2 Removal Of Barriers

The Parties agree to work together to facilitate the integration of interdisciplinary teams and to remove barriers to collaborative team practice. A "collaborative relationship" is defined as follows:

"A collaborative relationship entails a physician and a RN(EC) using complementary skills to work together to provide care to patients based on mutual trust and respect and an understanding of each others skills and knowledge. This involves a mutually agreed upon division of roles and responsibilities which may vary according to the nature of the practice personalities and skill sets of the individuals. The relationship must be beneficial to the physician, the RN(EC) and the patient."

7.3 Practice Nurse Compensation Pilots (Implementation date: October 1/05)

The Parties agree to develop an appropriate fee or compensation mechanism for the payment of primary care practice nurses.

The Parties agree that the following models will be pilot tested in 05/06 and 06/07:

(a) an annual grant of $21,000/RN will be offered to physicians in the Harmonized Models based on an average of 1 RN to every 4 physicians. An annual grant of $5,250 will be provided per physician in a Harmonized Model to offset the compensation cost of an office practice nurse; and

(b) a fee-for-service delegation model to be agreed to by the Parties.

Additional data and information on the nurses' contribution to services, practice efficiencies and patient access will be collected to allow for evaluation of the pilots.

7.4 Template Amendments (Implementation date: April 1/05)

The Parties agree that the template agreements for all Harmonized Models be amended to permit Nurse Practitioners to equitably contribute to the fulfillment of after hours coverage and bonuses. Specifically, Nurse Practitioners would be permitted to fulfill the obligation for one session of after hours care per week and through shadow billing to contribute to the achievement of home visits, prenatal care and office procedure premiums.

7.5 Consultation

The Parties agree to develop, as soon as possible, a process that would allow for joint community, MOHLTC and physician consultation to support both one time and ongoing capital and operating costs to facilitate group and interdisciplinary practice. This process will be coordinated by the PCCC who will invite the following organizations to participate:

- Ontario Medical Association;
- Ministry of Health and Long-Term Care;

- Association of Municipalities of Ontario; and
- Ministry of Public Infrastructure Renewal.

8. FOCUSED PRACTICE

8.1 Removal From Access Bonus (Implementation date: April 1/05)

GP psychotherapists' billings will no longer impact access bonuses. This will be achieved by the implementation of a code based review of billings to identify physicians practicing in this area.

These physicians will be identified once annually by the MOHLTC and this information will be shared with the GP psychotherapist as well as applicable Harmonized Model physicians on request.

A physician will be considered to be a GP psychotherapist when 50% or more of the dollar value of their annual FFS billings in the preceding 12 months consist of the following codes:

K004	FAMILY PSYCHOTHERAPY-2/MORE MEMBERS-PER 1/2HR.
K006	HYPNOTHERAPY-G.P.-IND. PER ½ HOUR
K007	IND. PSYCHOTHERAPY PER HALF HOUR – GP
K010	PSYCHOTHERAPY-GROUP-PER MEMBER PER1/2HR 7TH TO 9THHR
K011	HYPNOTHERAPY-GROUP-MAX.8- PER 1/2HR.-PER MEMBER.
K012	GROUP PSYCHOTHERAPY-FOUR PEOPLE PER ½ HR PER MEMBER
K024	GENERAL/FAMILY PRACT.-GR.PSYCHOTHERAPY-5 PEOPLE
K025	GENERAL/FAMILY PRACT.-GR.PSYCHOTHERAPY-6 TO12 PEOPLE

The Parties will develop and implement a self identification and verification process for GPs in the following focused practice areas in order to assess their impact upon the access bonuses

- Sports medicine;
- Allergists;
- Pain management;
- Sleep Medicine and
- Addiction medicine.

8.2 AFP For Focused Practice GPs (Implementation date: October 1/05)

The Parties will develop, and the MOHLTC will offer, AFPs, to focused practice GPs in HIV, palliative care, oncology and care of the elderly (to include appropriate consideration for Geriatric Specialists). Implementation of these AFPs to such focused practice GPs, will be staggered over the term of this Agreement in accordance with an implementation schedule agreed to by the Parties.

9. Advancement Of Primary Care Models

Principles and Goals:

- The Parties reaffirm their commitment to the harmonization and alignment of all primary care models so that physicians are given clear choices between practice models.

9.1 HSO And PCN (Implementation date: October 1/05)

The PCN and HSO models will be aligned into a new model that provides for common capitated services and treatment of outside use/negation.

This alignment will implement financial adjustments resulting from this Agreement and the alignment of outside use/negation formulae.

A time limited working group will be created by the Parties with representation from PCNs and HSOs to recommend a single method for the treatment of outside use/negation. This working group will make recommendations to the PSC by July 1/05. The financial adjustments relating to the capitation rates and outside use/negation will be implemented upon the amendment of the PCN and HSO models retroactive to May 1/05. All other financial adjustments will be implemented upon their effective date.

This new model will be made available to any physician.

9.2 Complement Based Models (Implementation date: July 1/05)

The Parties agree to make available to additional communities, as recommended by the PCCC and approved by the Parties, modified NGFP and CSC contracts to new northern and some southern rural communities.

9.3 Rurality Gradient (Implementation date: April 1/06)

The Parties shall introduce a “rurality” gradient in all FHGs and Harmonized Models through variation in compensation.

The rurality premium will be introduced into FHGs and Harmonized Models using the OMA RIO starting at a score of 45 with a payment of $5,000 per year per physician and the payment will increase by $1,000 for each further score of 5 on the rurality index. The PCCC will make recommendations on the detailed application of this item.

9.4 Annual Conference

The Parties will sponsor an annual conference for all primary care model leads to meet and share experiences, lessons learned and opportunities and to hear presentations on advancements in research or program development. Funding to be made available for conference organization, travel and accommodations by the MOHLTC.

10. FAMILY HEALTH GROUPS AND FAMILY HEALTH NETWORKS

Principles and Goals:

- the Parties remain committed to physician choice of compensation and voluntary participation.

10.1 FHG Contact (Implementation date: April 1/05)

The FHG template will be amended to provide for a physician contact for the purpose of providing information to the MOHLTC and the Telephone Health Advisory Service (THAS) provider.

10.2 FHN Hospital Premiums (Implementation date: April 1/05)

For areas with an OMA RIO score greater than 45, the hospital premium in Harmonized Models will be increased from $5,000 to $7,500.

10.3 FHN And FHG Evaluation

The Parties agree to an Evaluation by the PCCC of FHN and FHG size with respect to their ability to achieve the objective of increasing:

- Patient access to care;
- Provision of comprehensive primary health care;
- Physician and patient satisfaction; and
- Continuity of care.

The question of appropriate physician group size will be determined following the completion of the Evaluation expected by April 1, 2006. Pending a mutually agreed change following the Evaluation no size limit will be imposed.

10.4 FHG Agreement Term

The Parties agree to extend the term of existing FHG agreements to the end of the term of this Agreement.

The current Term of Agreement provision in the FHG agreement will be deleted and replaced with,

"This Agreement will remain in effect until March 31, 2008, but notwithstanding any other provision contained herein, this Agreement may be terminated before that date by either the Physicians or the Ministry giving the other 90 days written notice of their intention to so terminate".

10.5 Expansion Of Comprehensive Care Codes (Implementation date: April 1/06)

The current group of 13 FHG comprehensive codes which allow a 10% premium, will be expanded to include supportive care (C010), HIV care (K022), Diabetic Management (K030), palliative care (K023 and C882), immunization (G539), mini-assessment [WSIB related] (A008) and home visits (A901 and A902).

10.6 Option For Payment To Individual in FHNs (Implementation date: April 1/06)

The template agreements will be amended to provide an option for capitation payments to individual physicians and payment of the access bonus to the group.

10.7 FHG Dispute Resolution

The current "Dispute Resolution" provision in the FHG Agreement will be deleted and replaced with,

"Any disputes among the parties arising from matters under this Agreement may be referred to the Primary and Community Care Committee for consideration".

11. ADMINISTRATION

11.1 Per Patient Rostering Fee (Implementation date: date of Agreement ratification)

In PEMs, an incentive in the amount of $5.00 will be provided on a per patient basis for the initial rostering of patients during the 12 months following a physician joining a primary care model. Existing groups as a whole may elect to receive this payment instead of the payment currently received in their agreements.

(a) in existing Harmonized Models ("HM"), the HM may elected to receive $5.00 on a per patient basis for rostering patients for the remainder of the 12 month period for the remainder of their contract instead of any remaining payments available under that contract;

(b) a new physician joining a HM is entitled to an incentive in the amount of $5.00 per patient for rostering patients during the 12 month period following the date that physician joined the HM; and

(c) for FHGs, the FHG may elect to receive $5.00 per patient for rostering patients for the 12 month period commencing (date of Agreement ratification) or for the 12 month period after the signing of the FHG agreement instead of whatever payments they may otherwise be entitled to after that date under the existing FHG contract however, the group shall not be entitled to the CCM payment until October 1, 2005.

11.2 Review Of Group Management And Leadership Fee

The PCCC will review the current Group Management and Leadership Fee to ensure adequate funding to all models for administrative work, including both a floor and ceiling payment, in light of the following possible expanded roles, duties, activities and reporting requirements of the PEMs:

- acting as a local champion to primary health care renewal;
- liaising with local hospitals, Community Care Access Centres and public health to improve communications and coordination;
- ensuring appropriate data and reports are made to the MOHLTC; and
- acting as a champion for development/implementation of chronic disease management and local health promotion/disease prevention programs.

11.3 Office Practice Administration (Implementation date: April 1/07)

The Parties agree that the cost of administrative functions for Harmonized Models will be cost shared between the group and the MOHLTC on a sliding scale (based on group size as provided below). The MOHLTC will provide a grant to groups of five or more physicians who hire an administrator. The administrative functions will include, but will not be limited to, group administration, group on-call and extended hours organization, assistance with IT implementation and planning for interdisciplinary teams.

- Groups of 5-7: $12,500
- Groups of 8-14: $17,500
- Groups of 15-25: $25,000

11.4 Rostering Changes

The PCCC will explore options for enhancing the reporting of patient rostering changes (e.g. when a patient changes physician), including verification at time of health card renewal and communications to patients with appropriate forms to request updates on changes of physicians.

12. CARE OF PATIENTS IN HOSPITAL AND LONG TERM CARE FACILITIES

Principles and Goals:

- it is recognized that not all communities and their hospitals have the same needs and the role of family physicians providing services will vary. The Parties agree to support initiatives that will remove barriers to enhance the role of family physicians in providing inpatient care and support; and

- it is agreed that where possible and practical family physicians should be encouraged to continue to care for their patients in long term care institutions and should be supported in this choice through flexible compensation mechanisms**.**

12.1 LTC Capitation Rate (Implementation date: April 1/06)

The Parties agree that the long term care capitation rate for Harmonized Models will be increased to an annual gross payment amount of $1,131.11 per rostered patient. The fee codes included in the Long-Term Care Base Rate Payment for rostered patients will be expanded to include the following fee codes: the newly negotiated LTC Monthly Maintenance Fee ($85.70), E430, G003, G006, G007, G008, W771 and W972. Obligations associated with physicians choosing to roster LTC patients and receive the LTC capitation rate in addition to those already included in the Harmonized Model agreement are:

1. A three month medication review;

2. All discussions with the care staff of the institution related to the patients;

3. All telephone calls from the institution in respect of the resident during regular office hours Monday to Friday (excluding statutory holidays); and

4. Performing a minimum of two assessments each month.

13. SUPPORTING CHANGE

13.1 Length Of agreements

The Parties will establish a working group to make recommendations for reducing the complexity and length of the agreements.

13.2 Specialist Shared Care

The Parties will investigate opportunities for shared care models between family physicians and specialists related to chronic disease management including appropriate compensation.

13.3 Communications Committee

The Parties will establish a communications committee that will meet as required to discuss all planned communications and to collaborate on joint communications on primary care.

13.4 LEADERSHIP

Organized community based primary health care delivery models provide a unique opportunity to facilitate system integration and coordination. Primary care groups will play a key role in facilitating patient care coordination and system navigation.

The Parties will:

- promote, support and provide leadership for primary care and comprehensive care models;
- communicate the choices and aspects of the various models to physicians;
- assist implementation with a bipartite committee; and
- create a joint working group with the OHA, CCACs and Chief Medical Officer of Health to explore ongoing opportunities for collaboration and service integration at the local level.

SCHEDULE 1

COMPREHENSIVE CARE AGREEMENT

BETWEEN:

HER MAJESTY THE QUEEN, in right of Ontario, as represented by the Minister of Health and Long -Term Care (the "Ministry")

and-

[insert name of physician] **(the "Physician")**

1. Services

I agree to provide Comprehensive Care as defined in Schedule "A" during my regular office hours, to all my patients rostered with the prescribed Enrolment and Consent Form.

2. Payment

In return for fulfilling the terms of this Agreement, in addition to being able to bill fee-for service, I will be entitled to the premiums and bonuses set out in Schedule "B" beginning on the date that the Ministry receives a signed copy of this agreement or October 1, 2005, whichever is later (the "Commencement Date").

3. Term of the Agreement

This Agreement will remain in effect until March 31, 2008 unless extended by the Ministry. This Agreement may be terminated by either party giving the other party 90 days written notice of the desire to terminate.

I understand that the template for this Agreement was negotiated by the OMA and the Ministry and may be amended by them at any time 30 days after written notice of the amendment is sent to me. I may, within this time period, elect to give notice of termination of this Agreement to the Ministry. If no notice of termination is given, I will be deemed to have accepted the amendment.

I, the undersigned Physician agree to the terms and conditions of this Agreement.

Dated at _____, this day of _____200 _.

_____ _____

Witness name of physician

address

tel., fax, email

Her Majesty the Queen in Right of Ontario as represented
by the Minister of Health and Long–Term Care

_____

Per:

SCHEDULE "A"

DESCRIPTION OF COMPREHENSIVE CARE

Comprehensive Care assumes that the care is part of an on-going process into the future and provides care in the patient's family and social context. It includes the creation, management and maintenance of an appropriate medical record managed by the physician. Comprehensive Care includes the following services:

Health Assessments

(1) When necessary, the taking of a full history, including presenting complaint, if any, past illnesses, social history, family history, review of systems and performing a complete physical examination.

(2) Periodically taking a specific history and performing a physical examination as required to screen patients for disease.

(3) Regularly taking a specific history and performing a physical examination as required to respond to patient complaints and/or to manage chronic problems.

Diagnosis and Treatment

Assess and plan for patients' care based on the outcomes of a history and physical examination aided by appropriate investigations and consultations according to the results of complete, periodic, or regular health assessments. Care for and monitor episodic and chronic illness or injury. In the case of acute illness or injury, offer early access to assessment, referral for appropriate diagnostic testing, primary medical treatment, and advice on self-care and prevention. Provides or coordinates chronic disease management for conditions such as diabetes and hypertension.

Primary Reproductive Care

Provide primary reproductive care, including counselling patients on birth control and family planning, and educating about, screening for, and treating sexually transmitted diseases.

Primary Mental Health Care

Offer treatment of emotional and psychiatric problems, to the extent that the physician is comfortably able to provide the treatment. Where appropriate, refer patients to and collaborate with psychiatrists and appropriate mental health care providers.

Primary Palliative Care

Provide palliative care or offer to support the team responsible for providing palliative care to terminally ill patients. Palliative care includes offering office-based services, referrals to Community Care Access Centres or to such other support services as are required, and making patient visits where appropriate.

Support for Hospital, Home and Rehabilitation Facilities

Where applicable and where possible, assist with discharge planning, rehabilitation services, out-patient follow-up and home care services (excluding completion of requisite forms).

Service Coordination and Referral

Coordinate referrals to other health care providers and agencies, including specialists, rehabilitation and physiotherapy services, home care and hospice programs and diagnostic services, as appropriate. Appropriately monitor the status of patients who have been referred for additional care and collaborate on medical treatment of patients.

Patient Education and Preventative Care

Use evidence-based guidelines to screen patients at risk for disease, to attempt early detection and institute early intervention and counselling to reduce risk or development of harm from disease including appropriate immunizations.

Pre-Natal, Obstetrical, Post-Natal, and In-Hospital New Born Care

Provide or arrange to provide maternity services, including antenatal care to term, labour and delivery, and maternal and newborn care.

Professional Rights and Obligations

Nothing in the Agreement precludes a Physician from terminating his or her relationship with any patient in accordance with applicable guidelines issued by the College of Physicians and Surgeons of Ontario. Further, nothing in this Agreement shall create obligations for a Physician that go beyond his or her professional competence or that using the Physician's best efforts, are beyond the reasonable control of the Physician.

SCHEDULE "B"

PREMIUMS AND BONUSES

1. Comprehensive Care Payments:

I will be paid the following capitation rates for my rostered patients:

1. Average monthly capitation rate per rostered person of $1.00 (with no Block Coverage) up to a maximum of 6 months. If Block Coverage is not being provided after 6 months physician will cease to be eligible for any payments under this model.

2. When the physician provides Block Coverage they will receive an average monthly payment of $1.42 per rostered person.

3. 12 months after the Commencement Date, the average monthly payment will increase to $1.80 per rostered person.

4. On January 1/08 the payments in paragraph 2 will increase to $1.50 and the payment in paragraph 3 will increase to $2.15.

The actual age and sex adjusted capitation rates may be calculated by multiplying the rates listed in Schedule "C" by the dollar amount quoted above.

"Block Coverage" means at least one 3 hour block one day per week after hours or on Saturdays, Sundays or on statutory holidays.

2. Bonuses and Premiums

I will be entitled to receive the following premiums and bonuses:

(a) After hours add on premium

Effective October 1, 2005, I will be paid a 10% premium on the following fee codes for scheduled and unscheduled services provided during Block Coverage: A001, A003, A004, A007, A008, A888, K005, K013 and K017. A shadow billing code Q012 must accompany each submitted claim in order for the premium to be paid.

(b) Diabetes Management Incentive

Effective April 1/06, an annual fee of $60 per rostered person for coordinating, providing, and documenting all required elements of care for diabetic patients according to guidelines recommended by the Primary and Community Care Committee ("PCCC") and agreed to by the Parties.

(c) Add-on initial Smoking Cessation Fee

Effective April 1/06, an annual incentive fee of $15 added on to the normal visit fee for dialogue with patients who smoke. The specific requirements for the billing of this fee will be based on the recommendations from the Clinical Tobacco Intervention Task Force and will be recommended by the PCCC.

(d) Smoking Cessation Counselling Fee

Effective April 1/06 a fee code for each of a maximum of 2 follow-up counselling sessions in the 12 months following the date of the first service for each patient who has committed to quit smoking. This fee will be equal to the adjusted value of A007 over the term of this Agreement plus $1.50. To receive this payment, flow sheets and guidelines developed by the PCCC must be utilized.

(e) New Graduate-New Patient Incentive

Effective July 1/05, for the first year of comprehensive primary care practice (commenced within three years following graduation), a new patient declaration fee of $100 will be paid for up to 150 persons who qualify as new patients and have completed the MOHLTC prescribed "New Patient Declaration Form".

(f) Per Patient Rostering Fee

Effective (date to be determined), an incentive of $5.00 will be paid on a per patient basis for the initial rostering of patients during the 12 months following the Commencement Date.

(g) Seniors Care Premium

Effective October 1, 2005, a complex care premium on comprehensive care capitation payments of 15% will be paid for patients 70 years of age and older. Effective January 1, 2008, the complex care premium on comprehensive care capitation payments will apply to patients 65 years of age and older.

(h) Unattached Patient Fee

Effective October 1, 2005, an incentive in the amount of $150.00 will be paid on a per patient basis for the rostering of the acute care patient previously without a family physician, following the patient's discharge from an in-patient hospital visit. The payment of this incentive is subject to the Physician rostering the patient within three months of accepting responsibility for providing for the patient Comprehensive Care as set out in Schedule "A" and completion of the agreed "Unattached Patient Fee Form". This fee is not payable in addition to the Per Patient Rostering Fee set out in section 2 (f).

SCHEDULE "C"

CAPITATION RATE CALCULATOR

Average Enrolment with Estimated Monthly Comprehensive Care Fee Calculation (1)		
	Monthly Comprehensive Care Fee per Enrolled Patient	
Age Range	Male	Female
	Monthly Rate (4)	Monthly Rate (4)
0-4	1.06	1.01
5-9	0.56	0.54
10-14	0.44	0.46
15-19	0.46	0.82
20-24	0.46	1.04
25-29	0.50	1.08
30-34	0.58	1.08
35-39	0.72	1.17
40-44	0.80	1.20
45-49	0.88	1.30
50-54	1.02	1.46
55-59	1.16	1.47
60-64	1.27	1.51
65-69	1.44	1.59
70-74	1.67	1.70
75-79	2.01	2.03
80-84	2.11	2.10
85-89	2.35	2.39
90+	2.65	2.70

APPENDIX "F"

HOSPITAL CARE

1. In-patient Care

In recognition of the importance of the physician role in providing acute hospital based services the following changes will be implemented through the Schedule of Benefits:

a. Subsequent Visit Fee Increase

The following subsequent visit fees will be increased from $23.00 to **$29.20 effective October 1, 2005:**

Cxx2 Subsequent Visits (First 5 weeks)

Cxx7 Subsequent Visits (6^{th} to 13^{th} week)

Cxx8 Subsequent Visits (Concurrent Care)

Cxx9 Subsequent Visits (After 13^{th} week)

C121 Subsequent Visits – Visits due to inter-current illness and

Cxx0 Subsequent Visits (Supportive Care) will be increased from $14.95 to $ 17.75.

b. Most Responsible Physician ("MRP")

i. In recognition of the role of the MRP during the initial period of hospitalization two new fees will be introduced for subsequent visits provided by the MRP on the day following admission to hospital (Day 2) and on the second day following admission to hospital (Day 3).

ii. Additionally, a new discharge fee will be introduced in recognition of the requirements to ensure a timely and coordinated transfer of care from hospital to primary care physician.

Note: For the purposes of this section, Day 1 is considered the day of admission to hospital

1. Subsequent Visit by the MRP on the day following admission to hospital (Day 2).

   This fee is payable to the physician identified as the patient's MRP for the routine assessment of the patient on the day after admission to hospital.

   C-Fee Code Most Responsible Physician – Day 2

   Phase 1
   New Fee: $ 46.15
   Effective: October 1, 2005

Phase 2
New Fee: $ 55.45
Effective: October 1, 2006

2. Subsequent Visit by the MRP on the second day following admission to hospital (Day 3).

   This fee is payable to the physician identified as the patient's MRP for the routine assessment of the patient on the day after admission to hospital.

   C-Fee Code Most Responsible Physician – Day 3

   Phase 1

   New Fee: $ 46.15
   Effective: October 1, 2005

   Phase 2

   New Fee: $ 55.45
   Effective: October 1, 2006

3. Most Responsible Physician – Day of Discharge.

   This fee is payable to the MRP for routine assessment of the patient on the day of discharge and, in addition to this visit, includes completion by the physician of the discharge summary within 48 hours of discharge, arranging for follow-up of the patient (as appropriate) and prescription of discharge medications if any.

   C-Fee Code Most Responsible Physician – Day of Discharge

   Phase 1

   New Fee: $ 46.15

   Effective; October 1, 2005

   Phase 2

   New Fee: $ 55.45

   Effective: October 1, 2006

iii. The following should be noted with regard to Day 2 and Day 3:

1. In the case of conflicting claims for this service by different physicians, only the claim submitted by the MRP is eligible for payment. Additional claims will be paid at the subsequent visit rate;

2. In the event that the care of the patient is transferred during this day within the same hospital, the physician who was the MRP for the majority of the day will be the physician eligible for payment;

3. These services are not eligible for payment if the patient is discharged from the hospital on this day;

4. This service is not eligible for payment for visits related to the provision of routine postnatal care in hospital or for newborn care; and

5. In the event a patient is transferred from one hospital to another, a service provided by the MRP in the second or subsequent hospital on the day following admission (Day 2) or two days following admission (Day 3) is eligible for payment.

iv. The following should be noted with regard to Day of Discharge:

1. a patient must have been admitted to hospital for a minimum of 48 hours for a physician to be eligible to claim this service;

2. this service is not eligible for payment for hospital discharge following obstetrical delivery unless the mother required admission to an ICU during the hospital stay;

3. this service is not eligible for payment for hospital discharge of a newborn unless the infant was admitted to NICU;

4. in the case of duplicate claims for this service by physicians identifying themselves as the MRP, the physician to whom the patient is rostered, if any, shall have priority;

5. in the case of conflicting claims for this service by different physicians, only the claim submitted by the MRP is eligible for payment;

6. this service is not eligible for payment if the patient is transferred from acute care to another department within the same hospital; and

7. this service cannot be billed for "Z" prefix surgical procedures. This service can be billed for non "Z" prefix surgical procedures if all other criteria are met.

2. Critical Care

a. In recognition of the importance of critical care services and consistent with the recommendations of the Central Tariff Committee, the following specific changes to the critical care complement of services will be implemented.

Critical Care:

G401 Critical Care – Intensive Care Area 2nd to 10th day (inclusive)

Current Fee: $103.55 New Fee: $ 132.00 Effective: October 1, 2005

G401 Critical Care – Intensive Care Area – 2nd to 30th day

G402 Critical Care – Intensive Care Area – 31st day onwards

G406 Critical Care – Ventilatory Support – 2nd to 30th day

G407 Critical Care – Ventilatory Support – 31st day onwards

Effective: January 1, 2008

Comprehensive (ICU) Care:

G558 Comprehensive Care 2nd to 10th day (inclusive)

Current Fee: $151.00 **New Fee: $ 192.45**

Effective: October 1, 2005

G558 Comprehensive Care – 2nd day 30th day

G559 Comprehensive Care – 31st day onwards

Effective: January 1, 2008

Neonatal Intensive Care:

G611 Neonatal Intensive Care – Level B – 2nd day onwards

Current Fee: $75.35 **New Fee: $ 105.55**

G621 Neonatal Intensive Care – Level C – 2nd day onwards

Current Fee: $27.25 **New Fee: $ 66.70**

G601 Neonatal Intensive Care – Level A – 2nd to 30th day

G602 Neonatal Intensive Care – Level A – 31st day onwards

Effective: October 1, 2005

3. Trauma Care

In recognition of the need to recruit and retain physicians providing trauma care, the following changes will be made to the Schedule of Benefits:

a. Trauma Care Premium

i. A 50% premium will be introduced payable in addition to services provided for trauma patients who have an Injury Severity Score (ISS) of greater than 15 for individuals age 16 or more, or an ISS of greater than 12 for individuals less than age 16. This premium is available for all services rendered on the day of trauma.

ii. This premium is eligible for payment when claimed in addition to services listed in the Consultations and Visits Section, Surgical Procedures (Section M through Y of the Schedule of Benefits), Services listed in the Surgical Assistants' Services section of the General Preamble (Section B19) and Services listed in the Anesthetists' Services section of the General Preamble (Section B21). E-Fee Code Trauma Premium – Within 24 hours of admission (includes consults, surgery, anesthesia, assistant fees) diagnostic and lab service excluded.

Effective: October 1, 2005

b. Second Surgeon

i. Where two surgeons are required to work together on the same surgical procedure, both surgeons are able to claim as the operating surgeon where trauma patients have an ISS of greater than 15 for individuals age 16 or more, or an ISS of greater than 12 for individuals less than age 16. Trauma Second Surgeon-Revision to Surgical Preamble to allow second surgeon to bill as first surgeon

Effective: October 1, 2005

4. Emergency Department Funding

a. Alternate Funding Agreement ("EDAFA")

In recognition of the success of the EDAFAs in stabilizing emergency services within the province the following new investments will be made:

i. An additional **$**10.7M will be provided to adjust the existing EDAFAs to account for the emergency care codes changes introduced in the 2003 Re-opener:

05/06 $5.0M

06/07 $5.7M

ii. $6.9M will be invested to extend this amended EDAFA to remaining eligible hospitals:

04/05 $1.0M

05/06 $5.9M

iii. A new fee for Primary Care Physician Emergency Department Assessment will be introduced payable to the family physician for seeing his or her patient in emergency in those circumstances when the presence of the family physician is required.

1. The fee is payable to the patient's primary care physician when that physician renders an assessment of the patient in an emergency department covered under a EDAFA.

2. The service can only be claimed when the presence of the patient's family physician is required because of the complexity, obscurity or seriousness of the patient's condition.

3. The assessment must be at least as extensive as an intermediate assessment and include:

   a. any re-assessment of the patient during the same emergency room visit

   b. collaboration with the emergency room physician as appropriate A-Fee Code Primary Care Emergency Department Assessment

   New Fee: $- 76.90

   Effective: April 1, 2006

b. Other Emergency Service Investments

i. Additional investments will provide improvements in both FFS and EDAFA funding for physicians providing emergency services**:**

1. The following fees will be increased for physicians providing emergency services Emergency Department Physician on Duty:

   H103 Multiple Systems Assessment (Mon. to Fri. – Daytime)

   Current Fee: $28.35 **New Fee: $ 32.25**

   H123 Multiple Systems Assessment (Nights)

   Current Fee: $49.35 **New Fee: $ 54.95**

   H133 Multiple Systems Assessment (Evenings)

   Current Fee: $31.10 **New Fee: $ 35.30**

   H153 Multiple Systems Assessment (Saturdays, Sundays, Holidays)

Current Fee: $42.30 **New Fee: $- 47.40**

Effective: July 1, 2006

2. Additional investment will be provided for EDAFA adjustments resulting from the H-code increases noted in 1.

   Effective: July 1, 2006

3. The following Emergency Department H Codes will increase 2% on October 1, 2005 and an additional 2% on April 1, 2006:

H055 EMERGENCY MEDICINE - Emergency Department - Physician on Duty - Consultation

H065 Emergency Department - Physician on Duty - Consultation in Emergency Medicine

H101 Emergency Department - Physician on Duty - Monday to Friday - Daytime and Evenings (08:00h – 24:00h) - Minor assessment

H102 Emergency Department - Physician on Duty - Monday to Friday - Daytime and Evenings (08:00h – 24:00h) - Comprehensive assessment and care

H103 Emergency Department - Physician on Duty - Monday to Friday - Daytime and Evenings (08:00h – 24:00h) - Multiple systems assessment

H104 Emergency Department - Physician on Duty - Monday to Friday - Daytime and Evenings (08:00h – 24:00h) - Re-assessment

H105 Emergency Department - Physician on Duty - In-patient Interim Admission Orders

H112 Emergency Department - Physician on Duty - Nights (00:00h - 08:00h) - Premium per patient visit - When any other service is rendered by the physician on duty (and assessments may not be claimed)

H113 Emergency Department - Physician on Duty - Daytime and evenings (08:00h - 24:00h) on Saturdays, Sundays or Holidays - Premium per patient visit - When any other service is rendered by the physician on duty (and assessments may not be claimed)

H121 Emergency Department - Physician on Duty - Nights (00:00h – 08:00h) - Minor assessment

H122 Emergency Department - Physician on Duty - Nights (00:00h – 08:00h) - Comprehensive assessment and care

H123 Emergency Department - Physician on Duty - Nights (00:00h – 08:00h) - Multiple systems assessment

H124 Emergency Department - Physician on Duty - Nights (00:00h – 08:00h) - Re-assessment

H131 Emergency Department - Physician on Duty- Evenings (18:00h - 24:00h) - Minor assessment

H132 Emergency Department - Physician on Duty- Evenings (18:00h - 24:00h) -Comprehensive assessment and care

H133 Emergency Department - Physician on Duty- Evenings (18:00h - 24:00h) - Multiple Systems assessment
H134 Emergency Department - Physician on Duty- Evenings (18:00h - 24:00h) - Re-assessment
H151 Emergency Department - Physician on Duty - Saturdays, Sundays, Holidays - Daytime/Evenings (08:00h – 24:00h) - Minor assessment
H152 Emergency Department - Physician on Duty - Saturdays, Sundays, Holidays - Daytime/Evenings (08:00h – 24:00h) - Comprehensive assessment and care
H153 Emergency Department - Physician on Duty - Saturdays, Sundays, Holidays - Daytime/Evenings (08:00h – 24:00h) - Multiple systems assessment
H154 Emergency Department - Physician on Duty - Saturdays, Sundays, Holidays - Daytime/Evenings (08:00h – 24:00h) - Re-assessment

4. Additional investment will be provided for EDAFA adjustments resulting from the H-code increases noted in 3.

5. Clinical Decision Units ("CDUs")

The Parties have a mutual interest in exploring the utility of CDUs to manage the increasing demand on hospitals by avoiding unnecessary hospital admissions.

a. $3M will be invested January 1, 2008 for physician services in Year 4 for the purpose of piloting and evaluating CDUs;

i. it is agreed that CDUs are appropriate in specific circumstances with defined criteria for admission;

ii. exemptions to the EDAFA contracts will be made to permit EDAFA physicians to participate in CDU pilots;

iii. emergency departments with at least 35,000 visits per year will be eligible for consideration for pilot funding; and

iv. an evaluation of the pilots will be undertaken to identify potential cost savings with a view to reinvesting an appropriate amount.

6. Hospital Pediatric Stabilization Program

In recognition of the need to recruit and retain pediatricians to provide inpatient care a Hospital

Pediatric Stabilization program is being established. $5M will be invested annually to provide the

following program:

a. the program will be made available to hospitals to provide additional funding for pediatricians who provide hospital care;

b. program funding will be provided at a rate of $12,000 per pediatrician to a maximum of $84,000 per hospital;

c. the criteria for hospital eligibility is that the hospital has obstetrical services and a level 2 or higher neonatal unit;

d. the details of the program will be developed and jointly agreed to by the Parties; and

e. the program will commence in October 2005.

7. Emergency Department Education Funding

In recognition of the need to recruit and retain physicians to provide emergency services, the Parties agree that $2.5M in annual funding commencing April 1, 2005 will be provided to support educational initiatives for emergency department physicians in both community hospitals and AHSCs. Funding will be reduced to an appropriate amount upon AHSC AFP implementation

APPENDIX "G"

ACADEMIC HEALTH SCIENCES CENTRES

1. Principles

The following principles will guide this initiative:

a) Total funding per Full-Time Equivalent ("FTE") for a participating specialty group at any participating Academic Health Sciences Centre ("AHSC") will be essentially the same as the funding per FTE for the same specialty group at the other participating AHSCs;

b) Subject to appropriate local circumstances, a common template will be offered to each of the AHSCs pursuant to this initiative;

c) The AHSC Alternate Funding Plans ("AFPs") established in this initiative will represent the full breadth of the AHSC activities and, at a minimum, include all core specialties;

d) The funding and allocation of funds to AHSCs, including the allocation calculation, will be transparent between AHSCs and within the AHSCs to the level of specialty groups and will take into account retention and recruitment;

e) This AFP funding initiative is not an appropriate mechanism to address issues of relativity between specialties or sub-specialties. Accordingly, changes in the Schedule of Benefits arising under this Agreement and other applicable payment changes under this Agreement will be included in the calculation of Current Funding as defined herein; and

f) The AFPs will respect the autonomy of practice plans;

g) In order to be eligible for the new template and new funding contained in this initiative each practice plan in each AHSC must meet the requirements set out in the current AHSC Phase 1 Agreements as well as the following:

   i. it must be in writing and adopted by its members;

   ii. its leaders and representatives in the AFP governance must be chosen by a democratic process. At a minimum that democratic process must allow for the regular free election of leaders and representatives. Such elections must allow for participation from all members and be on a secret ballot or equivalent basis;

   iii. it must contain a written dispute resolution mechanism to deal with practice plan issues, such as distribution of funds to members. Such process must allow for third party review but that third party need not necessarily be from outside the practice plan; and

   iv. it must contain a written process and methodology for determining and distributing compensation to members.

h) The AFPs should not affect the professional autonomy or current status of participating physicians as independent contractors or employees, as the case may be;

i) The AFPs will recognize the respective responsibilities and accountabilities of the university, the hospital and the physicians;

j) The Parties and the AFPs must recognize that alignment between university, hospital and AFP business plans and deliverables is essential for the successful implementation of this initiative;

k) There must be comprehensive measurement and evaluation of AFP performance according to a clear set of deliverables;

l) The AFPs and the associated funding will recognize relevant accreditation requirements; and

m) When determining Current Funding for the purpose of allocation of the new funding in this initiative, all clinical earnings within the defined scope of each AHSC and all earnings from existing AFPs, including the Phase 1 AFP funding, will be included. However, true income relativity between AHSCs will not be possible without taking into account, through a consistent approach, all relevant sources of funding. Accordingly, the AHSC AFP Task Force established herein shall be asked to recommend how and to what extent relevant university and hospital funding currently paid to academic physicians should be included in the measurement of Current Funding with the understanding that the same definition of Current Funding will be used with all participating AHSCs.

2. New Investment

The MOHLTC has agreed to make the following new funding available (the "New Investment") for this initiative;

$25M in 2006-07,

$95M in 2007-08 and

an additional $7.5M in January 2008

($150M annualized for 2008-2009). This funding will be made available following the determination of the appropriate allocation and the development of a common AHSC AFP template.

3. Eligible AFPs

The following entities shall be entitled to an allocation from the New Investment, subject to application of the formula contained herein:

a) All existing Phase 1 AHSC AFPs; and

b) All existing AHSC AFPs that are not Phase 1 with the exception of the Hospital for Sick Children.

As a condition for participation, non-Phase 1 AFPs will agree to be integrated into their local AHSC AFP governance structure. This integration will not require these non-Phase I AFPs to join other existing practice plans.

4. AHSC AFP Task Force

The Parties will establish no later than September 1, 2005 a AHSC AFP Task Force to advise on the development of a common AHSC AFP template and the allocation and distribution of the New Investment as specified herein. The AHSC AFP Task Force will consist of two (2) members appointed by each of the OMA and the MOHLTC and an additional six (6) jointly appointed members having knowledge of Ontario AHSCs and comprising representation from academic physicians, the hospitals and the universities. The AHSC AFP Task Force may enlist the support of experts to assist it in its work, especially in the development of required methodologies and the application of the allocation formula.

5. Academic Physician Human Resource Strategy

The Parties agree that changes in complement may be required at AHSCs as a result of changing needs, services and programs. To that end the Parties recognize the need to develop a provincial Academic Physician Human Resource Strategy taking into account local AHSC human resource plans. Therefore:

a) An Academic Physician Human Resource Strategy Expert Panel will be appointed by the AHSC AFP Task Force to consult widely and make recommendations on a provincial physician human resource strategy for AHSCs; and

b) This Expert Panel shall report to the AHSC AFP Task Force.

6. Accountability Expert Panel

The Parties agree to establish, as soon as possible, an Accountability Expert Panel to advise them on the measurement, accountability and reporting of deliverables (the ”Accountability Framework”) and the methodology to be used to determine complement. The Panel will consult with representatives from academic physicians, the hospitals, the universities, the MOHLTC, the OMA and such other interests as the Panel deems appropriate to formulate its recommendation for the Accountability Framework. The Accountability Framework should address the following matters:

a) Appropriate methodologies for measuring AHSC deliverables including those that will be prescribed by the AHSC AFP Task Force;

b) Structures and processes for reporting the measurements; and

c) Processes and reporting structures on which to base the accountability for clinical deliverables and the tracking of the delivery and outcome of health services to the population.

The Accountability Expert Panel will report regularly to the AHSC AFP Task Force and the Parties and provide a final report within one year.

7. Allocating New Investment to Current Medical Staff

The calculation of the proportion of the New Investment to be applied to current medical staff at AHSCs will be determined by the Parties on the advice of the AHSC AFP Task Force and the balance will be available to support new complement.

The following methodology shall be used to establish the allocation and distribution of that portion of the New Investment allocated to current medical staff at the AHSCs eligible for funding under this Agreement.

Step 1: Determine List of Academic Specialties

The AHSC AFP Task Force will make recommendations to the Parties on the list of specialties to be used for the purposes of this initiative to ensure consistency across AHSCs. It is understood that the term specialty also refers to appropriate sub-specialties where such sub-specialties have historically been treated as such and the AHSC AFP Task Force will make recommendations on this matter.

Step 2: Determine FTE Count for Each Specialty Group in Each AHSC

Total funding for each AHSC shall be based upon the number of FTEs in each specialty in each AHSC. The methodology used to determine the number of FTEs in every AHSC will be based on the recommendation of the AHSC AFP Task Force and will be the same for all AHSCs. An external third party auditor will be engaged by the Parties to determine the accuracy of the FTE count, by specialty at each AHSC. A single physician may constitute more or less than one FTE.

It is understood that the use of an FTE count at any AHSC has no bearing on the independent contractor/employment status of any physician and is only a process for measuring complements in order to determine the allocation of the New Investment.

Step 3: Determine Relativity Ratio for Each Academic Specialty

To the maximum extent possible, the relativity between specialties at each AHSC will reflect the relativity of the average income of the same specialties in the non-academic physician community in Ontario. Average income will be calculated taking into account fees and such other payments ("Other Payments") that the Parties agree should be taken into account that will be in effect at the end of this Agreement. This relativity will be expressed as a ratio of the lowest earning specialty ("Relativity Ratios"). When the absence of appropriate comparators in the non-academic community precludes the establishment of a Relativity Ratio for any specialty, the AHSC AFP Task Force will recommend the Relativity Ratio for such specialty.

Step 4: Determine Current Funding for Each Specialty Group at Each AHSC

For the purpose of allocating the New Investment, Current Funding for each specialty group at each AHSC will be calculated as follows:

A measurement period to establish the volume and mix of clinical services provided during that period will be agreed upon by the Parties. Such clinical services shall then be valued using the fees and Other Payments in effect at the end of this Agreement to the maximum extent possible;

To this number shall be added any other funding as recommended by the ASHC AFP Task Force and approved by the Parties as described in Paragraph 1 Subsection (m) of this appendix; and

This total shall be referred to as Current Funding for that specialty group at that AHSC for the purposes of this calculation.

Step 5: Determine Unit Value for Allocation of New Investment

Current Funding for all participating specialty groups at all participating AHSCs will be summed.

To that sum will be added the portion of the New Investment allocated to current staff at the AHSCs as described in Paragraph 7. That number shall then be divided by the sum of all values that result by multiplying the FTEs in each specialty by that specialty's relativity ratio for all participating AHSCs. The resulting product will be called the Unit Value.

Step 6: Determine Total Funding for Each Specialty Group at Each AHSC

For each specialty in each participating AHSC, Total Funding shall be determined using the following formula:

# of FTEs x Relativity Ratio x Unit Value

In the event that the Current Funding for any specialty in any AHSC exceeds the Total Funding as calculated in this step, that specialty in that AHSC shall be entirely excluded from these calculations. However, it may be recommended by the AHSC AFP Task Force that this exclusion not apply to specialities at existing non-Phase 1 AHSC AFPs.

Step 7: Allocate New Investment for Each Specialty Group

The calculations described in Steps 4-6 shall be repeated with the exclusions noted in Step 6. The New Investment for each specialty in each AHSC shall be the difference between the Total Funding and the Current Funding for that specialty.

8. Administrative and Infrastructure Costs

Of the New Investment allocated to each participating AHSC AFP, 5% will be identified to be used by that AFP to support administrative and infrastructure costs and to address local issues.

9. Complement

The Parties agree that changes in complement may be required at AHSCs as a result of changing needs, services and programs. Complement changes (i.e. changes in the number of FTEs) can occur for many reasons. Where complement changes occur because of the transfer of programs or services from one AHSC to another, funding shall follow:

Complement increases funded through this initiative (as set out in paragraph 7) will be approved by the Parties with advice from the AHSC AFP Task Force and taking into consideration the provincial Academic Physician Human Resource Strategy. Funding for the clinical service portion of such complement increases will be derived from conversion or new utilization as the case may be.

10. Changes

The detailed process for allocation and distribution of the New Investment expresses the intention of the Parties. It is appreciated that changes may be required to this funding formula in order to allow the Parties to properly fulfill our intentions and for that reason, the Parties may agree to changes after consultation with the AHSC Task Force.

APPENDIX "H"

COMMUNITY CARE

1. Unattached Patient Fee

a) A one-time fee of $150 will be payable to primary care physicians who roster acute care patients previously without a family physician, following discharge from an in-patient hospital visit.

i. In order to be eligible to obtain this fee the physician must roster the patient within three months of accepting responsibility for providing patient care and provide primary care services for this patient; and

ii. This fee is not payable in addition to existing "new patient fees".

Effective: October 1, 2005

2. First Visit Premium

b) In recognition of the role of the family physician in ensuring a timely and coordinated transfer of care from the hospital most responsible physician (MRP) to the primary care physician, a new fee code will be introduced (in addition to the fee for the service provided) payable to the patient's primary care physician for the first visit after discharge from an acute care hospital provided that the physician sees the patient within two weeks of discharge.

New E-fee code First Visit Premium $25.00

Effective: October 1, 2006

3. Home Care

a) In recognition of the importance of the physician's role in supporting care in the community the following changes through the Schedule of Benefits will be made:

i. Increase fees for existing services

K070 Home Care Application
Current Fee: $17.00 **New Fee: $25.65**

K071 Acute Care Supervision
Current Fee: $10.70 **New Fee: $17.75**

K072 Chronic Care Supervision
Current Fee: $10.70 **New Fee: $17.75**

Effective: January 1, 2008

ii. The maximum limits for existing services will be revised as follows:

K071 Acute Care Supervision maximum 1 every week for the first 8 weeks following admission to home care program

K072 Chronic Care Supervision maximum 2 per month commencing in the 9th week following admission to the home care program

Effective: January 1, 2008

iii. Additionally, the description of Home Care Supervision will be amended to permit the service to be initiated by the physician

4. Palliative Care

a. In recognition of the importance of the physician role in supporting palliative care, new and revised palliative care codes for both hospital and community settings will be implemented as follows:

i. Special Palliative Care Consultation fee increase

A945 Family Practice and Practice in General
Special palliative care consultation

C945 Family Practice and Practice in General
Special palliative care consultation – Non Emergency Hospital In-Patient Service

Current Fee: $101.15

Effective: October 1, 2005 New Fee: $127.50

Effective: January 1, 2008 New Fee: $132.50

ii. Revision of definition of Special Palliative Care Consultation to permit Palliative Care Support (K023) to be claimed for time spent in excess of 50 minutes.

A945/C945 Family Practice and Practice in General -Palliative Care Support Revision - Allow K023 after 50 minutes

Effective: October 1, 2005

iii. Introduction of a new fee code for ongoing telephone management of palliative care patient.

G-Fee Code Telephone services to patient receiving palliative care at home

New Fee: $17.75
Effective: April 1, 2007

iv. Removal of the retroactive requirement for Palliative Care Assessment claim submission from the General Preamble.

C882/C982 Palliative Care Assessment
Redefine palliative consistently in the schedule

Effective: October 1, 2005

v. Introduction of a new fee code for house call special visits provided to palliative care patients.

B-Fee Code Family Practice and Practice in General
Special Visit to Home of Palliative Care Patient

New Fee: $ 63.80

Effective: October 1, 2005

vi. Increase Palliative care Subsequent visit fees.

C882 Family Practice and Practice in General
Subsequent Visits-Palliative Care

Current Fee: $23.00 **New Fee: $29.20**

Effective: October 1, 2005

C982 Palliative Care
Subsequent Visits-Palliative Care

Current Fee: $23.00 **New Fee: $ 29.20**

Effective: October 1, 2005

5. Regional Consulting Pediatrics

a. In recognition of the success and importance of the Regional Consulting Pediatrics Alternative Funding Plans in supporting specialized pediatric care in the community the following investments will be made:

i. $1M will be invested in 04/05 to adjust existing Regional Consulting Pediatric AFPs;

ii. An additional $5M is included in this Agreement to extend Regional Consulting Pediatric AFPs to 14 additional eligible communities.

05/06 $2M
06/07 $3M

APPENDIX "I"

LONG-TERM CARE

1. Monthly Management Fee

a) In recognition of the need to ensure that Long-Term Care residents have access to physician services, a monthly management fee will be introduced.

i. The monthly management fee will be an all inclusive fee for providing the services listed below to residents in Long Term Care Facilities operated under the *Nursing Homes Act, Homes for the Aged and Rest Homes Act and Charitable Institutions Act.*

1. Provision of all visits for routine care of residents regardless of the frequency of the service;

2. Additional visits due to "intercurrent illness";

3. Palliative care subsequent visits;

4. Admission assessments;

5. Pre-dental/pre-operative assessments;

6. Annual history and physical examination;

7. Pronouncement of Death unless the physician is required to make a visit to the LTC facility specifically to complete the pronouncement;

8. Three month medication review;

9. Any age related premiums applicable to these services;

10. All discussions with staff of the LTC facility related to the patient;

11. All telephone calls from the institution in respect of the resident from 0700 to 1700 Monday to Friday (excluding holidays);

12. All telephone calls from the family, Power of Attorney or Substitute Decision Maker in respect of the resident from 0700 to 1700, Monday to Friday (excluding holidays);

13. Monitoring of INR;

14. Limited Use and Section 8 forms;

15. CCAC forms and services; and

16. The following diagnostic and therapeutic procedures: venipuncture, injection, immunization, Pap smear, intravenous and those "G" prefix lab procedures listed under "Laboratory Medicine in Private Office"

ii. In order to be eligible for the Monthly Management Fee, the physician claiming the service must have signed a contract with the LTC facility where he/she is practicing based on a common template developed by the Parties.

iii. This fee may only be claimed by the resident's most responsible physician. Components of this service rendered by either the physician claiming the service or any other physician are included in the fee for this service and are not separately billable.

iv. A physician must perform a minimum of two assessments each month the service is claimed in order to bill this fee. If the physician performs less than two assessments in the calendar month (except as outlined in iv. 1. below), the appropriate "W" prefix code(s) can only be claimed.

v. The fee for this service is based on providing services for a full calendar month. When a resident is not in a LTC facility for a full month, the amount to be claimed is prorated to equal the fraction of the number of days in the month that the patient was in the LTC facility except:

1. If a resident is newly admitted to the LTC facility and an admission assessment is rendered in the same calendar month, the fee for a full calendar month can be claimed; and

2. In the event of the death of resident while in the LTC facility (or within 48 hours of transfer to hospital in the event that such a transfer occurs), the fee for a full calendar month can be claimed.

vi. In the absence of the residents' most responsible physician (e.g. while that physician is on vacation), the fee may still be claimed by the most responsible physician as long as the elements of the service are performed by another appropriately qualified physician.

W-Fee Code Monthly Management Fee – Long Term Care
New Fee: $85.70
Effective: April 1, 2006

vii. When a physician who is not the physician claiming the Monthly Management Fee (or who is not providing coverage for that physician) and who is already in the institution is asked to see a patient on an emergency basis, the service rendered is not included in the monthly management fee. This service is eligible for payment using the appropriate fee schedule code from the "General Listings" (i.e. an "A" prefix assessment)

2. Chronic Care W-code Fee Increases

a. Increase Subsequent Visit fees for complex continuing care facilities beds Wxx2 Chronic care visit, first 4 subsequent visits per month
Current Fee: $23.00 **New Fee: $29.20**
Effective: October 1, 2005

3. On-call Funding

a. Long Term Care

i. Investment of $8.2M to fund a new on-call program for the provision of on-call services to LTC facilities is provided to ensure availability of either the physician claiming the service or another appropriately qualified physician designated by the physician claiming the service between 1700 hours and 0700 hours Monday to Friday, 24 hour coverage on weekends and holidays. The service includes:

1. responding to all telephone calls from the institution in respect of the medical care of the resident; and

2. making telephone calls to the family, power of attorney (POA) or substitute decision maker (SDM) in respect of the medical care of resident. Where the criteria for claiming a special visit are met, visits to long-term care residents may be claimed in addition to the on-call fee.

ii. Administration of Long-Term Care on-call funding will be coordinated through Hospital On-Call Committee (HOCC) and administered locally by the LTC facility and the Medical Director; and

The funding will be allocated on the basis of $100 per bed with a minimum payment of $10,000 and a maximum of $30,000.

iii. The program will commence **October 1, 2005.**

b. Chronic Care

i. Investment of $1.8M in funding for the provision of on call services for complex continuing care beds;

ii. The program will be administered through the Hospital On-Call Committee (HOCC);

iii. The distribution of the funding will be determined by the Parties; and

iv. The program will commence **October 1, 2005**.

4. Long Term Care Application Fee

Introduction of a new fee code for completion of the Long-Term Care Eligibility form K-Fee Code: Long Term Care Application form

New Fee: $41.00
Effective: April 1, 2007

APPENDIX "J"

MENTAL HEALTH

1. Funding Improvements for Acute Care Psychiatry Services

In recognition of the complexity of care of acutely mentally ill individuals, investments have been made to attract and retain psychiatrists for the provision of hospital services.

a. Mental Health Sessional Fee Supplements
An investment of an additional $4.6 million (plus flow through impact specialist ATB increase) will be made to provide a premium through the introduction of a fee code payable to physicians who receive Mental Health Sessional Payments effective October 1, 2005.

b. Psychiatric Stipend
$14.4 million will be invested to enhance the remuneration of physicians providing psychiatric services in hospitals and to attract psychiatrists to work in hospitals. $ 5 million will be invested as of October 1, 2005 and an additional $9.4 million as of July 1, 2006 as follows:

i. the Mental Health Working Group (see 2. below) will recommend to the Parties the distribution of the funding no later than July 1, 2005 and March 31, 2006 respectively. Priority will be given to Schedule 1 hospitals without existing mental health sessionals and Schedule 1 hospitals that currently are underfunded relative to other Schedule 1 hospitals. Issues such as length of stay, ER volumes, etc, will also be considered; and

ii. details of the investment in Psychiatric Stipends will be jointly agreed to by the Parties and administered by the MOHLTC Health Services Division.

2. Mental Health Funding Working Group

a. The Working Group will examine the current funding sources for psychiatrists provided through government programs;

b. the Working Group will develop and recommend to the Parties a plan for the allocation of the funds referenced in section 1. b. These funds shall be directed toward hospital psychiatric services including, but not limited to, in-patient psychiatric services and emergency psychiatric services; and

c. the Working Group will consist of three members appointed by the OMA and three members appointed by the MOHLTC with a member of each of each group being appointed as co-chairs. The working group shall consult with representatives from various MOHLTC areas involved in related mental health funding.

d. The mandate for the Working Group is:

i. to obtain information on the various psychiatrist payment programs and service requirements;

ii. to identify areas of inconsistencies (e.g. funding level, geographic availability of Mental Health Sessional Payments, community and acute care programs);

iii. to develop options and make recommendations to the Parties on mental health issues including integrating payment and administration of the Mental Health Sessional Payments, the Psychiatric Stipend referenced in 1.b and payment to psychiatrists on ACT teams;

iv. $3 million will be available for harmonizing payments for the stipend program, flow-through funding and shared care models effective January 1, 2008; and

v. the Working Group will begin meeting as soon as possible after the Agreement is ratified and is required to submit its initial recommendations before July 1, 2005 and its final report no later than January 2006. It will meet as frequently as necessary in order to complete the mandate on time.

APPENDIX "K"

MEDICAL SERVICES PAYMENT COMMITTEE

1. The Medical Services Payment Committee ("MSPC") will consist of four members appointed by each of the Parties, all of whom will be expected to remain on the Committee for a minimum of two years and adopt roles of leadership in the fulfillment of the MSPC mandate. At least one of each Parties' representatives will also sit on PSC.
2. Each of the Parties will appoint a co-chair from its four members.
3. The MSPC will have an independent facilitator chosen by the Parties and subject to an annual review or a review at the request of either Party.
4. The MSPC will have training in relationship-building and conflict resolution as the Parties consider necessary.
5. The agenda of the MSPC will be set by the co-chairs in consultation with the facilitator. In the event of dispute, the facilitator will set the agenda.
6. Each Party will fund its own members and the MOHLTC will fund the administration costs of the Committee and the facilitator.
7. The MSPC will meet at least once a month.
8. The MSPC will function as a standing committee reporting regularly to the Parties, and to PSC as requested by the PSC. It shall have responsibility for making recommendations to the Parties with respect to changes to the Schedule of Benefits fee schedule and other payment mechanisms.

   The mandate for the MSPC is as follows:

   a. to provide advice and recommendations on timely and appropriate revisions to the fee schedule and other payment mechanisms to reflect current medical practice and meet the needs of the health care system;
   b. to continue to bring fees into relativity with consideration of innovation, access, integration and competitiveness;
   c. to conduct the specialty schedule reviews as outlined in paragraph 9;
   d. to provide advice and recommendations to the Parties on the use of new funding;
   e. if requested by the Parties, to consider and recommend options to address, either through fee schedule changes or other payment mechanisms, payment inequity issues, both with respect to on-going services and retention and recruitment needs;
   f. to oversee, as required, reviews and updates of the fee schedule and other payment mechanisms; to consult with current and future committees of the Parties functioning in support of the schedule, including the Central Tariff Committee, Relative Value Implementation Committee, the PCCC, the PHCC, the DSC and the Education and Prevention Committee;
   g. to include consideration of measurement and evaluation requirements in all cases when making recommendations;
   h. to provide an annual report to the Parties of its activities and recommendations by December 31st and additional reports as and when requested by the Parties; and
   i. to consider matters referred to it by either Party.

9. The MSPC will bring forward recommendations to the Parties to address fee relativity within each of the areas identified below. Working with the specific OMA Sections, a comprehensive review of intra-sectional fee relativity will be completed including specific areas of consideration as directed by the Parties.

(a) Ophthalmology
$3.7 million annualized will be made available January 1, 2008

(b) Diagnostic Radiology/Nuclear Medicine: $17.6 million annualized will be made available January 1, 2008. Split into two separate categories with appropriate allocation of the dollars

(c) Cardiac Diagnostic
$4.3M annualized will be made available January 1, 2008

(d) Physical Medicine
$1.1 million annualized will be made available January 1, 2008

(e) Surgical
$6.0M annualized will be made available January 1, 2008 as follows:
$4.0M annualized for General Surgery (including vascular)/Thoracic Surgery
$0.4M annualized for Plastic Surgery
$1.6M annualized Obstetrics and Gynecology

(f) Pediatrics
$6.0M annualized will be made available January 1, 2008

(g) Rural Medicine
$4.0M annualized will be made available January 1, 2008

APPENDIX "L"

PHYSICIAN FEE SCHEDULE

This Appendix describes changes that will be implemented through the Schedule of Benefits for Physician Services as an outcome of this Agreement.

For reference purposes only, this Appendix is divided into four parts. Specialist Professional Fees not shown are increased 2% April 1 2004 and Technical Fees are increased by 1% April 1 2005.

Part A: Fee schedule changes including fee increases, revisions of existing fee descriptions and introduction of new fee codes based upon recommendations from the Central Tariff Committee.

Part B: Fee schedule changes that are included in Appendices F (Hospital), H (Community Care), I (Long-Term Care) and J (Mental Health).

Part C: Specialist fee schedule changes addressing relativity, access and retention.

Part D: General Practice fee schedule changes addressing relativity, access and retention.

Appendix L

(Fee codes not included in Appendix L are eligible for across-the-board increase as set out in Agreement)

Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
Part A												
A - Fee code	Medical Management of Early Pregnancy, initial visit	A	New Fee Code			$95.65						$99.40
A - Fee code	Medical Management of Early Pregnancy, subsequent visit	A	New Fee Code			$29.70	$30.20		$30.95		$31.45	$31.95
A - Fee code	Special Nuclear Medicine Consultation	A	New Fee Code			$127.50						$132.50
A014	Anesthesia - Partial Assessment redefinition	GP	Revision	$20.60	$21.00	x						
A024	Dermatology - Partial Assessment redefinition	GP	Revision	$19.15	$19.55	x						
A034	General Surgery - Partial Assessment redefinition	GP	Revision	$20.50	$20.90	x						
A044	Neurosurgery - Partial Assessment redefinition	GP	Revision	$26.00	$26.50	x						
A064	Orthopaedic Surgery - Partial Assessment redefinition	GP	Revision	$19.50	$19.90	x						
A074	Geriatrics - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
A078	Geriatrics - Partial Assessment redefinition	GP	Revision	$24.65	$25.15	x						
A084	Plastic Surgery - Partial Assessment redefinition	GP	Revision	$19.50	$19.90	x						
A094	Cardiovascular and Thoracic Surgery - Partial Assessment redefinition	GP	Revision	$20.50	$20.90	x						
A134	Internal Medicine - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
A138	Internal Medicine - Partial Assessment redefinition	GP	Revision	$24.65	$25.15	x						
A184	Neurology - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
A188	Neurology - Partial Assessment redefinition	GP	Revision	$24.65	$25.15	x						
A194	Psychiatry - Partial Assessment redefinition	GP	Revision	$24.65	$25.15	x						
A204	Obstetrics & Gynecology - Partial Assessment redefinition	GP	Revision	$19.90	$20.30	x						
A234	Ophthalmology - Partial Assessment redefinition	GP	Revision	$20.50	$20.90	x						
A244	Otolaryngology - Partial Assessment redefinition	GP	Revision	$19.70	$20.10	x						
A264	Pediatrics - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$34.65	$35.35	x						
A284	Laboratory Medicine - Partial Assessment redefinition	GP	Revision	$21.30	$21.75	x						
A310	Physical Medicine - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
A318	Physical Medicine & Rehab - Partial Assessment redefinition	GP	Revision	$25.15	$25.65	x						

Appendix L

(Fee codes not included in Appendix L are eligible for across-the-board increase as set out in Agreement)

Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
A340	Radiation Oncology - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
A348	Radiation Oncology - Partial Assessment redefinition	GP	Revision	$24.65	$25.15	x						
A354	Urology - Partial Assessment redefinition	GP	Revision	$19.50	$19.90	x						
A414	Gastroenterology - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
A418	Gastroenterology - Partial Assessment redefinition	GP	Revision	$24.65	$25.15	x						
A474	Respiratory Disease - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
A478	Respiratory Disease - Partial Assessment redefinition	GP	Revision	$24.65	$25.15	x						
A484	Rheumatology - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
A488	Rheumatology - Partial Assessment redefinition	GP	Revision	$24.65	$25.15	x						
A604	Cardiology - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
A608	Cardiology - Partial Assessment redefinition	GP	Revision	$24.65	$25.15	x						
A614	Hematology - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
A618	Haemotology - Partial Assessment redefinition	GP	Revision	$24.65	$25.15	x						
A624	Clinical Immunology - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
A628	Clinical Immunology - Partial Assessment redefinition	GP	Revision	$24.65	$25.15	x						
A638	Nuclear Medicine - Partial Assessment redefinition	GP	Revision	$24.95	$25.45	x						
A644	General Thoracic Surgery - Partial Assessment redefinition	GP	Revision	$20.50	$20.90	x						
A895	Psychiatry - Consultation in association with special visit in hospital or LTC	A	Fee Increase	$134.25	$136.95	$178.50						$190.15
A990	Special Visits Premium - change weekday end time to 5:00pm	GP	Revision	$17.85	$18.20	x						
A994	Special Visits Premium - change weekday start time to 5:00pm	GP	Revision	$53.50	$54.55	x						
B990	Special Visits Premium - change weekday end time to 5:00pm	GP	Revision	$20.50	$20.90	x						
B994	Special Visits Premium - change weekday start time to 5:00pm	GP	Revision	$62.55	$63.80	x						
C014	Anesthesia - Specific re-assessment (remove comprehensive)	GP	Revision	$26.70	$27.25	x						
C024	Dermatology- Specific re-assessment (remove comprehensive)	GP	Revision	$24.30	$24.80	x						

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
C034	General Surgery - Specific re-assessment (remove comprehensive)	GP	Revision	$25.35	$25.85	x						
C044	Neurosurgery - Specific re-assessment (remove comprehensive)	GP	Revision	$26.00	$26.50	x						
C064	Orthopedic Surgery - Specific re-assessment (remove comprehensive)	GP	Revision	$24.65	$25.15	x						
C074	Geriatrics - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
C084	Plastic Surgery - Specific re-assessment (remove comprehensive)	GP	Revision	$24.65	$25.15	x						
C094	Cardiovascular & Thoracic - Specific re-assessment (remove comprehensive)	GP	Revision	$25.35	$25.85	x						
C109	Special Visits Premium - change weekday start time to 5:00pm	GP	Revision	$35.60	$36.30	x						
C134	Internal Medicine - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
C184	Neurology - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
C194	Psychiatry - Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
C204	Obstetrics & Gynecology - Specific re-assessment (remove comprehensive)	GP	Revision	$24.65	$25.15	x						
C234	Ophthalmology - Specific re-assessment (remove comprehensive)	GP	Revision	$24.95	$25.45	x						
C244	Otolaryngology - Specific re-assessment (remove comprehensive)	GP	Revision	$24.65	$25.15	x						
C264	Pediatrics - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$34.65	$35.35	x						
C314	Physical Medicine - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
C344	Radiation Oncology - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
C354	Urology - Specific re-assessment (remove comprehensivie)	GP	Revision	$24.65	$25.15	x						
C414	Gastroenterology - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
C474	Respiratory Disease - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
C484	Rheumatology - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
C604	Cardiology - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
C614	Hematology - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
C624	Clinical Immunology - Medical Specific re-assessment (remove comprehensive)	GP	Revision	$41.15	$41.95	x						
C644	General Thoracic Surgery - Specific re-assessment (remove comprehensive)	GP	Revision	$25.35	$25.85	x						
C895	Psychiatry - Consultation non-emergency hospital services	A	Fee Increase	$140.00	$142.80	$178.50						$190.15
C990	Special Visits Premium - change weekday end time to 5:00pm	GP	Revision	$17.85	$18.20	x						
C991	Special Visits Premium - change weekday end time to 5:00pm	GP	Revision	$10.15	$10.35	x						
C994	Special Visits Premium - change weekday start time to 5:00pm	GP	Revision	$53.50	$54.55	x						
C995	Special Visits Premium - change weekday start time to 5:00pm	GP	Revision	$26.75	$27.30	x						
C998B	Special Visits Premium - change weekday start time to 5:00pm	GP	Revision	$53.50	$54.55	x						
C998C	Special Visits Premium - change weekday start time to 5:00pm	GP	Revision	$53.50	$54.55	x						
E- Fee code	Anaesthsia ASA Emergency patient premium (applicable to ASA III, IV and V patients)	GP	New Fee Code			4 units						
E Add-on	Transvaginal Sonohysterography - add on code for use of Echovist contrast media for demonstration of tubal patency	B	New Fee Code			$136.35						
E Add-on	External approach to septoplasty, septorhinoplasty or partial septorhinoplasty (applicable to M012, M013 and M014)	P	New Fee Code			$119.20						
E - Fee code	Incision and drainage of extensive haematoma or pinna ***with packing of ear and external compression dressing*** under local anaesthesia	Y	New Fee Code			$92.40						
E Add-on	Mobilization of splenic flexure during bowel resection applicable to S167)	S	New Fee Code									
E Add-on	Laparoscopic to S411, S413, S416, and S436 Nephrectomies	T	New Fee Code			add 25%						
E Add-on	Laparoscopic or laparoscopic assisted procedures (S166, S167, S169, S171, R905, S798, S799, S800, S091, S092)	S	New Fee Code			add 25%						
E Add-on	Intra-operative cholangiogram (applicable to S287)	S	New Fee Code			$35.85						
E Add-on	Clinoidal drilling for complex aneurysm (applies to N105 and N154)	X	New Fee Code			$215.50						
E Add-on	Eye examination under general anaes <16 yrs old. (Add 30% to Z850 only)	Y	New Fee Code			add 30%						
E Add-on	Removal of calculus, upper 1/3 of ureter or renal pelvis	T	New Fee Code			$37.70						

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
E Add-on	Resection and fulgurization of ureteral or renal pelvic turmors (applicable to Z628) may be billed in combination with E760 and E761	T	New Fee Code			$233.65						
E158	Strabismus repair - two muscles, one or both eyes	Y	Fee Increase	$362.95	$370.20	$444.25						
E159	Strabismus repair - one muscle, one or both eyes	Y	Fee Increase	$257.55	$262.70	$315.25						
E162	Strabismus repair - three or more muscles, one or both eyes	Y	Fee Increase	$403.15	$411.20	$514.05						
E317	Incision and drainage of extensive haematoma or pinna ***with packing of ear and external compression dressing*** under general anaesthesia	Y	Revision	$137.20	$139.95	x						
E402	Special Visits Premium - change weekday start time to 5:00pm	GP	Revision	add 40%		x						
E411	Sole Delivery Premium - increase premium to 100% of appropriate delivery codes; maximum number of premiums per physician per year to remain at 25	K	Fee Increase	add 50%		add 100%						
E540	Permit to be claimed with E300	Y	Revision			x						
E761	If disintegrated by ultrasound - change to ***intracorporeal lithotripsy by any method***	T	Revision	$94.05	$95.95	x						
G - Fee code	Insulin Supervision - for patients on >= 3 multiple daily injections or insulin pump	J	New Fee Code			$10.60						
G198	Patch Test - industrial or occupational (maximum 90 per patient, per year)	J	Fee Increase	$1.87	$1.91	$2.39						
G206	Patch Test (maximum of 60 per patient, per year)	J	Fee Increase	$1.87	$1.91	$2.39						
G264	Occipital Nerve Block (initial)	J	Fee Increase	$19.45	$19.85	$34.10						
G265	Occipital Nerve Block (additional)	J	Fee Increase	$9.80	$10.00	$17.10						
G418	Electroencephalography (EEG) - Professional fee increase	J	Fee Increase	$28.60	$29.15	$37.95						
G424	Contact lens fitting (children < 4yrs old not subject to 3 month wait on visits)	J	Revision	$171.30	$174.75	x						
G650	Continuous ECG Monitoring - Holter Level 1 redefinition 12-35 hours	J	Revision	$46.95	$47.90	x						
G651	Continuous ECG Monitoring - Holter Level 1 redefinition 12-35 hours	J	Revision	$24.25	$24.75	x						
G652	Continuous ECG Monitoring - Holter Level 1 redefinition 12-35 hours	J	Revision	$33.20	$33.85	x						
G653	Continuous ECG Monitoring - Holter Level 2 redefinition 12-35 hours	J	Revision	$33.45	$34.10	x						
G654	Continuous ECG Monitoring - Holter Level 2 redefinition 12-35 hours	J	Revision	$23.15	$23.60	x						

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
G655	Continuous ECG Monitoring - Holter Level 2 redefinition 12-35 hours	J	Revision	$15.85	$16.15	x						
G656	Continuous ECG Monitoring - Holter Level 2 redefinition 36-59 hours	J	Revision	$50.15	$51.15	x						
G657	Continuous ECG Monitoring - Holter Level 2 redefinition 60 hours to 13 days	J	Revision	$66.85	$68.20	x						
G658	Continuous ECG Monitoring - Holter Level 1 redefinition 36-59 hours	J	Revision	$70.45	$71.85	x						
G659	Continuous ECG Monitoring - Holter Level 1 redefinition 60 or more hours	J	Revision	$93.95	$95.85	x						
G682	Continuous ECG Monitoring - Holter Level 1 redefinition 36-59 hours	J	Revision	$48.50	$49.45	x						
G683	Continuous ECG Monitoring - Holter Level 1 redefinition 36-59 hours	J	Revision	$66.40	$67.75	x						
G684	Continuous ECG Monitoring - Holter Level 1 redefinition 60 or more hours	J	Revision	$72.75	$74.20	x						
G685	Continuous ECG Monitoring - Holter Level 1 redefinition 60 or more hours	J	Revision	$99.60	$101.60	x						
G686	Continuous ECG Monitoring - Holter Level 2 redefinition 36-59 hours	J	Revision	$46.30	$47.25	x						
G687	Continuous ECG Monitoring - Holter Level 2 redefinition 36-59 hours	J	Revision	$31.70	$32.35	x						
G688	Continuous ECG Monitoring - Holter Level 2 redefinition 60 hours to 13 days	J	Revision	$69.45	$70.85	x						
G689	Continuous ECG Monitoring - Holter Level 2 redefinition 60 hours to 13 days	J	Revision	$47.55	$48.50	x						
Heading	Revise heading Intracranial Aneurysm Repair- ***Craniotomy and Endovascular Approaches*** above N105 and N154	X	Revision			x						
J866/J666	Revision to J866/J666 to incorporate change below	B	Revision			x						
J8XX/J6XX	SPECT - permit up to three claims with Gallium scans	B	New Fee Code			H-$44.60 P1-$26.70 P2-$13.40						
K - Fee code	Paediatric Adolescent Psychotherapy	A	New Fee Code			$62.20						$65.95
K - Fee code	Patient Case Conference	A	New Fee Code			$51.70						
K028	Sexually Transmitted Disease (STD) - **definition to include blood borne disease** and increase limit to 2 per patient per physician per day with a maximum of 4 per patient per physician per year	A	(2) Revisions	$50.45	$51.70	x						
K032	Specific Neurocognitive Assessment - permit with assessments/consultations	A	Revision	$50.45	$51.70	x						

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
K990	Special Visits Premium - change weekday end time to 5:00pm	GP	Revision	$17.85	$18.20	x						
K991	Special Visits Premium - change weekday end time to 5:00pm	GP	Revision	$10.15	$10.35	x						
K994	Special Visits Premium - change weekday start time to 5:00pm	GP	Revision	$53.50	$54.55	x						
K995	Special Visits Premium - change weekday start time to 5:00pm	GP	Revision	$26.75	$27.30	x						
Q990	Special Visits Premium - change weekday end time to 5:00pm	GP	Revision	$17.85	$18.20	x						
Q994	Special Visits Premium - change weekday start time to 5:00pm	GP	Revision	$53.50	$54.55	x						
R - Fee code	Endovascular aortic stent (all-inclusive code)	Q	New Fee Code			$1,330.40						
R - Fee code	Skin Allograft Procurement	M	New Fee Code			$17.25						
R - Fee code	Mitral Valve Reconstruction - Simple	Q	New Fee Code			$1,618.50						
R - Fee code	Mitral Valve Reconstruction - Complex	Q	New Fee Code			$2,021.05						
R208	Arthroscopic meniscal repair	N	Fee Increase	$235.75	$240.45	$336.65						
R486	Complete arthroplasty replacement (equal to R441)	N	Fee Increase	$605.60	$617.70	$619.90						
R549	Excision of Ganglion simple or complex	N	Fee Increase	$118.35	$120.70	$177.80						
S063	Tonsillectomy	S	Fee Increase	$145.70	$148.60	$178.35						
S065	Adenoidectomy	S	Fee Increase	$82.70	$84.35	$101.25						
S119	Percutaneous endoscopic gastrostomy - revise to a Z-code and increase fee relative to 1/2 of S118	S	Delete	$157.45	$160.60	x						
S641	Replace transpubic total prostatovesiculectomy with newer procedures	T	Delete	$930.60	$949.20	x						
S772	Endometrial Ablation ***by any method***	V	Revision	$214.35	$218.65	x						
S772/S773	Revision ***Note: Hysteroscopy codes Z582 or Z583 are not to be claimed in conjunction with S772 and S773.***	V	Revision		$0.00	x						
S773	Endometrial Ablation ***by any method*** within one year of previous ablation by same surgeon	V	Revision	$150.05	$153.05	x						
Spinal Revision	See appendix for specific listing				$0.00	x						
U990	Special Visits Premium - change weekday end time to 5:00pm	GP	Revision	$17.85	$18.20	x						
U991	Special Visits Premium - change weekday end time to 5:00pm	GP	Revision	$10.15	$10.35	x						
U994	Special Visits Premium - change weekday start time to 5:00pm	GP	Revision	$53.50	$54.55	x						
U995	Special Visits Premium - change weekday start time to 5:00pm	GP	Revision	$26.75	$27.30	x						

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
W895	Psychiatry - Consultation non-emergency long-term care in-patient services	A	Fee Increase	$134.25	$136.95	$178.50						$190.15
W990	Special Visits Premium - change weekday end time to 5:00pm	GP	Revision	$17.85	$18.20	x						
W994	Special Visits Premium - change weekday start time to 5:00pm	GP	Revision	$53.50	$54.55	x						
X - Fee code	Three dimensional CT acquisition sequencing	F	New Fee Code			$64.00						
Z - Fee code	Endoscopic transnasal ligation of the sphenopalatine artery for posterior epistaxis, unilateral	P	New Fee Code			$123.70						
Z - Fee code	Manual catheter declotting and irrigation of bladder	T	New Fee Code			$58.65						
Z119	Percutaneous endoscopic gastrostomy - revise to a Z-code and increase fee relative to 1/2 of S118	S	New Fee Code			$172.95						
Z299	Fiberoptic endoscopy of upper airway with rigid endoscope - permit to be claimed with other services	P	Revision	$8.40	$8.55	x						
Z457	Surgical removal of Hickman or Broviac catheter revised to read ***Surgical removal or repair of implanted central venous catheter***	J	Revision	$38.70	$39.45	x						
Z615	Filiform and Follower Urethral Dilation - remove wording *under general anaesthestic, and may include bladder catheterization*	T	Revision	$58.60	$59.75	x						
Z640	Resection and fulgurization of ureteral or renal pelvic turmors (applicable to Z628, billed in combination with E760 and E761	T	Delete	$266.00	$271.30	x						

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
Part B												
B - Fee Code	Family Practice and Practice in General - Special Visit to Home of Palliative Care Patient	A	New fee code			$63.80						
C - fee code	Most Responsible Physician - Day 2	A	New fee code			$46.15			$55.45			
C - fee code	Most Responsible Physician - Day 3	A	New fee code			$46.15			$55.45			
C - fee code	Most Responsible Physician - Day of Discharge	A	New fee code			$46.15			$55.45			
C012	Anaesthesia - SUB. VISITS (first 5 weeks)	A15	Fee Increase	$23.00	$23.60	$29.20						
C017	Anaesthesia - SUB. VISITS (6th to 13th week)	A15	Fee Increase	$23.00	$23.60	$29.20						
C018	Anaesthesia - SUB. VISITS - Concurrent care	A15	Fee Increase	$23.00	$23.60	$29.20						
C019	Anaesthesia - SUB. VISITS (after 13th week)	A15	Fee Increase	$23.00	$23.60	$29.20						
C022	Dermatology - SUB. VISITS (first 5 weeks)	A20	Fee Increase	$23.00	$23.60	$29.20						
C027	Dermatology - SUB. VISITS (6th to 13th week)	A20	Fee Increase	$23.00	$23.60	$29.20						
C028	Dermatology - SUB. VISITS - Concurrent care	A20	Fee Increase	$23.00	$23.60	$29.20						
C029	Dermatology - SUB. VISITS (after 13th week)	A20	Fee Increase	$23.00	$23.60	$29.20						
C032	General Surgery - SUB. VISITS (first 5 weeks)	A24	Fee Increase	$23.00	$23.60	$29.20						
C037	General Surgery - SUB. VISITS (6th to 13th week)	A24	Fee Increase	$23.00	$23.60	$29.20						
C038	General Surgery - SUB. VISITS - Concurrent care	A24	Fee Increase	$23.00	$23.60	$29.20						
C039	General Surgery - SUB. VISITS (after 13th week)	A24	Fee Increase	$23.00	$23.60	$29.20						
C042	Neurosurgery - SUB. VISITS (first 5 weeks)	A36	Fee Increase	$23.00	$23.60	$29.20						
C047	Neurosurgery - SUB. VISITS (6th to 13th week)	A36	Fee Increase	$23.00	$23.60	$29.20						
C048	Neurosurgery - SUB. VISITS - Concurrent care	A36	Fee Increase	$23.00	$23.60	$29.20						
C049	Neurosurgery - SUB. VISITS (after 13th week)	A36	Fee Increase	$23.00	$23.60	$29.20						
C062	Orthopedics - SUB. VISITS (first 5 weeks)	A36	Fee Increase	$23.00	$23.60	$29.20						
C067	Orthopedics - SUB. VISITS (6th to 13th week)	A41	Fee Increase	$23.00	$23.60	$29.20						
C068	Orthopedics - SUB. VISITS - Concurrent care	A41	Fee Increase	$23.00	$23.60	$29.20						
C069	Orthopedics - SUB. VISITS (after 13th week)	A41	Fee Increase	$23.00	$23.60	$29.20						
C072	Geriatrics - SUB. VISITS (first 5 weeks)	A41	Fee Increase	$23.00	$23.60	$29.20						
C077	Geriatrics - SUB. VISITS (6th to 13th week)	A28	Fee Increase	$23.00	$23.60	$29.20						
C078	Geriatrics - SUB. VISITS - Concurrent care	A28	Fee Increase	$23.00	$23.60	$29.20						
C079	Geriatrics - SUB. VISITS (after 13th week)	A28	Fee Increase	$23.00	$23.60	$29.20						
C082	Plastic Surgery - SUB. VISITS (first 5 weeks)	A49	Fee Increase	$23.00	$23.60	$29.20						
C087	Plastic Surgery - SUB. VISITS (6th to 13th week)	A49	Fee Increase	$23.00	$23.60	$29.20						
C088	Plastic Surgery - SUB. VISITS - Concurrent care	A49	Fee Increase	$23.00	$23.60	$29.20						
C089	Plastic Surgery - SUB. VISITS (after 13th week)	A49	Fee Increase	$23.00	$23.60	$29.20						

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
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C092	Cardiovascular & Thoracic Surgery - SUB. VISITS (first 5 weeks)	A17	Fee Increase	$23.00	$23.60	$29.20						
C097	Cardiovascular & Thoracic Surgery - SUB. VISITS (6th to 13th week)	A17	Fee Increase	$23.00	$23.60	$29.20						
C098	Cardiovascular & Thoracic Surgery - SUB. VISITS - Concurrent care	A17	Fee Increase	$23.00	$23.60	$29.20						
C099	Cardiovascular & Thoracic Surgery - SUB. VISITS (after 13th week)	A17	Fee Increase	$23.00	$23.60	$29.20						
C121	SUB. VISITS - Visits due to intercurrent illness	J	Fee Increase	$23.00	$23.60	$29.20						
C132	Internal Medicine - SUB. VISITS (first 5 weeks)	A31	Fee Increase	$23.00	$23.60	$29.20						
C137	Internal Medicine - SUB. VISITS (6th to 13th week)	A31	Fee Increase	$23.00	$23.60	$29.20						
C138	Internal Medicine - SUB. VISITS - Concurrent care	A31	Fee Increase	$23.00	$23.60	$29.20						
C139	Internal Medicine - SUB. VISITS (after 13th week)	A31	Fee Increase	$23.00	$23.60	$29.20						
C182	Neurology - SUB. VISITS (first 5 weeks)	A34	Fee Increase	$23.00	$23.60	$29.20						
C187	Neurology - SUB. VISITS (6th to 13th week)	A34	Fee Increase	$23.00	$23.60	$29.20						
C188	Neurology - SUB. VISITS - Concurrent care	A34	Fee Increase	$23.00	$23.60	$29.20						
C189	Neurology - SUB. VISITS (after 13th week)	A34	Fee Increase	$23.00	$23.60	$29.20						
C192	Psychiatry - SUB. VISITS (first 5 weeks)	A51	Fee Increase	$23.00	$23.60	$29.20						
C197	Psychiatry - SUB. VISITS (6th to 13th week)	A51	Fee Increase	$23.00	$23.60	$29.20						
C198	Psychiatry - SUB. VISITS - Concurrent care	A51	Fee Increase	$23.00	$23.60	$29.20						
C199	Psychiatry - SUB. VISITS (after 13th week)	A51	Fee Increase	$23.00	$23.60	$29.20						
C202	Obstetrics and Gynaecology - SUB. VISITS (first 5 weeks)	A38	Fee Increase	$23.00	$23.60	$29.20						
C207	Obstetrics and Gynaecology - SUB. VISITS (6th to 13th week)	A38	Fee Increase	$23.00	$23.60	$29.20						
C208	Obstetrics and Gynaecology - SUB. VISITS - Concurrent care	A38	Fee Increase	$23.00	$23.60	$29.20						
C209	Obstetrics and Gynaecology - SUB. VISITS (after 13th week)	A38	Fee Increase	$23.00	$23.60	$29.20						
C232	Ophthalmology - SUB. VISITS (first 5 weeks)	A40	Fee Increase	$23.00	$23.60	$29.20						
C237	Ophthalmology - SUB. VISITS (6th to 13th week)	A40	Fee Increase	$23.00	$23.60	$29.20						
C238	Ophthalmology - SUB. VISITS - Concurrent care	A40	Fee Increase	$23.00	$23.60	$29.20						
C239	Ophthalmology - SUB. VISITS (after 13th week)	A40	Fee Increase	$23.00	$23.60	$29.20						
C242	Otolaryngology - SUB. VISITS (first 5 weeks)	A43	Fee Increase	$23.00	$23.60	$29.20						
C247	Otolaryngology - SUB. VISITS (6th to 13th week)	A43	Fee Increase	$23.00	$23.60	$29.20						
C248	Otolaryngology - SUB. VISITS - Concurrent care	A43	Fee Increase	$23.00	$23.60	$29.20						

Appendix L

(Fee codes not included in Appendix L are eligible for across-the-board increase as set out in Agreement)

Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
C249	Otolaryngology - SUB. VISITS (after 13th week)	A43	Fee Increase	$23.00	$23.60	$29.20						
C262	Pediatrics - SUB. VISITS (first 5 weeks)	A45	Fee Increase	$23.00	$23.60	$29.20						
C267	Pediatrics - SUB. VISITS (6th to 13th week)	A45	Fee Increase	$23.00	$23.60	$29.20						
C268	Pediatrics - SUB. VISITS - Concurrent care	A45	Fee Increase	$23.00	$23.60	$29.20						
C269	Pediatrics - SUB. VISITS (after 13th week)	A45	Fee Increase	$23.00	$23.60	$29.20						
C312	Physical Medicine - SUB. VISITS (first 5 weeks)	A46	Fee Increase	$23.00	$23.60	$29.20						
C317	Physical Medicine - SUB. VISITS (6th to 13th week)	A46	Fee Increase	$23.00	$23.60	$29.20						
C318	Physical Medicine - SUB. VISITS - Concurrent care	A46	Fee Increase	$23.00	$23.60	$29.20						
C319	Physical Medicine - SUB. VISITS (after 13th week)	A46	Fee Increase	$23.00	$23.60	$29.20						
C342	Radiology Oncology - SUB. VISITS (first 5 weeks)	A55	Fee Increase	$23.00	$23.60	$29.20						
C347	Radiology Oncology - SUB. VISITS (6th to 13th week)	A55	Fee Increase	$23.00	$23.60	$29.20						
C348	Radiology Oncology - SUB. VISITS - Concurrent care	A55	Fee Increase	$23.00	$23.60	$29.20						
C349	Radiology Oncology - SUB. VISITS (after 13th week)	A55	Fee Increase	$23.00	$23.60	$29.20						
C352	Urology - SUB. VISITS (first 5 weeks)	A58	Fee Increase	$23.00	$23.60	$29.20						
C357	Urology - SUB. VISITS (6th to 13th week)	A58	Fee Increase	$23.00	$23.60	$29.20						
C358	Urology - SUB. VISITS - Concurrent care	A58	Fee Increase	$23.00	$23.60	$29.20						
C359	Urology - SUB. VISITS (after 13th week)	A58	Fee Increase	$23.00	$23.60	$29.20						
C412	Gastroenterology - SUB. VISITS (first 5 weeks)	A23	Fee Increase	$23.00	$23.60	$29.20						
C417	Gastroenterology - SUB. VISITS (6th to 13th week)	A23	Fee Increase	$23.00	$23.60	$29.20						
C418	Gastroenterology - SUB. VISITS - Concurrent care	A23	Fee Increase	$23.00	$23.60	$29.20						
C419	Gastroenterology - SUB. VISITS (after 13th week)	A23	Fee Increase	$23.00	$23.60	$29.20						
C472	Respiratory Disease - SUB. VISITS (first 5 weeks)	A56	Fee Increase	$23.00	$23.60	$29.20						
C477	Respiratory Disease - SUB. VISITS (6th to 13th week)	A56	Fee Increase	$23.00	$23.60	$29.20						
C478	Respiratory Disease - SUB. VISITS - Concurrent care	A56	Fee Increase	$23.00	$23.60	$29.20						
C479	Respiratory Disease - SUB. VISITS (after 13th week)	A46	Fee Increase	$23.00	$23.60	$29.20						
C482	Rheumatology - SUB. VISITS (first 5 weeks)	A57	Fee Increase	$23.00	$23.60	$29.20						

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
C487	Rheumatology - SUB. VISITS (6th to 13th week)	A57	Fee Increase	$23.00	$23.60	$29.20						
C488	Rheumatology - SUB. VISITS - Concurrent care	A57	Fee Increase	$23.00	$23.60	$29.20						
C489	Rheumatology - SUB. VISITS (after 13th week)	A57	Fee Increase	$23.00	$23.60	$29.20						
C602	Cardiology - SUB. VISITS (first 5 weeks)	A16	Fee Increase	$23.00	$23.60	$29.20						
C607	Cardiology - SUB. VISITS (6th to 13th week)	A16	Fee Increase	$23.00	$23.60	$29.20						
C608	Cardiology - SUB. VISITS - Concurrent care	A16	Fee Increase	$23.00	$23.60	$29.20						
C609	Cardiology - SUB. VISITS (after 13th week)	A16	Fee Increase	$23.00	$23.60	$29.20						
C612	Haemotology - SUB. VISITS (first 5 weeks)	A30	Fee Increase	$23.00	$23.60	$29.20						
C617	Haemotology - SUB. VISITS (6th to 13th week)	A30	Fee Increase	$23.00	$23.60	$29.20						
C618	Haemotology - SUB. VISITS - Concurrent care	A30	Fee Increase	$23.00	$23.60	$29.20						
C619	Haemotology - SUB. VISITS (after 13th week)	A30	Fee Increase	$23.00	$23.60	$29.20						
C622	Clinical Immunology - SUB. VISITS (first 5 weeks)	A18	Fee Increase	$23.00	$23.60	$29.20						
C627	Clinical Immunology - SUB. VISITS (6th to 13th week)	A18	Fee Increase	$23.00	$23.60	$29.20						
C628	Clinical Immunology - SUB. VISITS - Concurrent care	A18	Fee Increase	$23.00	$23.60	$29.20						
C629	Clinical Immunology - SUB. VISITS (after 13th week)	A18	Fee Increase	$23.00	$23.60	$29.20						
C642	General Thoracic Medicine - SUB. VISITS (first 5 weeks)	A26	Fee Increase	$23.00	$23.60	$29.20						
C647	General Thoracic Medicine - SUB. VISITS (6th to 13th week)	A26	Fee Increase	$23.00	$23.60	$29.20						
C648	General Thoracic Medicine - SUB. VISITS - Concurrent care	A26	Fee Increase	$23.00	$23.60	$29.20						
C649	General Thoracic Medicine - SUB. VISITS (after 13th week)	A26	Fee Increase	$23.00	$23.60	$29.20						
C982	Family Practice and Practice in General - Subsequent Visits - Palliative Care	A15, A16, A17, A18, A20, A23, A24, A26, A28, A30, A31, A34, A36, A38, A40, A41, A43, A45, A46, A49, A51, A55, A56, A57, A58	Fee Increase	$23.00	$23.60	$29.20						

Appendix L

(Fee codes not included in Appendix L are eligible for across-the-board increase as set out in Agreement)

Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
E - Fee code	Trauma Premium - Within 24 hours of admission (includes consults, surgery, anaesthesia, assistant fees) diagnostic and lab service excluded.	A	New fee code			add 50%						
E - Fee code	First Visit Premium - to be billed by GP for first visit after patient discharged from hospital	A	New fee code						$25.00			
G - Fee code	Telephone services to patient receiving palliative care at home		New fee code								$17.75	
G401	Critical Care - Intensive Care Area - 2nd to 10th day	J19, 3E	Fee Increase	$103.55	$105.60	$132.00						
G401	Critical Care - Intensive Care Area - 2nd to 30th day	J19, 3E	Revision	$103.55	$105.60							x
G402	Critical Care - Intensive Care Area - 31st day onwards	J19, 3E	Revision	$51.75	$52.80							x
G406	Critical Care - Ventilatory Support - 2nd to 30th day	J19, 3E	Revision	$89.70	$91.50							x
G407	Critical Care - Ventilatory Support - 31st day onwards	J19, 3E	Revision	$59.75	$60.95							x
G558	Comprehensive Care - 2nd to 10th day	J19, 3E	Fee Increase	$151.00	$154.00	$192.45						
G558	Comprehensive Care - 2nd to 30th day	J19, 3E	Revision	$151.00	$154.00							x
G559	Comprehensive Care - 31st day onwards	J19, 3E	Revision	$75.45	$76.95							x
G601	Neonatal Intensive Care - Level A - 2nd to 30th day	J20, 4E	Revision	$150.80	$153.80	x						
G602	Neonatal Intensive Care - Level A - 31st day onwards	J20, 4E	Revision	$75.35	$76.85	x						
G611	Neonatal Intensive Care - Level B - 2nd day onwards	J20, 4E	Fee Increase	$75.35	$76.85	$105.55						
G621	Neonatal Intensive Care - Level C - 2nd day onwards	J20, 4E	Fee Increase	$27.25	$27.80	$66.70						
K - Fee code	Long Term Care Application form	A	New fee code								$41.00	
K - Fee code	Mental Health Sessional fee increase - linked with billing code	A	New fee code			x						
Surgical Preamble	Trauma Second Surgeon - Revision to Surgical Preamble to allow second surgeon to bill as first surgeon.	SP- 3 #10	Revision			x						
W002	Family Practice and Practice in General - Chronic care visit, first 4 subsequent visits per month	A	Fee Increase	$23.00	$23.60	$29.20						
W022	Dermatology - Chronic care visit, first 4 subsequent visits per month	A	Fee Increase	$23.00	$23.60	$29.20						
W032	General Surgery - Chronic care visit, first 4 subsequent visits per month	A	Fee Increase	$23.00	$23.60	$29.20						
W062	Orthopedics - Chronic care visit, first 4 subsequent visits per month	A	Fee Increase	$23.00	$23.60	$29.20						

Appendix L

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
W072	Geriatrics - Chronic care visit, first 4 subsequent visits per month	A	Fee Increase	$23.00	$23.60	$29.20						
W132	Internal Medicine - Chronic care visit, first 4 subsequent visits per month	A	Fee Increase	$23.00	$23.60	$29.20						
W182	Neurology - Chronic care visit, first 4 subsequent visits per month	A	Fee Increase	$23.00	$23.60	$29.20						
W262	Pediatrics - Chronic care visit, first 4 subsequent visits per month	A	Fee Increase	$23.00	$23.60	$29.20						
W312	Physical Medicine - Chronic care visit, first 4 subsequent visits per month	A	Fee Increase	$23.00	$23.60	$29.20						
W882	Family Practice and Practice in General - Chronic care visit, palliative care	A	Fee Increase	$23.00	$23.60	$29.20						
W982	Specialists - Chronic care visit, palliative care	A	Fee Increase	$23.00	$23.60	$29.20						

Appendix L

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
Part C												
A014	Anesthesia - Partial Assessment	A	Fee Increase	$20.60	$21.00	$29.05					$30.10	$30.60
A024	Dermatology - Partial Assessment	A	Fee Increase	$19.15	$19.55			$20.40				
A025	Dermatology - Consultation	A	Fee Increase	$53.45	$54.50	$59.15						$66.15
A034	General Surgery - Partial Assessment	A	Fee Increase	$20.50	$20.90			$22.45				
A035	General Surgery - Consultation	A	Fee Increase	$75.00	$76.50	$81.60						$86.60
A045	Neurosurgery - Consultation	A	Fee Increase	$100.00	$102.00							$107.00
A055	Community Medicine - Consultation	A	Fee Increase	$73.85	$75.35							$82.90
A064	Orthopaedic Surgery - Partial Assessment	A	Fee Increase	$19.50	$19.90			$22.45				
A065	Orthopaedic Surgery - Consultation	A	Fee Increase	$56.15	$57.25	$66.30						$71.30
A071	Geriatrics - Office/Clinic - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
A073	Geriatrics - Office/Clinic - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
A074	Geriatrics - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
A075	Geriatrics - Office/Clinic - Consultation	A	Fee Increase	$140.00	$142.80							$147.80
A076	Geriatrics - Office/Clinic - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
A078	Geriatrics - Partial assessment	A	Fee Increase	$24.65	$25.15	$29.05					$30.10	$30.60
A084	Plastic Surgery - Partial Assessment	A	Fee Increase	$19.50	$19.90			$22.45				
A085	Plastic Surgery - Consultation	A	Fee Increase	$55.95	$57.05	$66.30						$71.30
A094	Cardiovascular and Thoracic Surgery - Partial Assessment	A	Fee Increase	$20.50	$20.90			$22.45				
A095	Cardiovascular & Thoracic Surgery - Consultation	A	Fee Increase	$59.55	$60.75	$66.30						$71.30
A131	Internal Medicine - Office/Clinic - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
A133	Internal Medicine - Office/Clinic - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
A134	Internal Medicine - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
A135	Internal Medicine - Consultation	A	Revision	$125.00	$127.50							$132.50
A136	Internal Medicine - Office/Clinic - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
A138	Internal Medicine - Partial assessment	A	Fee Increase	$24.65	$25.15	$29.05					$30.10	$30.60
A145	Internal Medicine - Consultation for Cardiology, Gastroenterology and Respiratory Disease	A	Delete	$112.35	$114.60							
A181	Neurology - Office/Clinic - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
A183	Neurology - Office/Clinic - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
A184	Neurology - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50

Appendix L

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
A185	Neurology - Office/Clinic - Consultation	A	Fee Increase	$125.00	$127.50							$147.80
A186	Neurology - Office/Clinic - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
A188	Neurology - Partial Assessment	A	Fee Increase	$24.65	$25.15	$29.05					$30.10	$30.60
A193	Psychiatry - Office/Clinic - Specific assessment	A	Fee increase	$57.10	$58.25							$64.05
A194	Psychiatry - Partial Assessment	A	Fee Increase	$24.65	$25.15	$29.05					$30.10	$30.60
A195	Psychiatry - Consultation	A	Fee Increase	$125.00	$127.50	$153.00						$162.95
A196	Psychiatry - Office/Clinic - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
A197	Psychiatry - Consultative - interview with parents	A	Fee Increase	$125.00	$127.50	$163.20						$173.80
A198	Psychiatry - Consultative - interview with child	A	Fee Increase	$125.00	$127.50	$163.20						$173.80
A204	Obstetrics & Gynaecology - Partial Assessment	A	Fee Increase	$19.90	$20.30			$22.45				
A205	Obstetrics and Gynecology - Consultation	A	Fee Increase	$75.00	$76.50	$81.60						$86.60
A221	Genetics - Partial Assessment	A	Fee Increase	$18.55	$18.90	$29.05					$30.10	$30.60
A225	Genetics - Consultation	A	Fee Increase	$122.00	$124.45	$142.80						$147.80
A226	Genetics - Office/Clinic - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
A234	Ophthalmology - Partial Assessment	A	Fee Increase	$20.50	$20.90			$22.45				
A235	Ophthalmology - Consultation	A	Fee Increase	$58.25	$59.40	$66.30						$71.30
A244	Otolaryngology - Partial Assessment	A	Fee Increase	$19.70	$20.10			$22.45				
A245	Otolaryngology - Consultation	A	Fee Increase	$56.15	$57.25	$66.30						$71.30
A261	Pediatrics - Minor Assessment	A	Fee increase	$17.30	$17.75							
A263	Pediatrics - Office/Clinic - Medical specific assessment	A	Fee increase	$53.15	$54.20	$58.25						$64.05
A264	Pediatrics - Medical specific re-assessment	A	Fee Increase	$34.65	$35.35	$45.90						$50.50
A265	Pediatrics - Consultation	A	Fee Increase	$135.00	$137.70	$142.80						$147.80
A266	Pediatrics - Office/Clinic - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
A283	Laboratory Medicine - Office/Clinic - Medical specific assessment	A	Fee increase	$49.50	$50.50							$55.55
A284	Laboratory Medicine - Partial Assessment	A	Fee Increase	$21.30	$21.75	$29.05					$30.10	$30.60
A285	Laboratory Medicine - Office/Clinic - Consultation	A	Fee Increase	$95.05	$96.95							$102.00

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
A286	Laboratory Medicine - Office/Clinic - Repeat or limited consultation	A	Fee increase	$63.45	$64.70							$71.20
A310	Physical Medicine and Rehabilitation - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
A311	Physical Medicine and Rehab - Office/Clinic - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
A313	Physical Medicine and Rehabilitation - Office/Clinic - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
A315	Physical Medicine and Rehabilitation - Consultation	A	Fee Increase	$125.00	$127.50			$142.80				$147.80
A316	Physical Medicine and Rehabilitation - Office/Clinic - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
A318	Physical Medicine - Partial assessment	A	Fee Increase	$25.15	$25.65	$29.05					$30.10	$30.60
A325	Genetics - Office/Clinic - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
A331	Diagnostic Radiology - Minor assessment	A	Fee increase	$17.30	$17.75							
A335	Diagnostic Radiology - Office/Clinic - Consultation	A	Fee Increase	$29.65	$30.25							$35.70
A338	Diagnostic Radiology - Minor assessment	A	Fee increase	$17.30	$17.75							
A340	Radiation Oncology - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
A341	Radiation Oncology - Office/Clinic - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
A343	Radiation Oncology - Office/Clinic - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
A345	Radiation Oncology - Consultation	A	Fee Increase	$112.35	$114.60	$127.50						$132.50
A346	Radiation Oncology - Office/Clinic - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
A348	Radiation Oncology - Partial Assessment	A	Fee Increase	$24.65	$25.15	$29.05					$30.10	$30.60
A354	Urology - Partial Assessment	A	Fee Increase	$19.50	$19.90			$22.45				
A355	Urology - Consultation	A	Fee Increase	$55.95	$57.05	$66.30						$71.30
A375	Geriatrics - Office/Clinic - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
A385	Neurology - Office/Clinic - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
A395	Psychiatry - Office/Clinic - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
A411	Gastroeterology - Office/Clinic - Comples medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
A413	Gastroenterology - Office/Clinic - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
A414	Gastroenterology - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
A415	Gastroenterology - Consultation	A	Fee Increase	$112.35	$114.60	$127.50						$132.50
A416	Gastroenterology - Office/Clinic - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
A418	Gastroenterology - Partial assessment	A	Fee Increase	$24.65	$25.15	$29.05					$30.10	$30.60

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
A435	Internal Medicine - Office/Clinic - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
A471	Respiratory Disease - Office/Clinic - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
A473	Respiratory Disease - Office/Clinic - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
A474	Respiratory Disease - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
A475	Respiratory Disease - Consultation	A	Fee Increase	$112.35	$114.60	$127.50						$132.50
A476	Respiratory Disease - Office/Clinic - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
A478	Respirology - Partial assessment	A	Fee Increase	$24.65	$25.15	$29.05					$30.10	$30.60
A481	Rheumatology - Office/Clinic - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
A483	Rheumatology - Office/Clinic - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
A484	Rheumatology - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
A485	Rheumatology - Office/Clinic - Consultation	A	Fee Increase	$125.00	$127.50							$132.50
A486	Rheumatology - Office/Clinic - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
A488	Rheumatology - Partial assessment	A	Fee Increase	$24.65	$25.15	$29.05					$30.10	$30.60
A515	Physical Medicine and Rehabilitation - Office/Clinic - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
A525	Clinical Immunology - Office/Clinic - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
A545	Gastroenterology - Office/Clinic - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
A565	Pediatrics - Office/Clinic - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
A575	Respiratory Disease - Office/Clinic - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
A595	Rheumatology - Office/Clinic - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
A601	Cardiology - Office/Clinic - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
A603	Cardiology - Office/Clinic - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
A604	Cardiology - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
A605	Cardiology - Consultation	A	Fee Increase	$112.35	$114.60	$127.50						$132.50
A606	Cardiology - Office/Clinic - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
A608	Cardiology - Partial assessment	A	Fee Increase	$24.65	$25.15	$29.05					$30.10	$30.60
A611	Hematology - Office/Clinic - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45

Appendix L

(Fee codes not included in Appendix L are eligible for across-the-board increase as set out in Agreement)

Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
A613	Haematology - Office/Clinic - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
A614	Haematology - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
A615	Hematology - Office/Clinic - Consultation	A	Fee Increase	$125.00	$127.50							$132.50
A616	Haematology - Office/Clinic - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
A618	Hematology - Partial assessment	A	Fee Increase	$24.65	$25.15	$29.05					$30.10	$30.60
A621	Clinical Immunology - Office/Clinic - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
A623	Clinical Immunology - Office/Clinic - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
A624	Clinical Immunology - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
A625	Clinical Immunology - Office/Clinic - Consultation	A	Fee Increase	$125.00	$127.50							$132.50
A626	Clinical Immunology - Office/Clinic - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
A628	Clinical Immunology - Partial assessment	A	Fee Increase	$24.65	$25.15	$29.05					$30.10	$30.60
A635	Nuclear Medicine - Office/Clinic - consultaton	A	Fee Increase	$64.40	$65.70							$71.30
A636	Nuclear Medicine - Office/Clinic - repeat consultaton	A	Fee increase	$44.20	$45.10							$49.55
A638	Nuclear Medicine - Partial Assessment	A	Fee Increase	$24.95	$25.45	$29.05					$30.10	$30.60
A644	General Thoracic Surgery - Partial Assessment	A	Fee Increase	$20.50	$20.90			$22.45				
A645	General Thoracic Surgery - Consultation	A	Fee Increase	$75.00	$76.50	$81.60						$86.60
A655	Haematology - Office/Clinic - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
A661	Pediatrics - Office/Clinic - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
A667	Pediatrics - Neurodevelopment Consultation	A	Fee Increase	$224.65	$229.15	$255.00						$271.60
A675	Cardiology - Office/Clinic - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
A695	Neurodevelopment - Consultation	A	Fee Increase	$224.65	$229.15	$255.00						$271.60
A735	Nuclear Medicine - Diagnostic consultation	A	Fee increase	$28.50	$29.20							
A775	Geriatrics - Comprehensive Geriatric Consultation	A	Fee Increase	$155.00	$158.10	$183.60						$195.55
A795	Psychiatry - Geriatric Consultation	A	Fee Increase	$168.40	$171.75	$183.60						$195.55
A935	Special Surgical Consultation	A	Fee Increase	$112.35	$114.60	$127.50						$132.50
C025	Dermatology - Consultation - Non-Emergency Hospital In-Patient Services	A	Fee Increase	$53.45	$54.50	$59.15						$66.15
C035	General Surgery - Consultation - Non-Emergency Hospital In-Patient Services	A	Fee Increase	$75.00	$76.50	$81.60						$86.60
C045	Neurosurgery - Consultation - Non-Emergency Hospital In-Patient Services	A	Fee Increase	$100.00	$102.00							$107.00

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
C055	Community Medicine - Consultation - Non-Emergency Hospital In-Patient Services	A	Fee increase	$73.85	$75.35							$82.90
C065	Orthopaedic Surgery - Consultation - Hospital In-Patient Service	A	Fee Increase	$61.15	$62.35	$66.30						$71.30
C071	Geriatrics - Non-Emergency Hospital In-Patient Services - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
C073	Geriatrics - Non-Emergency Hospital In-Patient Services - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
C074	Geriatrics - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
C075	Geriatrics - Consultation - Non-Emergency Hospital In Patient Services	A	Fee Increase	$125.00	$127.50	$142.80						$147.80
C076	Geriatrics - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
C085	Plastic Surgery - Consultation - Non Emergency Hospital In-Patient Services	A	Fee Increase	$55.95	$57.05	$66.30						$71.30
C095	Cardiovascular and Thoracic Surgery - Consultation - Non-Emergency Hospital In-Patient Services	A	Fee Increase	$75.00	$76.50	$81.60						$86.60
C131	Internal Medicine - Non-Emergency Hospital In-Patient Services - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
C133	Internal Medicine - Non-Emergency Hospital In-Patient Services - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
C134	Internal Medicine - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
C135	Internal Medicine - Non-Emergency Hospital In-Patient Services - Consultation	A	Fee Increase	$125.00	$127.50							$132.50
C136	Internal Medicine - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
C181	Neurology - Non-Emergency Hospital In-Patient Services - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
C183	Neurology - Non-Emergency Hospital In-Patient Services - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
C184	Neurology - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
C185	Neurology - Non-Emergency Hospital In-Patient Services - Consultation	A	Fee Increase	$125.00	$127.50							$147.80
C186	Neurology - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
C194	Psychiatry - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
C196	Psychiatry - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90

Appendix L

(Fee codes not included in Appendix L are eligible for across-the-board increase as set out in Agreement)

Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
C205	Obstetrics and Gynecology - Consultation - Non-Emergency Hospital In-Patient Services	A	Fee Increase	$75.00	$76.50	$81.60						$86.60
C225	Genetics - Consultation - Non Emergency Hospital In-Patient Services	A	Fee Increase	$125.00	$127.50	$142.80						$147.80
C226	Genetics - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
C235	Ophthalmology - Consultation - Non-Emergency Hospital In-Patient Services	A	Fee Increase	$58.25	$59.40	$66.30						$71.30
C245	Otolaryngology - Consultation - Non-Emergency Hospital In-Patient Services	A	Fee Increase	$56.15	$57.25	$66.30						$71.30
C263	Pediatrics - Non-Emergency Hospital In-Patient Services - Medical specific assessment	A	Fee increase	$53.15	$54.20	$58.25						$64.05
C264	Pediatrics - Medical specific re-assessment	A	Fee Increase	$34.65	$35.35	$45.90						$50.50
C265	Pediatrics - Consultation - Non Emergency Hospital In Patient Services	A	Fee Increase	$135.00	$137.70	$142.80						$147.80
C266	Pediatrics - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
C283	Laboratory Medicine - Non-Emergency Hospital In-Patient Services - Medical specific assessment	A	Fee increase	$49.50	$50.50							$55.55
C285	Laboratory Medicine - Non-Emergency Hospital In-Patient Services - Consultation	A	Fee Increase	$95.05	$96.95							$102.00
C286	Laboratory Medicine - Non-Emergency Hospital In-Patient Services - Limited consultation	A	Fee increase	$63.45	$64.70							$71.20
C288	Laboratory Medicne - CONCURRENT CARE	A33	Fee Increase	$23.00	$23.60	$29.20						
C311	'Physical Medicine and Rehab - Non-Emergency Hospital In-Patient Services - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
C313	Physical Medicine and Rehabilitation - Non-Emergency Hospital In-Patient Services - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
C314	Physical Medicine and Rehabilitation - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
C315	Physical Medicine and Rehabilitation - Consultation - Non Emergency Hospital In-Patient Services	A	Fee Increase	$125.00	$127.50			$142.80				$147.80
C316	Physical Medicine and Rehabilitation - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
C325	Genetics - Non-Emergency Hospital In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
C335	Diagnostic Radiology - Non-Emergency Hospital In-Patient Services - Consultation	A	fee Increase	$29.65	$30.25							$35.70

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
C341	Radiation Oncology - Non-Emergency Hospital In-Patient Services - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
C343	Radiation Oncology - Non-Emergency Hospital In-Patient Services - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
C344	Radiation Oncology - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
C345	Radiation Oncology - Consultation - Non-Emergency Hospital In-Patient Services	A	Fee Increase	$112.35	$114.60	$127.50						$132.50
C346	Radiation Oncology - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
C355	Urology - Consultation - Non-Emergency Hospital In-Patient Services	A	Fee Increase	$60.95	$62.15	$66.30						$71.30
C375	Geriatrics - Non-Emergency Hospital In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
C385	Neurology - Non-Emergency Hospital In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
C395	Psychiatry - Non-Emergency Hospital In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
C411	Gastroenterology - Non-Emergency Hospital In-Patient Services - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
C413	Gastroenterology - Non-Emergency Hospital In-Patient Services - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
C414	Gastroenterology - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
C415	Gastroenterology - Non-Emergency Hospital In-Patient Services - Consultation	A	Fee Increase	$125.00	$127.50							$132.50
C416	Gastroenterology - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
C435	Internal Medicine - Non-Emergency Hospital In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
C471	Respiratory Disease - Non-Emergency Hospital In-Patient Services - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
C473	Respiratory Disease - Non-Emergency Hospital In-Patient Services - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
C474	Respiratory Disease - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
C475	Respiratory Disease - Non-Emergency Hospital In-Patient Services - Consultation	A	Fee Increase	$125.00	$127.50							$132.50
C476	Respiratory Disease - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90

Appendix L

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
C481	Rheumatology - Non-Emergency Hospital In-Patient Services - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
C483	Rheumatology - Non-Emergency Hospital In-Patient Services - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
C484	Rheumatology - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
C485	Rheumatology - Non-Emergency Hospital In-Patient Services - Consultation	A	Fee Increase	$125.00	$127.50							$132.50
C486	Rheumatology - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
C515	Physical Medicine and Rehabilitation - Non-Emergency Hospital In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
C525	Clinical Immunology - Non-Emergency Hospital In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
C545	Gastroenterology - Non-Emergency Hospital In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
C565	Pediatrics - Non-Emergency Hospital In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
C575	Respiratory Disease - Non-Emergency Hospital In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
C595	Rheumatology - Non-Emergency Hospital In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
C601	Cardiology - Non-Emergency Hospital In-Patient Services - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
C603	Cardiology - Non-Emergency Hospital In-Patient Services - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
C604	Cardiology - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
C605	Cardiology - Non-Emergency Hospital In-Patient Services - Consultation	A	Fee Increase	$125.00	$127.50							$132.50
C606	Cardiology - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
C611	Hematology - Non-Emergency Hospital In-Patient Services - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
C613	Haematology - Non-Emergency Hospital In-Patient Services - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
C614	Haematology - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
C615	Hematology - Non-Emergency Hospital In-Patient Services - Consultation	A	Fee Increase	$125.00	$127.50							$132.50
C616	Haematology - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90

Appendix L

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
C621	Clinical Immunology - Non-Emergency Hospital In-Patient Services - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
C623	Clinical Immunology - Non-Emergency Hospital In-Patient Services - Medical specific assessment	A	Fee increase	$57.10	$58.25							$64.05
C624	Clinical Immunology - Medical specific re-assessment	A	Fee Increase	$41.15	$41.95	$45.90						$50.50
C625	Clinical Immunology - Non-Emergency Hospital In-Patient Services - Consultation	A	Fee Increase	$125.00	$127.50							$132.50
C626	Clinical Immunology - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
C635	Nuclear Medicine - Non-Emergency Hospital In-Patient Services - consultation	A	fee Increase	$64.40	$65.70							$71.30
C636	Nuclear Medicine - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	fee increase	$44.20	$45.10							$49.55
C645	General Thoracic Surgery - Consultation - Non-Emergency Hospital In-Patient Services	A	Fee Increase	$75.00	$76.50	$81.60						$86.60
C655	Haematology - Non-Emergency Hospital In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
C661	Pediatrics - Non-Emergency Hospital In-Patient Services - Complex medical specific re-assessment	A	Fee increase	$52.10	$53.15							$58.45
C667	Pediatrics - Neurodevelopmental - Consultation - Non-Emergency Hospital In-Patient Services	A	Fee Increase	$224.65	$229.15	$255.00						$271.60
C675	Cardiology - Non-Emergency Hospital In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
C695	Neurodevelopment - Consultation - Non-Emergency Hospital In-Patient Services	A	Fee Increase	$224.65	$229.15	$255.00						$271.60
C735	Nuclear Medicine - Diagnostic consultation - Non-Emergency Hospital In-Patient Services	A	Fee increase	$28.50	$29.20							
C775	Geriatrics - Comprehensive Geriatric Consultation - Non-Emergency Hospital In-Patient Services	A	Fee Increase	$155.00	$158.10	$183.60						$195.55
C795	Psychiatry - Geriatric Consultation - Non-Emergency Hospital In-Patient Services	A	Fee Increase	$168.40	$171.75	$183.60						$195.55
C935	Special Surgical Consultation - Non Emergency Hospital In-Patient Services	A	Fee Increase	$112.35	$114.60	$127.50						$132.50

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
E Add-on	Medical Specific Assessment, Medical Specific Re-Assessment, Complex Medical Specific Re-Assessment and Partial Assessment (Restricted to Specialty 07, 13, 18, 26, 28, 31, 34, 41, 47, 48, 60, 61, 62 and restricted to specified Diagnostic Codes 402, 428, 714, 720, 710, 250, 585, 491, 492, 493, 286, 287, 555, 556, 571, 345, 332, 340, 290, 042, 043, 044, 343, 515, 758 and new code for other seronegative spondyloarthropathies)	GP	New code			add 30%					add 40%	add 50%
E Add-on	Pediatrics Premium For Age Group - 0 - <30 days	GP, M	New code					add 30%				
E Add-on	Pediatrics Premium For Age Group - 30 days - <1yr	GP, M	New code					add 25%				
E Add-on	Pediatrics Premium For Age Group - 1yr - <2yr	GP, M	New code					add 20%				
E Add-on	Pediatrics Premium For Age Group - 2yr - <5yr	GP, M	New code					add 15%				
E Add-on	Pediatrics Premium For Age Group - 5yr - <16yr	GP, M	New code					add 10%				
E076	Internal Medicine - add-on for consultation with special visit to hospital	A	Delete	$12.65	$12.90	x						
E502	Obstetrics - VBAC	K	Fee Increase	$28.50	$29.05	$51.00						
E555	MUSCULOSKELETAL - GENERAL FEES - Fixation - Rigid external fixation (excluding casts) for closed reduction	N	Fee Increase	add 40%		add 50%						
E556	MUSCULOSKELETAL - GENERAL FEES - Wound Care - Extensive debridement of compound fractures or dislocations	N	Fee Increase	add 40%		add 50%						
E569	MUSCULOSKELETAL - GENERAL FEES - Fixation - Percutaneous pinning	N	Fee Increase	add 30%		add 50%						
E580	Musculoskeletal - Hand & Wrist - Reconstruction - Tendon repair - Extensor - each additional	N	Fee Increase	$46.35	$47.30	$70.95						
E581	Musculoskeletal - Hand & Wrist - Reconstruction - Tendon repair - Flexor - each additional	N	Fee Increase	$84.25	$85.95	$128.95						
F007	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Phalanx - open	N	Fee Increase	$187.55	$191.30	$248.70						
F010	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Intra-articular - open	N	Fee Increase	$211.05	$215.25	$279.85						
F011	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Metacarpal - open	N	Fee Increase	$165.05	$168.35	$218.85						
F015	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Bennett's - open	N	Fee Increase	$211.05	$215.25	$279.85						

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
F017	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Carpus - open	N	Fee Increase	$217.45	$221.80	$288.45						
F019	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Scaphoid - open	N	Fee Increase	$237.50	$242.25	$314.95						
F021	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Osteochondral - open	N	Fee Increase	$246.60	$251.55	$327.00						
F030	Musculoskeletal - Hand & Wrist - Reduction - Fractures - Radius - Distal - open	N	Fee Increase	$212.05	$216.30	$281.15						
G378	Diagnostic and Therapeutic Procedures - Gynecology - Insertion of intrauterine contraceptive device	J	Fee Increase	$21.00	$21.40			$25.50				
G478	Diagnostic and Therapeutic Procedures - Psychiatry - Electroconvulsive Therapy (ECT) cerebral - single or multiple - in-patient	J	Revision	$54.15	$55.25	$62.20						$66.25
G479	Diagnostic and Therapeutic Procedures - Psychiatry - Electroconvulsive Therapy (ECT) cerebral - single or multiple - out-patient	J	Fee Increase	$59.80	$61.00	$65.25						$75.70
H262	Pediatrics - Low birthweight newborn initial visit	A	Fee increase	$54.10	$55.45	$58.20				$61.00		
H263	Pediatrics - Non-Emergency Hospital In-Patient Services - Low birthweight newborn - subsequent viisit	A	Fee increase	$17.30	$17.75							
H312	Physical Medicine - Team Management, first twelve weeks	A	Fee Increase	$18.25	$18.60	$29.20						
H313	Physical Medicine & Rehab - Rehabilitation counselling	A	Fee increase	$50.45	$51.71							
H317	Physical Medicine - Team Management - thirteen to twenty six weeks	A	Fee Increase	$18.25	$18.60	$29.20						
H319	Physical Medicine - Team Management, twenty seventh week onwards	A	Fee Increase	$18.25	$18.60	$29.20						
J663B	Implement technical fee for scintimammography	B	New Code			$102.50						
J863B	Implement technical fee for scintimammography	B	New Code			$102.50						
K - Fee code	MTO form	A	New code				$34.85					
K - Fee code	Northern Health Travel Grant form	A	New code				$10.25					
K044	Genetics - Genetic family counselling	A	Fee increase	$50.45	$51.70							
K190	Psychiatry - Individual -psychotherapy in-patient	A	Fee Increase	$56.40	$57.55	$65.25						$68.80
K191	Psychiatry - Family psychiatric care, in-patient, per ½ hour or major part thereof	A	Fee Increase	$63.95	$65.25							$68.80
K192	Psychiatry - Hypnotherapy - individual	A	Fee Increase	$54.15	$55.25	$62.20						$65.65
K193	Psychiatry -Family psychotherapy - in-patients (two or more family members) per ½ hour or major part thereof	A	Fee Increase	$63.95	$65.25							$68.80

Appendix L

(Fee codes not included in Appendix L are eligible for across-the-board increase as set out in Agreement)

Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
K194	Psychiatry - Hypnotherapy - Group - for induction and training for hypnosis (up to eight people) per ½ hour or major part thereof - per member	A	Fee Increase	$11.10	$11.30							$11.95
K195	Psychiatry - Family psychotherapy - out-patients (two or more family members) per ½ hour or major part thereof	A	Fee Increase	$63.95	$65.25							$68.80
K196	Psychiatry - Family psychiatric care, out-patient, per ½ hour or major part thereof	A	Fee Increase	$63.95	$65.25							$68.80
K197	Psychiatry - Individual -psychotherapy out-patient	A	Fee Increase	$58.40	$59.55	$62.20						$65.65
K198	Psychiatry - Psychiatric Care - out-patient	A	Fee Increase	$58.40	$59.55	$62.20						$65.65
K199	Psychiatry - Psychiatric Care - in-patient	A	Fee Increase	$62.60	$63.85	$65.25						$75.70
K200	Psychiatry - Group psychotherapy, 4 people	A	Fee Increase	$13.95	$14.25	$15.30						$16.15
K201	Psychiatry - Group psychotherapy, 5 people	A	Fee Increase	$11.60	$11.85	$12.25						$12.90
K202	Psychiatry - Group psychotherapy, 6-12 people	A	Fee Increase	$9.85	$10.05	$10.20						$10.75
K203	Psychiatry - Group psychotherapy, 4 people	A	Fee Increase	$13.95	$14.25	$15.30						$16.15
K204	Psychiatry - Group psychotherapy, 5 people	A	Fee Increase	$11.60	$11.85	$12.25						$12.90
K205	Psychiatry - Group psychotherapy, 6-12 people	A	Fee Increase	$9.85	$10.05	$10.20						$10.75
K206	Psychiatry - Group psychotherapy, additional	A	Fee Increase	$9.15	$9.35	$9.70						$10.20
K207	Psychiatry - Group psychotherapy, additional	A	Fee Increase	$9.15	$9.35	$9.70						$10.20
K222	Genetics - Genetic care	A	Fee increase	$59.55	$61.05							
K267	Pediatrics - Annual Health Examination - child after second birthday	A	Fee increase	$29.65	$30.40							
K269	Pediatrics - Annual Health Examination - adolescent	A	Fee increase	$54.10	$55.45	$58.20				$61.00		
K313	Physical Medicine - Physiatric Management	A	Fee Increase	$3.35	$3.40	$6.10						
K620	Psychiatry - Assessments under the Mental Health Act - Consultation for involuntary psychiatric treatment (as mandated by Section 35a (2) of the Mental Health Act) - per ½ hour or major part thereof	A	Fee Increase	$56.05	$57.15	$65.25						$69.45
M138	Respiratory - Lungs and Pleaura - Excision - Hilar lymph node or lung biospy - with limited thoracotomy	P	Fee Increase	$402.80	$410.85	$534.10						
M142	Respiratory - Lungs and Pleaura - Excision - Pneumonectomy with or without radical mediastinal node dissection or pericardial resection	P	Fee Increase	$932.45	$951.10	$1,236.45						

Appendix L

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
M143	Respiratory - Lungs and Pleaura - Excision - Lobectomy with or without radical mediastinal node dessection	P	Fee Increase	$932.45	$951.10	$1,236.45						
M144	Respiratory - Lungs and Pleaura - Excision - Segmental resection, including segmental bronchus and artery	P	Fee Increase	$932.45	$951.10	$1,236.45						
M145	Respiratory - Lungs and Pleaura - Excision - Wedge resection of lung	P	Fee Increase	$421.90	$430.35	$559.40						
P003	Obstetrics - Prenatal general assessment	K	Fee increase	$54.10	$55.45	$58.20				$61.00		
P004	Obstetrics - Prenatal Care - Minor prenatal assessment	K	Fee Increase	$19.90	$20.40	$22.45				$29.20		$31.95
P005	Obstetrics - Antenatal preventative health assessment	K	Fee Increase	$40.65	$41.65							
P006	Obstetrics - vaginal delivery	K	Fee Increase	$338.95	$345.75	$395.75					$445.75	
P008	Postnatal assessment	K	Fee increase	$27.30	$29.20	$29.70	$30.20		$30.95		$31.45	$31.95
P009	Obstetrics - attendance at labour and delivery when assists, gives anesthetic or resuscitates newborn	K	Fee Increase	$338.95	$345.75	$395.75					$445.75	
P010	Obstetrics - attendance of obstetrical consultant at delivery	K	Fee Increase	$109.00	$111.20	$161.20					$211.20	
P018	Obstetrics - Cesarean section	K	Fee Increase	$406.70	$414.85	$464.85					$514.85	
P020	Obstetrics - operative delivery, rotation or assisted breech	K	Fee Increase	$369.75	$377.15	$427.15					$477.15	
P038	Obstetrics - attendance at labour when patient transferred	K	Fee Increase	$109.00	$111.20	$161.20					$211.20	
P041	Obstetrics - Cesarean section including tubal interruption	K	Fee Increase	$431.30	$439.95	$489.95					$539.95	
P042	Obstetrics - Cesarean section including hysterectomy	K	Fee Increase	$621.90	$634.35	$684.35					$734.35	
R534	Musculoskeletal - Hand & Wrist - Incision and Drainage - Tendon sheath	N	Fee Increase	$144.70	$147.60	$191.85						
R548	Musculoskeletal - Hand & Wrist - Reconstruction - Ligaments - Extensive/multiple repair - wrist	N	Fee Increase	$385.70	$393.40	$511.45						
R578	Musculoskeletal - Hand & Wrist - Reconstruction - Tendon repair - Extensor - single	N	Fee Increase	$123.75	$126.25	$164.10						
R585	Musculoskeletal - Hand & Wrist - Reconstruction - Tendon repair - Flexor - single	N	Fee Increase	$231.95	$236.60	$307.60						
R597	Musculoskeletal - Hand & Wrist - Reconstruction - Ligaments - Simple/singe repair - wrist	N	Fee Increase	$227.45	$232.00	$301.60						

Appendix L

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
R601	Musculoskeletal - Hand & Wrist - Reconstruction - Ligaments - Metacarpal phalangeal repair	N	Fee Increase	$238.90	$243.70	$316.75						
R629	Musculoskeletal - Hand & Wrist - Amputation - Revision of amputated finger tip	N	Fee Increase	$182.15	$185.80	$241.55						
S162	Digestive System - Intestines - Excision - Local excision of lesion of intestine	S	Fee Increase	$398.85	$406.85	$528.85						
S164	Digestive System - Intestines - Excision - Small intestine - duodenum	S	Fee Increase	$562.65	$573.90	$746.10						
S165	Digestive System - Intestines - Excision - Small intestine - Resection with anastomosis - other	S	Fee Increase	$518.50	$528.85	$687.55						
S166	Digestive System - Intestines - Excision - Small and large intestine terminal ileu, cecum and ascending colon (right hemicolectomy)	S	Fee Increase	$602.95	$615.00	$799.55						
S167	Digestive System - Intestines - Excision - Large intestine - any portion	S	Fee Increase	$602.95	$615.00	$799.55						
S168	Digestive System - Intestines - Excision - Ileostomy, subtotal colectomy	S	Fee Increase	$797.65	$813.60	$1,057.70						
S169	Digestive System - Intestines - Excision - Total coletomy with ileo-rectal anastomosis	S	Fee Increase	$937.35	$956.10	$1,242.90						
S170	Digestive System - Intestines - Excision - Ileostomy, subtotal colectomy	S	Fee Increase	$1,125.30	$1,147.80	$1,492.15						
S171	Digestive System - Intestines - Excision - Left hemicolectomy with anterior resection or proctosigmoidectomy)anastomosis below peritoneal reflection & mobilization of splenic flexure)	S	Fee Increase	$816.70	$833.05	$1,082.95						
S172	Digestive System - Intestines - Excision - Total colectomy with mucosal proctectomy with ileal pouch, ileoanal anastomosis and loop ileostomy	S	Fee Increase	$1,695.10	$1,729.00	$2,247.70						
S411	Urogenital and Urinary System - Kidney and Perinephrum - Excision - Partial or heminephrectomy	T	Fee Increase	$526.35	$536.90	$697.95						
S416	Urogenital and Urinary System - Kidney and Perinephrum - Excision - Nephrectomy - thoraco - abdominal or radical nephrectomy	T	Fee Increase	$659.90	$673.10	$875.00						
S423	Urogenital and Urinary System - Kidney and Perinephrum - Excision - Partial or heminephrectomy with total ureterectomy	T	Fee Increase	$571.55	$583.00	$757.85						
S645	Male Genital - Prostate - Excision - Prostatectomy (not to include investigate cystoscopy) and may include vasectomy Perineal	U	Fee Increase	$433.35	$442.00	$574.60						

Appendix L

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
S646	Male Genital - Prostate - Excision - Prostatectomy (not to include investigate cystoscopy) and may include vasectomy - Perineal with vesiculectomy	U	Fee Increase	$659.90	$673.10	$875.00						
S647	Male Genital - Prostate - Excision - Suprapubic - with or without removal of bladder stones - one stage	U	Fee Increase	$453.05	$462.10	$600.75						
S648	Male Genital - Prostate - Excision - Suprapubic - with or without removal of bladder stones - two stage, 1st stage	U	Fee Increase	$211.55	$215.80	$280.50						
S649	Male Genital - Prostate - Excision -Suprapubic - with or without removal of bladder stones - two stages - 2nd stage	U	Fee Increase	$255.75	$260.85	$339.15						
S650	Male Genital - Prostate - Excision - Retropubic - with or without removal of bladder stones - radical	U	Fee Increase	$453.05	$462.10	$600.75						
S651	Male Genital - Prostate - Excision - Retropubic - with or without removal of bladder stones - simple	U	Fee Increase	$760.45	$775.65	$1,008.35						
S652	Male Genital - Prostate - Excision - Staging pelvic lymphadenectomy for prostatic cancer	U	Fee Increase	$325.20	$331.70	$431.20						
S653	Male Genital - Prostate - Excision - Laproscopic radical prostatectomy	U	Fee Increase	$1,064.60	$1,085.90	$1,411.70						
S654	Male Genital - Prostate - Endoscopy - Transurethral resection of prostate for residual or regrowth of tissue within one year of previous prostatectomy by same surgeon	U	Fee Increase	$310.10	$316.30	$411.20						
S776	Femaie Genital - Corpus Uteri - Incision or Excision - Staging pelvic node lymphadenectomy for carcinoma	V	Fee Increase	$325.05	$331.55	$431.20						
S781	Femaie Genital - Corpus Uteri - Incision or Excision - Para-aortic lymph node dissection	V	Fee Increase	$325.05	$331.55	$431.20						
W025	Dermatology - Consultation - Non-Emergency Long-Term Care In-Patient Services	A	Fee Increase	$53.45	$54.50	$59.15						$66.15
W035	General Surgery - Consultation - Non-Emergency Long-Term Care In-Patient Services	A	Fee Increase	$59.55	$60.75	$81.60						$86.60
W045	Neurosurgery - Consultation - Non-Emergency Long-Term Care In-Patient Services	A	Fee Increase	$89.70	$91.50	$102.00						$107.00
W065	Orthopaedic Surgery - Consultation - Non-Emergency Long-Term Care In-Patient Service	A	Fee Increase	$56.15	$57.25	$66.30						$71.30
W074	Geriatrics - Non-Emergency Long-Term Care In-Patient Services - General re-assessment	A	Fee increase	$17.30	$17.75							
W075	Geriatrics - Consultation - Non-Emergency Long-Term Care In-Patient Service	A	Fee Increase	$112.35	$114.60	$142.80						$147.80

Appendix L

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
W076	Geriatrics - Non-Emergency Long-Term Care In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
W085	Plastic Surgery - Consultation - Non-Emergency Long Term Care In-Patient Service	A	Fee Increase	$55.95	$57.05	$66.30						$71.30
W095	Cardiovascular & Thoracic Surgery - Consultation - Non-Emergency Long-Term Care In-Patient Service	A	Fee Increase	$59.55	$60.75	$66.30						$71.30
W134	Internal Medicine - Non-Emergency Long-Term Care In-Patient Services - General re-assessment	A	Fee increase	$17.30	$17.75							
W184	Neurology - Non-Emergency Long-Term Care In-Patient Services - General re-assessment	A	Fee increase	$17.30	$17.75							
W185	Neurology - Consultation - Non-Emergency Long-Term Care In-Patient Service	A	Fee Increase	$112.35	$114.60	$127.50						$147.80
W186	Neurology - Non-Emergency Long-Term Care In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
W196	Psychiatry - Non-Emergency Long-Term Care In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
W225	Genetics - Consultation - Non-Emergency Long-Term Care In-Patient Service	A	Fee Increase	$112.35	$114.60	$142.80						$147.80
W226	Genetics - Non-Emergency Long-Term Care In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
W232	Internal Medicine - Type 1 Admission assessment, Long-term care facility	A	Fee increase	$54.10	$55.45	$58.20				$61.00		
W234	Internal Medicine - Non-Emergency Long-Term Care In-Patient Services - Admission assessment - Type 2	A	Fee increase	$17.30	$17.75							
W235	Internal Medicine - Consultation - Non-Emergency Long-Term Care In-Patient Service	A	Fee Increase	$112.35	$114.60	$127.50						$132.50
W236	Internal Medicine - Non-Emergency Long-Term Care In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
W237	Internal Medicine - Non-Emergency Long-Term Care In-Patient Services - Admission assessment - Type 3	A	Fee increase	$28.70	$30.70							
W239	Internal Medicine - Annual Physical Examination, Long-term care facility	A	Fee increase	$54.10	$55.45	$58.20				$61.00		
W265	Pediatrics - Consultation - Non-Emergency Long-Term Care In-Patient Service	A	Fee Increase	$112.35	$114.60	$142.80						$147.80
W266	Pediatrics - Non-Emergency Long-Term Care In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
W269	Pediatrics - Non-Emergency Long-Term Care In-Patient Services - Annual physical examination	A	Fee increase	$29.65	$30.70							
W272	Geriatrics - Type 1 Admission assessment, Long-term care facility	A	Fee increase	$54.10	$55.45	$58.20				$61.00		

Appendix L

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
W274	Geriatrics - Non-Emergency Long-Term Care In-Patient Services - Admission assessment - Type 2	A	Fee increase	$17.30	$17.75							
W277	Geriatricss - Non-Emergency Long-Term Care In-Patient Services - Admission assessment - Type 3	A	Fee increase	$28.70	$30.70							
W279	Geriatrics - Annual Physical Examination, Long-term care facility	A	Fee increase	$54.10	$55.45	$58.20				$61.00		
W305	Obstetrics and Gynecology - Consultation - Non-Emergency Long-Term Care In-Patient Services	A	Fee Increase	$57.30	$58.45	$81.60						$86.60
W310	Physical Medicine and Rehabilitation - Non-Emergency Long-Term Care In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
W314	Physical Medicine & Rehab - Non-Emergency Long-Term Care In-Patient Services - General re-assessment	A	Fee increase	$17.30	$17.75							
W325	Genetics - Non-Emergency Long-Term Care In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
W345	Otolaryngology - Consultation - Non-Emergency Long Term Care In-Patient Service	A	Fee Increase	$56.15	$57.25	$66.30						$71.30
W355	Urology - Consultation - Non-Emergency Long-Term Care In-Patient Service	A	Fee Increase	$55.95	$57.05	$66.30						$71.30
W375	Geriatrics - Non-Emergency Long-Term Care In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
W385	Neurology - Non-Emergency Long-Term Care In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
W395	Psychiatry - Non-Emergency Long-Term Care In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
W395	Psychiatry - Non-Emergency Long-Term Care In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
W419	Physical Medicine and Rehab. - Annual Physical Examination, Long-term care facility	A	Fee increase	$54.10	$55.45	$58.20				$61.00		
W435	Internal Medicine - Non-Emergency Long-Term Care In-Patient Services - Limited consultation	A	Fee increase	$73.85	$75.35							$82.90
W512	Physical Medicine and Rehab. - Type 1 Admission assessment, Long-term care facility	A	Fee increase	$54.10	$55.45	$58.20				$61.00		
W514	Physical Medicine & Rehab - Non-Emergency Long-Term Care In-Patient Services - Admission assessment - Type 2	A	Fee increase	$17.30	$17.75							
W515	Physical Medicine and Rehabilitation - Consultation - Non-Emergency Long-Term Care In-Patient Service	A	Fee Increase	$112.35	$114.60	$127.50		$142.80				$147.80

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
W516	Physical Medicine and Rehabilitation - Non-Emergency Long-Term Care In-Patient Services - Repeat consultation	A	Fee increase	$73.85	$75.35							$82.90
W517	Physical Medicine & Rehab - Non-Emergency Long-Term Care In-Patient Services - Admission assessment - Type 3	A	Fee increase	$28.70	$30.70							
W535	Ophthalmology - Consultation - Non-Emergency Long Term Care In-Patient Service	A	Fee Increase	$58.25	$59.40	$66.30						$71.30
W562	Pediatrics - Type 1 Admission assessment, Long-term care facility	A	Fee increase	$54.10	$55.45	$58.20				$61.00		
W564	Pediatrics - Non-Emergency Long-Term Care In-Patient Services - Admission assessment - Type 2	A	Fee increase	$17.30	$17.75							
W565	Pediatrics - Non-Emergency Long-Term Care In-Patient Services - Limited consultation	A	Fee Increase	$73.85	$75.35							$82.90
W567	Pediatrics - Non-Emergency Long-Term Care In-Patient Services - Admission assessment - Type 3	A	Fee increase	$28.70	$30.70							
W645	General Thoracic Surgery - Consultation - Non-Emergency Long-Term Care In-Patient Service	A	Fee Increase	$59.85	$61.05	$81.60						$86.60
W667	Pediatrics - Neurodevelopmental Consultation - Non-Emergency Long-Term Care In-Patient Service	A	Fee Increase	$224.65	$229.15	$255.00						$271.60
W695	Neurodevelopment - Consultation - Non-Emergency Long-Term Care In-Patient Service	A	Fee Increase	$224.65	$229.15	$255.00						$271.60
W775	Geriatrics - Comprehensive GeriatricConsultation - Non-Emergency Long-Term Care In-Patient Services	A	Fee Increase	$155.00	$158.10	$183.60						$195.55
W795	Psychiatry - Geriatric Consultation - Non-Emergency Long-Term Care In-Patient Service	A	Fee Increase	$168.40	$171.75	$183.60						$195.55
XXXB	Surgical assist base units	All	Fee Increase					Increase minimum base units to 5				Increase minimum base units to 6
XXXB	Surgical Assistant unit fee	All	Fee Increase	$10.20	$10.40							$11.40
XXXC	Anesthesia base units	All	Fee Increase			Increase minimum base units to 5					Increase minimum base units to 6	
XXXC	Anesthesia unit fee	All	Fee Increase	$11.77	$12.01			$12.51				$13.24
Z730	Female Genital - Cervix Uteri - Endoscopy - follow up to colposcopy	V	Fee Increase	$8.40	$8.55			$25.50				
Z776	Obstetrics - High Rick Pregnancies - Fetal blood sampling	K	Fee Increase	$33.15	$33.80			$40.80				

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
Z778	Obstetrics - High Rick Pregnancies - Amniocentesis - diagnostic or genetic	K	Fee Increase	$56.85	$58.00			$102.00				
Z779	Obstetrics - High Rick Pregnancies - Chorionic villus sampling	K	Fee Increase	$91.00	$92.80			$153.00				
	Surgical Preamble revision - to incorporate claims for post-operative visits	M	Revision			Permit claims for first visit in-hospital and first office visit		Permit claims for second visit in-hospital				

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
Part D												
A - Fee Code	Primary Care Emergency Department Assessment	A	New fee code				$76.90					
A001	Family Practice & Practice in General - Office/Clinic - Minor assessment	A	Fee increase	$17.30	$17.75							
A003	Family Practice & Practice in General - General assessment	A	Fee increase	$54.10	$55.45	$58.20				$61.00		
A003	General Assessment - exclude breast, *genital* or rectal as constituent elements of exam	A	Revision	$54.10	$55.45	x						
A004	Family Practice & Practice in General - Office/Clinic - General re-assessment	A	Fee increase	$29.95	$30.70							
A005	Family Practice & Practice in General - Office/Clinic - Consultation	A	Fee increase	$54.75	$56.10							
A006	Family Practice & Practice in General - Office/Clinic - Repeat consultation	A	Fee increase	$41.30	$42.35							
A007	Family Practice & Practice in General - Intermediate assessment	A	Fee increase	$28.50	$29.20	$29.70	$30.20		$30.95		$31.45	$31.95
A008	Family Practice & Practice in General - Office/Clinic - Mini assessment	A	Fee increase	$10.00	$10.25							
A110	Family Practice & Practice in General - Periodic oculo-visual assessment - aged 19 years and below	A	Fee increase	$39.15	$40.15							
A112	Family Practice & Practice in General - Periodic oculo-visual assessment - aged 65 years and above	A	Fee increase	$39.15	$40.15							
A115	Family Practice & Practice in General - Major eye examination - aged 20 to 64 inclusive	A	Fee increase	$41.30	$42.15							
A771	Family Practice & Practice in General - Office/Clinic - Certification of Death	A	Fee increase	$17.30	$17.75							
A777	Family Practice & Practice in General - Pronouncement of death - office	A	Fee increase	$27.30	$28.00	$29.70	$30.20		$30.95		$31.45	$31.95
A813	Family Practice & Practice in General - Office/Clinic - Midwife Requested Assessment (MRA)	A	Fee increase	$57.30	$58.75	$81.60						$86.60
A815	Family Practice & Practice in General - Office/Clinic - Midwife-Requested Special Assessment	A	Fee increase	$112.35	$115.15	$127.50						$132.50
A888	Family Practice & Practice in General - Office/Clinic - Emergency Department Equivalent – partial assessment	A	Fee increase	$27.85	$28.55							
A901	Family Practice & Practice in General - Office/Clinic - Housecall assessment - first patient seen	A	Fee increase	$40.75	$41.75							

Appendix L

(Fee codes not included in Appendix L are eligible for across-the-board increase as set out in Agreement)

Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
A902	Family Practice & Practice in General - Office/Clinic - Housecall Assessment - Pronouncement of death in home	A	Fee increase	$40.75	$41.75							
A903	Family Practice & Practice in General - Pre-operative assessment	A	Fee increase	$54.10	$55.45	$58.20				$61.00		
A905	Family Practice & Practice in General - Office/Clinic - Limited consultation	A	Fee increase	$43.55	$44.65							
A933	Family Practice & Practice in General - Office/Clinic - On-call Admission Assessment	A	Fee increase	$77.25	$79.20							
A945	Family Practice & Practice in General - Special pallative care consultation	A	Fee Increase	$101.15	$103.70	$127.50						$132.50
A945	Family Practice & Practice in General - Special palliative care consultation Revision - Allow K023 after 50 minutes.	A	Revision	$101.15	$103.70	x						
C002	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Subsequent visits - up to five weeks - per visit	A	Fee increase	$23.00	$23.60	$29.20						
C003	Family Practice & Practice in General - General assessment, hospital	A	Fee increase	$54.10	$55.45	$58.20				$61.00		
C004	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - General re-assessment	A	Fee increase	$29.95	$30.70							
C005	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Consultation	A	Fee increase	$54.75	$56.10							
C006	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Repeat consultation	A	Fee increase	$41.30	$42.35							
C007	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Subsequent Visits - 6th-13th wks incl. (max. of 3/wk)	A	Fee increase	$23.00	$23.60	$29.20						
C008	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Concurrent care	A	Fee increase	$23.00	$23.60	$29.20						
C009	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Subsequent Visits - after 13th week (max. of 6/mth)	A	Fee increase	$23.00	$23.60	$29.20						
C010	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Supportive care - per visit	A	Fee increase	$14.95	$15.30	$17.75						
C771	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Certification of death	A	Fee increase	$17.30	$17.75							

Appendix L

(Fee codes not included in Appendix L are eligible for across-the-board increase as set out in Agreement)

Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
C777	Family Practice & Practice in General - Pronouncement of death - hospital	A	Fee increase	$27.30	$28.00	$29.70	$30.20		$30.95		$31.45	$31.95
C813	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Midwife-requested emergency assessment (<50 mins.)	A	Fee increase	$57.30	$58.75	$81.60						$86.60
C815	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Midwife-requested emergency assessment (50-90 mins.)	A	Fee increase	$112.35	$115.15	$127.50						$132.50
C882	Family Practice & Practice in General - Subsequent Visits - Palliative Care	A	Fee Increase	$23.00	$23.60	$29.20						
C882/C982	Pallative Care Assessment - Redefine pallative consistently in the schedule	A	Revision	$23.00	$23.60	x						
C903	Family Practice & Practice in General - Pre-operative assessment, hospital	A	Fee increase	$54.10	$55.45	$58.20				$61.00		
C905	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Limited consultation	A	Fee increase	$48.40	$49.60							
C933	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - On-call Admission Assessment	A	Fee increase	$77.25	$79.20							
C945	Family Practice & Practice in General - Special pallative care consultation - Non-Emergency Hospital In-Patient Service	A	Fee Increase	$101.15	$103.70	$127.50						$132.50
C945	Family Practice & Practice in General - Special palliative care consultation Revision - Allow K023 after 50 minutes.	A	Revision	$101.15	$103.70	x						
E Add-on	Family Practice & Practice in General - 15% premium for A003, C003, W102, W109, A903, C903, W903 for patients aged 70 or older	A	New code			x						
E Add-on	Family Practice & Practice in General - 15% premium for A003, C003, W102, W109, A903, C903, W903 for patients aged 65 or older	A	Revision									x
E Add-on	Family Practice & Practice in General - 15% premium for A007 for patients aged 70 or older	A	New code			x						
E Add-on	Family Practice & Practice in General - 15% premium for A007 for patients aged 65 or older	A	Revision									x
E075	Family Practice & Practice in General - 20% premium for A003, C003, W102, W109, A903, C903, W903 for patients aged 75 or older	A	Delete	Add 20%		x						
E077	Family Practice & Practice in General - Identification of patient for major eye examination	A	Fee increase	$10.00	$10.25							

Appendix L

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
H001	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Newborn care in hospital and/or home	A	Fee increase	$50.95	$52.20							
H001	Newborn Hospital Care - 1) to require only 1 visit for payment purposes; and 2) revise definition of special visit premiums to allow with "routine care" under specific circumstances i.e. facilitating discharge of newborn from hospital outside of physician	A	(2) Revisions	$50.95	$52.20	x						
H002	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Low birth weight baby care (uncomplicated) - initial visit (per baby)	A	Fee increase	$31.95	$32.75							
H003	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Low birth weight baby care (uncomplicated) - subsequent visit	A	Fee increase	$15.85	$16.25							
H007	Family Practice & Practice in General - Non-Emergency Hospital In-Patient Services - Attendance at maternal delivery for care of high risk baby(s) - (if only service rendered at time of delivery)	A	Fee increase	$60.15	$61.65							
H055	Emergency Medicine - Consultation	A	Fee increase	$80.75	$82.75	$84.40	$86.10					
H065	Family Practice & Practice in General - Emergency Department - Physician on Duty - Consultation in Emergency Medicine	A	Fee increase	$53.80	$55.15	$56.25	$57.40					
H101	Family Practice & Practice in General - Emergency Department - Physician on Duty - Monday to Friday - Daytime and Evenings (08:00h – 24:00h) - Minor assessment	A	Fee increase	$14.05	$14.40	$14.70	$15.00					
H101	Emergency Department - Physician on Duty - Minor assessment - change weekday end time to 17:00h	A	Revision	$14.05	$14.40	x						
H102	Family Practice & Practice in General - Emergency Department - Physician on Duty - Monday to Friday - Daytime and Evenings (08:00h – 24:00h) - Comprehensive assessment and care	A	Fee increase	$34.65	$35.50	$36.45	$37.20					
H102	Emergency Department - Physician on Duty - Comprehensive assessment - change weekday end time to 17:00h	A	Revision	$34.65	$35.50	x						
H103	Family Practice & Practice in General - Multiple systems assessment, daytime	A	Fee increase	$28.35	$29.05	$29.65	$30.25	$32.25				

Appendix L

(Fee codes not included in Appendix L are eligible for across-the-board increase as set out in Agreement)

Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
H103	Emergency Department - Physician on Duty - Multiple systems assessment - change weekday end time to 17:00h	A	Revision	$28.35	$29.05	x						
H104	Family Practice & Practice in General - Emergency Department - Physician on Duty - Monday to Friday - Daytime and Evenings (08:00h – 24:00h) - Re-assessment	A	Fee increase	$14.05	$14.40	$14.70	$15.00					
H104	Emergency Department - Physician on Duty - Re-assessment - change weekday end time to 17:00h	A	Revision	$14.05	$14.40	x						
H105	Family Practice & Practice in General - Emergency Department - Physician on Duty - In-patient Interim Admission Orders	A	Fee increase	$17.30	$17.75	$18.10	$18.45					
H112	Family Practice & Practice in General - Emergency Department - Physician on Duty - Nights (00:00h - 08:00h) -Premium per patient visit - When any other service is rendered by the physician on duty (and assessments may not be claimed)	A	Fee increase	$14.05	$14.40	$14.70	$15.00					
H113	Family Practice & Practice in General - Emergency Department - Physician on Duty - Daytime and evenings (08:00h - 24:00h) on Saturdays, Sundays or Holidays - Premium per patient visit - When any other service is rendered by the physician on duty (and assessments may not be claimed)	A	Fee increase	$8.30	$8.50	$8.65	$8.80					
H121	Emergency Department - Physician on Duty - Minor assessment	A	Fee Increase	$24.45	$25.05	$25.75	$26.25					
H122	Emergency Department - Physician on Duty - Comprehensive assessment	A	Fee Increase	$60.60	$62.10	$63.80	$65.10					
H123	Family Practice & Practice in General - Multiple systems assessment, nights	A	Fee increase	$49.35	$50.60	$51.90	$52.95	$54.95				
H124	Emergency Department - Physician on Duty - Re-assessment	A	Fee Increase	$24.45	$25.05	$25.75	$26.25					
H131	Family Practice & Practice in General - Emergency Department - Physician on Duty- Evenings (18:00h - 24:00h) - Minor assessment	A	Fee Increase	$15.45	$15.85	$16.15	$16.45					
H131	Emergency Department - Physician on Duty - Minor assessment - change weekday start time to 17:00h	A	Revision	$15.45	$15.85	x						

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
H132	Emergency Department - Physician on Duty - Comprehensive assessment - change weekday start time to 17:00h	A	Revision	$35.15	$36.05	x						
H132	Emergency Department - Physician on Duty - Comprehensive assessment	A	Fee Increase	$35.15	$36.05	$40.10	$40.90					
H133	Family Practice & Practice in General - Multiple systems assessment, evenings	A	Fee increase	$31.10	$31.90	$32.65	$33.30	$35.30				
H133	Emergency Department - Physician on Duty - Multiple systems assessment - change weekday start time to 17:00h	A	Revision	$31.10	$31.90	x						
H134	Family Practice & Practice in General - Emergency Department - Physician on Duty- Evenings (18:00h - 24:00h) - Re-assessment	A		$15.45	$15.85	$16.15	$16.45					
H134	Emergency Department - Physician on Duty - Re-assessment - change weekday start time to 17:00h	A	Revision	$15.45	$15.85	x						
H151	Emergency Department - Physician on Duty - Minor assessment	A	Fee Increase	$20.95	$21.45	$22.05	$22.50					
H152	Emergency Department - Physician on Duty - Comprehensive assessment	A	Fee Increase	$51.95	$53.25	$54.70	$55.80					
H153	Family Practice & Practice in General - Multiple systems assessment, weekends	A	Fee increase	$42.30	$43.35	$44.50	$45.40	$47.40				
H154	Emergency Department - Physician on Duty - Re-assessment	A	Fee Increase	$20.95	$21.45	$22.05	$22.50					
K - fee code	Smoking Cessation Fee	A	New code									$15.40 All GPs
K - fee code	Smoking Cessation Counselling Fee	A	New code									$33.45 All GPs
K - fee code	GP Psychotherapy Premium	A	New code			5%		10%			15%	
K002	Family Practice & Practice in General - Interviews - With relatives or a person who is authorized to make a treatment decision on behalf of the patient in accordance with the Health Care Consent Act, conducted for a purpose other than to obtain consent - per ½ hour or major part thereof	A	Fee Increase	$50.45	$51.70							
K003	Family Practice & Practice in General - Interviews - Interviews with C.A.S. or legal guardian or a person who is authorized to make a treatment decision on behalf of the patient in accordance with the Health Care Consent Act, conducted for a purpose other than to obtain consent, per ½ hour or major part thereof	A	Fee Increase	$50.45	$51.70							

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
K004	Family Practice & Practice in General - Psychotherapy - Family - 2 or more family members in attendance at the same time - per ½ hour or major part thereof	A	Fee Increase	$54.75	$56.10							
K005	Family Practice & Practice in General - Primary Mental Health Care - Individual care - per ½ hour or major part thereof	A	Fee Increase	$50.45	$51.70							
K006	Family Practice & Practice in General - Hypnotherapy - Individual - per ½ hour or major part thereof	A	Fee Increase	$50.45	$51.70							
K007	Family Practice & Practice in General - Psychotherapy - Individual care - per ½ hour or major part thereof	A	Fee Increase	$50.45	$51.70							
K008	Family Practice & Practice in General - Interviews - Diagnostic interview and/or counselling with child and/or parent - for psychological problem or for learning disabilities - per ½ hour or major part thereof	A	Fee Increase	$50.45	$51.70							
K010	Family Practice & Practice in General - Psychotherapy - Group - per ½ hour or major part thereof - per member (seventh hour onward per day to a maximum of six services)	A	Fee Increase	$8.00	$8.20							
K011	Family Practice & Practice in General - Hypnotherapy - Group, for induction and training for hypnosis (up to eight people) - per ½ hour or major part thereof, per member	A	Fee Increase	$8.90	$9.10							
K012	Family Practice & Practice in General - Psychotherapy - Group - per ½ hour or major part thereof - per member (up to six hours per day) - four people	A	Fee Increase	$12.70	$13.00							
K013	Family Practice & Practice in General - Counselling - Individual care - per ½ hour or major part thereof	A	Fee Increase	$50.45	$51.70							
K014	Family Practice & Practice in General - Counselling - Counselling for transplant recipients, donors or families of recipients and donors - one or more persons - per ½ hour or major part thereof	A	Fee Increase	$50.45	$51.70							
K015	Family Practice & Practice in General - Counselling relatives on behalf of catastrophically or terminally ill patient - 1 or more persons - per ½ hour or major part thereof	A	Fee Increase	$50.45	$51.70							

Appendix L

(Fee codes not included in Appendix L are eligible for across-the-board increase as set out in Agreement)

Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
K016	Family Practice & Practice in General - Genetic Assessment - Patient or family direct contact - per ½ hour or major part thereof	A	Fee Increase	$59.55	$61.05							
K017	Family Practice & Practice in General - Annual health examination - child after 2nd birthday	A	Fee Increase	$29.65	$30.40							
K018	Family Practice & Practice in General - Sexual Assault Examination - Sexual Assault Examination for Investigation of Alleged Sexual Assault and Documentation - female	A	Fee Increase	$301.15	$308.70							
K021	Family Practice & Practice in General - Sexual Assault Examination - Sexual Assault Examination for Investigation of Alleged Sexual Assault and Documentation - male	A	Fee Increase	$237.55	$243.50							
K022	Family Practice & Practice in General - HIV Primary Care - Primary care of patients infected with HIV - time-based all-inclusive visit fee per patient per day - per unit (½ hour or major part thereof)	A	Fee Increase	$50.45	$51.70							
K023	Family Practice & Practice in General - Palliative Care Support - Time-based all-inclusive visit fee per patient per day for the purpose of providing pain and symptom management, emotional support and counselling to patients with terminal disease in the final year of life - per unit (½ hour or major part thereof)	A	Fee Increase	$50.45	$51.70							
K024	Family Practice & Practice in General - Psychotherapy - Group - per ½ hour or major part thereof - per member (up to six hours per day) - five people	A	Fee Increase	$10.45	$10.70							
K025	Family Practice & Practice in General - Psychotherapy - Group - per ½ hour or major part thereof - per member (up to six hours per day) - six to twelve people	A	Fee Increase	$8.90	$9.10							
K026	Family Practice & Practice in General - Ontario Hepatitis C Assistance Program (OHCAP) - Certification of Medical Eligibility for OHCAP	A	Fee Increase	$53.35	$54.70							
K027	Family Practice & Practice in General - Ontario Hepatitis C Assistance Program (OHCAP) - Certification of Medical Eligibility for OHCAP – includes only completion of Application for OHCAP – Physician's Form without an associated consultation or visit on the same day	A	Fee Increase	$21.30	$21.85							

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
K028	Family Practice & Practice in General - Genetic Assessment - Sexually Transmitted Disease (STD) Management - per ½ hour or major part thereof	A	Fee Increase	$50.45	$51.70							
K028	Family Practice & Practice in General - Genetic Assessment - Sexually Transmitted Disease (STD) Management - per ½ hour or major part thereof	A	(2) Revisions	$50.45	$51.70	x						
K029	Family Practice & Practice in General - Genetic Assessment - Insulin Therapy Support (ITS) - per ½ hour or major part thereof	A	Fee Increase	$50.45	$51.70							
K030	Family Practice & Practice in General - Diabetic Management Assessment	A	Fee increase	$30.00	$30.75	$34.75	$35.25		$36.00		$36.50	$37.00
K031	Family Practice & Practice in General - Health Protection and Promotion Act - Physician Report Completion of Physician Report in accordance with Section 22.1 of the Health Protection and Promotion Act	A	Fee increase	$100.00	$102.50							
K032	Family Practice & Practice in General - SPECIFIC NEUROCOGNITIVE ASSESSMENT - Diagnosis of Dementia	A	Fee Increase	$50.45	$51.70							
K032	Family Practice & Practice in General - SPECIFIC NEUROCOGNITIVE ASSESSMENT - Diagnosis of Dementia	A	Revision	$50.45	$51.70	x						
K033	Family Practice & Practice in General - Counselling, individual - over 3 services	A	Fee increase	$27.30	$28.00	$29.70	$30.20		$30.95		$31.45	$31.95
K040	Family Practice & Practice in General - Group Counselling - two or more persons - Where no group members have received more than 3 units of any counselling paid under codes K013 and K040 combined per provider per year, per unit	A	Fee Increase	$50.45	$51.70						$55.70	
K041	Family Practice & Practice in General - Counselling, group - over 3 services	A	Fee increase	$27.30	$28.00	$29.70	$30.20		$30.95		$31.45	$31.95
K070	Home Care Application	A	Fee Increase and Revision	$17.00	$17.45							$25.65
K071	Acute Care Supervision	A	Fee Increase and Revision	$10.70	$10.95							$17.75
K072	Chronic Care Supervision	A	Fee Increase and Revision	$10.70	$10.95							$17.75
K399	Family Practice & Practice in General - Allergy - Clinical interpretation by immunologists where a report of a survey is submitted in writing to the patient's physician	A	Fee increase	$28.35	$29.05							

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
K623	Family Practice & Practice in General - Assessments under the Mental Health Act - Application for psychiatric assessment - Form 1	A	Fee increase	$83.55	$85.65							
K624	Family Practice & Practice in General - Assessments under the Mental Health Act - Certification of involuntary admission - Form 3	A	Fee increase	$102.90	$105.45							
K629	Family Practice & Practice in General - Assessments under the Mental Health Act - All other re-certification(s) of involuntary admission including completion of appropriate forms	A	Fee increase	$30.55	$31.30							
K887	Family Practice & Practice in General - Community Treatment Order (CTO) - CTO initiation - including completion of the CTO form and all preceding CTO services directly related to CTO initiation - per unit	A	Fee increase	$59.50	$61.00	$65.55						$69.80
K888	Family Practice & Practice in General - Community Treatment Order (CTO) - CTO supervision - including all associated CTO services except those related to initiation or renewal - per unit	A	Fee increase	$59.50	$61.00	$65.55						$69.80
K889	Family Practice & Practice in General - Community Treatment Order (CTO) - CTO renewal - including completion of the CTO form and all preceding CTO services directly related to CTO renewal - per unit	A	Fee increase	$59.50	$61.00	$65.55						$69.80
W - Fee code	Monthly Management Fee - Long Term Care	A	New fee code				$85.70					
W001	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - Subsequent visits - Chronic care or convalescent hospital - additional subsequent visits per month after 4 (maximum 4 per patient per month)	A	Fee increase	$13.05	$13.40							
W002	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - Subsequent visits - Chronic care or convalescent hospital - first 4 subsequent visits per patient per month	A	Fee increase	$23.00	$23.60	$29.20						

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
W003	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - Nursing home or home for the aged - first 2 subsequent visits per patient per month	A	Fee increase	$22.00	$22.55							
W004	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - General re-assessment of patient in nursing home (as per the Nursing Homes Act)	A	Fee increase	$17.30	$17.75							
W008	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - Nursing home or home for the aged - additional subsequent visits per month after first 2 (max. of 2)	A	Fee increase	$13.05	$13.40							
W102	Family Practice & Practice in General - Type 1 Admission assessment, Long-term care facility	A	Fee increase	$54.10	$55.45	$58.20				$61.00		
W104	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - Admission assessment - Type 2	A	Fee increase	$17.30	$17.75							
W105	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - Consultation	A	Fee increase	$54.75	$56.10							
W106	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - Repeat consultation	A	Fee increase	$41.30	$42.35							
W107	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - Admission assessment - Type 3	A	Fee increase	$29.95	$30.70							
W109	Family Practice & Practice in General - Annual Physical Examination, Long-term care facility	A	Fee increase	$54.10	$55.45	$58.20				$61.00		
W121	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - Intercurrent illness	A	Fee increase	$22.00	$22.55							
W771	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - Certification of death	A	Fee increase	$17.30	$17.75							
W777	Family Practice & Practice in General - Pronouncement of death - long-term care facility	A	Fee increase	$27.30	$28.00	$29.70	$30.20		$30.95		$31.45	$31.95
W872	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - Nursing home or home for the aged - Palliative care	A	Fee increase	$22.00	$22.55	$29.20						

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Fee Code	Fee Code Description	Schedule of Benefits Section	Change	ATB and Targeted Fee Value								
				Existing Fee	April 2004	Oct 2005	April 2006	July 2006	Oct 2006	Jan 2007	April 2007	Jan 2008
W882	Family Practice & Practice in General - Non-Emergency Long-Term Care In-Patient Services - Chronic care or convalescent hospital - Palliative care	A	Fee increase	$23.00	$23.60	$29.20						
W903	Family Practice & Practice in General - Pre-operative assessment, long-term care facility	A	Fee increase	$54.10	$55.45	$58.20				$61.00		

APPENDIX "M"

DATA SHARING

The MOHLTC agrees to provide to the OMA (through the PSC) available data necessary to monitor and evaluate the initiatives and provisions set out in this Agreement. Relevant data sets include those necessary to implement and support: Primary Care Renewal including Family Health Teams; the Academic Health Sciences Centre initiative; the Standardization Committee; Hospital On-Call Payments; the Mental Health Working Group; Diagnostic Services Committee and the Systems Management Committee.

This will include but not be limited to:

i. the OHIP claims data base;
ii. shadow billing data where such are relevant to any AFP;
iii. service encounter reporting data ;
v. all data required to do the calculations required for the allocations anticipated in Appendix G (AHSC AFPs);
v. encrypted ODB Claims Data;
vi. Hospital Encounter Data (CIHI); and
vii. rostering, service and payment data for PCR models.

For this purpose the MOHLTC and the OMA will review and revise their Data Sharing Agreement as necessary. The provision of this information will be subject to compliance with all applicable privacy legislation, including the *Freedom of Information and Protection of Privacy Act* and the *Personal Health Information Protection Act, 2004*, as amended.

APPENDIX "N"

HOSPITAL ON-CALL COVERAGE

A. HOSPITAL ON-CALL COVERAGE PROGRAM – BASE PROGRAM

(1) General Practice Hospital On-Call Coverage

For the purpose of GP hospital on-call coverage, eligible hospitals are all hospitals where the services contained in this Section are provided except federally funded hospitals and alternative funding arrangements where on-call services are included in such arrangements.

General and family practitioners shall be reimbursed for being available to provide after-hours hospital services that may require but are not limited to broad based obstetrical coverage, admission and care of unassigned patients, surgical assisting and in-patient care. The following will be used to determine the amount payable for full coverage per eligible hospital per 12 month period.

This initiative is undertaken to address on-call general practice coverage in Ontario. Coverage less than full coverage shall be prorated on approval by HOCC.

(a) All Hospitals Except Level A, B, 1, 2, or 3 Hospitals (as set out in the Alternative Funding Agreement for Emergency Services)

# of Participating Physicians	Payment Per Hospital
5 or more	$75,000
4	$68,000
3	$60,000
2	$60,000
1	$45,000

(b) Level A, B, 1, 2, or 3 Hospitals (as set out in the Alternative Funding Agreement for Emergency Services)

# of Participating Physicians	Payment Per Hospital
5 or more	$40,000
4	$36,000
3	$33,000
2	$30,000
1	$25,000

(2) Specialist Hospital On-Call Coverage

For the purpose of specialist hospital on-call coverage, eligible hospitals are all hospitals where the services contained in this Section are provided except federally funded hospitals and hospitals and alternative funding arrangements where on-call services are included in such arrangements.

This initiative is being undertaken to address on-call specialist coverage in Ontario. Coverage less than full coverage shall be prorated on approval by HOCC.

(a) Level II Specialists

The Parties agree that funding will be provided for specialists being available to provide oncall hospital services in the specialties of Anesthesia, Cardiac Surgery, Critical Care Medicine, General Surgery, Orthopedic Surgery, Plastic Surgery, Psychiatry, Internal Medicine, Obstetrics and Gynaecology, Paediatrics, Thoracic Surgery, Urology, Neurosurgery, Vascular Surgery, Transplant Services.

The following will be used to determine the amount payable to the eligible hospitals for the full coverage per specialty per 12-month period.

# of Participating Physicians	Payment Per Hospital
5 or more	$75,000
4	$68,000
3	$60,000
2	$60,000
1	$45,000

(b) Level III Specialists

Funding will also be provided to specialists being available to provide on-call hospital services in the specialties of Cardiology, Endocrinology, Gastroenterology, Geriatric Medicine, Haemotology/Oncology, Nephrology, Neurology, Opthalmology, Respiratory Medicine, Diagnostic Radiology, Emergency Medicine, Otolaryngology, Hyperbaric Medicine, and Cardiac Surgical Assistants.

The following will be used to determine the amount payable to eligible hospitals per specialty per 12-month period.

# of Participating Physicians	Payment Per Hospital
5 or more	$15,000
4	$14,000
3	$13,500
2	$12,000
1	$ 8,000

(c) Level IV Specialists

Funding will also be provided to eligible hospitals for specialists being available to provide on-call hospital services in the specialties of Immunology, Dermatology, Physician Medicine and Rehabilitation, Rheumatology, Nuclear Medicine, Radiation Oncology, Interventional Radiology, and Infectious Disease.

Where one of the above specialists, in an eligible hospital, performs a special visit in the evening, night, on weekends or holidays, the physician shall receive, a call-in fee of $100, in addition to any other fee-for-service amounts which may be billed. The physician will be limited to 2 call-in fees per calendar day.

(3) Rurality Premiums

Each hospital with a 2004 OMA Rurality Index score greater than 45 shall receive a $15,000 per annum financial incentive for GP on-call funding. This incentive is in addition to the on-call funding as set out in this Agreement.

(4) GP Anesthesia Premium

This premium is intended to assist in retaining GP anesthetists within rural communities. Each eligible hospital as determined by the HOCC that does not have a Royal College certified anesthetist associated with it and where general practitioners provide a minimum of $10,000 of anesthetist services per year will receive an additional $15,000 per annum. This incentive is in addition to the on-call funding as set out in this Appendix.

(5) Concurrent Additional On-Call Rotas

The Hospital On-Call Coverage Committee (HOCC) will consider funding concurrent, additional on-call rotas in the following specialties: Anesthesia, Obstetrics, Family Medicine, Internal Medicine, and Neonatal Intensive Care. These applications will be reviewed based on existing guidelines and criteria, developed by the HOCC.

B. HOSPITAL ON-CALL COVERAGE PROGRAM – ENHANCED PROGRAM
Effective October 1, 2005

Physicians and Hospitals participating in the Enhanced Hospital On-Call Coverage Program – Enhanced Program must commit to the following:

- No hospital top-ups to any participating physicians for on-call services within the division/clinical service; and
- Hospitals may apply in exceptional circumstances for special consideration by the HOCC

(1) General Practice Hospital On-Call Coverage

For the purpose of GP hospital on-call coverage, eligible hospitals are all hospitals where the services contained in this Section are provided except federally funded hospitals and alternative funding arrangements where on-call services are included in such arrangements.

General and family practitioners shall be reimbursed for being available to provide after-hours hospital services that may require but are not limited to broad based obstetrical coverage, admission and care of unassigned patients, surgical assisting and in-patient care.

The following will be used to determine the amount payable for full coverage per eligible hospital per 12 month period.

This initiative is undertaken to address on-call general practice coverage in Ontario. Coverage less than full coverage shall be prorated on approval by HOCC.

Enhanced Program
Phase 1: October 1, 2005 to March 31, 2007

(a) All Hospitals Except Level A, B, 1, 2, or 3 Hospitals (as set out in the Alternative Funding Agreement for Emergency Services)

# of Participating Physicians	Payment Per Hospital
5 or more	$122,000
4	$110,610
3	$ 97,600
2	$ 97,600
1	$ 73,200

(b) Level A, B, 1, 2, or 3 Hospitals (as set out in the Alternative Funding Agreement for Emergency Services)

# of Participating Physicians	Payment Per Hospital
5 or more	$ 65,065
4	$ 58,560
3	$ 53,680
2	$ 48,800
1	$ 40,665

Phase 2: April 1, 2007 to March 31, 2008

(a) All Hospitals Except Level A, B, 1, 2, or 3 Hospitals (as set out in the Alternative Funding Agreement for Emergency Services)

# of Participating Physicians	Payment Per Hospital
5 or more	$172,000
4	$155,945
3	$137,600
2	$137,600
1	$ 103,200

(b) Level A, B, 1, 2, or 3 Hospitals (as set out in the Alternative Funding Agreement for Emergency Services)

# of Participating Physicians	Payment Per Hospital
5 or more	$91,730
4	$82,560
3	$75,680
2	$68,800
1	$57,330

(2) Specialist Hospital On-Call Coverage

For the purpose of specialist hospital on-call coverage, eligible hospitals are all hospitals where the services contained in this Section are provided except federally funded hospitals and alternative funding arrangements where on-call services are included in such arrangements. This initiative is being undertaken to address on-call specialist coverage in Ontario. Coverage less than full coverage shall be prorated on approval by HOCC.

(a) Level II Specialists

The Parties agree that funding will be provided for specialists being available to provide on-call hospital services in the specialties of Anesthesia, Cardiac Surgery, Critical Care Medicine, General Surgery, Orthopedic Surgery, Plastic Surgery, Psychiatry, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Thoracic Surgery, Urology, Neurosurgery, Vascular Surgery, Transplant Services.

The following will be used to determine the amount payable to eligible hospitals for full coverage per specialty per 12-month period.

Enhanced Program
Phase 1: October 1, 2005 to March 31, 2007

# of Participating Physicians	Payment Per Hospital
5 or more	$122,000
4	$110,610
3	$ 97,600
2	$ 97,600
1	$ 73,200

Phase 2: April 1, 2007 to March 31, 2008

# of Participating Physicians	Payment Per Hospital
5 or more	$172,000
4	$155,945
3	$137,600
2	$137,600
1	$103,200

(b) Level III Specialists

Funding will also be provided to specialists being available to provide on-call hospital services in the specialties of Cardiology, Endocrinology, Gastroenterology, Geriatric Medicine, Haemotology/Oncology, Nephrology, Neurology, Ophthalmology, Respiratory Medicine, Diagnostic Radiology, Emergency Medicine, Otolaryngology, Hyperbaric Medicine, and Cardiac Surgical Assistants.

The following will be used to determine the amount payable to eligible hospitals per specialty per 12-month period.

Enhanced Program
Phase 1: October 1, 2005 to March 31, 2007

# of Participating Physicians	Payment Per Hospital
5 or more	$24,400
4	$22,770
3	$21,960
2	$19,520
1	$13,010

Phase 2: April 1, 2007 to March 31, 2008

# of Participating Physicians	Payment Per Hospital
5 or more	$34,400
4	$32,105
3	$30,960
2	$27,520
1	$18,345

(c) Level IV Specialists

Funding will also be provided to eligible hospitals for specialists being available to provide on-call hospital services in the specialties of Immunology, Dermatology, Physical Medicine and Rehabilitation, Rheumatology, Nuclear Medicine, Radiation Oncology, Interventional Radiology, and Infectious Disease.

Where one of the above specialists, in an eligible hospital, performs a special visit in the evening, night, on weekends or holidays, the physician shall receive, a call-in fee of $100, in addition to any other fee-for-service amounts which may be billed. The physician will be limited to 2 call-in fees per calendar day.

(3) Rurality Premiums

Each hospital eligible per the 2004 OMA Rurality Index (with a rurality index greater that 45 shall receive an annual financial incentive of $15,000 for GP on-call funding. This incentive is in addition to the on-call funding as set out in this agreement.

(4) GP Anesthesia Premium

This premium is intended to assist in retaining GP anesthetists within rural communities. Each eligible hospital as determined by the HOCC that does not have a Royal College certified anesthetist associated with it and where general practitioners provide a minimum of ***$10,000*** of

anesthetist services per year will receive an additional amount annually. This incentive is in addition to the on-call funding as set out in this Appendix.

Phase: October 1, 2005 – March 31, 2008

$15,000 per annum

(5) Concurrent Additional On-Call Rotas

The Hospital On-Call Coverage Committee (HOCC) will consider funding concurrent, additional on-call rotas in the following specialties: Anesthesia, Obstetrics, Family Medicine, Internal Medicine, and Neonatal Intensive Care. These applications will be reviewed based on existing guidelines and criteria developed by the HOCC.

(6) Intra Sectional Allocation

Funding will be set aside to address intra-sectional variability of call level for neurology, cardiology, ophthalmology, otolaryngology and other sections if deemed appropriate based on HOCC developed criteria and with consultation with the relevant sections.

(7) Special Consideration

HOCC will continue to review requests for special consideration received from physician groups.

LETTER OF UNDERSTANDING
REGARDING PROFESSIONAL INCORPORATION FOR PHYSICIANS
September 22, 2004

The Parties, through the course of these negotiations, have allocated a sum of money to deal with the estimated cost to the Ontario Government of changes to the incorporation rules for physicians. The revised rules shall provide for non-voting shareholders who are family members of the physician voting shareholders.
The MOHLTC shall take all possible actions to ensure that the Incorporation changes contemplated herein are effective from January 1, 2006.

_____	_____
Hon. George Smitherman	Dr. John Rapin
Minister of Health and Long-Term Care	President, Ontario Medical Association

TAB 49

MEMORANDUM OF AGREEMENT

BETWEEN:

ONTARIO MEDICAL ASSOCIATION ("OMA")

-and-

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO as represented by THE MINISTER OF HEALTH AND LONG-TERM CARE ("MOHLTC")

WHEREAS the OMA and the MOHLTC (the "Parties") entered into the 2004 Physician Services Framework Agreement effective April 1, 2004 (the "2004 Framework Agreement");

AND WHEREAS, in the 2004 Framework Agreement the Parties made a wide range of investments to address important issues such as physician human resources, physician compensation, increasing access to services, extending comprehensive primary care and integrating in-hospital and after-hospital care;

AND WHEREAS, section 30 of the 2004 Framework Agreement states that the Parties recognize that, given the highly complex nature of this Agreement, its length of operation, the difficulty in accurately predicting the consequences and costs of many of the investment initiatives, the degree of current and future change the health care system is experiencing and the uncertainty of Federal funding for health, it is appropriate that the Parties re-assess its performance at the mid-point of its operation.

AND WHEREAS the reassessment began in March 2007 and is to be completed by October 1, 2007, taking into account the following:

a) the degree to which the investments are accomplishing our objectives;

b) whether the appropriate incentives are in place;

c) any new developments in health care initiatives and funding;

d) the success of cost reduction outcomes from the Hospital Standardization Initiative;

e) any changes in physician retention and recruitment;

f) the need for any changes in AFP funding;

g) the results of our system management processes regarding both utilization and performance management;

h) unforeseen events; and

i) the need for innovation, access, integration and competitiveness.

AND WHEREAS section 30.3 of the 2004 Framework Agreement provides that the Parties reserve $7.5 million effective October 1, 2007 ($15M annualized for 2008-2009) for this Re-Assessment process to assist with issues identified during this process;

AND WHEREAS the Parties have reassessed the 2004 Framework Agreement in accordance with Section 30 and agree to amend and supplement it as set out below; and

NOW THEREFORE the Parties have come to the following Memorandum of Agreement:

PART 1 - PHYSICIAN HUMAN RESOURCES

General

1. The Parties have identified health human resources as a priority under the reassessment. They agree that Ontario will benefit from initiatives that support physician development. The Parties agree that the initiatives set out in **Appendix "A"** will be referred to the Physician Human Resources Committee (PHRC), which will recommend steps for the development and implementation of such initiatives.

Consolidate Locum Programs

2. The Parties recognize that consolidating the administration of locum programs can enhance program delivery for physicians and communities, and gain administrative savings, which can be reinvested in locum programs.

   Building on the success of the HFO Emergency Department Coverage Demonstration Project, the Parties agree to consolidate the administration of further programs at Health Force Ontario (HFO), and to manage them on a not for profit basis. Despite the last sentence of section 18.1 of the 2004 Framework Agreement as it relates to the OMA Rural Locum Program, the transfer of the following locum programs will begin in January 2008 ending April 1, 2008:

   (a) MOHLTC Respite Locum Tenens Program;

   (b) MOHLTC Urgent Locum Tenens Program; and

   (c) OMA Rural Locum Program.

Continuing Medical Education

3. The Parties recognize the importance of Continuing Medical Education (CME) for all practising physicians and the differing barriers in accessing these opportunities. The Parties agree that the administration of the OMA CME program will be the responsibility of the OMA and will work together to determine the administrative details of the transition. The PSC will approve the CME program policy, eligibility and criteria.

   The MOHLTC agrees to maintain the funding negotiated to support the Continuing Medical Education (CME)/Rural Locum Program referred to in section 18.1 of the 2004 Framework Agreement within the OMA CME Program. This funding will support the OMA Rural Locum Program at HFO until September 1, 2008, unless either Party requires an extension of up to 3 months.

Northern Physician Retention Initiative

4. The MOHLTC agrees to fund the Northern Physician Retention Initiative for 2007-08.

Retention Incentive Program

5. The Parties are interested in exploring the opportunities for a program to retain existing physicians in the province or their practice, and in recruiting new physicians to the province. The Parties recognize that additional information is needed to support the successful development of such a program and they will work together to collect this information.

   It is recognized that there are a number of variables for the implementation of a program, and there are many details which need to be discussed and agreed upon, including parameters related to the program's guiding principles, eligibility, staging, activity thresholds, payment variables and accountability framework. The Parties will establish a Retention Incentive Committee chaired by the co-chairs of the Physicians Services Committee (PSC) based on the terms of reference attached in **Appendix "B"** to explore the parameters for a retention incentive program for inclusion in the 2008 Agreement. The Retention Incentive Committee will bring forward recommendations by January 1, 2008.

Service Recognition Payment

6. The Parties will make payments to physicians based on their length of continuous service. These payments will be made on the dates set out below to a physician subject to that physician satisfying conditions of continuous practice in the province of Ontario and other conditions described in this section.

   (a) Payment Dates

The payment dates are: October 1, 2008, October 1, 2009, October 1, 2010, October 1, 2011 and October 1, 2012.

(b) Eligibility

All physicians residing in the province of Ontario who are engaged in active medical practice will be eligible to receive a payment on one or more of the payment dates.

(c) Payment Amounts

Subject to the other conditions set out in this section, a physician will receive a payment in the amount set out below if he or she achieves the following number of years of continuous practice on the payment date:

5 years of continuous practice	$1,250
10 years of continuous practice	$2,500
15 years of continuous practice	$3,125
20 years of continuous practice	$3,750
25 years of continuous practice	$4,375
30 years of continuous practice and every 3 years thereafter	$5,000

(d) Calculation of Years of Continuous Practice

Subject to subsections (e) and (h) below, the term "years of continuous practice" means the sum of:

(i) the number of years from the date of a physician's registration with the College of Physicians and Surgeons of Ontario (CPSO) until October 1, 2007, with any additional part of a year not being counted; and

(ii) the number of years after October 1, 2007 during which the physician has a continuous medical practice in Ontario up to a payment date.

If a physician does not have a continuous practice after October 1, 2007 and subsection (h) does not apply, then the above definition does not apply, and the years of continuous service for that physician are counted from the time that the physician recommences a continuous medical practice in Ontario.

(e) Continuous Practice

Subject to subsection (h) below, a physician, who does not remain in continuous medical practice in the year preceding and up to a payment date, will not receive a payment on the payment date. For greater certainty, a physician who retires or dies before a payment date is not eligible to receive a payment.

(f) Minimum Earnings

A physician whose clinical earnings from the Government of Ontario, received directly or indirectly, are less than $50,000 in the year preceding the payment date, will not receive a payment on that payment date. A physician will receive credit for this year towards his or her years of continuous practice as set out in subsection (d) above.

(g) Prorated Payments

A physician whose clinical earnings from the Government of Ontario, received directly or indirectly, are more than $50,000 but less than $100,000 in the year preceding the payment date, will receive 50% of the payment specified in subsection (c) if the physician is eligible to receive a payment on that payment date.

(h) Temporary Absences

A physician may be permitted a temporary absence from the requirement of continuous practice in the province of Ontario for illness or injury, medical training, or parental leave. The Parties will establish criteria and a mechanism for eligible physicians to make application for a temporary absence. If the temporary absence is for less than one year, the year will be counted towards years of continuous service.

(i) Administration

These payments will be jointly administered by the OMA and the MOHLTC. The Parties will develop any necessary operating processes, procedures or interpretations for these payments.

(j) Continuation of program

The Parties may at future negotiations agree to modify, extend or discontinue the payment program. If the payment is reduced or discontinued, the funding will remain in the physician services budget and the Parties will determine the reallocation of the funding.

Pregnancy and Parental Leave Benefit Program

7. Effective October 1, 2007, the Parties agree to amend the Pregnancy and Parental Leave Benefit Program (PPLBP), which is described in section 15.2 of the 2004 Framework Agreement, and Schedule B of their Funding Agreement dated April 1, 2005 as follows:

   (a) Change the eligibility requirements so that a physician can be eligible for the PPLBP without having to be remunerated by the MOHLTC through OHIP or an Alternate Funding Agreement (AFA);

   (b) Set out the benefits under the PPLBP for physicians who receive benefits from an employer or through Employment Insurance (EI) so that they are eligible for a supplemental payment under the PPLBP that is the difference between the amount they receive from their employer or EI up to the amount payable under the PPLBP; and

   (c) Clarify the definition of a physician's Eligible Earnings so that Eligible Earnings means the sum of OHIP payments (but not technical fees), remuneration under an AFA, salary from an employer for the provision of medical professional services and all other medical professional income.

Repatriation

8. The Parties will implement a relocation support program to encourage physicians, who are not currently living or practicing in Ontario and who have a connection to Ontario or Canada, to practise in Ontario. The MOHLTC will, through HFO, begin the implementation of this new program in 2007-2008 with advice from the PHRC on the elements of the program, based on the potential elements described in **Appendix "A"**.

PART 2 - PRIMARY CARE

Unattached Patients

9. The Parties recognize that as a result of incentives introduced under the 2004 Framework Agreement, a significant number of unattached patients now have access to a physician to provide such comprehensive care. The Unattached Patient Working Group (UPWG) will continue to provide recommendations to the PSC. Building on the work of UPWG, the initiatives set out in sections 10 to 12 are intended to further reduce the number of unattached patients and to assist those in areas of high need to have access to comprehensive health care.

10. The Parties agree to amend section 6.3 of Appendix E of the 2004 Framework Agreement to increase the allowable new patient fee threshold for new graduate

physicians from 150 to 300 effective October 1, 2007. For each new patient to a maximum of 300 in each fiscal year, the age adjusted new patient fee premium will be paid.

11. In addition to the provisions in the 2004 Framework Agreement, the Parties agree to amend applicable primary care agreements effective October 1, 2007 as follows:

    (a) The new patient fee premium for patients over the age of 75 will increase from $120 to $180; and

    (b) The new patient fee premium for patients aged 65 to 74 will increase from $110 to $120.

    New graduates will be eligible for these new fee premium increases under applicable primary care agreements.

12. Existing primary care agreements include a fee for rostering the first 50 patients per fiscal year. The Parties agree to increase the fee premium threshold of 50 patients per fiscal year to 55 patients per fiscal year effective October 1, 2007 and to 60 patients per fiscal year effective April 1, 2008, and to amend applicable primary care agreements accordingly.

Primary Care Payment for Capitated Models

13. The MOHLTC will transfer $500,000 to the OMA on October 1, 2007 to make a one-time payment to recognize physicians who participate in capitated primary care models, subject to criteria agreed to by the PSC. The Parties may transfer funds between this funding to the payment referred to in section 20 and vice versa.

Obstetrical Coverage

14. The Parties acknowledge that access to maternity and obstetrical care in some communities is limited. The initiatives set out in sections 15 and 16 are intended to encourage physicians to continue to provide this important service.

15. Effective October 1, 2007, the Parties agree to amend:

    (a) The Family Health Group (FHG) letter of agreement to permit the provision of obstetrical deliveries outside regular office hours to be counted towards the exemption from after hours service requirements for FHGs; and

(b) Applicable primary care agreements to increase the obstetrical bonus fee from $3,200 to $5,000 for physicians providing a minimum of 5 deliveries per year.

16. The Parties agree that the PSC, through the Primary and Community Care Committee (PCCC), shall develop future financial incentives for those physicians providing obstetrical care.

GP Focused Practice Physicians

17. The Parties agree to establish a subcommittee of the PSC, based on the terms of reference in Appendix "C", to assess the impact of the billings of GP Focused Practice Physicians on the access bonuses of physicians in primary care models.

18. The PSC will establish criteria and guidelines, as approved by the Parties, by July 31, 2007 for use by the PSC subcommittee to develop a process, criteria and guidelines to identify and assess individual applications on a case by case basis from GPs practicing in a focused practice outside of those identified in Section 8.1 of the 2004 Framework Agreement and provide approval, on an exception basis, for the focused practice billings of these physicians to be exempt from the application of the access bonus.

Comprehensive Care Model

19. The Parties agree to amend section 2(a) of Schedule "B" of the Comprehensive Care Agreement ("CCM Agreement") to increase the after hours premium from 10% to 20% effective October 1, 2007.

PART 3 - HOSPITAL CARE

Wait Time Reduction Payment

20. Further to section 29.5 of the 2004 Framework Agreement, the MOHLTC will transfer $3 million to the OMA on October 1, 2007 to recognize physicians who participated in the start-up of the Wait Time Information System initiative before April 1, 2008, subject to criteria agreed to by the PSC.

21. The Parties will request the Physician Hospital Care Committee (PHCC), established under section 25.1 of the 2004 Framework Agreement, to form a subcommittee on Wait Time services. The subcommittee will bring forward recommendations to the PHCC by February 1, 2008 to support the role of physicians in managing access to Wait Time services.

Most Responsible Physician (Hospitalist) Program

22. Responding to the report on MRPs prepared by the Physician Hospital Care Committee (PHCC), the Parties agree to establish a working group of the PSC. This working group will develop, by December 31, 2007, a program for most responsible physician (MRP) services, which will include recommendations for remuneration of full-time hospitalists and community physicians who provide in-patient care. The working group will take into consideration the recommendations of the MOHLTC's review of top-up payments.

PART 4 - COMMUNITY CARE

Palliative Care

23. The Parties agree to introduce a weekly palliative care case management fee code of $51.70 into the OHIP Schedule of Benefits, as recommended by the OMA's Central Tariff Committee ("CTC"). This fee will be implemented no later than January 1, 2008.

PART 5 - MEDICAL SERVICES PAYMENTS

Schedule of Benefits

24. The Parties agree that the retention of physicians in Ontario is dependent upon the Parties keeping the fee schedule up-to-date and reflecting new procedures, best practices, and latest evidence. For this purpose, despite any provision of the 2004 Framework Agreement, including Appendix L, the Schedule of Benefits will be amended as set out in the attached **Appendix "D"** and on the dates set out in that appendix to implement these fee changes recommended by the CTC.

    All fee changes will result in a direct flow through to all applicable APP and primary care models.

Medical Services Payment Committee

25. The Parties will require the Medical Services Payment Committee (MSPC), as described in section 13.1 of the 2004 Framework Agreement, to identify areas of the Schedule of Benefits for review for issues related to relativity, including the work that commenced on surgical procedures. The MSPC will make recommendations to the PSC at a fee code level by February 2008.

PART 6 – PHYSICIAN WORKING ENVIRONMENTS

Third Party Working Group

26. Further to section 17.4 of the 2004 Framework Agreement, the Parties recognize that GPs spend approximately 11.5 hours per week and specialists spend approximately 7 hours per week on administration. The Parties agree the PSC will develop an implementation plan by November 1, 2007 to address the comprehensive package of recommendations developed by the bilateral Third Party Working Group to reduce the administrative burden upon physicians.

27. During the 2007-2008 fiscal year, the PSC will move forward on initiatives to improve the physician workplace environment including:

    (a) Hospital Booking Standardization: To review hospital surgical/diagnostic/medical booking processes and make recommendations on standardization and streamlining; and

    (b) Education package: To develop education packages for physicians, employers, and insurers on best practices.

Forms Review

28. To further the goals set out in section 17 of the 2004 Framework Agreement and section 26 above, the MOHLTC will work with other ministries as appropriate, and will bring forward recommendations to the PSC to eliminate, consolidate, simplify or streamline forms used by the MOHLTC, and the Ministries of Transportation (MTO) and Community and Social Services (MCSS). These activities will be initiated for the 2007-2008 fiscal year.

CPSO Initiative

29. Before November 2007, the Parties will work together to discuss with the CPSO the amendment or revocation of a clause of the professional misconduct regulations under the *Medicine Act* and the CPSO's policy and guidelines related to requirements for physicians to respond to requests from third parties.

PART 7 – LOCAL HEALTH INTEGRATION NETWORKS ("LHINS")

30. The Parties recommend establishing a tripartite committee which reports to the PSC, consisting of membership from the OMA, MOHLTC, and LHIN chief executive officers. This committee will provide a mechanism by which the Parties and LHINs communicate about issues of province-wide interest. The Parties commit to developing terms of reference for this committee by June 30, 2007.

PART 8 - COMMITTEE STRUCTURE

31. The Parties will review the committee structures under the 2004 Framework Agreement for rationalization in the 2008 Agreement, including reviewing the Diagnostic Services Committee (DSC) as contemplated by section 20.4 of the 2004 Framework Agreement.

AGREED UPON BY THE PARTIES:

HER MAJESTY THE QUEEN in right of Ontario, as represented by the Minister of Health and Long-Term Care

Per: _____

Date

Hugh MacLeod
Assistant Deputy Minister

ONTARIO MEDICAL ASSOCIATION

Per: _____

Date

Name:
Title:

Per:

Name:
Title:

APPENDIX "A"

RESPONSIBILITIES OF THE PHRC

The Parties agree that the following items will be referred to the PHRC who will be responsible for recommending to the PSC by January 31, 2008 how these items will be developed and implemented.

Make Our Post-Graduate Education System More Competitive

1. The Parties agree on the need to retain Ontario educated medical students and to attract students from other jurisdictions to pursue residency education in the province. The PHRC will develop a program as soon as possible that defers or pays interest payments on Canada Student Loans for medical residents during the period they are pursuing required core specialty training. The program will be developed in consultation with Ministry of Training, Colleges and Universities.

Keep Our New Graduates

2. The PHRC will develop options to reduce or eliminate the student loan repayment for Ontario-educated medical students over a threshold number of years of practice in Ontario. The program may include eligibility requirements related to provincial needs and encourage practice in areas of high need. The program will be developed in consultation with the Ministry of Training, Colleges and Universities. In developing the options, the linkages with other retention programs for all physicians will be considered.

Mentorship and Training

3. The Parties are concerned about the loss of experienced physicians who may be considering reducing their hours of work or retiring. The PHRC will develop a mentorship program to provide opportunities for experienced physicians to transfer their skills and knowledge to other physicians with a focus on areas of higher need.

Repatriation

4. The PHRC will evaluate the proposed components of a repatriation program and identify those that provide the greatest incentive for continuation. The PHRC should respect HFO's ethical recruitment principles and guidelines, and should recognize the perspectives of current Ontario physicians. The components include any of the following:

    (a) A program to help relocating physicians defray moving costs;

(b) A program to help relocating physicians defray registration, certification and examination costs;

(c) The development of an educational program to help newly recruited physicians to understand and appreciate the practice environment in Ontario (e.g. “Everything You Need to Know About Professional Practice in Ontario”);

(d) A physician mentorship program that matches new recruits with established practicing Ontario physicians for a defined period of time;

(e) A physician mentorship program that matches potential recruits with established practicing Ontario physicians who can provide peer to peer advice;

(f) A community visit/locum program for potential recruits;

(g) HFO recruitment event honoraria and related expenses program for current Ontario physicians; and

(h) Research with former Ontario physicians on current and future programs.

APPENDIX "B"

RETENTION INCENTIVE COMMITTEE

TERMS OF REFERENCE

1. The Retention Incentive Committee (the "Committee") will examine the numerous and complex elements that make up a retention incentive program and will make recommendations to the Parties by January 1, 2008 on the structure of a program.

2. In developing recommendations on the program, the Committee will take into consideration:

    a. Current retention models within Ontario and in other jurisdictions.

    b. The development of funding, structure and desired outcomes of physician retention models. These models should look at needs of physicians at various stages of their career.

    c. Research and feedback collected from physicians with respect to maintaining physicians in active practice.

    d. Options to address recruitment and retention of physicians at different stages of their career that may not be addressed by a provincial retention program, and analyse and develop policy on these initiatives.

    e. Outcome-based measures to evaluate the effectiveness of the program.

3. The Committee will consist of members appointed by each of the Parties and will include financial and physician expertise.

4. The Committee will be chaired by co-chairs of Physician Services Committee.

5. The Committee will report to the Physician Services Committee.

6. It is recognized that an effective retention program will require consideration of a variety of elements to ensure that the program will provide the appropriate incentive to ensure desired outcomes as defined by the Parties are met, be administratively efficient, be fiscally sustainable and have clear tax treatment. The design elements under consideration include, but are not limited to:

    a. eligibility;

    b. staging;

    c. activity threshold;

d. payment variables;

e. variations for location or specialty;

f. years of service;

g. management;

h. administration;

i. appeal mechanism; and

j. tax implications.

APPENDIX "C"

GP FOCUSED PRACTICE INDIVIDUAL CASE REVIEW/CONSIDERATION

TERMS OF REFERENCE

Through the 2007 reassessment process, the parties have agreed to work together to develop a defined process and criteria for reviewing special circumstance requests from self identified GP focused practice physicians seeking an exemption so their billings will no longer impact access bonuses.

This process would apply only to GP focused practice physicians outside the five (5) self identified GP focused practice areas stipulated in Section 8.1 of the 2004 Physician Services Framework Agreement. GP focused practice areas not to be included in this process are: Sports Medicine, Allergists, Pain Management, Sleep Medicine and Addiction Medicine. Those GP Focused practice areas are being assessed through an alternate process as per the Framework Agreement.

A time limited working group of the PSC will be established to undertake this task.

The mandate of the working group is as follows:

- to work together to develop a process and an implementation strategy for a special circumstance review process for GP focused practice physicians seeking an exemption so their billings will no longer impact access bonuses.

- to develop a process plan for the review. The process plan should include the methodologies for: the central collection of requests; the analysis/assessment of requests for exemption using the approved review criteria; the method for communication of the review/assessment decisions and identification of a dispute resolution mechanism.

- to develop stringent criteria that each individual special circumstance exemption request from a GP physician in a focused practice area must meet to be considered for assessment. The mandatory criteria should include:
    - the demonstrated need of the focused practice area in the specific community (number of patients, lack of similar practicing physicians in community, wait times);
    - must be a Royal College of Physicians and Surgeons (RCPS) acknowledged focused practice area – e.g. existing specialty area;
    - illustrated support from GP's and other related specialists or hospital in the specific community regarding the need for the exemption for the specific GP focused practice area;
    - appropriate training or qualifications to support the particular area of focus.

- to determine if there is any other fair and reasonable approach that would achieve the same goals

- to analyse data to determine the potential cost of the various options that might be recommended.

- will make recommendations to the Physician Services Committee (PSC) on the review process plan and the criteria that must be met for the request to be successful.

APPENDIX "D"

SCHEDULE OF BENEFITS FOR PHYSICIAN SERVICES AMENDMENTS

Fee Code	Fee Code Description	Current Fee Code Description	Proposed Draft Fee Code Description	Action	Existing Fee	Oct 1 2007	Feb 1 2008	Apr 1 2008
R227	Superior Labral Anterior Posterior (SLAP) Repair	N/A	Superior Labral Anterior Posterior (SLAP) Repair	New code			$336.65	
J165C	Transvaginal Sonohystography	Transvaginal Sonohystography	No change	Fee Revision	$75.70		$31.55	
J476C	Transvaginal Sonohystography	Transvaginal Sonohystography	No change	Fee Revision	$75.70		$31.55	
G399	TSH - procedural fee	N/A	Transvaginal sonohysterography, introduction of catheter, with or without injection of contrast media	New code			$44.15	
S302	Pancreas Transplant - procurement of donor pancreas	N/A	Pancreas Transplant - procurement of donor pancreas	New code			$679.50	
S308	Pancreas Transplant - pancreas transplantation	N/A	Pancreas Transplant - pancreas transplantation	New code			$2,378.30	
S303	Pancreas Transplant - back-bench pancreas graft preparation	N/A	Pancreas Transplant - back-bench pancreas graft preparation	New code			$339.75	
E649	Embolectomy/and or Thrombectomy - revise descriptor for same operative site	embolectomy and/or thrombectomy when done in conjunction with other vascular procedures	Note: 1. E649 is only eligible for payment under the following circumstances: a. when embolectomy and/or thrombectomy is rendered at a site other than the main operative site, or b. when embolectomy and/or thrombectomy is rendered at the main operative site and thrombus and/or embolus was present prior to surgery. [Commentary: E649 is not eligible for payment when rendered at the main operative site in any other circumstance other than 1(b)]	Revision - Add'n of Note	$112.45	x		

"x" denotes effective date of change for changes other than fee revisions

Fee Code	Fee Code Description	Current Fee Code Description	Proposed Draft Fee Code Description	Action	Existing Fee	Oct 1 2007	Feb 1 2008	Apr 1 2008
G420	Ear syringing and/or extensive curretting or debridement unilateral or bilateral - remove existing limit of 3	Ear syringing and/or extensive curetting or debridement uni - or bilateral, limited to 3 per physician per patient per 12 month period (Apr 1-Mar 31). Services in excess of the limit are not insured	Ear syringing and/or extensive curetting or debridement, unilateral or bilateral	Revision - Removal of limits	$11.25		x	
G360	Thermal dilution studies - maximum of one per day to a maximum of 5 days per hospital admission at same institution	when thermal dilution studies done in addition by a physician, once a day to a maximum of 5 days	when thermal dilution studies rendered in addition to Z438 Note: Thermal dilution studies must be rendered personally by the physician and are limited to a maximum of one per day to a maximum of 5 days per hospital admission at the same institution.	Revision	$49.35		x	
J199B	Penile Doppler - professional fee (P1)	N/A	Penile Doppler - professional fee (P1)	New code			$10.05	
J499C	Penile Doppler - professional fee (P2)	N/A	Penile Doppler - professional fee (P2)	New code			$7.50	
J199B/J499B	Penile Doppler - technical fee	N/A	Penile Doppler - technical fee	New code			$7.05	
R105	Partial mastectomy with radical node dissection	Partial mastectomy with radical node dissection	N/A	Delete	$658.15		x	
R117	Mastectomy - female - subcutaneous with nipple preservation	Mastectomy - female - subcutaneous with nipple preservation	subcutaneous with nipple preservation	Revision - to PMT Rules	$273.95		x	
R109	Mastectomy, radical or modified radical	Mastectomy, radical or modified radical (with or without biopsy)	Mastectomy, radical or modified radical (with or without biopsy)	Revision - to PMT Rules	$658.15		x	
Skin Grafts	Not payable in conjuction with R117; payable with R109 same patient, same day	Note: R117 - include skin grafts if required.	Skin grafts are not eligible for payment with R117. [Commentary: Skin grafts are payable with R109 , same patient same day.]	Revision			x	
E505	With limited axillary node sampling - allow with R111, R108, R117, R148, R149; disallow E506	with limited axillary node sampling	with limited axillary node sampling	Revision - allow with add'l codes	$178.05		x	
E546	with axillary node dissection up to the level of the axillary vein	with axillary node dissection up to the level of the axillary vein	No change	Fee Increase	$315.95		$388.75	

Fee Code	Fee Code Description	Current Fee Code Description	Proposed Draft Fee Code Description	Action	Existing Fee	Oct 1 2007	Feb 1 2008	Apr 1 2008
E507/E506	With sentinel node biopsy (per draining) add	N/A	E507 – with sentinel node biopsy (per draining basin), to R010E506 – with axillary sentinel node biopsy, to R111	New code			$330.45	
R877	Repair of abdominal aortic aneurysm to iliac arteries	N/A	aneurysm with repair of iliac artery aneurysm (unilateral or bilateral)	New code			$2,002.75	
E626	Plus implantation of interior mesennteric artery	plus implantation of inferior mesenteric artery, add	with implantation of inferior mesenteric artery, to R802, R816, R817 or R877, add	Revision	$174.35		$174.35	
E627	Ruptured	ruptured, add	ruptured, to R802, R816, R817 or R877, add	Revision	$317.75		$317.75	
J200/J500	Disallow same day as J200 or J500	Ankle pressure measurements with segmental pressure recordings and/or pulse volume recordings and/or Doppler recordings.	J200/500 Ankle pressure measurements with segmental pressure recordings and/or pulse volume recordings and/or Doppler recordings – uni - or bilateral Note below G517: not to be claimed in conjunction with J200	Revision and PMT rule disallowing J200/500 with G517	T - $20.90			x
Foot Care Codes	Foot care - revise wording to clarify that paring of lesions does not constitute removal by electrocoagulation and/or curetting; or that simple trimming or clipping of nails constitutes extensive debridement	N/A	Note: Paring of a lesion does not constitute Z159, Z160 or Z161 and is not eligible for payment. Note: Trimming or clipping of nails does not constitute Z110.	Revision - Add'n of Notes	$17.45			x
S266	Living donor orthotopic liver transplantation - recipient	N/A	Living donor -orthotopic liver transplant	New code			$5,289.55	
S265	Living donor hepatectomy	N/A	Living donor, hepatectomy	New code			$4,760.60	
E765	with reconstruction or repair of hepatic artery		amend MR to allow E765 to be claimed with S266	Revision - PMT Rule			$300.45	
G254	Management of post liver transplant	Management of post liver transplant	Management of post liver or pancreas transplant immunosuppression	Revision	$21.00		x	
Z586	Hysteroscopy with lysis of intrauterine synechiae	N/A	Hysteroscopy with lysis of intrauterine adhesions/synechiae requiring a minimum of 60 minutes of surgical time	New code			$349.00	
K122	Paediatric psychotherapy - individual, per unit	N/A	Paediatric psychotherapy - individual, per unit	New code			$65.65	
K123	Paediatric psychotherapy - family, per unit	N/A	Paediatric psychotherapy - family, per unit	New code			$68.80	

Fee Code	Fee Code Description	Current Fee Code Description	Proposed Draft Fee Code Description	Action	Existing Fee	Oct 1 2007	Feb 1 2008	Apr 1 2008
K120	Paediatric adolescent care	Paediatric adolescent care	N/A	Delete	62.2		x	
E645	Off-pump coronary artery bypass grafting	N/A	Off-pump coronary artery bypass grafting	New code			$366.50	
R160	Pre-Malignant Lesions including biopsy of each lession - face or neck - simple excision - single lesion	N/A	Pre-Malignant Lesions including biopsy of each lession - face or neck - simple excision - single lesion	New code			$53.20	
R161	Face or neck - simple excision - two lesions	N/A	Face or neck - simple excision - two lesions	New code			$87.40	
R162	Face or neck - simple excision - three or more lesions	N/A	Face or neck - simple excision - three or more lesions	New code			$174.75	
R163	Pre-Malignant Lesions including biopsy of each lession - other areas - simple excision - single lesion	N/A	Pre-Malignant Lesions including biopsy of each lession - other areas - simple excision - single lesion	New code			$43.60	
R164	Other areas - simple excision - two lesions	N/A	Other areas - simple excision - two lesions	New code			$71.80	
R165	Other areas - simple excision - three or more lesions	N/A	Other areas - simple excision - three or more lesions	New code			$143.55	
E542	When performed outside hospital	When performed outside hospital	When performed outside hospital	Revision - Appl to new codes	$11.15		x	
J054	Radiofrequency Ablation (RFA)	N/A	Percutaneous radiofrequency ablation using CT or ultrasound guidance	New code			$404.95	
A/C365	Special Interventional Radiological Consultation	N/A	Special Interventional Radiological Consultation	New code			$132.50	
K030	Diabetic Management Assessment - increase limit from 3 to 4 per patient per year	Maximum 3 per patient per year.	Maximum 4 per patient per 12 month period.	Revision	$34.75		x	
Z273	Muscle core biopsy	N/A	muscle core biopsy using a 6mm or larger Bergstrom muscle biopsy needle or equivalent kit - includes one or more biopsies	New code			$63.35	
Z610	Intravesical instillation of BCG or immunotherapeutic or chemotherapeutic agent for treatment of bladder cancer	N/A	Intravesical instillation of BCG or immunotherapeutic agent or chemotherapeutical agent for the treatment of bladder cancer	New code			$25.65	
Z524	Drainage of hematoma or deep neck abscess	Drainage of haematoma or deep neck abscess	No change	Fee increase	$153.35	$271.05		

Fee Code	Fee Code Description	Current Fee Code Description	Proposed Draft Fee Code Description	Action	Existing Fee	Oct 1 2007	Feb 1 2008	Apr 1 2008
E643	When using laser with microlaryngoscopy for benign disease for direct microlaryngoscopy	N/A	when using laser with microlaryngoscopy for benign disease, to Z323 add	New code			$121.65	
P022	P022 - Oxytocin infusion for induction			Delete	$67.75		x	
P023	P023 - Oxytocin infusion for stimulation	Oxytocin infusion for stimulation of desultory labour	Oxytocin infusion for induction or augmentation of labour	Revision	$67.75		x	
C142/C143	MRP Day 2 and Day 3 codes for patients discharged from ICU	N/A	C142 First subsequent visit by the MRP following transfer from an Intensive Care Area C143 Second subsequent visit by the MRP following transfer from an Intensive Care Area	New codes			$55.45	
M083	Intranasal ethmoidectomy, including maxillary antrostomy with endoscope - unilateral	N/A	Intranasal ethmoidectomy including maxillary antrostomy, with endoscope – unilateral	New code			$350.00	
E844	Intranasal ethmoidectomy, including maxillary antrostomy with endoscope - bilateral, to M083	N/A	Intranasal ethmoidectomy, including maxillary antrostomy with endoscope - bilateral, to M083	New code			$200.00	
Z350	Endoscopic sphenoidotomy - unilateral	N/A	Endoscopic sphenoidotomy - unilateral	New code			$121.25	
E843	Endoscopic sphenoidotomy - bilateral, to Z350	N/A	Endoscopic sphenoidotomy - bilateral, to Z350	New code			$103.05	
E845	When performed using a 3D CT/MRI image guided system, to M083 or Z350	N/A	When performed using a 3D CT/MRI image guided system, to M083 or Z350	New code			$140.00	
Z351	Endocopic septoplasty	N/A	Endocopic septoplasty	New code			$122.40	
M086	Trans-nasal endoscopic repair of CSF rhinorrhea with or without 3D CT/MRI image guided system	N/A	Trans-nasal endoscopic repair of CSF rhinorrhea with or without 3D CT/MRI image guided system	New code			$822.45	
M066	Closure of antral fistula - simple	Closure of antral fistula - minor	N/A	Delete	$98.80		x	
M054	Intranasal maxillary antrostomy - unilateral - by endoscopic or endonasal approach	Maxillary intranasal antrostomy - unilateral	Intranasal maxillary antrostomy – unilateral – by endoscopic or endonasal approach	Revision	$123.70		$121.25	
M061	Trans-septal sphenoidotomy or sphenoid sinusectomy	Trans-septal sphenoidotomy or sphenoid sinusectomy	Trans-septal sphenoidectomy for tumour or radical exenteration of disease	Revision	$355.65		$355.65	

Fee Code	Fee Code Description	Current Fee Code Description	Proposed Draft Fee Code Description	Action	Existing Fee	Oct 1 2007	Feb 1 2008	Apr 1 2008
M064	External transethmoidal sphenoidotomy or sphenoid sinusectomy	External transethmoidal sphenoidotomy or sphenoid sinusectomy	External transethmoidal sphenoid sinusectomy	Revision	$612.65		$612.65	
E980	When performed endoscopically	When performed endoscopically	N/A	Delete	$41.25		x	
M060	Intranasal ethmoidectomy - unilateral	Intranasal ethmoidectomy - unilateral	N/A	Delete	$158.25		x	
50% rule	Pay…at 85% if billed in conjuction with …			Revision			x	
M054, M083	When billed in conjuction with M012, M013, M014, M015, M016, M019, M024 - pay M054, M083 at 85%			Revision - PMT Rule			x	
M067	Closure of antral fistula under general anaesthestic	Closure of antral fistula - complex or involving general anaesthetic (to include Caldwell-Luc if necessary)	Closure of antral fistula under general anaesthestic (to include Caldwell-Luc if necessary)	Revision			x	
M019	Septorhinoplasty with autologous bone or cartilage graft - from site other than nose			Delete			x	
M024	Septorhinoplasty with non-autologous graft or implant.			Delete			x	
E841	with autologous bone or cartilage graft - from site other than nose, to M014,	N/A	with autologous bone or cartilage graft - from site other than nose, to M014,	New fee			$206.20	
E842	with non-autologous graft or implant, to M014	N/A	with non-autologous graft or implant, to M014	New fee			$58.60	
M012	Septoplasty	Septoplasty (when intranasal ethmoidectomies or antrostomies are done in addition, add 50% of the appropriate fees to M012, M013, M014, M015, M016, M019, M024)	Septoplasty	Revision			x	
Z311	Removal of foreign body - local anaesthetic	Removal of foreign body - simple	Removal of foreign body - local anaesthetic	Revision			x	
Z312	Removal of foreign body - general anaesthetic	Removal of foreign body - complicated, or involving general anaesthetic	Removal of foreign body - general anaesthetic	Revision			x	
Z302	Turbinate reduction	Turbinate reduction - uni- or bilateral (to include cautery, cryosurgery, turbinectomy)	Turbinate reduction - unilateral or bilateral, (by any method)	Revision			x	
G870	Botulinum toxin injection(s) of extraocular muscle(s) - unilateral	N/A	Botulinum toxin injection(s) of extraocular muscle(s) - unilateral	New code			$120.00	

Fee Code	Fee Code Description	Current Fee Code Description	Proposed Draft Fee Code Description	Action	Existing Fee	Oct 1 2007	Feb 1 2008	Apr 1 2008
G871	Botulinum toxin injection(s) for blepharospasm - unilateral or bilateral	N/A	Botulinum toxin injection(s) for blepharospasm - unilateral or bilateral	New code			$120.00	
G872	Botulinum toxin injection(s) for hemifacial spasm - unilateral or bilateral	N/A	Botulinum toxin injection(s) for hemifacial spasm - unilateral or bilateral	New code			$120.00	
G873	Botulinum toxin injection(s) for spasmodic dysphonia	N/A	Botulinum toxin injection(s) for spasmodic dysphonia	New code			$120.00	
G874	Botulinum toxin injection(s) for sialorrhea - unilateral or bilateral	N/A	Botulinum toxin injection(s) for sialorrhea - unilateral or bilateral	New code			$50.00	
G875	Botulinum toxin injection(s) for the following conditions: oromandibular dystonia, limb dystonia, cervial dystonia or spasticity - first injection	N/A	Botulinum toxin injection(s) for the following conditions: oromandibular dystonia, limb dystonia, cervial dystonia or spasticity - first injection	New code			$40.00	
G876	Botulinum toxin injection(s) for the following conditions: oromandibular dystonia, limb dystonia, cervial dystonia or spasticity - each additional injection to maximum of 11	N/A	Botulinum toxin injection(s) for the following conditions: oromandibular dystonia, limb dystonia, cervial dystonia or spasticity - each additional injection to maximum of 11	New code			$10.00	
G877	With EMG guidance, for one injection	N/A	With EMG guidance, for one injection	New code			$18.85	
G878	With EMG guidance, for two or more injections	N/A	With EMG guidance, for two or more injections	New code			$28.10	
G879	With ultrasound guidance, for one injection	N/A	With ultrasound guidance, for one injection	New code			$18.85	
G880	With ultrasound guidance, for two or more injections	N/A	With ultrasound guidance, for two or more injections	New code			$28.10	
E543	Use of disposable EMG hypedermic electrode outside hospital	use of disposable EMG hypodermic electrode outside hospital when G599 is payable in full (maximum 1 per patient per day).	Use of disposable EMG hypedermic electrode outside hospital	Revision			$30.60	
G468	Botulinum toxin injection of extraocular muscle(s) with electromyographic control per muscle(s)	Botulinum toxin injection of extraocular muscle(s) with electromyographic control per muscle(s)	N/A	Delete	$82.95		x	
G464	Botulinum toxin injection(s) for treatment of spasmodic dysphonia	Botulinum toxin injection(s) for treatment of spasmodic dysphonia	N/A	Delete	$82.95		x	
G597	Botulinum toxin - Injection into first muscle per day	Botulinum toxin - Injection into first muscle per day	N/A	Delete	$20.40		x	

Fee Code	Fee Code Description	Current Fee Code Description	Proposed Draft Fee Code Description	Action	Existing Fee	Oct 1 2007	Feb 1 2008	Apr 1 2008
G598	Botulinum toxin - additional injections to 8	Botulinum toxin - additional injections to 8	N/A	Delete	$10.20		x	
G599	Botulinum toxin - with electromyographic guidance of injection(s) into one or more muscle(s)	Botulinum toxin - with electromyographic guidance of injection(s) into one or more muscle(s)	N/A	Delete	$20.40		x	
G121/G120	Digit photoplethsmography	Impedance plethysmography	Impedance plethysmography or Digital Photoplethysmography (PPG)	Revision			x	
Rxxx	Total ankle replacement	N/A	Total ankle replacement	New code			$1,177.50	
	Long-term ventilated care	N/A	N/A	Revision - PMT rule		x		
Gxxx	Intravenous local anaesthetic infusion for central neuropathic pain	N/A	Intravenous local anaesthetic infusion for central neuropathic pain	New code			$125.00	
X186	Using dedicated xeroradiography equipment - unilateral	Using dedicated xeroradiography equipment - unilateral	N/A	Delete	T - $31.40	x		
X187	Using dedicated xeroradiography equipment - bilateral	Using dedicated xeroradiography equipment - bilateral	N/A	Delete	T - $48.25	x		
R035	Simple excision of pilonidal cyst - assistant fee	Pilonidal cyst simple excision or marsupialization	no change	Revision - add surg assist units	$183.30		x	
Rxxx	Pilonidal cyst with patient BMI greater than 40 - simple excision or marsupialization	N/A	Pilonidal cyst with patient BMI greater than 40- simple excision or marsupialization	New code			$183.30 6 asst	
Sxxx	Insertion of intraperitoneal chemotherapy port	N/A	Insertion of intraperitoneal chemotherapy port by laparotomy or laparoscopy when sole procedure	New code			$186.95	
Syyy	Removal of intraperitoneal chemotherapy port	N/A	Removal of intraperitoneal chemotherapy port by laparotomy or laparoscopy when sole procedure	New code			$186.95	
Exxx	– with resection of diaphragm including reconstruction (applicable to S727)	N/A	– with resection of diaphragm including reconstruction (applicable to S727)	New code			$145.00	
Exxx	Head and neck intraoperative cranial nerve monitoring	N/A	Intraoperative monitoring of cranial nerves remote from the skull base	New code			$125.00	

Fee Code	Fee Code Description	Current Fee Code Description	Proposed Draft Fee Code Description	Action	Existing Fee	Oct 1 2007	Feb 1 2008	Apr 1 2008
Gxxx	Peripheral nerve catheter insertion	N/A	Percutaneous peripheral nerve catheter insertion	New code			$109.30	
Sxxx	Completion thyroidectomy following a previous subtotal or hemi-thyroidectomy	N/A	Completion thyroidectomy following a previous subtotal or hemi- thyroidectomy	New code			$425.25	
Exxx/Eyyy	- with magnetic resonance spectroscopy - new fee	N/A	with magnetic resonance spectroscopy	New code			Exxx=$19.40 Eyyy=$9.70	
Sxxx	Laparoscopic placement of probe(s) for ablation of renal tumour	N/A	Laparoscopic placement of probe(s) for ablation of renal tumour	New code			$404.95	
S640	Stereotatic prostate brachytherapy	Stereotatic prostate brachytherapy	N/A	Delete	$ 627.15	x		
	Bone Mineral Density (BMD) - revise limits to meet OHTAC recommendations	N/A	N/A	Revision - PMT rules				x
Rzzz	Laparoscopic banding for morbid obesity	N/A	Laparoscopic Banding for Morbid Obesity	New code			$525.00	
Gxxx	Given capsule endoscopy - P fee Only	N/A	Given capsule endoscopy to identify gastrointestinal bleeding of obscure origin when conventional techniques have failed to identify a source	New code			$122.25	
R259	Osteotomy of ulna	Osteotomy - radius or ulna	Osteotomy - ulna	Revision	$297.85		x	
Rxxx	Osteotomy of radius	N/A	Osteotomy - radius with or without ulna	New code			$411.20	
N282	Brachial Plexus	Brachial Plexus	No change	Fee increase	$593.85	$1,000.00		
S420	Nephroureterectomy	Nephroureterectomy, total, with resection of ureterovesical junction	No change	Fee increase	$592.55	$673.10		
Sxxx	Congenital Diaphragmatic hernia - primary	N/A	Congenital Diaphragmatic hernia - primary or first-stage	New code			$576.90	
Syyy	Congenital Diaphragmatic hernia - secondary	N/A	Congenital Diaphragmatic hernia - Secondary or subsequent stage	New code			$366.00	
S337	Diaphragmatic hernia – trans-abdominal	Diaphragmatic other than oesophageal hernia - One stage procedure - trans-abdominal	N/A	Delete	$508.55		x	
S338	Diaphragmatic hernia – trans-thoracic	Diaphragmatic other than oesophageal hernia - One stage procedure - trans-thoracic	N/A	Delete	$508.55		x	

Fee Code	Fee Code Description	Current Fee Code Description	Proposed Draft Fee Code Description	Action	Existing Fee	Oct 1 2007	Feb 1 2008	Apr 1 2008
S339	Diaphragmatic hernia – second stage	Diaphragmatic other than oesophageal hernia - One stage procedure - second stage	N/A	Delete	$295.40		x	
Exxx	Synovectomy for rheumatoid arthritis or synovial tumour requiring minimum 30 minutes	N/A	synovectomy for rheumatoid arthritis or synovial tumour requiring minimum 30 minutes to resect, add	New code			$175.00	
Sxxx	Closure of "H" fistula via neck or chest	N/A	Closure of H-type tracheo-oesophageal fistula via neck or chest	New code			$923.05	
Syyy	Repair of esophageal atresia with or without tracheal fistula	N/A	Repair of esophageal atresia with or without tracheal fistula	New code			$1,153.85	
S102	Closure of esophago-tracheal fistula	Closure of oesophago-tracheal fistula (includes oesophageal reconstruction and lengthening if necessary)	N/A	Delete			x	
Sxxx	Omphalocele or gastroschisis repair	N/A	Omphalocele or gastroschisis - primary or first stage repair	New code			$375.80	
Exxx	- primary repair where mobilization of the abdominal wall musculature is required	N/A	Omphalocele or gastroschisis - primary or first stage repair - requiring mobilization of abdominal wall musculature	New code			$100.00	
Syyy	Omphalocele or gastroschisis - second repair	N/A	Omphalocele or gastroschisis - Second/subsequent stage repair	New code			$475.80	
S334	Omphalocele or gastroschisis repair - one stage	Omphalocele or gastroschisis repair - one stage	N/A	Delete	$375.80		x	
S335	Omphalocele or gastroschisis repair - multiple stage - gross method or Silon method	Omphalocele or gastroschisis repair - multiple stage - gross method or Silon method	N/A	Delete	$375.80		x	
S336	Omphalocele or gastroschisis repair - second stage	Omphalocele or gastroschisis repair - second stage	N/A	Delete	$375.80		x	
R483	Knee hemiarthroplasty double component	Knee hemiarthroplasty double component	No change	Fee increase	$417.70	$619.90		
Z456	Insertion of permanent feeding line	Insertion of permanent feeding line, e.g. Hickman or Broviac catheter	Insertion of implantable central venous	Revision	$135.50		x	
Z446	Insertion of subcutaneous venous access reservoir	Insertion of subcutaneous venous access reservoir (chemoshunt)	Insertion of subcutaneous venous access reservoir	Revision	$135.50		x	
Exxx	when performed in newborn or child	N/A	when performed in newborn or child, add to Z456 and Z446	New code			$172.65	

Fee Code	Fee Code Description	Current Fee Code Description	Proposed Draft Fee Code Description	Action	Existing Fee	Oct 1 2007	Feb 1 2008	Apr 1 2008
G224	Ankle block	N/A	N/A	Revision PMT rule	$15.55		x	
R244	Revision Total Knee Arthroplasty	Revision total arthroplasty knee	No change	Fee increase	$838.00		$1,174.30	
Rxxx	Replacement liner	N/A	Replacement liner	New code			$353.25	
Gxxx	Serial oral or parenteral provocation testing to a food, drug or other substance	N/A	Serial oral or parenteral provocation testing to a food, drug or other substance in a hospital setting where full cardioresuscitative equipment is readily available when an anaphylactic reaction is considered likely based on a documented history, and the service is performed under direct and ongoing physician attendance	New code			$184.95	
G196	Penicillin hypersensitivity skin test (incl. rev to G195, G199 & GE582)	hypersensitivity skin test for validated drugs or agents	hypersensitivity skin test for validated drugs or agents	Revision	$1.05		$17.00	
G195	Local anaesthetic hypersensitivity skin test	Local anaesthetic hypersensitivity skin test, to a maximum of 25 per year, per test	Local anaesthetic hypersensitivity skin test	Revision			$17.00	
G199	Insect venom skin testing	Insect venom skin testing including physician interpretation, to a maximum of 30 per year, per test	Insect venom skin testing	Revision			$17.00	
E582	when testing with penicillin minor determinant mixture outside a hospital setting.	when testing with penicillin minor determinant mixture outside a hospital setting.	Cost of reagents for penicillin testing outside a hospital setting	Fee increase			$32.20	
E526	Balancing mastopexy	Breast skin reconstruction by local flaps or grafts - with contralateral balancing mastopexy or reduction, to include nipple transplantation, add	no change	Fee increase	$283.35	$401.35		
P031	Suture of incompetent cervix in pregnancy cervical clerage	Suture of incompetent cervix in pregnancy cervical cerclage - any technique	Prophylactic cervical cerclage – any technique	Revision	$145.10		x	
Pxxx	Emergency cervical clerage	N/A	Emergency cervical cerclage when the external os is open to 2 cm or more and the membranes visible or prolapsed- any technique	New code			$250.00	
Pxxx	Percutaneous amniofusion	N/A	Percutaneous amniofusion	New code			$248.85	

Fee Code	Fee Code Description	Current Fee Code Description	Proposed Draft Fee Code Description	Action	Existing Fee	Oct 1 2007	Feb 1 2008	Apr 1 2008
	Mandatory inclusion of hospital number on in-patient and surgical claims	N/A	N/A					x
	Automate payment for age premiums (E021, E014, E009, E019, E007, E018)and K099	N/A	N/A					x

TAB 50

Lawyers for both the OMA and MOHLTC are still making sure there are no drafting mistakes. Changes now will only be technical corrections mutually agreed to. None are expected.

MEMORANDUM OF AGREEMENT

BETWEEN:

THE ONTARIO MEDICAL ASSOCIATION

(The "OMA")

- and -

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

WHEREAS the OMA and the MOHLTC are parties (the "Parties") to a Physician Services Agreement in effect until March 31, 2008 (the "2004 Agreement"), a Reassessment Agreement made pursuant thereto in 2007, and had previously been Parties to Agreements in 1996, 1997 and 2000 and a Memorandum dated April 8, 2003;

AND WHEREAS the Government of Ontario consults and negotiates with OMA as the representative of the medical profession in Ontario;

AND WHEREAS the MOHLTC is charged with the responsibility for health care in the Province of Ontario in a stewardship role;

AND WHEREAS over the past four years the Parties have demonstrated that a focus on measurable outcomes can transform the health system and foster renewal while delivering results for patients;

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

AND CONSIDERING the following principles of the Parties that support this Agreement and the delivery of health care:

- Patients first
- Innovation and the need for ongoing flexibility to meet public needs
- Performance – a focus on results including quality and access
- Transparency and accountability to the taxpayer
- Sharing risks for controllable results and being able to show returns on the Government's investments.

Now the Parties have come to the following 2008 Physician Services Agreement (the "Agreement").

1. RELATIONSHIP

1.1 As stated in the recitals, the Parties acknowledge the importance of our ongoing relationship based on mutual respect, trust, consultation and co-operation. The MOHLTC acknowledges that the OMA is the representative of physicians in Ontario for the purpose of this relationship, these negotiations and this Agreement.

1.2 The Parties also understand that the significant changes to the Ontario health care system require new multilateral and collaborative approaches.

1.3 The Parties expect this Agreement to deliver clear and measurable change in two priority areas: access to family health care for all Ontarians, and reducing congestion in Emergency Departments. To support these and other goals the MOHLTC has made a wide range of investments across the profession to improve patient care throughout the health care system.

1.4 The Parties also acknowledge that the results achieved from these investments will need to be measured and evaluated at regular intervals during the term of this Agreement.

1.5 The Parties agree to continue the Physician Services Committee ("PSC"). The Parties agree that matters arising from this Agreement and the continuing development and strengthening of our relationship will be considered at the PSC. The PSC will continue to provide a broad and structured process for regular liaison and communication between the MOHLTC and the medical profession through its representation by the OMA. The mandate and terms of reference for the PSC are more completely set out in Appendix "A" of this Agreement.

1.6 To implement and oversee the achievement of results under this Agreement, the Parties have or will establish a number of committees in addition to the PSC, as set out in Appendix "A".

1.7 The Parties agree to establish a Financial Planning and Oversight Committee (FPOC), as set out in Appendix "B".

1.8 The Parties agree to continue the Physician – LHIN Tripartite Committee (PLTC), as set out in Appendix "C".

2. DISPUTE RESOLUTION

2.1 The Parties believe that a clear dispute resolution process is important both with regard to disagreements between the Parties concerning the interpretation and application of this Agreement and issues of fair representation that may arise as a result of actions taken by the Parties during the term of this Agreement. The dispute resolution process is set out in Appendix "G".

3. GENERAL FEE INCREASE

3.1 For professional services rendered during the period October 1, 2008 to September 30, 2009, the monthly remittance advice payment will be increased by 3% of the value of services provided within this service period. Effective October 1, 2009, the 3% will be allocated by the Physician Services Payment Committee (PSPC) to the OHIP Schedule of Benefits, in addition to a 2% fee increase effective October 1, 2009.

3.2 The Parties agree to the following global increase to the OHIP Schedule of Benefits, based upon the fee-for-service payments for services rendered in the year ending March 31, immediately preceding the effective date below:

Effective October 1, 2009; 5% (five)
Effective October 1, 2010; 3% (three)
Effective September 1, 2011; 4.25% (four decimal two five)

3.2.1(a) One-half of the increase each year will be allocated on an equal percentage basis to each OHIP Specialty.

3.2.1(b) One-half of the increase each year will be allocated to OHIP Specialties by the Physician Services Payment Committee (PSPC), based upon a relativity methodology agreed to by the Parties. The PSPC is defined in Section 5.4 of the Health Insurance Act.

3.2.2 The amount of increase allocated to each Specialty by 3.2.1 (a) and (b) will be allocated by the PSPC to fee codes billed by that Specialty or in the form of other payments agreed to by the Parties.

3.2.3 The PSPC in making its recommendations, especially for 2009/10, will take into consideration the work done by the Medical Services Payment Committee (MSPC) prior to this Agreement, in identifying codes as deserving change. The MSPC is a committee established under the 2004 Physician Services Agreement.

3.2.4 The MSPC shall carry out the mandate assigned to the PSPC until the PSPC is operational.

3.3 The rate of increase provided for in 3.1 and 3.2 shall flow through to the following contractual payments, excluding administrative and other non-clinical payments, made directly or indirectly by the Ministry to physicians (excluding civil servants):

- Funding agreements for clinical services entered into by the Ministry of Health and Long-Term Care including Alternate Payment Plans and Alternate Funding Plans

- Primary care models, salaries, sessionals, capitation and Monthly Comprehensive Care Fee payments
- Mental Health Sessionals, Sessional Fee Supplement, Psychiatric Stipend, Physicians compensation in Divested Provincial Psychiatric Hospitals, Physicians compensation in Assertive Community Treatment Teams, OPOP sessionals, Visiting Specialist Program and Urgent Locum Tenens Program for Specialists sessionals, and the Hospital Pediatric Stabilization Program
- Fees for medical services listed in the OHIP Schedule of Benefits that are paid by Ministries other than the MOHLTC,

on a basis that achieves comparable economic increases as the physicians paid fee-for-service receive under s.3.1 and 3.2 for such practice. Where there is no corresponding OHIP Specialty, the flow through shall be the unadjusted increases provided for in 3.1 and 3.2.

Non-clinical payments include payments for teaching, research, the Academic Health Sciences Centre (AHSC) AFP Innovation Fund, recruitment, mentoring, honoraria, Hospital On Call Payments and HealthForceOntario (HFO) stipends.

Where a contract does not distinguish between clinical and administrative or non-clinical payments, the Parties will agree to a flow through to be calculated upon no less than 80% of the total contract value.

The PSC will adjust on an annual basis the maximum allowable OHIP billings for non fee service contracts to reflect general fee increases in this contract.

4. DIAGNOSTIC SERVICES

4.1 The Ministry agrees to segregate technical fees from the Physician Services budget into a Diagnostic Services budget and to establish a new supporting structure both by April 1, 2009 involving the OMA and other key stakeholders.

4.2 A fund of $15 million for technical fees will be provided, with the method of allocation to be determined by the PSC. Any future funding increases will be determined through a separate process.

5. PRIMARY CARE

Unattached Patient Bonus and Registry

5.1 The Parties share a common goal that all Ontarians should have access to high quality family health care and agree that using a systematic approach to identify unattached patients will assist in achieving this goal. The Parties share the commitment to work together to a target of attaching a minimum of 500,000 unattached patients to a family physician within three years of ratification of this Agreement, while ensuring the stability

of current patient rosters. The parties agree that approximately 400,000 patients at any one time are in transition between family health care providers. An Unattached Patient Collaboration Initiative will be established as described in Appendix "D".

In Office Service Bonus

5.2 The PSC will develop a payment to PEM physician and physician groups who provide a broad range of in-office services. A recommendation will be made to the parties for implementation by April 1, 2010. A fund of $5 million will be set aside in the first year of the program and $10 million will be set aside on an annual basis thereafter.

Out of Office Service Bonus

5.3 To compensate those family physicians that provide services outside of their offices that are required by the public for effective and timely access to health care, the Parties have agreed to the programs set out at Appendix "E" as follows:

- Individual Incentive Bonuses for Aging at Home/End of Life Care, and Maternity and Newborn Care.
- PEM Group Bonus Payment for Out-of-Office Care.

PEM Group Bonus Payment for After Hours Care

5.4 (a) A bonus program will be established for physician groups who reduce their rostered patient use of EDs. Up to $2.5 million dollars will be available in 20011/12 for this program.

(b) If a physician group meets the determined target for CTAS IV and V visits to the ED by their rostered patients they will be eligible for a bonus paid to the group. The targets will be based on NACRS data and be sensitive to rurality. Advice on targets will be received from the ED Expert Panel and the PSC will make recommendations to the Parties.

Locum Programs and Service Bonus Calculations

5.5 Effective April 1, 2009, the services provided by a physician working as a "locum" shall count toward the entitlement to all service-related premiums and bonus thresholds on behalf of the physician for whom the "locum" is standing in for patient service. The Parties shall establish a simple reporting procedure to support this process.

Chronic Disease Management - Diabetes

5.6.1 All family physicians will be eligible to bill Q040A for the Diabetes Management Incentive (DMI). Those not already eligible for the DMI will be eligible effective April 1, 2009.

5.6.2 With the establishment of the MOHLTC Diabetes Registry, a new DMI will be paid to all family physicians who fulfill the incentive criteria based on the current Canadian Diabetes Association Practice Guidelines, including registration of each patient on the Diabetes Registry and provision to the patient of MOHLTC information resources on how to access the Registry for the self-care component. The fee will be established by the Parties.

5.6.3 In the interim, in order not to disrupt the chronic disease initiative established in 2004 with respect to diabetes care, the current DMI fee (Q040) will be available to all family physicians.

5.6.3.1 Effective April 1, 2009, Q040A will be paid at $75.00.
5.6.3.2 Phasing out of this incentive will be considered by the Parties based on physician participation in the Diabetes Registry.

5.6.4 To encourage the adoption and use of the Diabetes Registry by physicians and their patients, a new bonus will be awarded to physicians who register their patients. This is a one-time program that will only apply to patients registered within the first 12 months after the Diabetes Registry is active. The thresholds and bonus amounts for this one-time program are described below.

Threshold	**Bonus amount per physician**
Between 15 and 49 patients	$500.00
50 patients or more	Additional $500.00

5.6.5 To continue promotion of Chronic Disease Management, effective April 1, 2009, existing after hours codes Q012 and Q016 will also be eligible to be billed with K030A and any other applicable CDM codes.

G.P. Focused Practice

5.7.1 In recognition of specialized services provided by GP Focused Practice physicians and their possible impact on the access bonus of physicians participating in Harmonized Model agreements, the Parties agree to extend the focused practice self-identification process as follows:

5.7.1(a) Through the PSC, the Parties may identify specific focused practice areas for exemption.

5.7.1(b) Any focused practice family physician may apply for a full exemption to access bonus impact as originally identified in the 2007 Reassessment through the Program Eligibility Review Committee as set out in Appendix “A.1”.

5.7.2 Recognizing that there will continue to exist other focused practice physicians not covered by the preceding options, effective October 1, 2009, the Parties agree that focused practice physicians will be eligible to bill two assessments in follow-up to a focus practice consultation without any impact on an access bonus when a patient has been referred from a harmonized physician. Harmonized physicians may refer up to 6 patients per year per 1,000 rostered patients (pro-rated for average size of rostered practice during the year) to any such self identified focus practice physician.

5.7.3 FHG and CCM Agreements

The Parties agree to extend the term of existing FHG and CCM agreements to the end of the term of this Agreement.

The current Term of Agreement provision in the FHG and CCM agreement will be deleted and replaced with,

"This Agreement will remain in effect until March 31, 2012, but notwithstanding any other provision contained herein; this Agreement may be terminated before that date by either the Physicians or the Ministry giving the other 90 days written notice of their intention to so terminate".

Inter-Professional Shared Care

5.8.1 Beginning in 2009/10, the MOHLTC will provide full salary support for up to 500 currently licensed nurses to be added to eligible practices. Access will be expanded to currently licensed nurses for non-harmonized Patient Enrolment Model (PEM) practices (FHGs and CCMs) to support three key priority areas: Aging at Home Strategy, End of Life Care, and mental health and addictions.

5.8.2 The Parties will develop a simple application process and an eligible practice may apply for financial support from the program based on the following criteria:

a) Demonstrated focus on one or more of three priority areas: aging at home (CDM, home visits, LTC visits), End of Life care, mental health and addictions.

b) A commitment by a practice to attach 200 to 400 patients per nurse as a result of the program.

c) Partnering or co-ordination arrangements with a local Community Care Access Centre, mental health organization, or LTC facilities.

d) Demonstrated alignment to the health needs of the population in the community served by a practice.

The application may provide for a reasonable administration cost in its budget.

5.8.3 An application may be made to cover the full salary cost of a nurse in any of the pre-existing nurse pilot projects pursuant to 5.8.2. This will apply to harmonized models that took part in a pilot project.

Capitation Rate

5.9 In the last fiscal year of this Agreement the PSC shall strike a Working Group to consider expert advice and submissions toward updating the capitation methodology, possibly to incorporate the burden of illness of patients. The Working Group shall report to the PSC by December 1, 2011.

Student Health Clinics

5.10 The Parties agree that the PSC shall appoint an agreed upon person to provide a review and analysis of the services provided by Student Health Clinics no later than January 1, 2011. The review will identify any shortfall in service to the unique communities served by such clinics and the appropriateness of current compensation arrangements for physicians serving in such clinics including availability of primary care models and rostering.

Hospital Services Payments

5.11 Effective October 1, 2008, the Parties shall amend the existing list of codes used to determine the threshold for payment of the special payment for hospital services in harmonized models to include C122, C123, C124, C142, C143 and any Cxxx enhanced MRP codes created pursuant to s.6.1.1.

Northern and Rural Harmonized Models

5.12.1 Effective April 1, 2009, Appendix "D" of the Family Health Network (FHN) Agreement shall be amended as follows:

"In northern and rural areas, at least 50% of the FHN Physicians must have active in-patient hospital privileges and involvement, where appropriate, with discharge planning, rehabilitation services, out-patient follow-up and home care services. In the categories of in-patient hospital privileges and involvement with discharge planning, physicians 65 years of age and older will not have to be counted in the preceding requirement."

5.12.2 Any Harmonized Model agreement shall also be amended to be consistent with section 5.12.1.

5.12.3 Effective April 1, 2009, in northern and rural areas where at least 50% of the FHN Physicians must have active in-patient hospital privileges, each FHN Physician shall be eligible for a new special payment for hospital services where a physician shall receive a revised payment of $12,500 after submitting valid claims for services totalling $6,000 in

any fiscal year from the list of services set out in Schedule 4 of the FHN contract. The basket of services will be modified to reflect the changes outlined in 5.11.

Community Health Centres (CHCs) and Aboriginal Health Access Centres (AHACs)

5.13 The Physician - LHIN Tripartite Committee (as described in Appendix "C") will review the alignment of CHC physician compensation with CHC service profile and accountability within their LHIN. Compensation models, including a fully salaried model, will be considered during the review. Consideration of the impact on the AHAC model will be undertaken by the PSC. The review will be completed no later than October 1, 2009.

6. HOSPITAL CARE

Enhanced Funding for MRP Physicians Admitting Unscheduled Patients

6.1.1 Effective October 1, 2009, a 30% increase will be targeted to key fee codes for MRP care (codes include: admission assessment codes C933, C122, C123, C124, C142, C143; subsequent visit codes Cxx2, Cxx7, Cxx9; and Cxx5 consultation codes). The increased codes will be billable by MRP physicians caring for patients admitted to hospital. Routine admissions for labour and delivery (including routine newborn assessments) will not be eligible for the enhanced MRP codes. The increased codes will reflect the importance and scope of the MRP role.

6.1.2 Access to the enhanced fee codes for MRP care by a physician will require an annual declaration by the physician's hospital that there is no top-up or financial subsidies provided to that physician for direct or indirect MRP care.

6.1.3 The MOHLTC commits funding to provide peer support and best practice guidelines for hospitals and their hospitalists to reorganize their MRP program to meet the program requirements.

6.1.4 The Parties will examine the progress of hospitals that are not part of the enhanced program.

6.1.5 A further $33 million will be available for an incentive payment through the MRP Collaboration Initiative fund (Section 9.3) to recognize MRP physician groups at the hospital and LHIN level that receive enhanced fee codes for meeting established targets related to effective management of hospital patients. Key indicators: average length of stay, "may not require hospital" rate, and readmission rates. The incentive will be split to recognize both physician contributions at the LHIN level and at the hospital level (proposed 25/75 ratio).

Hospital On Call Programs

6.2 The Parties agree that an effective HOCC program with appropriate participation by LHIN-based hospital networks is important to the provincial health care system.

6.2.1 The MOHLTC will undertake responsibility for the administration of the HOCC program as of March 31, 2009, or such earlier date as is agreed upon by the Parties.

6.2.2 A Working Group reporting to the Physician-LHIN Tripartite Committee will be appointed to conduct a detailed review of HOCC and the Physician-LHIN Tripartite Committee will report to the three parties. The Working Group will consist of representatives from the MOHLTC, LHINs and the OMA. The Working Group will receive expert advice and will complete its work by October 1, 2010. The review will consider the effectiveness of HOCC, including:

- A methodology for providing data regarding the use of HOCC funds to allow for appropriate audit.
- The participation of doctors in Criticall Ontario.
- An enhanced premium for physicians required to stay in house on call.
- The use of Regional Call networks.
- Enhanced coverage for long-term care, sexual assault centres, chronic care facilities and palliative care programs.
- The role of LHINs and hospitals.
- Permitting physicians to register for on call at more than one hospital or facility for different shifts.
- Establishing a common payment per on call shift.
- Such other priorities as the Parties may request.

6.2.3 The Parties agree to work together on an appropriate physician compensation plan required to address any policy changes brought forward as a result of the review. To facilitate this, the MOHLTC has reserved $20 million annually commencing April 1, 2011. Ongoing funding will depend on annual reporting to the MOHLTC of the distribution of funding to the individual physician level.

6.2.4 An On Call Coverage Collaboration Initiative fund of $22 million will be established as set out in Section 9.3 to recognize physicians in each LHIN where following implementation of recommendations pursuant to 6.2.2, a comprehensive regional on-call coverage program is in place and aligned to the needs of that community.

Emergency Department Funding

6.3.1 Ensuring timely access to ED services 24/7 is a goal shared by both Parties. To recognize the importance of this goal, the ED Collaboration Initiative fund (Section 9.3)

of up to $14 million will pay an incentive initiative to recognize ED physicians at the LHIN level whose LHIN hospitals meet the following goals:

(a) All the EDs at hospitals in a LHIN did not close for any period of time over the course of the year due to physician staffing issues.

(b) All the EDs at hospitals in a LHIN achieved the wait time benchmarks established by the ED expert panel for CTAS IV and V patients. (This assumes the establishment and functionality of the Emergency Department Information System.)

6.3.2 For MOHLTC-designated urgent care clinics (UCCs), there will be no reduction in the access bonus for patients that use the UCC. The Parties will monitor the effect of this initiative on ED volumes.

AHSC AFP – Northern Ontario School of Medicine

6.4.1 The Parties agree to establish a Northern Ontario School of Medicine (NOSM) alternate funding program (AFP) involving NOSM participating physicians, participating hospitals and the universities, with a target to have it in place April 1, 2009. This agreement will be based on and aligned with, wherever applicable, the provincial AHSC AFP template agreement.

6.4.2 The participating physicians, hospitals and university will be required to establish a governance organization within the applicable parameters of the provincial AHSC AFP template agreement. Accountability and reporting requirements included in the provincial AHSC AFP template agreement, wherever applicable, will apply.

6.4.3 Funding provisions for the NOSM AFP are set out at Appendix “F”.

7. MENTAL HEALTH

Divested Provincial Psychiatric Hospitals

7.1.1 Effective April 1, 2009, the MOHLTC will provide funding to applicable LHINs to bring the compensation for divested psychiatric hospital services provided by FRCPC psychiatrists (psychiatrist 2) to a target range of $206,690 to $239,269; psychiatrist 1 (non FRCP psychiatrist) $169,894 to $196,674; pediatrician/developmental specialist $206,690 to $239,269; and general physician $150,995 to $174,796 (FY2007/08) per full-time equivalent per year (at the appropriate percentage of a FTE depending on service commitment). Ongoing funding will depend on annual reporting to the MOHLTC of the distribution of funding to the individual physician level.

Assertive Community Treatment Programs

7.1.2 Effective April 1, 2009, the MOHLTC will provide funding to LHINs to bring the compensation for services provided by psychiatrists working on Assertive Community Teams (ACT) aligned with the applicable ranges in section 7.1.1 per full-time equivalent per year at the appropriate percentage of a FTE. Ongoing funding will depend on annual reporting to the MOHLTC of the distribution of funding to the individual physician level.

Ontario Psychiatric Outreach Program

7.1.3(a) Effective April 1, 2009, in regard to the Ontario Psychiatric Outreach Program, the sessional rate paid to psychiatrists participating in the Northern Ontario Francophone Psychiatry Program (NOFPP), the University of Toronto Psychiatry Outreach Program (UTPOP) and the University of Western Ontario Psychiatry Outreach Program (UWOPOP) will be aligned with the current mental health sessional rate of $459/3-4 hour session. Any increases in this rate pursuant to Section 3 of this Agreement will flow through to said rate.

(b) A maximum of three sessions can be billed per day.

(c) A program honorarium of $300 will be paid for any scheduled day of work as travel to reflect the extra effort required to provide care pursuant to this program, and the disruptive impact on the physician's practice. If approved by the program director, the honorarium will be paid for a day booked for travel even if the travel is cancelled within 48 hours of departure through no fault of the physician.

(d) Reasonable travel expenses, including meals and lodging, are covered at cost.

(e) Travel time will be remunerated at the sessional rate provided in (a) above and, if approved by the program director, the honorarium will be paid for a day booked for travel even if the travel is cancelled within 48 hours of departure through no fault of the physician.

Mental Health Sessional Payments and the Sessional Fee Supplements

7.1.4 Mental Health Sessional Payments and the Sessional Fee Supplements paid via community mental health agencies, addiction agencies and non-Schedule 1 hospitals, will be expanded by increasing the number of allowable sessionals by 40% in two stages:

a) Stage 1, 20% increase effective 2009/10.

b) Stage 2, 20% increase effective 2010/11.

The goal of this investment is to strengthen access to community mental health services for high-risk individuals. The funding will be aligned with current provincial goals of

unattached patients, emergency department congestion, and the provincial strategy on mental health and addictions.

7.1.5 The MOHLTC agrees to harmonize its current mental health funding programs. The MOHLTC will establish a technical advisory group to advise on the recommended actions to achieve this result. The goals of said harmonization are to:

a) Combine mental health sessional, sessional fee supplements, and psychiatric stipend funding currently paid to Schedule 1 hospitals and centralize these in one area of the MOHLTC for distribution and tracking.

b) Combine current mental health sessional and sessional fee supplements paid via community mental health agencies, addiction agencies and non-Schedule 1 hospitals and flow them from one area in the MOHLTC to the LHINs.

8. ENHANCED CARE FOR FRAIL ELDERLY

8.1 As part of the Aging at Home Strategy, the Ministry will put in place an enhanced interdisciplinary team-based care model for the provision of specialized health services to the frail elderly, including LHIN-based outreach. The target date for this model will be April 1, 2009.

8.2 Geriatricians participating in the enhanced model will be compensated at a fiscal year 2008/2009 FTE rate of $330,000 annually.

8.3 The MOHLTC will invest to support the recruitment of an additional 10 FTE Geriatricians to participate in the enhanced model.

9. LHIN PHYSICIAN COLLABORATION INCENTIVE FUND

9.1 The Ministry will establish a new LHIN Physician Collaboration Incentive Fund to recognize and reward the local efforts of physician groups who work together and in collaboration with other service providers to support the needs of patients in targeted areas of care.

9.2 The establishment of targets and the implementation of these incentive funds will be the responsibility of the Physician – LHIN Tripartite Committee.

9.3 A total of $100M will be available to support four LHIN Physician Collaboration Incentive Fund initiatives:

- $33M for a MRP Collaboration initiative (Section 6.1.5) to recognize MRP physician groups at the hospital and LHIN level for meeting established targets related to effective management of hospital patients in 2009/10 and 2010/11. To allow for evaluation of target achievements, payment is made in the

following fiscal year. Key indicators are: average length of stay, "may not require hospitalization" rates, and readmission rates.

- $14M for an ED Collaboration initiative (Section 6.3.1) to recognize ED physician groups at the hospital and LHIN level meeting established targets related to effective management of ED patients in 2009/10 and 2010/11. To allow for evaluation of target achievements, payment is made in the following fiscal year. Key indicators are: Wait time benchmarks, 24/7 ED access.

- $31M for an Unattached Patients Collaboration initiative (Appendix "D") to recognize physicians who work together at the local and LHIN level to achieve established targets for rostering unattached patients in 2009/10 and 2010/11. To allow for evaluation of target achievements, payment is made in the following fiscal year.

- $22M in 2011/12 for an On Call Coverage Collaboration initiative (Section 6.2.4) to recognize HOCC physician groups in those LHINs where a comprehensive regional on-call coverage program is in place and aligned to the needs of that community.

10. RECRUITMENT AND RETENTION INITIATIVES

Student Loan Interest Relief

10.1 In order to support the attraction and retention of new graduates, the MOHLTC will implement the following program in 2009/10 regarding student debt relief:

(a) Eligible debt is that incurred through any Canadian government (Federal or Provincial) student loan program;

(b) Eligible trainee physicians are those in an Ontario government funded post-graduate medical training program;

(c) The Ministry will pay the full interest on the eligible debt through the end of the residency training program;

(d) Ontario residents will not be required to make any payments on the principal of the eligible debts during their training; and

(e) To qualify for this program, the physician must make a commitment at the time of enrolling in the program to stay practicing in Ontario for five years after successful completion of the residency program. If the physician leaves practice in Ontario, they will reimburse the Government the full cost of the amounts paid under this program.

Alternate Funding Agreement Recruitment

10.2 The MOHLTC will provide new funding to support AFP and APP recruitment or Specialty Review funding up to the following amounts:

2009/10 - $ 4.5 million
2010/11 - $ 8.0 million
2011/12 - $15.0 million

11. INCORPORATION

11.1 The MOHLTC will recommend to the Government any necessary amendments to the regulations under the *Business Corporations Act* and the *Regulated Health Professions Act* to expand the definition of "family member" for the purpose of holding non-voting shares in a Medicine Professional Corporation (MPC) to include; common law spouses, adopted children, stepchildren and step-parents. Subject to appropriate legislative drafting of the definitions, stepchildren shall mean children of a current or former spouse or common law spouse in regard to whom the physician has had a relationship of "in-loco-parentis" at some time, and step-parent shall mean the spouse or common law spouse of a parent of the physician who is not a natural or adoptive parent of the physician.

11.2 MPCs shall be entitled to sign any APP, AFP or similar agreement with the MOHLTC and there shall not be any special requirements for physician shareholders in the MPCs who do not provide services under the agreements. Existing requirements will continue for participating or designated physicians, including the execution of declarations and consents.

11.3 The Parties agree to explore options for simplifying the College application/renewal process for MPCs. The review process will involve all affected Parties.

12. BENEFITS

12.1 Pursuant to S. 14.1 of the 2004 Framework Agreement between the parties the MOHLTC has agreed to contribute $25 million annually to the OMA health related insurance program. The MOHLTC will pay the entire amount to the OMA annually for this purpose. The nature of an insurance program means that the actual annual expenditure will vary depending upon such considerations as registration numbers, variance from actual assumptions and utilization. Recognizing therefore that actual fund expenditure will vary from year to year, the OMA will make appropriate fiscal arrangements to hold the payments received from the MOHLTC solely for the insurance program. It is acknowledged that the OMA may, in any given year, make a program expenditure that is to be recovered from future MOHLTC payments for this program. The OMA agrees that the fiscal records of the insurance program will be available for audit by the Government of Ontario. Should the OMA accumulate a surplus exceeding

$25 million in this account, the Parties shall discuss an adjustment to the MOHLTC obligation to make future contributions.

13. CLERKSHIPS

13.1 The Clerkship Stipend program set out in S.19.1 of the 2004 Agreement is continued and is amended effective July 1, 2008 to provide a payment of $750.00 per month.

13.2 The funding provided for clinical rotations as set out in S.19.2 of the 2004 Agreement shall be continued and effective April 1, 2011, will be available for all training more than 100 kilometres from the border of the student's home community, within Ontario subject to eligibility criteria to be developed by the PSC.

14. TELEMEDICINE

14.1 Increases provided in this Agreement, including Section 3, shall flow through to corresponding relevant fee codes, including any unique codes for Telemedicine.

14.2 The MOHLTC confirms its recognition of the OMA as the representative of physicians in any consideration of compensation matters relating to Telemedicine.

15. VISITING SPECIALIST CLINIC PROGRAM AND URGENT LOCUM TENENS PROGRAM FOR SPECIALISTS

15.1 (a) Effective April 1, 2009, the sessional rate paid to Specialists participating in the Visiting Specialist Clinic program or Urgent Locum Tenens Program for Specialists will be aligned with the Ontario Psychiatric Outreach Program (OPOP) at a sessional rate of $459 per 3-4 hour session. Any increases in the OPOP rate pursuant to Section 7.1.3(a) of this Agreement will flow through to said rate.

(b) The physician may choose to bill fee-for-service to OHIP or claim a stipend as outlined above. Physicians are encouraged to bill fee-for-service rather than the stipend on days where FFS billings are expected to exceed the sessional rate.

(c) A maximum of three sessions can be billed per day.

(d) A physician may either bill fee-for-service or stipend on any approved clinic day, but claiming both types of payment for the same clinic day is prohibited. This does not apply if a physician has provided office or on call services in his/her home community prior to providing service at the clinic site.

(e) A physician is allowed a $300 honorarium per day of clinical service and/or travel. If approved by the program director, the honorarium will be paid for a day booked for travel even if the travel is cancelled within 48 hours of departure through no fault of the physician.

(f) Travel time will be remunerated at the sessional rate provided in (a) above and, if approved by the program director, the honorarium will be paid for a day booked for travel even if the travel is cancelled within 48 hours of departure through no fault of the physician.

16. HEALTH CARD VALIDATION

16.1 The MOHLTC commits to make "real-time" health card validation accessible to office-based providers by March 31, 2011.

17. ALTERNATE PAYMENT PLANS

Genetics

17.1 The MOHLTC will provide a funding contribution to support the compensation for services provided by CCMG and FRCP geneticists to a target rate to be agreed to by the Parties, effective October 1, 2010. The Parties expect to be informed by the compensation currently paid to geneticists across institutions in Ontario.

Infectious Diseases

17.2 The Parties agree to negotiate an APP for Infectious Diseases specialists (both Pediatric and Internal Medicine subspecialists) engaged in infectious disease prevention and control, to be in place by October 1, 2010.

17.3 LABORATORY PHYSICIANS

17.3.1 The MOHLTC shall make the following investments to assist hospitals to recruit new laboratory physicians and expand capacity for laboratory medicine:

- $1M in 2009/10
- $3M in 2010/11
- $5M in 2011/12

A payment of up to $100,000 per new recruit will be made to bring the laboratory physician up to the Uniform Minimum Level of Compensation. Payment will be made once the recruit is on-site and licensed in Ontario.

Recruitment funding will reflect a regional/provincial approach to rationalization of lab physician distribution, be aligned with public need, and reflect advances in quality of care and benefits of technology.

17.3.2 Laboratory physicians will receive the additional payment based on the percentage set out in Section 3.1.

17.3.3 The Uniform Minimum Level of Compensation will increase by the percentages stated in Section 3.2.1a). The Parties agree to consider a relativity adjustment for laboratory physicians to be applied to the Uniform Minimum Level of Compensation.

17.3.4 The Parties agree to establish a Laboratories Physician Committee to report to the PSC to provide guidance on initiatives currently underway as per the 2004 Laboratory Physicians Agreement.

18. INTERPROFESSIONAL HEALTH CARE — SPECIALISTS

18.1 The Parties are committed to the development of collaborative care models that will improve patient access to needed health care services. The PSC will evaluate the effectiveness of existing pilots and will consider options to move effective pilots into programs with ongoing funding and will report to the Parties. The Parties will address physician compensation related to these programs.

19. NORTHERN AND RURAL PROGRAMS

19.1 Subject to consultation with affected physicians, the Parties intend to align the following programs with RIO 2008-BASIC methodology:

- Rural CME
- Rural Medicine Investment Program (RMIP)
- Hospital Rurality Premium Top-Up
- Rurality Premium

The Parties will discuss the impact on physician compensation.

19.2 The MOHLTC will continue the Northern Physician Retention Initiative.

20. DATA SHARING

20.1 Following ratification, the Parties will review and revise their current data sharing agreement as necessary. The provision of this information will be subject to the compliance with all applicable privacy legislation, including the *Freedom of Information and Protection of Privacy Act* and the *Personal Health Information Protection Act*, 2004, as amended.

21. TERM AND RENEWAL

21.1 This Agreement will begin on April 1, 2008, and will terminate at the end of March 31, 2012. Negotiations to establish the next Physician Services Framework Agreement will begin no later than January 10, 2012. The MOHLTC recognizes the OMA as the representative of the medical profession for the purposes of these negotiations. The Parties may mutually agree to utilize the services of the “Independent

Facilitator" set out in Appendix "A" Physician Services Committee to assist the Parties in negotiations for a new agreement in 2012.

The undersigned representatives of the Parties hereby agree to unanimously recommend acceptance of this Agreement to their respective principals.

DATED AT TORONTO, ONTARIO THIS ____ DAY OF _____, 200____.

FOR THE OMA	FOR THE MOHLTC
_____	_____
_____	_____
_____	_____

Appendix A

PHYSICIAN SERVICES COMMITTEE

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

Co-Chairs
Each of the Parties will appoint a co-chair.

Facilitator
The PSC will have an independent facilitator chosen by the Parties and subject to an annual review or a review at the request of either Party.

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

Agenda Setting
The agenda of the PSC will be set by the co-chairs appointed by the Parties, in consultation with the facilitator. In the event of a dispute, the facilitator will set the agenda.

Funding
Each Party will fund its own members and the MOHLTC will fund the administration costs of the Committee and the facilitator.

Meetings
The PSC will normally meet twice a month.

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

- To build and sustain a strong positive relationship between the Government of Ontario and the medical profession;
- To receive and consider reports and recommendations as set out in this Agreement;
- To advise the Parties in connection with the changing role of physicians within the health care system, as it pertains to the Agreement, including possible improved models of delivery of and compensation for services;
- To develop recommendations, either on its own initiative or as a result of reports and recommendations received from committees reporting to it, to the MOHLTC and the OMA leading to the enhancement of the quality and effectiveness of medical care in Ontario;
- To develop and recommend patient education programs;

- To participate in the Dispute Resolution Process in accordance with its requirements as described elsewhere in this Agreement;
- To consider matters referred to it by either Party.

Committees

1. *The Parties plan to rely on ad hoc working groups to work on various mutual initiatives*
   - Issue-specific, time-limited
   - Established by PSC or FPOC

2. *The following ongoing committees will report to PSC:*
   - Laboratory Physicians Committee
   - Academic Medicine Steering Committee
   - Third Party Implementation Advisory Committee
   - Program Eligibility Review Committee
   - Forms Committee

Appendix A.1

PROGRAM ELIGIBILITY REVIEW COMMITTEE

Core Membership
Core membership will be composed of staff from each Party supplemented with other representatives as needed.

Facilitator
The PSC will provide facilitation support to this Committee.

Funding
Each Party will fund its own members and the MOHLTC will fund the administration costs of the Committee.

Reporting
The Program Eligibility Review Committee will report to the PSC. Reports will be presented to the PSC as requested.

Mandate
To review requests and appeals and make physician eligibility decisions on physician payment programs including but not limited to:

- Clerkship Stipend Program
- Continuing Medical Education
- GP Focused Practice
- GP Psychotherapy
- Mental Health Stipend Program
- Northern Physician Retention Initiative
- Hospital Pediatric Stabilization Program
- Pregnancy and Parental Leave Benefit Program
- Service Recognition Payment
- Rural Medicine Incentive Program

Appendix B

FINANCIAL PLANNING AND OVERSIGHT COMMITTEE

Membership
Each Party will appoint individuals with senior decision-making authority.

Co-Chairs
Each of the Parties will appoint a co-chair.

Reporting
The FPOC will report to the Parties.

Agenda Setting
The agenda of the FPOC will be set by the co-chairs.

Funding
Each Party will fund its own members and the MOHLTC will fund the administration costs of the Committee and the facilitator.

Meetings
The FPOC will meet once monthly.

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

- To track Agreement-related expenditures;
- To review utilization reports on a monthly basis;
- To realign and adjust within budget the initiatives under this Agreement to achieve their objectives;
- To negotiate any outstanding compensation matters arising from the Agreement;
- To identify efficiencies and maximize return on funding provided under this Agreement;
- To track expenditures from the LHIN Physician Collaboration Incentive Fund and the PEM Group Bonuses on an ongoing basis, and make any recommendations for adjustments to the fund and bonuses;
- If funding for any one component of the LHIN Physician Collaboration Incentive Fund and the PEM Group Bonuses has not been fully distributed, make recommendations for changes within the parameters of the Incentive Fund and bonuses;
- To recommend to the Parties appropriate and effective steps to be taken to deal with system management issues.

2008 Priorities

- To consider approaches to review the appropriate use of the fee schedule, including expert reviews.
- Collection of physician level compensation data across all government funded programs.

Appendix C

PHYSICIAN - LHIN TRIPARTITE COMMITTEE

Mandate
The Parties understand that the significant changes to the Ontario health care system require new multilateral and collaborative approaches. The Physician – LHIN Tripartite Committee (PLTC) will provide a forum for the OMA, the MOHLTC and representatives of the LHINs to meet regularly to discuss, review, and respond to matters of mutual interest for the benefit of the health care system.

Areas of Responsibility
The PLTC will:

- Provide a mechanism through which the parties can obtain input from each other about proposed planning, funding and service delivery decisions that affect physicians;
- Provide a mechanism through which the parties can receive early notice about activities/initiatives that involve physicians and may have implications for the other Parties;
- Establish and monitor programs and targets for the LHIN Physician Collaboration Incentive Funds established in Section 9 of this 2008 Physician Services Agreement;
- Discuss effective strategies for communicating with physicians and engaging physicians in LHIN initiatives;
- Collectively identify and address issues of provincial significance;
- Address any specific issue directed to it by the parties;
- Conduct reviews identified in the 2008 Agreement: HOCC; CHC.

Membership
Each party will appoint 3 representatives, for a total of 9 members. Each party will identify a Co-Chair.

Co-Chairs
Meetings of the Committee will be facilitated by an agreed upon neutral facilitator. The Co-Chairs will set the agenda.

Reporting
The PLTC reports to the parties.

Frequency of Meetings
The Committee will meet every 2 months or more often as agreed to by the parties.

Budget:
The parties will be responsible for the honoraria and expenses of their respective members.

Appendix D

UNATTACHED PATIENTS

1. Principles

1.1 The Parties share a common goal that all Ontarians should have access to high quality family health care and agree that using a systematic approach to identify unattached patients will assist in achieving this goal. Once an unattached patient information system is in place and functioning, an appropriate goal will be to establish an acceptable timeframe which is considered an acceptable wait to find a family doctor when moving, a doctor retires, upon arriving in the province, and in other circumstances that result in a resident not having a family doctor.

1.2 The Parties share the commitment to work together to a target of attaching a minimum of 500,000 unattached patients within three years of ratification of this Agreement, while ensuring the stability of current patient rosters. The Parties agree that approximately 400,000 patients at any one time are in transition between family health care providers. Attaching new patients will be supported by new fees and fee enhancements as set out below.

2. Fees and enhancements for rostering unattached patients

2.1 **New Unattached Patient payments for family physician:**

2.1.1 A new Complex/Vulnerable New Patient fee, a one-time payment of $350 for attaching the patient, will be introduced effective April 1, 2009.

> (a.1) The Minister's Expert Panel on Unattached Patients will recommend to government identification criteria of this patient group. The OMA and others will provide input on the definition to this Expert Panel.
>
> (a.2) The Parties will decide how to apply the $350 fee to this group of patients.
>
> (b) If the MOHLTC unattached patient information system is not ready on April 1, 2009, this fee will apply to "complex or vulnerable" hospital inpatient or ED patients pursuant to a methodology agreed to by the Parties. If required, the identification of patients will be updated on an annual basis at the hospital level.

2.1.2 Unattached mother and newborn(s) within 2 weeks of birth:

Effective April 1, 2009, physicians taking on as new patients an unattached mother within two weeks of giving birth, will be eligible for a $350 fee for attaching both the mother and newborn. Complete care for the newborn should be provided within two

weeks of birth and rostering of the mother and newborn must occur within three months of being attached.

Physicians taking on as new patients an unattached woman after 30 weeks of pregnancy will be eligible for the $350 new patient fee providing the newborn is attached at birth and receives appropriate care within two weeks of birth and both are rostered within three months.

In the case of multiple births, the new patient fee for each additional newborn of an unattached mother will be $150.

2.1.3 The new fee codes for all patients listed above will not be subject to any billing maximums.

2.2 **Expanded access to unattached patient codes**

2.2.1 All family physicians in PEM models can bill both existing and new fees applicable to New Patients (from the unattached patient information system or through other mechanisms).

2.2.2 Fee codes for patients attached from the unattached patient information system will not be subject to any billing maximums.

2.2.3 Payment of all new patient fees is subject to current requirements (i.e. patient must be rostered and Unattached Patient Fee Form completed).

2.3 **Enhanced payments for caring for complex/vulnerable patients**

2.3.1 For physicians in harmonized models, an annual payment of $500 will be added to the existing capitation rate for any complex/vulnerable patients rostered through this initiative. One year after the patient's enrolment this annual payment will end and the physician will then receive the appropriate capitation rate according to the current schedule. For salaried and blended salaried model physicians in harmonized models, a $500 capitation payment will flow for one year following rostering. At the end of the year, this payment will cease.

2.3.2 For physicians in non-harmonized models, the rostering physician will receive 150% of the value of all fees billed applicable to these patients during the first year of care. At the end of the first year of care, fees billed will be paid at the regular rate.

3. Unattached Patients Collaboration Initiative

3.1 A new "community-level" incentive of up to $31 million will be introduced that will reward all PEM family physicians in LHIN-defined geographic sub-regions if community-specific targets for attaching new patients are achieved.

3.2 Once the unattached patient information system is in place for a period of time, the target will be a timeframe to “being attached to a primary care physician”.

3.3 Over the course of the Agreement, the specific targets may change from the community level to the level of the LHIN.

3.4 Twenty-five percent (25%) of the bonus available will be allocated for greater recognition of those who make a significant contribution to attaching patients.

3.5 The bonus will be payable on a pre-determined timeframe when the target is achieved within each community/LHIN.

Appendix E

OUT OF OFFICE INCENTIVE BONUSES

1.1 Bonus Categories

- Aging at Home/End of Life Care: three bonus categories – LTC Homes, Palliative Care, Home Visits

- Maternity & Newborn: One bonus category – Labour & Delivery

2.1 The bonus initiative is structured around two or three levels of bonuses depending on the activity and is based on yearly volume of activity in each area. Bonuses can be earned by providing services to both rostered and non-rostered patients and payments begin in 2009/10.

2.1.1 "A" or "B" level bonuses will be applicable to all family physicians.

2.1.2 "C" level bonuses will be applicable to physicians in patient-enrolled models only.

2.1.3 Eligibility for a yearly bonus in a given category will be based on the number of persons (for home visits: patients and services combined) served by a physician as identified by key billing codes in that category (see Schedule A).

Schedule A – Bonuses

	Home Visits		
Bonus Level	**A**	**B**	**C**
Necessary annual criteria	3 or more patients served and 12 or more encounters	6 or more patients served and 24 or more encounters	17 or more patients served and 68 or more encounters
Annual Bonus	$1,000	$2,000	$5,000

	Long-Term Care		**Labour and Delivery**		**Palliative Care**	
Bonus Level	**A**	**C**	**A**	**C**	**A**	**C**
Necessary annual criteria	12 or more patients served	36 or more patients served	5 or more patients served	23 or more patients served	4 or more patients served	10 or more patients served
Annual Bonus	$2,000	$5,000	$5,000	$8,000	$2,000	$5,000

3. PEM Group Bonus Payment for Out of Office Care

3.1 This special bonus will reflect the extent to which rostered patients reflect population demographics in the physician's community. In 2011/12, it will reward top performing groups who have a rostered population reflective of their community and who provide the broad range of out of office services which meet the needs of their rostered patients. The Parties will design together the methodology for awarding this group bonus at year three of the Agreement.

Appendix E Schedule A
List of Billing Codes

Long Term Care	
W010A	LTC Management
W102A	LTC Assessment
W002A	Subs. visit (Chronic)
W008A	Subs. visit (Nurs., Aged)
W121A	Add'l visits (Nurs., Aged)
W003A	Subsequent Visit
W001A	Additional Subs. Visit
W109A	Annual physical exam
W107A	Admis. Assess, type 3
W777A	Pronouncement of death
W903A	Pre-operative assess.
W004A	General Reassessment
W104A	Admis. Assess. Type 2
Home Visits	
A901A	House Call
A902A	Home Visits
B990A	Spec. Visit Premium
B992A	Spec. Visit Premium
B994A	Spec. Visit Premium
B996A	Spec. Visit Premium
B910A	Special Visit
B914A	Special Visit
B916A	Special Visit
Palliative Care	
K023A	Palliative Care
C882A	Palliative Care
A945A	Palliative Care Consult
C945A	Palliative Care Consult
W882A	Palliative Care Subs. Visit
W872A	Paliative Care Subs. Visit
B998A	Spec. visit Premium

Labour & Delivery	
P006A	Vaginal Delivery
P007A	Post-natal Care
P009A	Attendance at L&D
P020A	Operative Delivery
P018A	Caesarean Section

Appendix F

NORTHERN ONTARIO SCHOOL OF MEDICINE (NOSM) FUNDING ARRANGEMENTS

1. The government agrees to make available funding to establish an AFP to support teaching, research, recruitment, leadership and innovation, and AFP administration. Funding is based on applying the provincial AHSC AFP methodology in consideration of the proportional number of students at NOSM.

Academic Support:
$2,620,932 in annual funding to support teaching and research.

AHSC AFP Administration Funding:
$218,411 in annual funding to support the NOSM PCTA AFP administrative costs.

Recruitment Funding:
Up to $436,822 will be made available annual to support the recruitment of clinical teachers to NOSM.

Innovation Funding:
$436,822 will be added to the $10 million AHSC AFP Leadership and Innovation Fund to recognize the NOSM PCTA AFP's eligibility to participate in this initiative.

AHSC AFP alignment:
An additional $3.3 million will be used to address any further alignment issues with the AHSC AFP initiative.

The use of all of the above funds is subject to the requirements around governance, principles, accountabilities and reporting contained within the provincial AHSC AFP framework.

Appendix G

DISPUTE RESOLUTION

1) If the OMA and the MOHLTC have a disagreement regarding the interpretation and/ or the application of this Agreement, the matter will first be referred to the PSC for consideration. The PSC will make recommendations to the Parties regarding the resolution of the disagreement and may enlist the support of an agreed upon mediator to assist it. Failing settlement of the matter, either Party may then use any other available dispute resolution process.

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

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

Side Letters to Agreement

[Date]

Mr. Jonathan Guss
Chief Executive Officer
Ontario Medical Association

RE: Segregation of Technical Fees

Dear Jonathan,

As you know, the Diagnostic Services Committee ("DSC") was established as part of the 2004 Physician Services Agreement. A tripartite committee with Ministry of Health and Long-Term Care ("MOHLTC"), the Ontario Medical Association ("OMA") and the Ontario Hospital Association ("OHA") representation, the DSC's mandate was to provide advice to the Minister on the planning and coordination of an efficient and effective diagnostic service system. The DSC reported its findings and recommendations in March 2008.

One recommendation of this committee is the segregation of the diagnostic funding envelope. The DSC report states: "A separate envelope for the compensation of diagnostic technical services and equipment will enable a more sustained focus on the needs of diagnostic services and facilitate broader system improvements."

To support this direction, the Ministry agrees to segregate technical fees from within the Physician Services budget into a Diagnostic Service budget and establish a new supporting structure by April 1, 2009.

We will keep you apprised of progress and next steps involving OMA. I want to thank your representatives for their contribution to this initiative.

Sincerely

Ron Sapsford
Deputy Minister

Copy OHA, IHF, LHINs

Date

Mr. Jonathan Guss
Chief Executive Officer
Ontario Medical Association

RE: Mental Health Sessional Payments

Dear Jonathan,

I am writing to confirm that the MOHLTC will work with the Ministry of the Attorney General and Ministry of Children and Youth Services to align sessional payments and salaries for mental health providers (psychiatrists, paediatricians and family physicians) that are paid by those two ministries with rates negotiated under the 2008 Physician Services Agreement.

We will keep you apprised of progress and next steps involving OMA. I want to thank your representatives for their contribution to this initiative.

Sincerely

Ron Sapsford
Deputy Minister

Copy MAG/MCYS

[Date]

Mr. Jonathan Guss
Chief Executive Officer
Ontario Medical Association

RE: Public Health Physician Compensation

Dear Jonathan,

I am writing to confirm that the Ministry of Health and Long-Term Care ("MOHLTC") will use its best efforts, funding the additional costs, and working with the local Board of Health, to achieve, effective April 1, 2009, salaries for Medical Officers of Health and Associate Medical Officers of Health within the following ranges.

Benefit levels will be maintained with additional costs funded by the MOHLTC.

Medical Officers of Health: $235,000 to $275,000

Associate Medical Officers of Health: $200,000 to $240,000

Effective October 1, 2010, there will be a three percent (3%) increase to the above salary grid. Effective September 1, 2011, there will be a four decimal two five percent (4.25%) increase to the resulting salary grid.

Sincerely

Ron Sapsford
Deputy Minister

TAB 51

INFOBulletin

Keeping health care providers informed of payment, policy or program changes

To: Physicians and Hospitals

Published By: Health Services Branch

Date Issued: May 7, 2012 **Bulletin #:** 4561

Re: **Amendments to the Schedule of Benefits for Physician Services - Effective April 1, 2012**

In recognition of the latest evidence, improvements in technology, and changes in standards of care, a number of changes are being implemented to the Schedule of Benefits for Physician Services (Schedule). This bulletin describes where to access details about these changes including implementation timelines.

New Fee Codes

New services have been introduced into the Schedule for:

- Positron Emission Tomography (PET) and Computed Tomography (CT) scans for esophageal cancer
- Physician to physician e-consultations conducted through secure e-mail:
  - The referring physician initiates the e-consultation with the intention of continuing the care, treatment and management of the patient.
  - The consultant physician provides opinion/advice/recommendations on patient care, treatment and management to the referring physician within thirty days.

Please refer to the corresponding charts for more information on these new fee codes.

Deleted Fee Codes:

Several fee codes have been deleted from the Schedule.

Please refer to the corresponding charts for more information.

Ontario

Revised Fee Codes:

Additionally, there are a number of fee code revisions being introduced. Some examples of the changes include, but are not limited to, the following:

Referrals for Diagnostic Services

Diagnostic services listed in the following sections of the Schedule must be submitted with an eligible referring physician or practitioner number on the claim:

- Nuclear Medicine
- Diagnostic Radiology
- MRI
- Diagnostic Ultrasound
- Pulmonary Function Studies
- Diagnostic and Therapeutic Procedures (where the service is listed with both a Professional and Technical component)

Effective July 1, 2012, the absence of a referring physician number on a claim will result in a rejection of the claim and will require resubmission with the referring physician billing number on the claim in order for payment to be made.

Self-referral means a situation where the referring physician (i.e., the physician ordering the diagnostic service) and the physician rendering any component of the diagnostic service are the same physician. It also refers to a situation where the referring physician and the physician rendering any component of the diagnostic service are members of the same physician's group or physician's hospital group. Where the physician rendering the diagnostic service is also the referring physician, this physician must insert his/her billing number in the referring physician field.

Effective April 1, 2012, the fee paid for self-referrals for the above services will be reduced by 50%. The only exception to this is when services described by X172 and X178 are provided under the Ontario Breast Screening Program.

In addition, for ultrasound services, comparison views initiated by the radiologist are no longer eligible for payment.

Computed Tomography (CT) and/or Magnetic Resonance Imaging (MRI) for Chronic Low Back Pain –X-ray, CT or MRI studies of the lumbar spine are only eligible for payment when rendered for low back pain with suspected or known pathology. Examples include, but are not limited to: infection, tumour, osteoporosis, ankylosing spondylitis, fracture, inflammatory process, radicular syndrome, and cauda equina syndrome.

Pre-operative Echocardiograms - Pre-operative echocardiography for non-cardiac elective surgery is only eligible for payment when the service is medically necessary, and is not payable solely for the pre-operative preparation of the patient.

Electrocardiograms (ECGs) and/or Pulmonary Function Tests (PFTs) provided with the annual health visit - Payment for ECGs and PFTs will be included in the annual well person visit and will not be eligible for separate payment except where the patient has symptoms, signs, or an indication supported by current clinical practice guidelines relevant to the individual patient's circumstances.

Charts detailing all of the fee code changes referenced within are available as attachments to this bulletin at:
http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bulletin_4000_mn.html

The new version of the Schedule is available at:
www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html

Hard copies of the Schedule will not be distributed. If you would like to order a paper copy or compact disk (CD) of the Schedule for a fee, please visit
https://www.publications.serviceontario.ca

Physicians without access to the Internet can contact ServiceOntario at 1-800-668-9938.

This Bulletin is a general summary provided for information purposes only. Physicians, hospitals, and other health care providers are directed to review the *Health Insurance Act*, Regulation 552, and the Schedules under that regulation, for the complete text of the provisions. You can access this information at www.e-laws.gov.on.ca . In the event of a conflict or inconsistency between this bulletin and the applicable legislation and/or regulations, the legislation and/or regulations prevail.

TAB 52

2012 PHYSICIAN SERVICES AGREEMENT

BETWEEN:

ONTARIO MEDICAL ASSOCIATION

("OMA")

-and-

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO,

AS REPRESENTED BY THE MINISTER OF HEALTH

AND LONG -TERM CARE

("MOHLTC")

WHEREAS the OMA and the MOHLTC entered into a Memorandum of Agreement that recognizes the OMA as the exclusive representative of physicians practicing in Ontario ("OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement") and, further, that the OMA and MOHLTC shall negotiate Physician Services Agreements;

NOW the OMA and the MOHLTC ("Parties") have negotiated this 2012 Physician Services Agreement (the "Agreement").

1. PAYMENTS

1.1 The Parties agree to a payment discount of 0.5% on all physician payments, in effect from April 1, 2013.

1.2 This discount will be applied to fee-for-service payments as well as primary care models, primary care specialized models, AFP/APP agreements and physician programs in the same manner as September 1, 2011 flow through payments. The discount will also apply to on-call payments.

1.3 The Parties agree to continue their work on evidence-based initiatives during the term of this agreement as set out in **Appendix "A"**.

1.4 The Parties will analyze the potential savings that arise from the Phase II and other initiatives. The amount of the payment discount in section 1.1 will be reduced effective October 1, 2013 by an amount equal to 100% of the savings in the physician services budget. The Parties agree to track the health system savings that result from these measures.

2. REVIEW OF APRIL 1, 2012 CHANGES TO THE SCHEDULE OF BENEFITS

2.1 The Parties agree that the changes to the Schedule of Benefits made as of April 1, 2012 will be amended as more particularly described in **Appendix "B"**.

3. APRIL 1, 2012 FLOW THROUGH

3.1 The Parties agree the April 1, 2012 decreases to the Schedule of Benefits (as amended above) will be flowed through to Specialist APPs, GP Specialized APPs, GP Psychotherapists, Sleep Medicine, Nuclear Medicine and Radiation Oncology as set out in **Appendix "C"**.

4. PRIMARY CARE

4.1 The Parties are committed to continuing the reform and renewal of primary health care in Ontario. All primary health care models are continued and amended as described in **Appendix "D"**.

5. VIRTUAL CARE

5.1 The Parties acknowledge the importance of virtual care. The Parties agree to the initiatives set out in **Appendix "E"**.

6. EVIDENCE & APPROPRIATENESS

6.1 The Parties recognize the need for the public health care system to fund appropriate treatments and procedures based upon current evidence.

The Parties agree on the use of evidence and best practice to ensure that the provision of healthcare is relevant to and appropriate for the clinical needs of patients. Accordingly, the Parties have agreed upon:

(a) revisions to the Schedule of Benefits;

(b) the inclusion of educational comments on various service fee codes in the Schedule to support the appropriate provision of such services;

(c) the removal of various tests from the MOHLTC's Laboratory Requisition form;

(d) recommendations for further analysis and/or consultations.

all of which are described in more detail in **Appendix "F"**.

7. SYSTEM SAVINGS AND SUSTAINABILITY

7.1 The Parties agree on the importance of ensuring the sustainability in the health care system and measures to promote efficiency of resources. The Parties agree to the measures described **Appendix "G"**.

8. BILATERAL MONITORING AND ACCOUNTABILITY PROCESS

8.1 The Parties agree to,

(a) establish a bilateral process to monitor the savings initiatives under this agreement, including efforts to monitor utilization,

(b) a plan to monitor the agreement's savings initiatives, and

(c) an agreed upon process to be negotiated if an estimated target for an initiative is not achieved.

8.2 The Parties agree that the performance of the investments and savings provided for in this Agreement will be managed through a process of measurement and evaluation as determined by the Parties. This process will begin upon the commencement of this Agreement and the Physician Services Committee ("PSC") will develop appropriate measurements and one or more evaluation templates by March 31, 2013. The on-going process of performance measurement and evaluation will be carried out jointly. The results of the investment and savings performance management process will be reported regularly to the PSC. The PSC will, based on the information reported, make recommendations to the Parties regarding the need for any appropriate actions

8.3 The PSC will develop a work plan outlining specific steps which will address:

(a) the ongoing measurement and evaluation of the investments and savings provided for in this Agreement; and

(b) the ongoing measurement of utilization and advice regarding reasons for utilization changes.

8.4 The Parties may constitute a sub-committee of the PSC to support the PSC in monitoring, evaluation, development of options and action plans that may be required.

8.5 At the end of the first full year of measurement and evaluation, the Parties will assess the process and consider changes if the process is not yielding responses that are satisfactory to both Parties.

8.6 The Parties agree to amend the schedule to the data-sharing agreement between them to add "data on government funded programs whose administration has been, or will be, transferred to government, community/commercial laboratory payment claims data and other data as mutually agreed by the parties during the course of the PSA".

9. CPSO COMPLAINTS PROCESS

9.1 The OMA has requested that the Ministry amend the Health Professions Procedural Code so that the CPSO does not have to conduct a full investigation into complaints about matters that are outside the jurisdiction of the CPSO and to better manage frivolous and vexatious complaints.

The Ministry undertakes to consult with interested parties in 2013, and bring forward recommendations by March 2014 to the Government of Ontario for legislative amendments.

10. CMPA

10.1 The Parties recognize that the base Canadian Medical Protective Association ("CMPA") fees have not increased since 1986. The current agreement amongst the Parties and the CMPA commenced on January 1, 2009 and continues in effect until December 31, 2013 ("2009 CMPA Agreement"). The Parties agree to forthwith enter into negotiations with the CMPA with the aim to enter into a new agreement to replace the 2009 CMPA Agreement which will have a term from January 1, 2014 to December 31, 2023 and which will require physician contributions as set out in **Appendix "H"**.

10.2 The Parties shall review and update the tort reform measures recommended by the Medical Malpractice Coverage Committee in 2001, and report back to the PSC by June 2013 and thereafter as required by the PSC.

11. CONTINUANCE OF PHYSICIAN PROGRAMS

11.1 The Parties agree to continue the Physician Programs set out in **Appendix "I"** or otherwise modify or discontinue the programs as set out in that Appendix.

12. COMMITTEES

12.1 The Parties agree the Forms Committee and Primary Health Care Committee will continue with expanded mandates set out in **Appendix "J"**. The Parties agree that the PSC will decide which other bilateral committees will be continued and their ongoing mandates.

13. NFFS AGREEMENTS

13.1 The Parties agree upon the need to standardize non-fee-for-service agreements ("NFFS"). The Parties agree to use the Specialist NFFS Agreement attached hereto as **Appendix "K"** as the boilerplate for all Specialist NFFS Agreements entered into or renewed after the date of this Agreement, with the understanding that adjustments may need to be made to the boilerplate as appropriate for particular agreements.

13.2 The Parties agree to negotiate a standard boilerplate for Primary Care NFFS Agreements by January 31, 2013 with recommendations to the PSC. The Parties agree that the Primary Care NFFS Agreement boilerplate will use the terms of the Specialist NFFS Agreement as appropriate.

13.3 The Parties will also review existing primary care agreements to standardize/update terms and make recommendations to the PSC.

14. INCORPORATION

14.1 The Ministry acknowledges the request made by the OMA to permit non-voting shares of a Medicine Professional Corporation to be held by a family trust. The Ministry will consult with the CPSO, the Ministry of Finance and others by June 2013 and report back to the PSC with any recommendations.

14.2 The MOHLTC acknowledges that the OMA also requested that corporations whose voting shares are held by physicians and partnerships of physicians also be allowed to hold voting shares of Medicine Professional Corporations. The MOHLTC agrees to consult with relevant third parties in 2013. The Ministry will provide the PSC with a status report on the consultations by June 2013 and will provide any recommendations in early 2014.

15. STATUTORY AMENDMENTS

15.1 The government undertakes to introduce and support legislation as soon as possible upon the return of the Legislature in 2013 (and effective as of the date of introduction), providing statutory immunity from action or other proceeding against the OMA's directors, officers, members, employees, agents for acts done in good faith when the OMA:

(a) enters into agreements with the MOHLTC or the government e.g. Physician Services Agreements, or

(b) makes recommendations to the MOHLTC or the Government of Ontario respecting fee codes or other matters affecting physician payments.

16. TERM AND RENEWAL

16.1 This Agreement will begin on October 1, 2012, and will terminate on March 31, 2014. Negotiations to establish the next Physician Services Agreement will begin no later than December 1, 2013. The MOHLTC recognizes the OMA as the exclusive representative of the physicians practicing in Ontario for the purposes of these negotiations. The Parties acknowledge that these negotiations will be conducted in accordance with the process set out in the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement.

The undersigned representatives of the Parties hereby agree to unanimously recommend acceptance of this Agreement to their respective principals.

DATED AT TORONTO, ONTARIO AS OF THIS 7th DAY OF NOVEMBER, 2012

FOR THE OMA

FOR THE MOHLTC

APPENDIX "A"

EVIDENCE AND APPROPRIATENESS – PHASE II

The Parties agree to the following changes to promote the use of evidence and best practices for the provision of health care that is appropriate for the clinical needs of patients:

A. Phase II review

1. In order to ensure appropriate use of health care resources, the PSC will establish a working group to work on Phase II recommendations to minimize:

- Overuse: the use of health care resources and procedures in the absence of evidence that they could help the patients receiving them;
- Misuse: failures to execute clinical care plans and procedures properly; and
- Underuse: failures to employ health care practices of proven benefit.

Phase II recommendations are those that require further analysis and/or consultations and will focus on tests, treatments, or services that are currently underused. Where possible, the recommendations will align with Health Quality Ontario (HQO) / Ontario Health Technology Assessment Committee (OHTAC) recommendations.

2. Phase II recommendations shall include:

i. Limit self-monitoring (blood glucose test strips) and blood glucose tests and A1C tests

ii. Investigations in the work-up of dementia

iii. Appropriate sleep lab testing

iv. Anaesthesia requirements for vasectomies, cataracts and endoscopy

v. Lipid testing

vi. Serum protein electrophoresis

vii. Appropriate ultrasound imaging

viii. Vitamin B12 (part 2) - Remove vitamin B12 from the Ontario laboratory requisition form (align with HQO/OHTAC recommendation

ix. Cease funding of routine pre-operative cardiac testing for asymptomatic patients undergoing low or moderate risk non-cardiac surgeries (part 2) - Pending the outcome of discussions with experts about defining moderate / intermediate and exposing these patient categories to pre-operative cardiac testing, align Schedule of Benefits with moderate / intermediate risk accordingly.

x. Genetics Strategy

xi. Companion Diagnostics – Recommend Cobas EGFR Mutation Test be required for Erlotinib (a drug for treatment of lung cancer funded under the Exceptional Access Program)

xii. Review of Physician Schedule of Benefits for Bone Mineral Density Testing by DXA (Dual Energy x-Ray Absorptiometry) with most current Osteoporosis Canada Guideline

xiii. Review relevancy of Pre-dental/Pre-operative Assessments with the services provided by hospital-based pre-operative assessment clinics.

xiv. Review the utilization and relevancy of Pre-operative Consultations.

xv. Review changes in practice patterns for the provision of cardiac services and the impact on utilization arising from changes in this agreement.

B. Effective April 1, 2013

1. Appropriate Prescribing

Identify areas for quick wins (narcotics and controlled substances) and longer-term savings opportunities from improved prescribing among physicians and implement targeted educational strategies and tracking mechanisms to harness savings. This would be a voluntary program, confidential to the physician, with PSC oversight on the program. Physician data used in this program that identifies a physician will be kept confidential to the physician and the Physician Services Committee.

APPENDIX "B"

REVIEW OF APRIL 1, 2012 CHANGES

TO THE SCHEDULE OF BENEFITS

The Parties agree to:

(a) amend the Schedule of Benefits, effective April 1, 2013, and

(b)develop new billing codes and payment rules,

as described below:

1. **Optical Coherence Tomography**
   - Increase G818 and G820 from $25 to $35, with current maximums remaining as is.
   - Create new code Gxxx at $35 for patients receiving active treatment (injections or laser). Maximum of 4 in any combination of G820, G818 or Gxxx.
   - Create new code Gyyy at $25 for active management of retinal disease. After the G818/G820/Gxxx limit is reached, Gyyy may be billed for following active retinal disease.
     - Limits and treatment regimen for Gyyy to be reviewed by OHTAC with direct involvement by the Section on Ophthalmology.
   - Create new code for Gzzz for OCT related to treatment of children at $35.
     - OHTAC and the Section on Ophthalmology should review the use of OCT in this age group to determine appropriate annual limit.

2. **After-hours Procedure Premiums**
   - Add-on to surgical codes, payable when a case commences in the evening (after 5pm) or at night (after midnight) fully restored.

3. **Anaesthesia Flat Fee for Procedural Sedation**
   - Increase flat fee from $60 to $75 when anaesthesiologist is providing one on one care.
   - Additional recommendations:
     1. Consider solution for supervisory code for anaesthesiology.
     2. Consider a separate solution for providing anaesthesia for cataracts, colonoscopy, cystoscopy and sigmoidoscopy in low volume settings, particularly rural settings.

3. Continue efforts to move some procedures out of hospitals and into out of hospital facilities or alternate care settings within hospitals that lend themselves to care delivered by Anaesthetic Care Teams.

- Schedule of Benefits Amendment, including creation of new fee code effective April 1, 2013.
- Consider a supervisory code ;PSC or similar committee shall review low volume services.

4. **Laparoscopic premiums**
   - Restore laparoscopic surgical fee premiums E792A, E793A, E862A and E863A from 10% to 25%.
   - Procedures eligible for the laparoscopic premium should be reviewed to determine both the time differential between the laparoscopic and open approaches and the proportion of the procedures performed laparoscopically.
   - Based on that data analysis, an appropriate premium (which may be greater or less than 25%) should be restored on a procedure by procedure basis.

5. **Intensive and Coronary Care Premium (C101)**
   - Complete restoration of Premium applied for each patient seen on a visit to ICU or CCU, in addition to fees payable for services, claimed by a physician who was not the MRP.

6. **Lumbar Spine**
   - For X-ray or CT studies of the lumbar spine; April 1, 2012 OHIP Schedule of benefits change required physicians to repay for the diagnostic service if subsequently found not to be medically necessary.
   - Delete Commentary Section 1 in paragraph 28, page D4 of the Diagnostic Radiology Preamble.

28. X-ray or CT studies of the lumbar spine should not be routinely ordered or rendered for low back pain without suspected or known pathology.
[Commentary:
~~1. The physician requesting the diagnostic services subsequently found not to be medically necessary in accordance with s. 18.2 (1) and 18.2 (2) of the Health Insurance Act will be responsible for repayment.~~

2. Examples of suspected or known pathology include infection, tumour, osteoporosis, ankylosing spondylitis, fracture, inflammatory process, radicular syndrome, and cauda equina syndrome.]

7. **Cataracts**
   Enlist OHTAC to do a full evidence-based review in order to determine clear and objective criteria describing indications for cataract extractions, i.e. when is the patient's vision sufficiently impaired that extraction becomes medically necessary and therefore should be insured. The Section on Ophthalmology should be directly involved in the discussion.

8. **Review of Payment for assessment with surgical procedures (manual review)**
   - Put in place to restrict billing of higher paying assessment/consultation fees on the day of a surgical procedure when a previous assessment/consultation had already been billed.
   - Physicians can submit rejected codes for manual review.
   - The ministry will review these claims and the medical rule.

9. **Review of Pediatric Consults**
   - The ministry has set up an exemption process for the changes to pediatric consults and it is believed that this has resolved all of the issues. The Section on Pediatrics will be solicited to determine whether the revision is still creating problems in providing pediatric specific services to adult patients and whether there are any problems with the exemption process.

10. **Self Referral regulation (effective April 1, 2012)**

    The MOHLTC agrees to remove the Section entitled "Diagnostic Services Rendered by the Referring Physician" (and the accompanying Note and Commentary) under the heading "GENERAL PAYMENT RULES" on page GP12 of the General Preamble.

    The Expert Panel on Appropriate Utilization of Diagnostic and Imaging Studies shall continue its work.

APPENDIX "C"

APRIL 2012 FLOW THROUGH

EFFECTIVE JANUARY 1, 2013

Reverse Flow Through

1. Specialist APPs and Physician Programs

The Parties agree to a methodology whereby specialty changes arising from the April 2012 Schedule of Benefits changes are applied to specialist AFP/APP agreements and physician programs in the same manner as the September 1, 2011 flow through under the 2008 PSA.

2. Primary Care Specialty Models

The Parties agree that the family physician average change will be applied against the primary care specialized models outlined below in the same manner as the September 1, 2011 flow through under the 2008 PSA.

(a) Rural and Northern Physician Group Agreement (RNPGA 1 and 2)

(b) Weeneebayko Health Authority (WHA)

(c) GP Focus – Palliative APP

(d) GP Focus – HIV APP

(e) GP Focus – Care for the Elderly

(f) Toronto Palliative Care

(g) Algonquin FHT

(h) St. Joseph's Health Centre

(i) Community Health Centres

(j) Aboriginal Health Access Centres (AHAC)

(k) Blended Salary Model (cFHT)

(l) Sherbourne

(m) Shelter Health Network

(n) Inner City Health (ICHA)

(o) Sioux Lookout

(p) Group Health Centre (GHC)

Equivalent Flow Through

3. GP Psychotherapy

The GP Psychotherapy premium will be reduced from 15% to 12%.

4. Nuclear Medicine

Nuclear Medicine professional fees shall be reduced by 5%.

5. Sleep Studies

The professional fees for sleep studies shall be reduced by 5%.

6. Radiation Oncology Fee Codes

The professional fees for treatment planning for radiotherapy shall be reduced by 5% (X310, X311, X312, X313).

APPENDIX "D"

PRIMARY CARE INITIATIVES

1. PRIMARY HEALTH CARE COMMITTEE

The Parties have agreed upon many key initiatives to be implemented as part of this Physician Services Agreement, and the implementation details will require significant work. There are also several items that require review/evaluation prior to the end of this agreement. Accordingly, the Parties agree that a reconstituted Primary Health Care Committee (PHCC) is required for the duration of this agreement. The PSC shall develop and agree upon the terms of reference and mandate of the PHCC.

2. Personalized Health Visit (January 1, 2013)

The Parties agree that the annual health exam shall be replaced by a personalized health visit for adult patients 18 to 64 years. A new fee code will be established for this personalized health visit and it will be valued at $50. For patients in other age groups, the billing for the annual health exam will remain the same.

3. SUPPORT FOR QUALITY –EXCELLENT CARE FOR ALL ACT (April 1, 2013)

The Parties recognize that a high quality health care system is one that is accessible, appropriate, effective, efficient, equitable, integrated, patient centred, population health focussed, and safe. The Parties agree to expand the government's Primary Health Care quality agenda to Family Health Teams, Aboriginal Health Access Centres and Community Health Centres. Other primary health care providers shall be welcome to participate on a voluntarily basis.

The Parties will collaborate in developing the plan, rollout and implementation of the Primary Health Care quality agenda. This collaboration will include; the development of annual quality improvement plans, indicator development, development of patient experience surveys and public reporting. The PHCC will be the primary vehicle for discussions between both Parties regarding rollout and implementation. No data will be published at an individual physician level, a third party (eg. HQO) will be responsible for publishing the results.

4. ACCESS IMPROVEMENTS

4.1 DAYTIME ACCESS (April 1, 2013)

The PHCC shall study the issue of daytime access to primary care physicians who participate in Patient Enrollment Model ("PEM") primary care agreements ("PEM Physicians"). The PHCC shall make recommendations on possible guidelines to inform PEM Physicians on operating during daytime hours, including possible standards for group size, and strategies and support for advanced access.

4.2 ENHANCED AFTER-HOURS ACCESS (April 1, 2013)

The Parties agree that larger sized PEM groups should offer an additional number of after-hours blocks of coverage to accommodate for larger total group roster. The Parties agree on the following:

(a) to amend the Family Health Network ("FHN"), Family Health Organization ("FHO") and Family Health Group ("FHG") to create an enhanced after-hours service requirement for groups with 10 or more physicians. The revised number of after-hours service blocks required would be:

NUMBER OF PHYSICIANS IN GROUP	TOTAL NUMBER OF AFTER-HOURS SERVICE BLOCKS
10 – 19	7
20 – 29	8
30 – 74	10
75 - 100	15
100 – 199	20
200 +	25

(b) that northern FHN and FHO groups who require 50% of its physicians to maintain active in-patient hospital privileges, shall be exempt from the enhanced after-hours service requirements set out in subsection (a).

(c) to amend the FHO and FHN agreements to ensure the staffing of additional physicians after-hours may be necessary if the group determines that the volume and needs of their patients make such additional staffing necessary.

4.3 HOUSE CALLS (April 1, 2013)

The Parties agree that primary care physicians should be encouraged to provide more house calls with a focus on homebound and frail elderly patients. Accordingly, the Parties agree to enhance the current premium for house calls and to implement new house call incentives for homebound and frail elderly patients as follows:

(a) A new fee code, at the same value as the A901, will be developed for house calls to homebound and frail elderly patients. The definition of "homebound and frail elderly patient" for the purposes of this fee code shall be developed by the PHCC.

(b) The current premiums for house calls shall be revised as follows:

	Home Visits			
Bonus Level	A	B	C	D
Necessary annual criteria	3 or more patients served and	6 or more patients served and	17 or more patients served and	32 or more served and
	12 or more encounters	24 or more encounters	68 or more encounters	128 or more encounters
Annual Bonus	$1,500	$3,000	$5,000	$8,000

- All family physicians are eligible for level A & B
- Only PEM Physicians are eligible for level C & D

(c) When a CCM, FHG or FHN physician provides more than 68 house calls per year to more than 17 patients (Level C), physicians will receive a 20% premium on the additional house call services if at least 75% of the house calls were provided to their enrolled and non-enrolled homebound and frail elderly patients during the fiscal year. This will be made as an annual payment after year end.

(d) When a FHO physician provides more than 68 house calls per year to more than 17 patients (Level C), all subsequent house calls to home bound and frail elderly patients will be paid out of basket. Further, FHO physicians will also receive a 20% premium on the additional house call services if at least 75% of the house calls provided to their enrolled and non-enrolled homebound and frail elderly patients during the fiscal year. This will be made as an annual payment after year end.

(e) The payment of all A901 fee codes billed by a physician for services provided to patients enrolled to a physician in a different PEM group will be reduced by 50%. The Parties agree to review the impact of this reduction 6 months following its effective date.

5. TERMINATION OF THAS OBLIGATION (January 1, 2013)

The Parties agree to amend all PEM primary care agreements to delete the service requirements and payment terms for the provision of Telephone Health Advisory Services ("THAS"). PEM groups may continue to provide THAS on a voluntary basis. The THAS service provider will continue to provide encounter information to all PEM physicians for their patients via fax. PEM groups will also continue to be required to report after-hours clinic schedules to the THAS service provider in order to provide information about such services to the group's patients.

6. ACCESS BONUS

6.1 Termination of the Access Bonus Rebate for Focused Practice GP Services (Immediate)

The Parties agree to cancel the access bonus rebate ($237.91 per eligible physician) established in the 2008 Physician Services Agreement that recompensed capitation based PEM Physicians for enrolled patient use of focused practice GPs.

6.2 Review of Access Bonus

The PHCC will conduct a policy review of the access bonus payment in capitation based PEMs to review the intent and current application of outside use and the access bonus. The review will consider: (a) the value of negative access bonuses throughout the province; (b) the impact on emergency departments; (c) exemptions for Urgent Care Centres and GP focused practices; and (d) the impact from walk-in clinics. The PHCC will make recommendations to the Parties on possible amendments to capitation based PEM agreements and/or alternatives to the access bonus payment. The review shall be completed by the end of the term of this Agreement.

7. PREMIUM AND PAYMENT CHANGES

7.1 Premium Changes – Elimination

The Parties agree on eliminating the following service premiums in PEM agreements and the savings may be allocated to offset the implementation costs of the Acuity Modifier described in section 7.5 of this Appendix:

- In Office Service Bonus (section 5.2 in the 2008 PSA) (Immediate);
- Out of Office Service Bonus (section 3.1 of Appendix "E" of the 2008 PSA) (April 1, 2013); and
- Preventative Care Management Services Enhancement Fee (section 2.1 of Appendix "I" of the FHO/FHN Agreement) (April 1, 2013).

7.2 Capitation and Long Term Care Patients (Immediate)

Capitation based PEM agreements allow for the enrollment of long term care ("LTC") patients as a distinct category of enrolled patients with a higher base rate capitation value than non-LTC enrolled patients. The basket of services for enrolled LTC patients includes the W010 LTC monthly management fee code. The Parties agree that when an enrolled patient moves to an LTC facility, the physician shall not be permitted to bill both the W010 and base capitation rate for that patient.

The Ministry shall also revise the LTC patient enrollment process to make it administratively easier for physicians to enroll such patients.

7.3 Payment Change – CCM Fee Reduction for Large Rosters (April 2013)

The Parties agree to amend PEM primary care agreements to reduce the comprehensive care capitation payment (ie. CCM fee) by 50% for each patient a physician enrolls above 2,400. The PHCC shall develop methodology to determine how this reduction shall be applied.

7.4 Payment Change- Diabetic Management Fee

The Parties agree that the Q040 diabetes management fee shall be reduced from $75 to $60 effective April 1, 2013.

7.5 Payment Change –Acuity Modifier

The Parties agree to set aside $40 million to develop and implement a premium for PEM agreements for the acuity of patients enrolled to a physician ("Acuity Modifier"). The PHCC will advise/support the systems implementation of the Acuity Modifier in two phases over two years:

- Year 1 – selecting of an acuity adjustment tool, testing it against OHIP data, and designing the payment system.
- Year 2 – conducting systems testing, adjusting the tool to Ministry payment systems, providing physician education, and developing a communications plan.

The PHCC shall report back to the Parties by January 2014 with recommendations for the acuity adjustment tool that will be selected as the Acuity Modifier.

Until the Acuity Modifier is implemented, the Parties agree to implement an interim modifier ("Interim Modifier"). The Interim Modifier will be developed by the Parties through the PHCC based on information provided by OHIP, Canadian Institute for Health Information, and Ontario Drug Benefits program claims data. The Interim Modifier shall be recommended to the Parties for approval March 1, 2013, for implementation in fiscal 2012/13, and will be replaced by the Acuity Modifier once that has been approved and implemented.

8. MANAGED ENTRY INTO FHN, FHO, AND FHG AGREEMENTS (Immediate for FHG and April 2013 for FHN/FHO)

The Parties agree to the following managed entry process to allow physicians to join existing or start new FHN, FHO, and FHG groups effective immediately:

- There shall be no limit for physicians wishing to join existing or create a new FHG.

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

    - 20 physicians in a prioritized stream for new graduate physicians and physicians seeking to practice in an area of high need;
    - 20 physicians in the regular stream (all applications not prioritized) which will be processed on a first come, first served basis;
    - Any unused spots from one stream will shift to the other stream;
    - Any unused spots can be rolled over to subsequent months; and
    - Replacement physicians will be processed outside the Managed Entry process.

This process will be evaluated at the end of the term of this agreement.

9. INTERPROFESSIONAL HEALTH PROVIDER FUNDING (April 1, 2013)

The Parties agree to expand the availability of Interprofessional Health Providers ("IHPs") for patients in the community with primary care needs. Full salary funding will be made available to support the integration of IHPs, including PAs, into non-Family Health Team affiliated PEM groups of three or more physicians. . The PHCC will work through the implementation details, which may include the following criteria: (a) the basis of community need; (b) roster size; (c) involvement in quality improvement initiatives; and (d) integration with other healthcare providers in the region to support population based planning and service provision.

10. FHG GOVERNANCE AGREEMENTS (April 2013)

The Parties agree to amend the FHG agreement to require each group to establish and maintain a written governance agreement between the physician members to formally set out the terms of their relationship. The governance agreement shall include terms to address:

- the nature of the relationship between the physicians,
- roles, responsibilities and obligations of the Group Physicians,
- a process for:
    - decision-making;
    - the admission of new physicians;
    - the withdrawal of physicians;
    - the expulsion of physicians;
    - approving contracted physicians; and
    - dispute resolution mechanism for disputes that may arise between physicians.

- the election of a "Lead Group Physician" and an "Associate Lead Group Physician" who are able to sign contracts, including amendments, extensions or renewals, on behalf of all physicians.

APPENDIX "E"

VIRTUAL CARE

EFFECTIVE APRIL 1, 2013

In recognition of the importance of virtual care, the parties agree to the following initiatives:

1. **Northern Health Travel Grant (NHTG)**
   The NHTG program will encourage the replacement of face-to-face visits with virtual equivalents where clinically appropriate.

2. **Specialist to Primary Care Virtual Follow-up**
   Establish a Working Group to evaluate existing pilots and programs and will use this data to develop recommendations for a comprehensive, provincial business and technology model for hospital to primary care communications.

3. **Patient eConsults**
   An evaluation project will be developed to enable standards-based, patient-initiated patient to primary care provider eConsultations, including initial evaluations in capitated sites followed by an evaluation in a Fee for Service setting.

4. **Primary Care to Specialist eReferral**
   eReferral fee codes will be established for dermatology and ophthalmology, with subsequent expansion to other specialties.

5. **Realignment of Telemedicine Premium – OTN working group**

   Establish a Working Group to evaluate Personal Video Conferencing (PVC) deployment progress, utilization, volume and workflow trends. In the short term, the Working Group will develop:
   - PVC utilization or deployment targets that signal a diminishing need for full telemedicine premium; and
   - New premiums for northern and non-northern telemedicine consultations based on utilization patterns and adoption requirements.

APPENDIX "F"

EVIDENCE AND APPROPRIATENESS – PHASE I

The Parties agree to the following changes to promote the use evidence and best practices for the provision of health care to and appropriate for the clinical needs of patients:

A. Reduce Unnecessary Testing –Effective November 1, 2012

1. Revised Laboratory Requisition Form

The Parties agree that there is overuse/misuse of certain laboratory tests. As such, it was recommended that these laboratory tests be removed from the Ontario laboratory requisition form but still available to patients with appropriate indications. They were removed effective November 1, 2012:

- Removal of Ferritin;
- Thyroid stimulating hormone; and
- Vitamin B12.

B. Reduce Unnecessary Testing - Effective January 1, 2013

1. AST

Based on expert consultations conducted by Health Quality Ontario, AST is a less specific test for liver disorders than ALT, and so has limited utility in the community setting. Therefore, OHTAC recommended that AST testing in community laboratories should be restricted to patients under the care of a specialist at a hospital.

2. Chloride

Based on expert consultations conducted by Health Quality Ontario, chloride testing in the community setting has limited utility. Therefore, OHTAC recommended that chloride testing in the community should be reduced by removing chloride from the Ontario laboratory requisition form.

3. Creatine Kinase

Creatine kinase in community laboratories is being frequently ordered in patients on statin therapy, often as a screening test. Based on a rapid review conducted by Health Quality Ontario, OHTAC recommended that creatine kinase be removed from the laboratory requisition form.

4. Folate

Based on expert consultations conducted by Health Quality Ontario, it was identified that folate deficiency is rare in Canada and there is unnecessary testing occurring in Ontario. OHTAC recommends that folate testing be restricted to red blood cell folate, except when ordered by or on the advice of physicians with expertise in hematological, inflammatory or gastrointestinal disorders.

5. Reflexive testing

There are a number of conditions for which reflexive testing could be used to increase the efficiency of test ordering. Instead of ordering a sequence of tests one clinical visit at a time, or ordering multiple tests (some unnecessary) at the same time, reflexive testing allows the clinician to indicate the clinical situation or condition in question, and the laboratory to run the necessary tests using a diagnostic algorithm.

6. Thyroid scans

Language is to be added to the OHIP Schedule of Benefits clarifying that thyroid scans should only be ordered for hyperthyroidism (inc. nodules associated with hyperthyroidism), congenital hypothyroidism, masses in neck or mediastinum suspected to be thyroid in origin and that scans are not generally indicated for investigation of thyroid nodules (except if associated with hyperthyroidism) and adult hypothyroidism.

7. Diagnostics by other practitioners (requirement of referring field for tracking)

Review and evaluate appropriateness of diagnostic studies (e.g., x-rays) ordered by non-physicians (e.g., chiropractors). For tracking and evaluative purposes, require referring provider number be provided for OHIP payment purposes.

C. Schedule of Benefits Alignment with Recommendations Screening & Routine Tests (Effective January 1, 2013)

1. Colon cancer screening intervals

To align with Cancer Care Ontario's screening program, increase colorectal cancer follow-up screening intervals. For asymptomatic patients whose colonoscopy has either no polyps or small (<1 cm) hyperplastic polyps present, the recommended interval for follow up colonoscopy is to be set at 1 every 5 years or 1 every 10 years based on individual patient indications.

2. Cervical cancer screening

Revise the Schedule of Benefits and PEM cervical cancer screening bonuses accordingly to reflect CCO's new guidelines on cervical cancer screening, including increasing the interval of screening from a 2-year interval to a 3-year interval, and defining when to start (21 years of age) and stop (after the age of 70) screening.

3. Annual stress tests

As identified by the American College of Cardiology and the American College of Physicians in the Choosing Wisely Campaign, language is to be added to the OHIP Schedule of Benefits clarifying that annual stress tests to asymptomatic patients at low risk for coronary heart disease should not be billed to OHIP.

4. Pre-Operative Cardiac Testing

As identified by the American College of Cardiology and the American College of Physicians in the Choosing Wisely Campaign, language is to be added to the OHIP Schedule of Benefits clarifying that pre-operative testing including cardiac testing (echo, ECG, and nuclear imaging), pulmonary function testing, routine chest x-rays, and laboratory testing is not necessary for patients undergoing low/moderate-risk non-cardiac surgery and should not be billed to OHIP.

5. Chest x-rays

Language is to be added to the OHIP Schedule of Benefits clarifying that routine chest x-rays for screening and routine pre-admission for ambulatory and in-patients with

unremarkable history/physical exam is not medically necessary and should not be billed to OHIP.

D. Reducing Procedures Not Supported By Evidence (Effective January 1, 2013)

1. Arthroscopic Lavage

Based on Ontario Health Technology Advisory Committee ("OHTAC") recommendations, language is to be added to the OHIP Schedule of Benefits clarifying that arthroscopic lavage for osteoarthritis of knee should not be billed to OHIP.

2. Injection of Hyaluronic acid

Based on OHTAC recommendation, Hyaluronic acid is not insured, however the injection of hyaluronic acid is insured (G370). Since the substance being injected is not recommended, OHIP should consider no longer paying for the injection of hyaluronic acid.

APPENDIX "Q"

SYSTEM SAVING AND SUSTAINABILITY

The Parties agree on the following measures to promote the efficient use of resources to ensure the sustainability in the health care system:

Effective April 1, 2013

1. Annual Consecutive Consultations

Reduce the fee for annual consecutive consultations by the same specialist on the same patient for the same clinical diagnosis to a limited / repeat consult fee or a specific assessment fee.

2. Multiple consultations

Clarify the language within the OHIP Schedule of Benefits to limit patient benefit to one second opinion consultation (where a second opinion consultation is one requested by the patient).

3. Group appointments

Shared appointments or group care for chronic diseases and some mental health issues enhance or preserve patient care and result in cost savings. The diseases where shared appointments or care can be employed include:

- Diabetes
- Congestive Heart Failure
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Hypercholesterolemia
- Fibromyalgia

The Parties shall create group care codes for the disorders outlined above similar to existing, per patient GP group psychotherapy codes.

4. Hospital supplies and equipment

The Ministry and OMA shall establish a province-wide product/supplies standard for specific procedures, resulting in a reduction in the number of vendors and reduced cost, without impacting patient care. The OMA shall encourage physicians to standardize their use of hospital supplies and equipment. Areas of initial focus include the equipment, technology and prosthetics used for the following: Hip, Knee replacements, Spine, Cataract/Cataract lenses, vascular stents and cardiac stents.

Effective October 1, 2013

5. **Medically Complex Patients**

In order develop proposals for medically complex patients, both post-discharge and on-going, the Parties agree to develop demonstration projects to measure results, to be evaluated after one year. To that end, the Ministry agrees to reserve $10M for the period October 2013 to October 2014 for this initiative.

APPENDIX "H"

CANADIAN MEDICAL PROTECTIVE ASSOCIATION FEES

EFFECTIVE JANUARY 1, 2014

The Parties agree to the following physician contribution schedule for Canadian Medical Protective Association (CMPA) fees. Should Ontario CPI exceed 4%, the physician contribution schedule below may be revised as agreed to by the Parties.

			New Rate - Physician Contribution								
Current Rate	Type of Work	Year 2014	Year 2015	Year 2016	Year 2017	Year 2018	Year 2019	Year 2020	Year 2021	Year 2022	Year 2023
$300	Interns and Residents; Clinical Fellows	$300	$300	$300	$300	$300	$300	$300	$300	$300	$300
$400	Administrative Medicine; Pathology (Anatomic;General;Neuropathological; Medical Biochemistry; Medical Microbiology; Pathology (Neurological); Physical Medicine and Rehabilitation; Community Medicine (Public Health)	$600	$615	$625	$640	$655	$665	$680	$695	$710	$725
$685	Clinical Assistance (Medical, Surgical); Assistance at surgery - no other professional work; Family Med or Group Practice (excl emergency shifts, incl emergency shifts); Psychiatry; Surgical practice - without operative treatment	$850	$870	$885	$900	$923	$945	$965	$985	$1,005	$1,025
$890	Chronic Pain Management - without general or spinal anesthesia; Obstetrical Practice - without labour and delivery; Allergy; Clinical Immunology; Dermatology; Diagnostic Imaging; Endocrinology; Gastroenterology; Genetics; Haematology; Occupational Medicine; Infectious Diseases; Intensive Care - full time; Internal Medicine and its specialties not elsewhere noted; Nephrology; Neurology; Nuclear Medicine; Medical Oncology; Ophthalmology; Paediatric - may include shift in Emergency Department; Respiratory Medicine; Rheumatology; Sports Medicine; Therapeutic Radiology/Radiation Oncology; Hematology.	$1,160	$1,185	$1,145	$1,170	$1,195	$1,220	$1,245	$1,270	$1,300	$1,325
$1,240	Family/General Practice with Obstetrics; Fam/Gen Practice with Anaesthetic/Surgery/Emerg Dept Work	$1,464	$1,495	$1,526	$1,559	$1,590	$1,626	$1,660	$1,695	$1,730	$1,765
$1,880	Cardiology; Opthamology; Emergency Medicine/Emergency.	$1,830	$1,870	$1,910	$1,950	$1,990	$2,030	$2,075	$2,115	$2,160	$2,205
$3,500	General Surgery; Gynaecologic Surgery - Without labour and delivery; Paediatric Surgery; Plastic Surgery; Thoracic Surgery; Urology; Vascular Surgery.	$4,270	$4,360	$4,450	$4,545	$4,640	$4,740	$4,835	$4,940	$5,040	$5,150
$6,900	Anesthetic; Cardiovascular Surgery; Neurosurgery; Obstetrics, Orthopedic Surgery	$5,975	$6,100	$6,230	$6,365	$6,495	$6,630	$6,770	$6,915	$7,060	$7,210

Notes:

1. 2014 rate is the current rate plus the larger of 3.0% or 2.5% for all types of work, except Interns, residents, and clinical fellows, which remains the same as the current rate over the entire period.
2. The rates for 2015-2023 are increased annually by 2.1% (the historical average of CPI over the past 10 years = 2005-2014).

APPENDIX "I"

PHYSICIAN PROGRAMS

1. CONTINUED PROGRAMS

The Parties agree to continue the following programs previously developed by the Parties:

(a) Clerkship Stipend Program (Final Year Medical Student Bursary Program);

(b) Continuing Medical Education (CME);

(c) Rural Family Medicine Locum Program;

(d) Northern Physician Retention Initiative (NPRI) & NPRI CME;

(e) Pregnancy and Parental Leave Benefit Program (PPLBP);

(f) Northern and Rural Recruitment and Retention Initiative and the Postgraduate Return of Service Program (Formerly UAP);

(g) Northern Specialist Locum Programs;

(h) Emergency Department Coverage Demonstration Project;

(i) Rural Medicine Investment Program;

(j) Physician Health Benefits Program (PHBP);

(k) Hospital Pediatric Stabilization Program;

(l) Hospital On-Call Coverage Program;

(m) Resident Loan Interest Relief Program;

(n) Mental Health Stipends;

(o) Mental Health Sessional Payments and Sessional Fee Supplements;

(p) Divested Psychiatric Physician Hospital funding;

(q) Assertive Community Treatment Program;

(s) Ontario Psychiatric Outreach Program;

(t) Enhanced Care for the Frail and Elderly Funding Initiative;

(u) Funding for Infectious Disease Specialists;

(v) Funding for Geneticists;

(w) Clinical Decision Units; and

(x) any other programs not listed above that the parties have agreed to continue.

2. MODIFIED PROGRAM

The Parties agree to modify the ED Summer Incentive to focus funding on specific needs. HFO will restrict access to the Summer Incentive to the highest need hospitals (i.e. some 30 or more EDs). These could include:

- Rural Northern Physician Group Arrangement (RNPGA) hospitals with 2 physicians and 24-hour emergency coverage,
- Emergency Department Coverage Demonstration Project (EDCDP), participating hospitals;
- EDCDP Regional Referral Centres; and
- If necessary, other hospitals based on a timely assessment of need.

3. DISCONTINUED PROGRAMS

The Parties agree to discontinue the following programs:

(a) Service Recognition Program (Discontinuance Date - Upon final payment on October 1, 2012)

The 2007 Reassessment agreement, paragraph 6(j) states:

"Continuation of program:

The Parties may at future negotiations agree to modify, extend or discontinue the payment program. If the payment is reduced or discontinued, the funding will remain in the physician services budget and the Parties will determine the reallocation of the funding."

(b) HOCC Collaboration Fund (Discontinuance Date – Immediate)

The 2008 Physician Services Agreement, section 6.2.4 states:

"An On Call Coverage Collaboration Initiative fund of $22 million will be established as set out in Section 9.3 to recognize physicians in each LHIN where following implementation of recommendations pursuant to 6.2.2, a comprehensive regional on-call coverage program is in place and aligned to the needs of that community."

(c) Technical Fee Payment (Discontinuance Date – Immediate)

The 2008 Physician Services Agreement, section 4.2 states:

"A fund of $15 million for technical fees will be provided, with the method of allocation to be determined by the PSC. Any future funding increases will be determined through a separate process."

APPENDIX "J"

CONTINUED BILATERAL SUBCOMMITTEES

The Parties agree for the following bilateral subcommittees to continue under their current terms of reference, subject to the following revisions:

1. Joint Forms Committee

The mandate of the Joint Forms Committee shall expand to make recommendations on the following:

- fees for Forms;
- review current undervalued and unremunerated Government forms;
- Standardize hospital forms that require physician input/signature;
- Review of the document requirements for the exceptional access program process (Section 16 of the Ontario Drug Benefit Act); and
- fee for the Out of Country Forms.

2. Primary Health Care Committee

As set out in Appendix "D", the Parties have agreed upon many key initiatives to be implemented as part of this Physician Services Agreement, and the implementation details will require significant work. Accordingly the Parties agree to reconstitute the Primary Health Care Committee (PHCC) under terms of reference developed by the PSC. The PHCC's responsibilities shall include the following initiatives specifically identified in Appendix "D":

- Support for Quality – Excellent Care for All Act (section 3);
- Daytime Access (s. 4.1);
- House Calls (a) and (e) (s. 4.3);
- Review of Access Bonus (s.6.2); and
- Payment Change – CCM Fee Reduction for Large Rosters (s.7.3).
- Payment Change –Acuity Modifier (s.7.5); and
- Interprofessional Health Provider Funding (s.9)

APPENDIX "K"

APP BOILER PLATE PROVISIONS FOR SPECIALIST PHYSICIANS

Basic APP Boilerplate Provisions for Specialist Physicians

This Agreement effective as of the 1st day of , 20[ ]

Among:

Her Majesty the Queen
in right of Ontario
as represented by
the Minister of Health and Long-Term Care

(the "Ministry")

- and -

.....

(the "Group")

- and -

.....

(the "Hospital")

- and -

Ontario Medical Association (the "OMA")

BACKGROUND

1. The purpose of this Agreement is **[NTD: To be determined on a case-by-case basis.]**

2. The Parties acknowledge that the Ontario Health Insurance Plan (the "Plan") is established by the Health Insurance Act (Ontario) to provide for health care services for all insured persons of Ontario. All payments under this Agreement are made by the Government of Ontario under the Plan.

In consideration of the mutual covenants and agreements contained in this Agreement, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree as follows:

ARTICLE 1 – DEFINITIONS

1.1 **Interpretation.** For the purposes of interpretation:

(a) words in the singular include the plural and vice-versa;

(b) words in one gender include all genders;

(c) the background and the headings do not form part of the Agreement; they are for reference only and shall not affect the interpretation of the Agreement;

(d) any reference to dollars or currency shall be to Canadian dollars and currency; and

(e) "include", "includes" and "including" shall not denote an exhaustive list.

1.2 **Definitions.** In the Agreement, the following terms shall have the following meanings:

"Agreement" means this agreement, the appendices, and any amendments entered into under this agreement as of the date of the amendments.

"Business Day" means any working day, Monday to Friday inclusive, excluding statutory and other holidays, namely: New Year's Day; Family Day; Good Friday, Easter Monday; Victoria Day; Canada Day; Civic Holiday; Labour Day; Thanksgiving Day; Remembrance Day; Christmas Day; Boxing Day and any other day on which the Ministry has elected to be closed for business.

"Clinical Services" has the meaning ascribed to it in Appendix "A".

"CMPA" means the Canadian Medical Protective Association.

"College" means the College of Physicians and Surgeons of Ontario.

"Declaration and Consent" means a declaration and consent in one of the forms attached to the Agreement as Appendix "F".

"Defaulting Party" means the Group and/or the Hospital.

"Designated Physician" means a physician who meets the requirements for a Group Physician as set out in Appendix "B", and who is designated by a Medicine Professional Corporation to provide Services on behalf of the Medicine Professional Corporation.

"Effective Date" means the date set out at the top of the Agreement.

"Event of Default" has the meaning ascribed to it in section 12.3.

"Fee-For-Service" means the submission of accounts to the Ontario Health Insurance Plan under the *Health Insurance Act*.

"FTE Position" means a full-time equivalent position where full-time means the provision of a minimum of [**NTD: To be completed when the Agreement is drafted, such as hours, vacation and permissible leaves if applicable.**]

"Force Majeure" has the meaning ascribed to it in section 17.2.

"Funding Year" means:

(a) in the case of the first Funding Year, the period beginning on the Effective Date and ending on **[March 31, 20XX]**; and

(b) in the case of Funding Years subsequent to the first Funding Year, the period beginning on the date that is April 1 following the end of the previous Funding Year and ending on the following March 31.

"Funds" means the funds as set out in Appendix "D".

"Governance Agreement" means the governance agreement referred to in section 3.1.

"Group Number" means **[To be completed when the Agreement is drafted.]**

"Group Physician" means:

(a) a physician who meets the requirements for a Group Physician as set out in Appendix "B"; or

(b) a Medicine Professional Corporation that has identified one or more Designated Physicians.

"*Health Insurance Act*" means the *Health Insurance Act*, R.S.O. 1990, c. H.6.

"Indemnified Parties" means her Majesty the Queen in right of Ontario, her ministers, agents, appointees and employees.

"Indirect Services" has the meaning ascribed to it in Appendix "A".

"Insured Person" means an insured person as defined in the *Health Insurance Act*.

"Insured Service" means an insured service as defined in the *Health Insurance Act*.

"Medicine Professional Corporation" has the same meaning ascribed to the term Physician Corporation under O. Reg. 665/05 made under the *Business Corporations Act*, R.S.O. 1990, c. B.16.

"MNI" means the master number index **[NTD: To be completed when the Agreement is drafted.]**

"Notice" means any communication given or required to be given pursuant to the Agreement.

"Notice Period" means the period of time within which the Defaulting Party is required to remedy an Event of Default, and includes any such period or periods of time by which the Ministry considers it reasonable to extend that time.

"**OHIP**" means the Ontario Health Insurance Plan established under the *Health Insurance Act*.

"**Party**" means the Ministry, the Group, the Hospital or the OMA.

"**Parties**" means the Ministry, the Group, the Hospital and the OMA.

"**Personal Health Information**" means personal health information as defined in the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Schedule A.

"**Records**" means the records and other documents referred to in section 9.1.

"**Report**" means a report referred to in Appendix "E".

"**Services**" has the meaning ascribed to it in Appendix "A".

"**Service Encounter Report**" means a report prepared in a manner similar to the manner in which physicians bill Fee-For-Service.

"**Schedule of Benefits**" means the schedule of benefits for physician services under the *Health Insurance Act*.

1.3 **Physicians as Natural Persons and Medicine Professional Corporations.** Every reference in the Agreement to a Group Physician shall be understood to mean a Group Physician as a natural person or as a Medicine Professional Corporation, and the following interpretative guidelines shall apply:

(a) where the Group Physician is a natural person, the provisions of the Agreement shall be read as drafted; and

(b) where the Group Physician is a Medicine Professional Corporation, the provisions of the Agreement shall be read to apply to the Medicine Professional Corporation as a corporation, with the understanding that:

(i) a Designated Physician shall provide Services on behalf of the Medicine Professional Corporation; and

(ii) all remuneration for the Services of any Designated Physician shall be paid to the Medicine Professional Corporation.

1.4 **Despite Section 1.3.** Despite section 1.3, where the provision relates to an appointment, membership, privilege, qualification, obligation, activity, service or right of a Group Physician that cannot be held or performed by a corporation, the provision shall be understood to refer to the Designated Physician in her or his capacity as the agent of the Medicine Professional Corporation.

ARTICLE 2 – TERM

2.1 **Term.** The term of the Agreement shall commence on the Effective Date and shall continue until terminated pursuant to Article 12

ARTICLE 3 – GOVERNANCE AGREEMENT ESTABLISHED

3.1 **Governance Agreement Established.** The Group represents, warrants and covenants that is has and shall maintain in writing, for the period during which the Agreement is in effect, a governance agreement among Group Physicians that:

(a) establishes the respective and mutual obligations of the Group Physicians, and the processes to support those obligations;

(b) establishes the roles and responsibilities of the Group Physicians, including a process for decision-making;

(c) requires all officers of the Group to be elected through an open and democratic process;

(d) establishes a dispute resolution mechanism to resolve disputes that may arise between or among Group Physicians;

(e) provides that all premiums, contributions and remittances of any nature arising from any payments made under the Agreement are remitted to the proper authority;

(f) states the relationship among the Group Physicians;

(g) creates a set of governing principles and guidelines that:

(i) establishes the expected code of conduct and ethical responsibilities at all levels of the Group;

(ii) enables efficient decision-making among the Group Physicians;

(iii) ensures the ongoing effective functioning of the Group;

(iv) facilitates the delivery of Services; and

(v) enables the timely identification of risks to the delivery of Services, and strategies to address the identified risks;

(h) creates a set of policies and processes for the purposes of:

(i) receiving, managing, allocating and distributing the Funds;

(ii) managing access to personal, financial and other information;

(iii) ensuring that any reports or information a Group Physician provides to the Group is consistent and sufficient to enable the Group to meet its obligations under the Agreement; and

(iv) dealing with amendments to the Agreement; and

(l) deals with such other matters as the Group considers necessary to ensure that all Group Physicians properly and efficiently carry out their respective and mutual obligations under the Agreement.

[NTD: While governance agreements will be consistent with the requirements above, the contents of the Group governance agreements will differ depending on the size and complexity of the Groups.]

3.2 **Managing Disputes.** The Group acknowledges that it has the sole responsibility for resolving any disputes that may arise between or among Group Physicians, and that the Ministry has no responsibility in this regard.

ARTICLE 4 – PROVISION OF SERVICES

4.1 **Provision of Services.** The Group shall provide Services in every Funding Year.

ARTICLE 5 – PHYSICIAN RETENTION AND QUALIFICATIONS

5.1 **Retention Obligation.** The Group shall:

(a) ensure the continued retention of such number of FTE Positions as are set out in Appendix "C";

(b) ensure that every Group Physician meets the criteria for Group Physicians as set out in Appendix "B";

(c) ensure that every Group Physician has, at the time the Group Physician begins to provide Services, malpractice protection through a commercial insurance program or through the Group Physician's membership in the CMPA;

(d) where a Group Physician is providing Services as a natural person, ensure that the Group Physician signs a Declaration and Consent in the form titled "Declaration and Consent for Natural Persons as Group Physicians" as set out in Appendix "F", within 10 days of starting to provide Services in that capacity;

(e) where a Group Physician is providing Services as a Medicine Professional Corporation, ensure that the Group Physician signs a Declaration and Consent in the form titled "Declaration and Consent for Medicine Professional Corporations as Group Physicians" as set out in Appendix "F", within 10 days of starting to provide Services in that capacity; and

(f) submit the signed copy of the Declaration and Consent to the Ministry as soon as a Group Physician signs the Declaration and Consent.

5.2 **Signing a Declaration and Consent Clarified.** A physician may, at any time, change the status under which the physician is providing Services, and shall sign a new Declaration and Consent as provided for in section 5.1(d) or (e) to reflect the change.

ARTICLE 6 – FUNDS

6.1 **Funds Provided.** The Ministry shall provide the Funds directly to the Group for the provision of Services:

(a) on a pro rata basis to reflect:

(i) the proportion of the Funding Year during which the Group provides Services; and

(ii) the number of FTE Positions the Group filled during the Funding Year;

(b) only for the stated Funding Year and not on a cumulative basis;

(c) in equal monthly instalments on the last Business Day of every month; and

(d) by electronic transfer directly into an account designated by the Group.

6.2 **Use of Funds.** The Group shall use the Funds only to remunerate Group Physicians for the provision of Services.

6.3 **No Fee-For-Service.** The Group shall not retain the services of any physician to provide any Clinical Service or Indirect Service on a Fee-For-Service basis, except as provided for in the Agreement.

ARTICLE 7 – BILLINGS AND OTHER PAYMENTS

7.1 **No Group Physician to Claim or Accept Payment.** The Group shall ensure that no Group Physician claims or accepts payment, directly or indirectly, by any means, including through any person, the Hospital, any other entity or OHIP for any Clinical Service or Indirect Service that the Group Physician provides.

7.2 **Ministry's Rights of Set-Off or Deduction.** If a Group Physician accepts payment contrary to section 7.1, the amount of any such payment shall constitute a debt due and owing by the Group to the Ministry, and:

(a) the Ministry shall provide Notice to the Group of the amount of any such payment, and the name of the Group Physician it was paid on account of; and

(b) the Ministry may retain an amount equal to the payment by way of deduction or set-off out of any Funds to be provided to the Group.

7.3 **Exceptions to section 7.1.** Despite section 7.1, all Group Physicians may claim or accept payment, directly or indirectly, by any means, including through any person, the Hospital, any other entity or OHIP:

(a) for the Clinical Services and/or Indirect Services they provide pursuant to the *Workplace Safety and Insurance Act, 1997*, S.O. 1997, c. 16;

(b) for the Clinical Services they provide pursuant to the following K codes under the Schedule of Benefits: K018, K021, K051, K052, K053, K061, K018, K050, K054 and K055;

(c) for the Clinical Services and/or Indirect Services they provide in the [service area/Hospital] that are covered by any reciprocal medical billing arrangement between the Ministry and the provinces (including Quebec) and territories of Canada, to a total maximum of [$.....] for the Group; and

(d) for the technical component of an Insured Service set out in the Schedule of Benefits under the *Health Insurance Act*.

7.4 **Nothing in the Agreement Shall Prohibit.** Nothing in the Agreement shall prohibit a Group Physician from:

(a) claiming or accepting payment for any services the Group Physician provides to persons who are not Insured Persons;

(b) applying for funds under any of the physician programs listed in Appendix "H"; or

(c) accepting payments:

(i) in the form of stipends from a hospital or university for administrative activities that are not Administrative Activities;

(ii) including royalties or honoraria for articles written for journals (whether peer reviewed or not), newspapers or other publications;

(iii) from the Workplace Safety and Insurance Board for reports a Group Physician writes or other activities in which the Group Physician participates pursuant to the *Workplace Safety and Insurance Act, 1997*, S.O. 1997, c. 16; or

(iv) for participation in accreditation surveys, peer review examinations and external reviews of departments or programs.

ARTICLE 8 – REPORTS

8.1 **Reports from the Group.** The Group shall submit to the Ministry the Reports as required in Appendix "E".

8.2 **Reporting Services and Billing for Services Provided Pursuant to Section 7.3.** The Group shall:

(a) provide every Group Physician with the Group Number and the MN; and

(b) ensure that every Group Physician:

(i) prepares Service Encounter Reports;

(ii) uses the Group Number and the MNI when preparing Service Encounter Reports; and

(iii) uses the MNI when preparing all Fee-For-Service claims for the services the Group Physician provides pursuant to section 7.3.

ARTICLE 9 – GROUP RECORDS

9.1 **Record Maintenance.** The Group shall, and shall require the Group Physicians to, keep and maintain:

(a) all financial records relating to the Funds or otherwise to the Services in a manner consistent with generally accepted accounting principles; and

(b) all non-financial documents and records relating to the Funds or otherwise to the Services.

9.2 **Audit.** The Ministry, its authorized representatives or an independent auditor identified by the Ministry may, at its own expense, upon twenty-four hours Notice to the Group and during normal business hours, enter upon the Group's premises to:

(a) inspect and copy the Records; and

(b) conduct an audit or investigation of the Group in respect of the expenditure of the Funds and/or the Services.

9.3 **Disclosure.** To assist in respect of the rights set out in section 9.2, the Group shall disclose any information requested by the Ministry, its authorized representatives or an independent auditor identified by the Ministry, and shall do so in a form requested by the Ministry, its authorized representatives or an independent auditor identified by the Ministry, as the case may be.

9.4 **Disclosure of Personal Health Information.** Nothing in the Agreement shall require the Group, except as otherwise permitted or authorized by law, to disclose any Personal Health Information contained in any of the Records to anyone.

9.5 **No Control of Records.** No provision of the Agreement shall be construed so as to give the Ministry any control whatsoever over the Records of the Group and/or the Group Physicians.

9.6 **Auditor General.** For greater certainty, the Ministry's rights under this Article are in addition to any rights provided to the Auditor General pursuant to section 9.1 of the *Auditor General Act*, R.S.O. 1990, c. A.35.

9.7 **Purpose.** The Ministry may only exercise its rights under this Article for the purpose of confirming that the Group has met its obligations under the Agreement.

ARTICLE 10 – HOSPITAL RESPONSIBILITIES

10.1 **Hospital's Rights Not Derogated From.** Nothing in the Agreement shall derogate from the Hospital's rights to determine medical staff appointments, to safeguard the quality of care provided in the Hospital or to exercise its rights and meet its responsibilities under applicable legislation and regulations.

10.2 **Hospital Funds and Payments.** The Hospital shall:

(a) use best efforts to continue to provide, in every Funding Year, the overall level of funding, resources and support for the provision of Services that it provided at the time of entering in this Agreement; and

(b) not use any monies from its global operating budget to pay Group Physicians for the provision of Services.

10.3 **No Fee-For-Service.** The Hospital shall not retain the services of any physician to provide any Clinical Service or Indirect Service on a Fee-For-Service basis, except as provided for in the Agreement.

ARTICLE 11 – OMA DUES

11.1 **OMA Dues.** The Parties recognize that all Group Physicians receiving Funds through the Agreement, whether members of the OMA or not, are required to pay OMA dues and assessments that the OMA would charge each Group Physician as if she or he were a member of the OMA.

11.2 **Ensuring Payment.** To ensure the payment to the OMA of OMA dues and assessments:

(a) the Group shall provide to the OMA the names and billing numbers of all Group Physicians;

(b) the OMA may advise the Group of the name of any Group Physician who has not paid their OMA dues or assessments and the amount outstanding, and request the Group to pay that amount to the OMA;

(c) upon receiving a request under section 11.2(b), the Group shall deduct from the Funds the amount requested by the OMA and remit such amount to the OMA.

ARTICLE 12 – TERMINATION, EVENTS OF DEFAULT AND CORRECTIVE ACTION

12.1 **Termination by Either Ministry or Group.** Either the Ministry or the Group may, in their sole discretion, at any time and for any reason, terminate the Agreement upon giving three months Notice to the other Parties.

[NTD: The length of notice may need to be revised on a case-by-case basis.]

12.2 **Termination by Group.** The Group may, in its sole discretion, terminate the Agreement immediately upon giving Notice to the Ministry if the Ministry fails to provide Funds in

accordance with Article 6, unless the failure was caused by a circumstance of Force Majeure as provided for in Article 17.

12.3 **Event of Default.** Each of the following events shall constitute an Event of Default:

(a) the Group breaches any representation, warranty, covenant or other material term of the Agreement, including failing to provide Reports in accordance with Article 8;

(b) the Hospital breaches any representation, warranty, covenant or other material term of the Agreement, including failing to provide Reports in accordance with Article 8;

(c) the Hospital makes an assignment, proposal, compromise, or arrangement for the benefit of creditors, or is petitioned into bankruptcy, or files for the appointment of a receiver;

(d) the Group and/or the Hospital cease to operate; and

(e) an event of Force Majeure that continues for a period of 60 days or more.

12.4 **Consequences of Event of Default.** If an Event of Default occurs, the Ministry may, at any time, in proportion to the Event of Default, and in relation to the Defaulting Party, take one or more of the following actions:

(a) initiate any action the Ministry considers necessary in order to facilitate the continued provision of the Services;

(b) provide the Defaulting Party with an opportunity to remedy the Event of Default;

(c) suspend the payment of Funds for such period as the Ministry determines appropriate;

(d) reduce the amount of the Funds;

(e) cancel all further instalments of Funds;

(f) demand the repayment of any Funds remaining in the possession or under the control of the Group;

(g) demand the repayment of an amount equal to any Funds the Group used, but did not use in accordance with the Agreement;

(h) demand the repayment of an amount equal to any Funds the Ministry provided to the Group; and/or

(i) terminate the Agreement at any time, including immediately, upon giving Notice to the Parties.

12.5 **Opportunity to Remedy.** If, in accordance with section 12.4(b), the Ministry provides the Defaulting Party with an opportunity to remedy the Event of Default, the Ministry shall provide Notice to the Defaulting Party of:

(a) the particulars of the Event of Default; and

(b) the Notice Period.

12.6 **Not Remedying.** If the Ministry has provided the Defaulting Party with an opportunity to remedy the Event of Default pursuant to section 12.4(b), and:

(a) the Defaulting Party does not remedy the Event of Default within the Notice Period;

(b) it becomes apparent to the Ministry that the Defaulting Party cannot completely remedy the Event of Default within the Notice Period; or

(c) the Defaulting Party is not proceeding to remedy the Event of Default in a way that is satisfactory to the Ministry,

the Ministry may extend the Notice Period, or initiate any one or more of the actions provided for in sections 12.4(a), (c), (d), (e), (f), (g), (h) and (i).

12.8 **Dispute Resolution.** A Party to the Agreement may submit a disagreement regarding the interpretation and application of the Agreement to the Physician Services Committee for mediation. The PSC will make written recommendations to the Parties regarding the resolution of the disagreement.

12.9 If the matter remains unresolved after two weeks from the date the recommendation was provided, then either Party may submit the disagreement to expedited arbitration before an agreed upon arbitrator for final and binding determination.

[NTD: Section numbers will need to be renumbered]

12.7 **When Termination Effective.** Termination under this Article shall take effect as set out in the Notice.

12.8 **Funds on Termination.** If either the Ministry or the Group terminates the Agreement pursuant to section 12.1, or the Group terminates the Agreement pursuant to section 12.2, the Ministry:

(a) shall cancel all further instalments of Funds;

(b) may demand the repayment of any Funds remaining in the possession or under the control of the Group; and/or

(c) may demand the repayment of an amount equal to any Funds the Group used, but did not use in accordance with the Agreement.

ARTICLE 13 – REPAYMENT

13.1 **Repayment of Overpayment.** If the Ministry provides Funds in excess of the funds to which the Group is entitled under the Agreement, the Ministry may, at any time, request the payment of monies equal to the excess Funds.

13.2 **Debt Due.** If:

(a) the Ministry demands pursuant to the Agreement the repayment of any Funds from the Group; or

(b) the Group owes any Funds or any other money to the Ministry, whether or not their return or payment has been demanded by the Ministry,

such Funds or other money shall be deemed to be a debt due and owing to the Ministry by the Group, and the Group shall pay or return the amount to the Ministry immediately, unless the Ministry directs otherwise.

13.3 **Interest Rate.** The Ministry may charge the Group interest on any money owing by the Group at the then current interest rate charged by the Province of Ontario on accounts receivable.

13.4 **Payment of Money to Ministry.** The Group shall pay any money owing to the Ministry by cheque payable to the "Ontario Minister of Finance" and mailed to the Ministry at the address provided in section 14.1.

ARTICLE 14 – NOTICE

14.1 **Notice In Writing and Addressed.** Notice shall be in writing and shall be delivered by email, postage-prepaid mail, personal delivery or fax, and shall be addressed to the Ministry and the Parties as set out in Appendix "G", or as any of the Parties may later designate to the other Parties by Notice.

14.2 **Notice Given.** Notice shall be deemed to have been received:

(a) in the case of postage-prepaid mail, seven days after a Party mails the Notice; or

(b) in the case of email, personal delivery or fax, at the time the other Party receives the Notice.

14.3 **Postal Disruption.** Despite section 14.2(a), in the event of a postal disruption:

(a) Notice by postage-prepaid mail shall not be deemed to be received; and

(b) the Party giving Notice shall provide Notice by email, personal delivery or by fax.

ARTICLE 15 – RELATIONSHIPS

15.1 **Parties Independent.** The Ministry, the Group, the Group Physicians, the Hospital and the OMA are and shall remain independent and each Party shall be responsible for its

her or his own actions and nothing in the Agreement is intended to or shall be construed so as to:

(a) constitute the Ministry, the Group, any of the Group Physicians, the Hospital or the OMA as a partner, employee, agent or representative of the Ministry;

(b) constitute a joint venture among any of the Ministry, the Group, the Group Physicians, the Hospital or the OMA;

(c) permit the Group, any of the Group Physicians, the Hospital or the OMA to represent to third parties that they have any right or authority to enter into any agreement on behalf of the Ministry; or

(d) permit the Group, any of the Group Physicians, the Hospital or the OMA to enter into any agreement with anyone on behalf of the Ministry.

ARTICLE 16 – LIMITATION OF LIABILITY, INDEMNIFICATION AND INSURANCE

16.1 **Limitation of Liability.** The Indemnified Parties shall not be liable to the Group, any of the Group Physicians, the Hospital or the OMA for any losses, taxes, payments (of any kind), damages (whether incidental, indirect, special or consequential), injury, loss of use or loss of profit (together the "**Losses**") of the Group, any of the Group Physicians, the Hospital or the OMA arising from or in connection with the provision of Services, except to the extent that the Losses were caused by the negligence or wilful misconduct of an Indemnified Party or the Indemnified Parties.

16.2 **Indemnification.** The Hospital hereby agrees to indemnify and hold harmless the Indemnified Parties from and against any and all liability, loss, costs, damages and expenses (including legal, expert and consultant fees), causes of action, actions, claims, demands, lawsuits or other proceedings, by whomever made, sustained, incurred, brought or prosecuted, in any way arising out of or in connection with its obligations under the Agreement or otherwise in connection with the Agreement, unless solely caused by the negligence or wilful misconduct of the Ministry.

16.3 **Hospital's Insurance.** The Hospital represents and warrants that it has, and shall maintain for the term of the Agreement, at its own cost and expense, with insurers having a secure A.M. Best rating of B+ or greater, or the equivalent, all the necessary and appropriate insurance that a prudent person carrying out a program with similar obligations as provided for under the Agreement would maintain, including commercial general liability insurance on an occurrence basis for third party bodily injury, personal injury and property damage, to an inclusive limit of not less than two million dollars ($2,000,000) per occurrence. The policy shall include the following:

(a) the Indemnified Parties as additional insureds with respect to liability arising in the course of performance of the Hospital's obligations under, or otherwise in connection with, the Agreement;

(b) a cross-liability clause;

(c) contractual liability coverage; and

(d) a 30 day written notice of cancellation, termination or material change.

16.4 **Proof of Insurance.** The Hospital shall provide the Ministry with certificates of insurance, or other proof as may be requested by the Ministry, that confirms the insurance coverage as provided for in section 16.3. Upon the request of the Ministry, the Hospital shall make available to the Ministry a copy of each insurance policy.

[NTD: Sections 16.2, 16.3 and 16.4 apply to Hospitals and will not be changed to Group if there is no Hospital-party to the Agreement.]

ARTICLE 17 – FORCE MAJEURE

17.1 **Definition of Party.** For the purposes of section 17.1 through 17.5, "Party" shall mean the Ministry or the Group, and "Parties" shall mean the Ministry and the Group.

17.2 **Force Majeure Means.** Subject to section 17.4, "Force Majeure" means an event that:

(a) is beyond the reasonable control of a Party; and

(b) makes a Party's performance of its obligations under the Agreement impossible or so impractical as reasonably to be considered impossible in the circumstances.

17.3 **Force Majeure Includes.** Force Majeure includes:

(a) infectious diseases, war, riots and civil disorder;

(b) storm, flood, earthquake and other severely adverse weather conditions;

(c) lawful act by a public authority; and

(d) strikes, lockouts and other labour actions,

if such events meet the test set out in section 17.2.

17.4 **Force Majeure Shall Not Include.** Force Majeure shall not include:

(a) any event that is caused by the negligence or intentional action of a Party or such Party's agents or employees; or

(b) any event that a diligent Party could reasonably have been expected to:

(i) take into account at the time of the execution of the Agreement; and

(ii) avoid or overcome in the carrying out of its obligations under the Agreement.

17.5 **Failure to Fulfill Obligations.** Subject to section 12.3(e), the failure of either Party to fulfill any of its obligations under the Agreement shall not be considered to be a breach of, or Event of Default under, the Agreement to the extent that such failure to fulfill the

obligation arose from an event of Force Majeure, if the Party affected by such an event has taken all reasonable precautions, due care and reasonable alternative measures, all with the objective of carrying out the terms and conditions of the Agreement.

ARTICLE 18 – GENERAL PROVISIONS

18.1 **Invalidity or Unenforceability of Any Provision.** The invalidity or unenforceability of any provision of the Agreement shall not affect the validity or enforceability of any other provision of the Agreement. Any invalid or unenforceable provision shall be deemed to be severed.

18.2 **Waivers in Writing.** If a Party fails to comply with any term of the Agreement, that Party may only rely on a waiver of any other Party if the other Party has provided a written waiver in accordance with the Notice provisions. Any waiver must refer to a specific failure to comply and shall not have the effect of waiving any subsequent failures to comply.

18.3 **Governing Law.** The Agreement and the rights, obligations and relations of the Parties shall be governed by and construed in accordance with the laws of the Province of Ontario and the applicable federal laws of Canada. Any actions or proceedings arising in connection with the Agreement shall be conducted in Ontario.

18.4 **Agreement into Effect.** The Parties shall do or cause to be done all acts or things necessary to implement and carry into effect the terms and conditions of the Agreement to their full extent.

18.5 **Approval and Consent in Writing.** Any approval or consent granted pursuant to this Agreement shall not be valid unless given in writing by the Party giving the approval or consent.

18.6 **Reference to Statute.** Any reference in the Agreement to any statute or any section thereof shall, unless otherwise expressly stated, be deemed to be a reference to such statute or section as amended, restated or re-enacted from time to time.

18.7 **Survival.** The following shall survive termination of the Agreement for a period of 7 years as provided below:

(a) the interpretation provisions and definitions as set out in Article 1 and such other definitions that may be referred to in any other provisions that survive;

(b) the provisions respecting billing and the rights of set-off in Article 7;

(c) the Group's obligation to submit Reports and use numbers as set out in Article 8, if any Report remains outstanding upon termination of the Agreement;

(d) the Group's obligations respecting the maintenance and disclosure of Records as set out in Article 9, subject to the provisions contained in that Article;

(e) the Ministry's rights as set out in section 9.2, subject to the provisions contained in that Article 9;

(f) the provisions respecting Event of Default as set out in Article 12;

(g) the Ministry's rights regarding Funds, and/or an amount equal to Funds, on termination as set out in sections 12.8(a), (b) and (c);

(h) the Ministry's right relating to the provision of excess Funds as set out in section 13.1;

(i) the Group's obligations respecting the repayment to the Ministry as set out in sections 13.2 and 13.4;

(j) the Ministry's right to charge interest on money owing as set out in section 13.3;

(k) the method of repaying money as set out in section 13.4;

(l) the provisions relating to Notice as set out in Article 14;

(m) the limitation of liability provision as set out in section 16.1;

(n) the indemnification by the Hospital provision as set out in section 16.2; and

(o) the general provisions in Article 18.

18.7 **Appendices.** The Agreement includes the following Appendices:

(a) Appendix "A" – Services;

(b) Appendix "B" – Physician Categories and Definitions;

(c) Appendix "C" – Retention;

(d) Appendix "D" – Funds;

(e) Appendix "E" – Reports;

(f) Appendix "F" – Declaration and Consent Forms;

(g) Appendix "G" – Contact Information; and

(h) Appendix "H" – Physician Programs.

[NTD: The order of the appendices may need to be revised in light of other changes made to the boilerplate.]

18.8 **Counterparts.** The Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

18.9 **Rights and Remedies Cumulative.** The rights and remedies of the Parties under the Agreement are cumulative and are in addition to, and not in substitution for, any of their

rights and remedies provided by law or in equity.

18.10 **No Assignment.** No Party shall assign any part of the Agreement without the prior written consent of the other Parties.

18.11 **Agreement to Extend.** All rights and obligations contained in the Agreement shall extend to and be binding on the Parties' respective heirs, executors, administrators, successors and permitted assigns.

18.12 **Entire Agreement.** The Agreement constitutes the entire agreement between the Parties with respect to the subject matter contained in the Agreement and supersedes all prior oral or written representations and agreements.

18.13 **Agreement Amended.** The Agreement may only be amended by a written agreement duly executed by the Parties.

The Parties have made the Agreement by their duly authorized signing officers as of the last date written below.

Her Majesty the Queen in right of Ontario
as represented by the Minister of Health and Long-Term Care

_____ _____

Name Date
Minister

Group

_____ _____

Name Date
I have the authority to bind the Physician Organization.

Hospital

_____ _____

Name Date
I have the authority to bind the Hospital.

Ontario Medical Association

_____ _____

Name Date
I have the authority to bind the OMA.

APPENDIX "A" – SERVICES

Services will be set out here, including a description of Clinical Services and Indirect Services.

APPENDIX "B" – PHYSICIAN CATEGORIES AND DEFINITIONS

All physician categories (e.g., Group Physicians, Group Contracted Physicians, Service Extenders, Fellows, etc.) and qualifications will be set out here based on the particular circumstances and specialty of the physicians.

For example, for Group Physicians, the following may be provided:

1. Every Group Physician who is a natural person, and every Designated Physician where the Group Physician is a Medicine Professional Corporation, shall:

   (a) be a member of the Group;

   (b) be a member of the College and hold a certificate of registration to practise medicine issued by the College under the *Medicine Act*;

   (c) hold a certification in [specialty] from the Royal College of Physicians and Surgeons of Canada;

   (d) have malpractice protection through a commercial insurance program or membership in the CMPA or its equivalent; and

   (e) have a medical staff appointment at the Hospital.

APPENDIX "C" – RETENTION

Retention requirements will be set out here.

APPENDIX "D" – FUNDS

The Funds will be set out here.

APPENDIX "E" – REPORTS

Reports and report requirements will be set out here – dates for the submissions of Reports, particulars about the content of Reports, and the manner of submitting Reports (if required).

APPENDIX "F" – DECLARATION AND CONSENT FORMS

See attached.

Declaration and Consent for Natural Persons as Group Physicians

To: **Ministry of Health and Long-Term Care (the "Ministry")**

And To: **[Enter Name of Group] (the "Group")**

And To: **[Enter Name of Hospital] (the "Hospital")**

And To: **Ontario Medical Association (the "OMA")**

1. I am a Group Physician as that term is defined in the agreement entered into between the Ministry, the Group, the Hospital and the OMA effective as of the ___ day of _____, 20___, including all appendices and any amendments to the agreement (the "**Agreement**").

2. Capitalized terms used, but not defined, in this Declaration and Consent have the same meanings as those terms have in the Agreement.

3. I have read and understand the Agreement.

4. I authorize the lead physician for the Group, as may be specified from time to time in Appendix "G" of the Agreement (or as may be designated in writing to all Parties in accordance with the Agreement), to sign the Agreement on my behalf.

5. In consideration of the remuneration I will receive from the Group:

   (a) I shall continue to be a Group Physician for as long as I provide Services;

   (b) as a Group Physician, I am a member of the Group and shall continue to be a member of the Group for as long as I provide Services, and agree that the obligations of the Group under the Agreement are the obligations of the Group Physicians collectively,

   (c) I shall be bound by the terms and conditions of the Agreement as a Group Physician;

   (d) I authorize the Ministry to disclose to the OMA my name and the fact that I am a Group Physician under the Agreement; and

   (e) I authorize the Ministry to disclose to the Group the following data in Ministry records relating to the Clinical Services and Indirect Services I provide as part of the Services:

      (i) my name;
      (ii) the fee code for the Clinical Service and/or Indirect Service;
      (iii) the date on which I provided the Clinical Service and/or Indirect Service;
      (iv) the monetary value of the Clinical Service and/or Indirect Service;
      (v) the MNI and/or name of the facility where I provided the Clinical Service and/or Indirect Service;

(vi) my OHIP billing number; and
(vii) the number of Clinical Services and/or Indirect Services I provided.

8. I agree that sections 5(d) and 5(e) of this Declaration and Consent shall survive the termination of the Agreement.

Date: _____

Name of physician: _____

Signature of physician: _____

Name of witness: _____

Signature of witness: _____

OHIP Number
(billing number): _____

College Registration Number: _____

Declaration and Consent for Medicine Professional Corporations as Group Physicians

To: **Ministry of Health and Long-Term Care (the "Ministry")**

And To: **[Enter Name of Group] (the "Group")**

And To: **[Enter Name of Hospital] (the "Hospital")**

And To: **Ontario Medical Association (the "OMA")**

1. _____ **[Enter name of Medicine Professional Corporation] (the "MPC")** is a Group Physician as that term is defined in the agreement entered into between the Ministry, the Group, the Hospital and the OMA effective as of the ___ day of _____, 20___, including all appendices and any amendments to the agreement (the "Agreement").

2. Capitalized terms used, but not defined, in this Declaration and Consent have the same meanings as those terms have in the Agreement.

3. On behalf of and with the authority of the MPC, I declare that:

   (a) The MPC has read and understands the Agreement;

   (b) The MPC is duly incorporated and validly subsisting pursuant to the laws of Ontario;

   (c) The MPC has full power and authority to enter into the Agreement and to observe, perform and comply with the terms and conditions of the Agreement, and all necessary action has been taken in order to enter into and authorize the Agreement;

   (d) The MPC holds, and shall continue to hold for as long as it provides Services, all registrations and certificates necessary to carry on business in Ontario and to perform its obligations under the Agreement; and

   (e) The MPC authorizes the lead physician for the Group, as may be specified from time to time in Appendix "G" of the Agreement (or as may be designated in writing to all Parties in accordance with the Agreement), to sign the Agreement on behalf of the MPC.

4. In consideration of the remuneration the MPC will receive from the Group:

   (a) the MPC shall continue to be a Group Physician for as long as it provides Services;

   (b) as a Group Physician, the MPC is a member of the Group and shall continue to be a member of the Group for as long as it provides Services, and agrees that the obligations of the Group under the Agreement are the obligations of the Group Physicians collectively;

(c) the MPC shall be bound by the terms and conditions of the Agreement as a Group Physician, and acknowledges that any reference in the Agreement to an appointment, membership, privilege, qualification, obligation, activity, service or right of the Group Physician that cannot be held or performed by a corporation, shall be understood to refer to the Designated Physician in her or his capacity as the agent of the MPC;

(d) the MPC authorizes the Ministry to disclose to the OMA the name of the MPC and the fact that the MPC is a Group Physician under the Agreement; and

(e) the MPC authorizes the Ministry to disclose to the Group the following data in Ministry records relating to the Clinical Services and Indirect Services the Designated Physician provides as part of the Services:

(i) the Designated Physician's name;
(ii) the fee code for the Clinical Service and/or Indirect Service;
(iii) the date on which the Designated Physician provided the Clinical Service and/or Indirect Service;
(iv) the monetary value of the Clinical Service and/or Indirect Service;
(v) the MNI and/or name of the facility where the Designated Physician provided the Clinical Service and/or Indirect Service;
(vi) the Designated Physician's OHIP billing number; and
(vii) the number of Clinical Services and/or Indirect Services the Designated Physician provided.

5. The MPC agrees that sections 4(d) and 4(e) of this Declaration and Consent shall survive the termination of the Agreement.

_____
Name of Medicine Professional Corporation

_____
Name and Title of Authorized Signing Officer

_____ _____
Signature of Authorized Signing Officer Date

I, the undersigned Designated Physician, of _____ **[enter name of Medicine Professional Corporation]**:

(a) agree to be bound by the terms and conditions of the Agreement as a Designated Physician; and

(b) authorize the Ministry to make disclosures in accordance with section 4(e) of this Declaration and Consent, and agree that section 4(e) of this Declaration and Consent shall survive the termination of the Agreement.

Date: _____

Name of physician:	_____
Signature of physician:	_____
Name of witness:	_____
Signature of witness:	_____
CHIP Number (billing number):	_____
College Registration Number:	_____

APPENDIX "G" – CONTACT INFORMATION

Ministry:

Ministry of Health and Long-Term Care
Specialist Physician Contracts Unit
Negotiations Branch
3rd Floor, 1075 Bay Street
Toronto, ON M5S 2B1

Attention:
Fax:
E-mail:

The Group:

Group name:
Address:

Attention:
Fax:
E-mail:

The Hospital:

Hospital name:
Address:

Attention:
Fax:
E-mail:

Ontario Medical Association:

Ontario Medical Association
150 Bloor Street West
Suite 900
Toronto, ON M5S 3C1

Attention:
Fax:
E-mail:

APPENDIX "H" – PHYSICIAN PROGRAMS

The physician programs will be set out here.

TAB 53

New agreement between Ontario's doctors and government protects patient care

TORONTO, Dec. 9, 2012 /CNW/ - Today, the Ontario Medical Association (OMA) ratified a new Physician Services Agreement (PSA) with the provincial government. The vote took place this morning following a referendum with Ontario's doctors where 81% voted in support of the agreement.

The new contract runs from October 1, 2012 to March 31, 2014. The OMA Board unanimously endorsed the agreement in November, and was followed by a comprehensive information campaign to educate physicians across the province about the contents of the deal. During the course of a week, physicians were able to vote online or by phone and nearly 21,000 doctors cast a ballot, representing the highest voting turnout in the history of the OMA.

Key components of the deal include:

- Helping the government find almost $400 million in savings including:
  - A 0.5 per cent payment discount for all physicians; and
  - Finding more than $100 million in savings from health system reform; reducing unnecessary lab testing and streamlining hospital equipment purchases.
- New priority investments to expand access to family doctors for seniors and patients with higher needs, including an expansion of house calls;
- Modernizing the delivery of health care and lowering wait times through e-consultations, enabling patients to communicate with their doctor more easily, allowing for more virtual connections between family doctors and specialists and an expansion of telemedicine services.

The almost $400 million in savings found in this latest agreement is in addition to the over $300 million that Ontario's doctor have already helped the government find in the past couple of years. Since 2003, Ontario's doctors have had tremendous success improving patient care and strengthening the health care system, including:

- Helping 2.1 million more Ontarians find a family doctor that did not have one in 2003;
- Over 7 million patients are benefitting from electronic medical records;
- Savings totaling almost $700 million which have been re-invested back into the health services;
- Nearly 10 million patients rostered in primary care groups along with nearly 8,000 doctors.

Quotes

"These negotiations were challenging but I'm very pleased we were able to roll up our sleeves and reach an agreement tha not only enhances patient care but also protects the improvements that have been made in recent years."

"Ontario's doctors demonstrated tremendous leadership by being active partners in helping the province with its fiscal challenges. If we are going to build on our successes in recent years to improve health care in Ontario, doctors and government need to continue to work in partnership."

Dr. Doug Weir, President
Ontario Medical Association

SOURCE: Ontario Medical Association

For further information:

OMA Media Relations at 647.302.1600
media@oma.org @OntariosDoctors

Organization Profile

Ontario Medical Association

New OMA President: 'Healthcare Will Decide This Election'

Media Advisory - Disaster Psychiatry Canada: Psychiatric Dimensions of Disasters

OMA Brings Awareness to Wait Times Crisis in New Campaign

More on this organization

TAB 54

Tentative 2012 Physician Services Agreement
Executive Summary

The OMA Board has unanimously endorsed the Tentative 2012 Physician Services Agreement — key components are summarized below. For additional details, please refer to the OMA website (www.oma.org/tentativePSA). Questions on the Agreement may be forwarded to the OMA via email (negotiations@oma.org) or telephone 1.800.268.7215/416.599.2580.

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Schedule of Benefits Amendments Related to Review of April 1, 2012 Changes

Effective April 1, 2013

Optical Coherence Tomography (OCT)

OCT will be increased from $25 to $35. G818 and G820 will increase from $25 to $36, with current maximums left as is. A new code Gxxx will be created at $35 for patients receiving active treatment (injections or laser). A maximum of 4 in any combination of G820, G818 or Gxxx will be permitted. A new code Gyyy will be created at $25 for active management of retinal disease. After the G818/G820/Gxxx limit is reached, Gyyy may be billed for following active retinal disease. Limits and treatment regimen for Gyyy will be reviewed by the Ontario Health Technology Advisory Committee (OHTAC) with direct involvement of the Section on Ophthalmology. A new code Gzzz will be created for OCT related to treatment of children at $35. OHTAC and the Section on Ophthalmology will review the use of OCT in this age group to determine appropriate annual limit.

After-Hours Procedure Premiums

The add-on to surgical codes, payable when a case commences in the evening (after 5 p.m.) or at night (after midnight), will be fully restored from 40% to 50% for evenings, and from 65% to 75% for after-midnight.

Anesthesia Flat Fee for Procedural Sedation

The flat fee will be increased from $60 to $75 when one-on-one care is provided. Additional recommendations include considering a solution for a supervisory code for

anesthesiology; as well as a separate solution for providing anesthesia for cataracts, colonoscopy, cystoscopy and sigmoidoscopy in low volume settings, particularly rural settings. Efforts will continue to move some procedures out of hospitals and into out-of-hospital facilities or alternate care settings within hospitals that lend themselves to care delivered by Anesthetic Care Teams.

Laparoscopic Premiums

In April, laparoscopic surgical fee premiums E792A, E793A, E862A were reduced from 25% to 10%. Procedures eligible for the laparoscopic premium will be reviewed to determine both the time differential between the laparoscopic and open approaches and the proportion of the procedures performed laparoscopically. Based on that data analysis, an appropriate premium (which may be greater or less than 25%) should be restored on a procedure-by-procedure basis.

Intensive and Coronary Care Premium (C101)

This premium will be completely restored and applied for each patient seen on a visit to ICU or CCU, in addition to fees payable for services claimed by a physician who was not the MRP.

Lumbar Spine

For CT/MRI studies of the lumbar spine, the April 1, 2012 OHIP Schedule of Benefits change required ordering physicians to repay for the diagnostic service if subsequently found not to be medically necessary. This repayment obligation will be withdrawn. Imaging of the lumbar spine should be based upon current evidence-based guidelines, and requisitions for imaging must adhere to these guidelines.

Cataracts

OHTAC will be enlisted to do a full evidence-based review in order to determine clear and objective criteria describing indications for cataract extractions, i.e. when is the patient's vision sufficiently impaired that extraction becomes medically necessary and therefore should be insured. The Section on Ophthalmology will be directly involved in the discussion.

Self-Referral Regulation

The Ministry agrees to repeal Self-Referral regulations, and the Expert Panel on Appropriate Utilization of Diagnostic and Imaging Studies shall continue its work.

Reverse & Equivalent Flow Through

Effective January 1, 2013

Specialist APPs

Flow through arising from the April 2012 changes will be applied to the clinical contract value calculated for each APP/APP Agreement, and AHSC APPs. Where possible, flow through will be implemented as an adjustment to the Service Encounter Premium. Other clinical physician payments that received positive flow through from the 2008 PSA, such as mental health sessionals and stipends, will be subjected to reverse flow through.

Primary Care Specialized Models

Flow through arising from the April 2012 changes to family physicians will be applied against the clinical base of the following primary care specialized models: Rural and Northern Physician Group Agreement (RNPGA 1 and 2); Weeneebayko Health Authority (WHA); GP Focus Practice Models – Palliative APP, HIV APP, Care of the Elderly, Toronto Palliative Care; Algonquin FHT; St. Joseph's Health Centre; Community Health Centres; Aboriginal Health Access Centres (AHAC); Blended Salary Model (cFHT); Sherbourne; Shelter Health Network; Inner City Health (ICHA); Sioux Lookout; and Group Health Centre (GHC).

Equivalent Flow Through Effective January 1, 2013

GP Psychotherapy

The GP Psychotherapy premium will be reduced from 15% to 12%, proportional to the reduction in A007.

Other changes consistent with the 5% professional fee reductions for Diagnostic Radiology, MRI and Diagnostic Ultrasound include:

- A reduction of 5% for Nuclear Medicine Professional Fees
- A reduction of 5% for sleep studies professional fees
- A reduction of 5% for Radiation Oncology treatment planning codes (X310, X311,X312, X313)

Primary Care

Effective January 1, 2013

Telephone Health Advisory Service (THAS)

Physician payments for THAS will be discontinued and physicians will not be required to provide on call to THAS, however physician groups may continue to do so on a voluntary basis. Physician groups will still be required to report after hour's clinic schedules. PEM groups will continue to receive a report when enrolled patients use TelehealthOntario.

Access Bonus Rebate

The Access Bonus Rebate (approximately $160 per physician) will be discontinued.

In Office Service Bonus (2008 PSA s.5.2)

The $10 million set aside each year for PCM physician and physician groups who provide a broad range of in-office services will be discontinued.

Personalized Health Visit

The annual health exam will be replaced by a periodic health review for adult patients 18 to 64 years valued at $50. For patients in other age groups, the billing for the annual health exam will remain the same. There is no adjustment to the capitation rate.

Effective April 1, 2013

Managed Entry

The current stream of 25 managed entry positions into FHNs and FHOs will be expanded to 40 physicians per month — 20 in a prioritized stream based on local need; and the remainder on a first come, first serve basis. Unfilled spots can be shifted to either stream or into subsequent months. There will be unlimited entry into FHGs effective immediately.

Comprehensive Care Capitation

Individual PEM physicians with more than 2,400 patients will receive the full value of the CCM fee for the first 2,400 rostered patients. For each subsequent patient, the fee will be reduced by 50%.

Diabetes Management Fee

The fee payable on the Q040 (diabetes code tied to the Diabetes Registry) will be reduced from $75 to $60.

FHN/FHO Capitation + W010

Residents in a long-term care (LTC) facility should be either rostered as an LTC patient, or seen on a fee-for-service basis (and able to bill W010). They should not be rostered as part of the regular practice. The contract language will be tightened, and the Ministry will work with the OMA to simplify rostering LTC patients.

Interprofessional Shared Care Nurses – Eligibility Expansion

Patient access to interdisciplinary primary health care services will be expanded by allocating Interdisciplinary health team provider (IHP) resources, including Physician Assistants (PAs), to non-FHT affiliated physician groups of three physicians or more, including Family Health Groups, Family Health Networks, Family Health Organizations and RNPGAs.

PEM Group Bonus Payment for Out of Office Care (2008 PSA, Appendix E, s.3)

The special bonus to be awarded to top performing groups who have a rostered population reflective of their community and who provide the broad range of out of office services which meet the needs of their patients will be discontinued.

The Out of Office Service Bonus outlined in s.5.3 will continue.

Preventive Care Management Service Enhancement Fee

The $6.86 Preventive Care Management Service Enhancement (Q001 - Q005) Fee will be discontinued. The annual Preventive Care Bonus will continue.

House Calls

To encourage primary care physicians to provide more house calls, enhancements will be made to the existing bonuses for primary care physicians to provide house call visits to homebound and frail elderly patients.

Acuity Modifier

To incent physicians to increase the number of high-acuity patients on their roster, a one-time acuity modifier is proposed and will be developed by the Primary Care Policy Committee (until an acuity-adjusted capitation model is developed and implemented). $40 million has been set aside for this initiative.

Quality Improvement Plans (FHTs, AHACs, and CHCs)

Participation in the Excellent Care for All Act annual quality improvement plans will be expanded to include physicians practising in FHTs, AHACs, and CHCs. Other primary health groups may participate on a voluntary basis.

Primary Care Policy Committee

A primary care committee will be established to implement primary care initiatives and address policy issues identified in the Tentative Agreement.

FHG Template Agreement

Family Health Group contracts will be amended to require a lead physician to be declared for FHG groups and physicians will be required to have a governance agreement.

Access – Regular Hours – Analysis and Recommendations

The Primary Care Policy Committee will do an analysis of daytime access in primary care and make recommendations before the end of the Tentative Agreement.

Access – After Hours – FHG/FHN/FHO

New enhanced after hours requirements will apply to groups with 10 or more physicians (exempting Northern group practices):

- 10-19 physicians – 7 blocks (2 additional)
- 20-29 physicians – 8 blocks (3 additional)
- 30-74 physicians – 10 blocks (5 additional)
- 75-100 physicians – 15 blocks (10 additional)
- 100-199 physicians – 20 blocks (15 additional)
- 200+ physicians – 25 blocks (20 additional)

Virtual Care

Northern Health Travel Grant

The Northern Health Travel Grant approval process will be modified to encourage the replacement of face-to-face visits with virtual equivalents, where clinically appropriate, reducing NHTG utilization.

Specialist to Primary Care Virtual Follow-Up

A working group will be established to evaluate existing pilots and programs, and will use this data to develop recommendations for a comprehensive, provincial business and technology model for hospital to primary care communications.

Patient eConsults

An evaluation project will be developed to enable standards-based, patient-initiated patient to provider eConsultations, including initial evaluations in capitated sites followed by an evaluation in a fee-for-service setting.

Primary Care to Specialist eReferral

eReferral fee codes will be established for dermatology and ophthalmology, with subsequent expansion to other specialties.

Realignment of Telemedicine Premium

Establish an OTN Working Group to evaluate Personal Video Conferencing (PVC) deployment progress, utilization, volume and workflow trends. In short term the Working Group will develop:

- PVC utilization or deployment targets that signal a diminishing need for full telemedicine premium.
- New premiums for northern and non-northern telemedicine consultations based on utilization patterns and adoption requirements.

Evidence and Appropriateness

Under the mandate of making changes to promote the use of evidence and best practices for the provision of health care to and appropriate for the clinical needs of patients, a series of recommendations were brought forward. The majority of savings are from the health system budget.

Reduce Unnecessary Testing – Effective November 1, 2012

3 items were removed from the lab req as of November 1 (Ferritin, TSH, Vitamin B12). These laboratory tests have been removed from the Ontario laboratory requisition form but are still available to patients with appropriate indications.

Reduce Unnecessary Testing – Effective January 1, 2013

Aspartate Aminotransferase (AST)

Based on expert consultations conducted by Health Quality Ontario, Aspartate Aminotransferase (AST) is a less specific test for liver disorders than Alanine Aminotransferase (ALT), and so has limited utility in the community setting. Therefore, OHTAC has recommended that AST testing in community laboratories be restricted to patients under the care of a specialist at a hospital.

Chloride

Based on expert consultations conducted by Health Quality Ontario, chloride testing in the community setting has limited utility. Therefore, OHTAC has recommended that chloride testing be removed from the Ontario laboratory requisition form.

Creatine Kinase

Creatine kinase in community laboratories is being frequently ordered in patients on statin therapy, often as a screening test. Based on a rapid review conducted by Health Quality Ontario, OHTAC has recommended that creatine kinase be removed from the Ontario laboratory requisition form.

Folate

Expert consultations conducted by Health Quality Ontario identified that folate deficiency is rare in Canada, and there is unnecessary testing occurring in Ontario. OHTAC recommends that folate testing be restricted to red blood cell folate, except when ordered by or on the advice of physicians with expertise in hematological, inflammatory or gastrointestinal disorders.

Reflexive Testing

There are a number of conditions for which reflexive testing could be used to increase the efficiency of test ordering. Instead of ordering a sequence of tests one clinical visit at a time, or ordering multiple tests (some unnecessary) at the same time, reflexive testing allows the clinician to indicate the clinical situation or condition in question, and the laboratory to run the necessary tests using a diagnostic algorithm.

Thyroid Scans

Language will be added to the OHIP Schedule of Benefits clarifying that thyroid scans should only be ordered for hyperthyroidism (including nodules associated with hyperthyroidism), congenital hypothyroidism, masses in neck or mediastinum suspected to be thyroid in origin, and that scans are not generally indicated for investigation of thyroid nodules (except if associated with hyperthyroidism) and adult hypothyroidism.

Diagnostics Ordered by Other Practitioners

Review and evaluate appropriateness of diagnostic studies (e.g., X-rays) ordered by non-physicians (e.g., chiropractors). For tracking and evaluative purposes, referring provider number must be provided to OHIP for payment purposes.

Schedule of Benefits Alignment with Recommendations Screening & Routine Tests – Effective January 1, 2013

Colon Cancer Screening Intervals

To align with Cancer Care Ontario's Screening Program, colorectal cancer follow-up screening intervals for asymptomatic patients, or surveillance after polyps are identified after a high-quality colonoscopy that is negative, will be increased. Follow-up screening intervals will be set at 1 every 5 years, or 1 every 10 years, based on individual patient indications.

Cervical Cancer Screening

The Schedule of Benefits and PEM cervical cancer screening bonuses will be revised accordingly to reflect Cancer Care Ontario's new guidelines on cervical cancer screening, including increasing the interval of screening from a 2-year interval to a 3-year interval, and defining when to start screening (21 years of age) and stop screening (after the age of 70).

Annual Stress Tests

As identified by the American College of Cardiology and the American College of Physicians in the "Choosing Wisely" campaign, language will be added to the OHIP Schedule of Benefits clarifying that annual stress tests to asymptomatic patients at low risk for coronary heart disease should not be billed to OHIP.

Pre-Operative Cardiac Testing

As identified by the American College of Cardiology and the American College of Physicians in the "Choosing Wisely" campaign, language will be added to the OHIP Schedule of Benefits clarifying that pre-operative testing including cardiac testing (echo, ECG, and nuclear imaging), pulmonary function testing, routine chest X-rays, and laboratory testing is not necessary for patients undergoing low/moderate-risk non-cardiac surgery and should not be billed to OHIP.

Chest X-rays

Language will be added to the OHIP Schedule of Benefits clarifying that routine chest X-rays for screening and routine pre-admission for ambulatory and inpatients with unremarkable history/physical exam is not medically necessary and should not be billed to OHIP.

Reducing Procedures Not Supported By Clinical Evidence – Effective January 1, 2013

Arthroscopic Lavage

Based on OHTAC recommendations, language will be added to the OHIP Schedule of Benefits clarifying that arthroscopic lavage for osteoarthritis of knee should not be billed to OHIP.

Injection of Hyaluronic Acid

Based on OHTAC recommendation, hyaluronic acid is not insured, however the injection of hyaluronic acid is insured (G370). Since the substance being injected is not recommended, OHIP should consider no longer paying for the injection of hyaluronic acid.

Phase II Review

In order to ensure the appropriate use of health-care resources, a working group will be established on Phase II recommendations to minimize:

- **Overuse:** the use of health-care resources and procedures in the absence of evidence that they could help the patients receiving them;
- **Misuse:** failures to execute clinical care plans and procedures properly; and
- **Underuse:** failures to employ health-care practices of proven benefit.

Phase II review items are those that require further analysis and/or consultations and will focus on tests, treatments, or services that are currently underused. Where possible, the recommendations will align with Health Quality Ontario and Ontario Health Technology Assessment Committee recommendations.

Phase II Review:
Limit self-monitoring (blood glucose test strips) and blood glucose tests and A1C tests; Investigations in the work-up of dementia; Appropriate sleep lab testing; Anesthesia requirements for vasectomies, cataracts and endoscopy; Lipid testing, Serum protein electrophoresis; Appropriate ultrasound imaging; Vitamin B12 (part 2) - Remove vitamin B12 from the Ontario laboratory requisition form (align with HQO/OHTAC recommendation); Cease funding of routine pre-operative cardiac testing for asymptomatic patients undergoing low/moderate risk non-cardiac surgeries (part 2) - Pending the outcome of discussions with experts about defining moderate/intermediate and exposing these patient categories to pre-operative cardiac testing, align Schedule of Benefits with moderate/intermediate risk accordingly; Genetics Strategy; Companion Diagnostics – Recommend Cobas EGFR Mutation Test be required for Erlotinib (a drug for treatment of lung cancer funded under the Exceptional Access Program); Review of Physician Schedule of Benefits for Bone Mineral Density Testing by DXA (Dual Energy X-Ray Absorptiometry) with most current Osteoporosis Canada Guideline; Review relevancy of Pre-dental/Pre-operative Assessments with the services provided by hospital-based pre-operative assessment clinics; Review the utilization and relevancy of Pre-operative Consultations; Review changes in practice patterns for the provision of cardiac services and the impact on utilization arising from changes in the Tentative Agreement.

Phase II also includes:
Appropriate Prescribing – improved prescribing among physicians and targeted educational strategies and tracking mechanisms to harness savings. This would be a voluntary program, confidential to the physician, with OMA oversight of the program. No physician data will be transmitted to the CPSO nor to any other institution.

System Savings and Sustainability

Annual Consecutive Consultations

The fee for annual consecutive consultations by the same specialist on the same patient for the same clinical diagnosis will be reduced to a limited/repeat consult fee or a specific assessment fee.

Multiple Consultations

The language within the Schedule of Benefits will be tightened to limit patients to one second opinion consultation (where a second opinion consultation is requested by the patient).

Group Appointments

Shared appointments or group care employed especially for chronic diseases and some mental health issues enhance or preserve patient care and result in cost savings. These diseases include Diabetes, Congestive Heart Failure, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Hypercholesterolemia, and Fibromyalgia. Group care codes will be created for these disorders similar to existing, per patient GP group psychotherapy codes.

Medically Complex Patients

In order to develop proposals for medically complex patients, both post-discharge and ongoing, demonstration projects will be established to measure results, which will be evaluated after one year. The Ministry will provide $10M for the period October 2013 to October 2014 for this initiative.

Hospital Supplies and Equipment

A province-wide product/supplies standard will be established for specific procedures, resulting in a reduction in the number of vendors and reduced cost, without impacting patient care. Areas of initial focus include the equipment, technology and prosthetics used for the following: hip, knee replacements, spine, cataract/cataract lenses, vascular stents and cardiac stents.

Other Payment Matters

Discontinued Programs

- Service Recognition Program (2007 Reassessment) – Subsequent to the final payment on October 1, 2012, the program will be discontinued. All eligible physicians should have now received at least one payment.

- HOCC Collaboration Fund (2008 PSA) – the $22M one-time funding for on-call collaboration will be repurposed.

- Technical Fee Payment $15M (2008 PSA) – This funding will be terminated.

Modified Programs

- ED Summer Incentive – This is a program that was additional money outside any agreement. The proposal is to move to Needs-Based Funding (2013/14). HFO will restrict access to the Summer Incentive to the highest need hospitals (i.e. some 30 or more EDs).

CMPA

The CMPA Agreement, currently set to expire in 2014, will be extended until 2023. In 2014, the physician contribution portion for each specialty will increase the greater of $200 or 22%, and then by a 2.1% per year inflationary adjustment. If the provincial Consumer Price Index exceeds 4%, the CMPA Agreement will be re-opened. Note: a detailed chart will be made available on the OMA website for member reference.

Payment Discount

A payment discount of 0.5% on all physician payments (professional fees, technical fees, primary care payments, specialist APPs, other physician clinical payments such as mental health sessionals and stipends) will be effective April 1, 2013.

The Parties agree to continue their work on evidence-based initiatives and analyze the potential savings that arise from the Phase II and other initiatives.

The amount of the payment discount will be reduced effective October 1, 2013 by an amount equal to savings in the physician services budget

Other Issues

1. **Representation & Negotiation Rights Agreement**
   The OMA and the Ministry have finalized a standalone Memorandum of Agreement document that provides for a framework for all future negotiations, including conciliation, identifies a formal Dispute Resolution mechanism and provides for a continuation of the Physician Services Committee.

   For this, and future negotiations, the ministry commits not to implement any unilateral changes prior to completion of a facilitation and conciliation process.

2. **Standard Non Fee-For-Service (NFFS) Contract**
   We have agreed to a Standard NFFS agreement to be used for future NFFS agreements. The Standard agreement will facilitation the negotiation of future NFFS contracts with the Ministry. This Standard agreement includes a right for physicians to require arbitration to resolve any disputes with the Ministry regarding the interpretation and application of the NFFS agreement.

   This Standard NFFS agreement will apply to specialist agreements, and the parties have agreed to continue to work to modify the agreement for primary care agreements.

3. **College of Physicians and Surgeons of Ontario (CPSO) Complaint Process**
   At present, the CPSO is required to investigate any complaint into a physician's conduct, including if the complaint is clearly frivolous.

   The Parties agree that the CPSO should not have to conduct a full investigation into complaints about matters that are outside the jurisdiction of CPSO and that there is a need to better manage frivolous and vexatious complaints.

   As this issue could affect other regulated health professions, the Ministry will undertake consultations with other regulatory colleges and patient advocacy groups in 2013 and bring forward recommendations to the Government of Ontario for legislative amendments by March 1, 2014.

4. **Tort Reform**
   The Parties will review and update the tort reform measures recommended by the OMA, MOH, CMPA Medical Malpractice Coverage Committee in 2001, including reforms for:
   - OHIP subrogation,
   - Prejudgment interest,
   - Family Law Act awards,
   - Limitation of general damages.

   The parties shall report back to the PSC by June 2013, and thereafter as required.

5. **Forms**
   The Parties believe that the PSA should not unduly contribute to the administrative burden on physicians' practices. The Parties agree to continue the Joint Forms Committee, and expand its mandate to include fees, Out-of-Country forms, and standardization of hospital forms.

6. **Email Requirement**
   The Parties undertake to encourage physicians to voluntarily provide the Ministry with email addresses to permit email notification by all parties to primary care agreements.

Bilateral Monitoring and Accountability Process

The Physician Services Committee will develop a workplan outlining specific steps that will address the ongoing measurement and evaluation of the investments and savings provided for in this Agreement; and the ongoing measurement of utilization and advice regarding reasons for utilization changes. At the end of the first full year of measurement and evaluation, the Parties will assess the process and consider changes if the process is not yielding responses that are mutually satisfactory.

Term

The Tentative 2012 Physician Services Agreement runs from October 1, 2012 to March 31, 2014.

TAB 55

Table A.1.4 Average gross clinical payment per physician and annual percentage change, by province/territory, 2011–2012 to 2015–2016

Payments by fiscal year	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Total
2011–2012	273,657	328,685	n/a	279,434	288,504	372,041	312,875	342,819	349,470	273,484	NR	NR	327,486
2012–2013	276,502	339,672	255,148	296,935	279,209	367,398	308,857	365,688	348,221	271,483	NR	NR	327,412
2013–2014	275,937	349,642	255,561	290,199	308,580	364,791	326,720	356,776	354,492	276,718	244,514	NR	334,959
2014–2015	277,124	364,771	259,264	302,123	310,438	357,357	340,900	365,097	365,765	279,437	266,956	NR	336,133
2015–2016	275,761	366,934	262,164	290,457	325,096	348,056	343,944	353,656	380,384	284,918	289,685	NR	338,727
Percentage change by fiscal year	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Total
2011–2012	—	—	—	—	—	—	—	—	—	—	—	—	—
2012–2013	1.0	3.3	—	6.3	4.0	-1.2	-2.3	6.7	-0.4	-0.7	—	—	0.0
2013–2014	-0.2	2.9	0.2	-2.3	9.4	-0.7	5.8	-2.5	1.8	2.7	—	—	2.3
2014–2015	0.4	4.3	1.1	4.1	1.6	-2.0	4.3	2.3	3.2	0.3	9.2	—	0.3
2015–2016	-0.5	0.6	1.5	-3.9	4.7	-2.6	0.9	-3.1	4.0	2.0	8.5	—	0.8

Notes

— Data was not applicable for a given category.

n/a: Not applicable.

NR: Not reported

The above indicator is the sum of each province's expenditures for clinical payments to physicians divided by the total number of physicians as reported by each province

Due to the greater proportion of short-term, retiring and locum physicians and their lower associated payments in certain smaller jurisdictions relative to larger ones, in an attempt to improve comparability, CIHI has agreed to calculate the average payment per physician using only permanent in-province physicians in P.E.I. and physicians whose total gross payments are at least $50,000 in Yukon.

Managing and laboratory specialists are not included.

Each physician receiving clinical payments was counted equally regardless of the amount of money he or she received or the level of activity (e.g., full time, part time, casual).

Based on gross payments.

Data for Newfoundland and Labrador is not finalized and should be considered preliminary.

Sources

National Physician Database and National Health Expenditure Database, Canadian Institute for Health Information.

TAB 56

IN THE MATTER OF A CONCILIATION
Under the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement, 2012

BETWEEN:

THE ONTARIO MEDICAL ASSOCIATION

-AND-

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO, AS REPRESENTED BY THE MINISTER OF HEALTH AND LONG-TERM CARE

Conciliator's Report

The Hon. Warren K. Winkler, Q.C.

December 11, 2014

The Conciliator's Report is the result of negotiations between the Ontario Medical Association ("OMA") and the Ministry of Health and Long-Term Care of Ontario ("MOHLTC" or the "Ministry") (collectively the "Parties"), which took place from November 10 to December 3, 2014. The purpose of these negotiations was to establish a 2014 Physician Services Agreement between the Parties ("2014 PSA").

1) The Parties

The OMA represents the political, clinical and economic interests of over 34,000 physicians, residents and medical students across Ontario. The OMA plays a leading role in shaping health care policy and implementing initiatives that strengthen and enhance Ontario's health care system.

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

2) The Physician Services Agreement

The Physician Services Agreements ("PSAs") are negotiated agreements between the OMA and the Ministry that determine central features of Ontario's health care system. The compensation for physicians for providing health care services is a major component of the PSA. The most recent PSA ("2012 PSA") was a short-term agreement reached in November 2012 that expired in March 2014. The Parties have been in negotiations to reach the 2014 PSA since January 2014.

3) Joint Process for Negotiation of the 2014 Physician Services Agreement

The OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement(December 11, 2012) (the "DRA") sets out a two-phase negotiation process agreed to between the Parties for the purpose of establishing the PSA (the "Joint Process"). The Joint Process regulates the present negotiation of the 2014 PSA. Under the DRA, the Parties agree to participate in the Joint Process in good faith and to make all reasonable efforts to reach an agreement. Neither party can seek to end the negotiations before the conclusion of the Joint Process. In addition, the Minister cannot advise the Government of Ontario to unilaterally implement proposals prior to the completion of the Joint Process.

a) Phase One: Negotiation and Facilitation

In the first phase of the Joint Process, the Parties are to commence negotiations at least four months before the end of the term of the most recent PSA. The Joint Process allows for the appointment of a neutral facilitator after the Parties have negotiated bilaterally, and without assistance, for a period no greater than 120 days. If the Parties do not reach an agreement with the facilitator, the facilitator will issue written recommendations to the Parties. The facilitator's recommendations are confidential. The Parties are to resume direct negotiations within fourteen days of receipt of the facilitator's recommendations, with the aim of reaching an agreement. Failing settlement, the Parties enter phase two of the Joint Process.

On January 14, 2014, following much preparatory work, the Parties commenced negotiations for the 2014 PSA. At the end of July 2014, it was clear that the Parties could not reach agreement and the provisions for facilitation in the DRA were invoked. Dr. David Naylor (the Facilitator") was appointed as facilitator in August 2014, with the assistance of Ms. Lisa Purdy. The facilitation commenced in September 2014. By September 27, 2014, the Parties had not reached an agreement. Dr. Naylor provided his facilitator's recommendations on October 9, 2014 (the ((Facilitator's Recommendations"). The Parties resumed negotiations but were unable to reach an agreement thus triggering the second phase of the Joint Process.

b) Phase Two: Conciliation

The second phase of the Joint Process allows for the appointment of a neutral conciliator to assist in the negotiation of the PSA. The conciliator may review and consider the facilitator's recommendations. If the Parties do not reach an agreement with the conciliator within fourteen days of the conciliator's appointment, the conciliator is mandated to issue a written report. In contrast to the facilitator's report which is confidential, the conciliator's report is to be a public document. Absent a settlement resulting from conciliation, within seven days following receipt of the conciliator's report, the Parties are to reconvene for a period of ten days in a final attempt to resolve the dispute in direct bargaining.

4) The Conciliation

The Parties appointed me, the Honourable Warren K. Winkler Q.C. (the ((Conciliator"), assisted by Ms. Debra Lovinsky, to help advance the negotiations of the 2014 PSA (the ((Conciliation"). I reviewed the Facilitator's Recommendations and briefs submitted by the Parties prior to the Conciliation. The Conciliation spanned twenty-four days, including eleven days of face-to-face meetings. The first meeting took place on November 10, 2014 and the sessions concluded on December 3, 2014. At the end of the day on December 3rd, the Ministry tabled its final position (the ((Ministry's Proposal") to the OMA. After lengthy deliberations that continued through to December 5th, the OMA advised that it was unable to accept the Ministry's Proposal. The rejection resulted in the release of this report (the ((Conciliator's Report") in accordance with the terms of the DRA.

a) The Parties' Contributions

I would like to commend both Parties for their tireless work in an attempt to resolve the most significant and pressing public interest dispute facing Ontario and its citizens - the funding and delivery of physician services. The Parties approached the meetings with mutual respect. It was apparent that their primary and mutual concern was the continued provision of the best quality of physician services to Ontarians.

The pivotal importance of the current PSA negotiations to Ontario's health care system was reflected by the dedicated involvement of Dr. Bob Bell, the Deputy Minister of Health and Long-Term Care, and his counterpart Dr. Ron Sapsford, Chief Executive Officer of the OMA. I would like to express my gratitude for the wisdom and sound judgment that each brought to bear throughout the bargaining sessions that occurred during the Conciliation.

b) Significant Moves by the Parties

At the outset of the Conciliation, the Parties were far apart in their respective positions. In fact, no issues had been agreed upon up to that time. Constraining the Parties' ability to move forward was a fundamental disagreement regarding the baseline for the Physician Services Budget ("PSB"). At the root of this disagreement were projected savings from the 2012 PSA, which had not been realized. To further compound this problem, the Ministry was looking for significant savings in the 2014 PSA. Remarkably, the Parties were able to resolve the issue of the PSB baseline, opening the way for meaningful discussions on the threshold issue of the necessary savings required by the Ministry. I particularize these items below:

i) The Baseline for the Physician Services Budget

The PSB is the total amount of annual spending on physicians through expenditure streams or programs managed by the Ministry. Agreement on the PSB baseline is a critical foundation for the 2014 PSA. The Parties were able to agree on a PSB for fiscal year 2013/2014 of $11.2978 billion, thus establishing a concrete baseline for the negotiation of the 2014 PSA.

ii) Cost Increase of CMPA

The Canadian Medical Protective Association (the ((CMPA") fees for physicians are included in the PSA base. Significant increases in respect of the premium were included by the Ministry initially as a charge against the total budget. This posed a problem going forward as it intertwined with other collateral agreements between the Parties. In an effort to clear this roadblock and permit the negotiations to progress, the Ministry removed CMPA increases from the PSB for the duration of the 2014 PSA.

iii) Three-year Term

The Parties had proceeded throughout the negotiations on the assumption that the 2014 PSA would be for a two-year term. Because the 2014 fiscal year was two-thirds over, almost all of the negotiated savings to the PSB would necessarily have to be realized during the second year of the agreement. Therefore, at my instance, the Parties agreed to a three-year term for the 2014 PSA. This was a significant breakthrough. Not only did it provide a manageable time frame for the achievement of mutually agreed savings targets, but it also enabled the Parties to fashion a third year that would provide physicians with some respite from the cost containment model of the second year.

iv) Targeted Savings

The focus of the Conciliation was squarely on the savings required by the Ministry in the second year of the agreement. The Ministry's opening position, in this respect, was that it required $740 million in savings. The Parties searched for areas in which these savings could be achieved with an emphasis on those areas that would not directly impact on physicians' fees. This latter goal could not, on any analysis, be achieved. In other words, the full savings could not be realized without impacting fees. As well, there was always disagreement as to the total amount of savings required.

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.

v) Collaborative Framework

At the start of the Conciliation it became obvious to me that there was a pressing need for a collaborative dialogue analysing the current system of financing of the delivery of physicians services. My concerns stemmed from the debate between the Parties regarding the cost-savings asked for by the Ministry in the 2014 PSA. First, there was an issue arising from the reconciliation of the savings which were to have been generated by the 2012 PSA. The Ministry asserted that any agreed savings that failed to be achieved in the last agreement had to be obtained in the 2014 PSA. Secondly, the OMA stressed that the PSB failed to take into account cost increases generated by forces beyond the control of physicians, such as population growth, increased usage and an aging population. Finally, the OMA took issue with the Ministry's position that the Parties could only look for savings from within the health care system and from physicians' earnings, and not by increasing the budget or finding alternative sources of funding.

It is apparent that these positions are irreconcilable in the longer term. Absent some rationalization, the system may not be sustainable. Thus, the consensus emerged that without systemic changes to the health care system, the Parties seemed to be on a collision course so that a PSA, at some point in the future, may not be achievable.

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 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.

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

c) The OMA's Position

Although the OMA did not table a final position, throughout the Conciliation it pressed the Ministry to address the rising cost of practice for physicians through increases. In particular, the OMA sought a general increase in fees in year three. In addition, the OMA was adamant that it could not accept any further savings in the third year. To this point, the MOHLTC was looking for $32.7 million in savings in year three. It was not prepared to agree to an increase to cover the cost of practice.

d) The Ministry's Proposal

The Ministry sought to address the outstanding gap between the Parties by responding in two areas – savings and the cost of practice – both in the third year. The Ministry tabled its final position (the "Ministry's Proposal") on the last day of the Conciliation. The proposal was for a three-year term. It provided for savings in the amount agreed upon by the Parties in years one and two. Importantly, in the third year, the Ministry conceded its position for a further savings of $32.7 million. Moreover, it offered a one-time lump-sum contribution in year three to physicians' cost of practice in the amount of $117 million (1% of the PSB). The Ministry included in its proposal the agreed upon Task Force and the Minister's Roundtable.

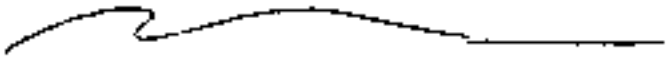
5) The Conciliator's Recommendations

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

The rejection of the Ministry's proposal means that the Parties must reconvene within seven days to work towards an agreement. In the circumstances, I would urge the OMA to reconsider its rejection of the Ministry's Proposal. Similarly I would urge the Ministry to not resile from its final offer.

I would like to express my gratitude to the Parties for their cooperation throughout

All of which is respectfully submitted,



The Honourable Warren K. Winkler, Q.C.

TAB 57

December 5, 2014
(Revised January 9, 2015)

MEMORANDUM OF AGREEMENT
PHYSICIAN SERVICES AGREEMENT

BETWEEN:

HER MAJESTY THE QUEEN
in right of Ontario, as represented by the
MINISTER OF HEALTH AND LONG-TERM CARE
("MOHLTC")

and

THE ONTARIO MEDICAL ASSOCIATION
("OMA")

WHEREAS the MOHLTC and the OMA entered into the 2012 Physician Services Agreement ("2012 PSA"), which expired on March 31, 2014, and their representatives have been negotiating a 2014 Physician Services Agreement in accordance with the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement.

The undersigned representatives of the Parties hereby unanimously agree to recommend acceptance of this Agreement to their respective principals and will work in good faith to achieve ratification of this Agreement by their respective principal, the Government of Ontario or the members of the OMA, as the case may be:

1. **Starting Base for the Physician Services Budget**

The Parties agree that the Physician Services Budget (PSB) for Fiscal Year 13/14 is $11,297.8 million.

The PSB means those payments by the MOHLTC to physicians known as fee for service (FFS) payments, alternate payment plans (APPs), primary health care, and hospital on-call coverage (HOCC) and sexually transmitted disease (STD) services, as well as the MOHLTC payments to subsidize physicians for a portion of their fees to the Canadian Medical Protective Association (CMPA).

2. **Canadian Medical Protective Association (CMPA)**

For the 10-year period set out in Appendix "H" of the 2012 Physician Services Agreement (2012 PSA), the MOHLTC agrees to pay for the costs of reimbursing physicians for their CMPA fees, minus the

b. The Parties will manage expenditures for physician services to achieve no more than $11,720.9 million for Fiscal 16/17 using any initiatives that are to be agreed. The payment discounts would remain in place.

c. The savings proposals from Fiscal 14/15 and 15/16 as set out in Appendix "A" would be continued into Fiscal Year 16/17.

d. At the end of Fiscal Year 16/17, if the actual expenditures for the PSB (minus $70 million) are lower than $11,720.9 million, plus a one-time adjustment of $32.7 million, any difference would be paid to physicians in a lump sum in a manner to be agreed by the Parties. If expenditures for the PSB for Fiscal Year 16/17 (minus $70 million) are higher than $11,720.9 million, plus a one-time adjustment of $32.7 million, then the difference would be recovered by an adjustment from payments to physicians equal to that difference. Any changes in the amount that the MOHLTC pays for CMPA reimbursement from Fiscal 13/14 would be held neutral for these calculations. If there is any carry-over required from Years 1 and 2 arising from over-expenditure in those years, then this amount would adjust the amount owing by or paid to physicians as the case may be.

e. At the beginning of Fiscal Year 16/17, the MOHLTC will make $117 million (i.e. 1% of the PSB for Fiscal 16/17) available for a one-time lump sum payment. Funding would be distributed as agreed by the Parties.

5. Term and Renewal

The Agreement will begin on December 3, 2014 and will terminate on March 31, 2017. Negotiations to establish the next Physician Services Agreement will begin no later than November 30, 2016 and will be conducted in accordance with the process set out in the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement. The MOHLTC recognizes the OMA as the exclusive representative of physicians practising in Ontario for the purpose of these negotiations.

December 5, 2014
(Revised January 9, 2015)

APPENDIX A

(New Appendix A substituting the savings initiatives proposed on December 5, 2014 -- the text is shown as track changes in the chart to better describe the initiatives previously proposed)

1. The Parties will implement the following savings initiatives valued at $259 million over Fiscal Years 14/15 and 15/16 as described in the chart below:

		Savings to be achieved ($M)	
Title	Description	2014/15	2015/16
Enrolment	Eliminate enrollment premiums (except complex vulnerable patients and high needs patients!, including per patient roster fee, new patient fees, and HCC enrollment premiums paid to physicians (Q200, Q201, Q202, Q013, Q033, Q054, Q055, Q056, Q057 and the complex vulnerable top up on capitation and fee for services related to complex patients)	-	48
CME	1. Discontinue premiums paid to primary care physicians [Q555-557] effective 15/16; 2. Cancel CME program effective 14/15; 3. Cancel CME component in NPRI effective 14/15.	12	20
HCCC One Time	Do not make three payments of $12M over two fiscal years.	24	12
Acuity Modifier	Do not make payment for "interim modifier" in 2014/15 and 2015/16. Delay future payment until final acuity modifier implemented.	40	40
Walk In Clinics	Reduce: A888 to value of A007 (from $35.40 to $33.70)	-	14
HCCC - freeze	Hold HCCC funding at current level.	-	3
Managed entry	Continue 20/month entry into capitated models (FHN/FHO) in areas of high need.	-	13
Income Stabilization	Target entry to the Income Stabilization program to underserviced areas of the province only.	-	9
Chronic Disease Assessment Premium	Adjust eligibility for selected specialties	-	24
		76	183
		259	

2. In order to achieve further savings, starting on January 1, 2015, the Parties agree that:

(a) An additional 0.5% payment discount shall be applied to fee for service payments, automated fee for service premiums (excluding L codes, but including the L800 series), and clinical payments under primary care agreements and specialist alternate payment programs (APPs). It is estimated that this discount would achieve savings of approximately $73.5 million.

(b) Savings of $247.5 million shall be distributed to each OHIP specialty using the reverse CANDI methodology proposed by the OMA on January 5, 2015. An additional payment discount shall

ADDITIONAL ARRANGEMENTS

In addition to the Physician Services Committee, the Minister of Health and Long-Term Care and the Ontario Medical Association agree to strike committees based on the terms of reference attached in Schedules 1 and 2.

SCHEDULE 2

Minister's Roundtable – Health System Transformation

The Parties have agreed to establish a roundtable for communication and dialogue between all stakeholders in the health care system including government, physicians, nurses, hospitals and the public, to discuss matters of common interest relating to the health care system. The roundtable will meet on a scheduled 6-month interval with the mandate of targeting and implementing positive changes to the health care system.

TAB 58

Ministry of Health and Long-Term Care's Implementation Plan

January 7, 2015
(REVISED JANUARY 12, 2015)

PROCESS TO DATE

- The Ministry and OMA began negotiations for a Physician Services Agreement (PSA) on January 14, 2014 under the agreed on Joint Process and negotiated bilaterally without assistance for longer than the minimum 120 day period required by the Joint Process.

- The parties engaged the services of a Facilitator (Dr. David Naylor) on September 4, 2014, which concluded with the issuance of the confidential Facilitator's Report on October 9, 2014.

- The parties met to consider the Facilitator's report and recommendations from October 21 to October 31, including without prejudice meetings.

- The parties engaged the services of a Conciliator (former Chief Justice Warren Winkler) on November 3, 2014 and met with him between November 10, 2014 to December 3, 2014. The Ministry presented to the OMA a proposal (or offer) for a PSA dated December 5, 2014, which the OMA rejected.

- The Conciliator's Report was received on December 11, 2014. The Conciliator recommended to the parties:

  "In the circumstances, I would urge the OMA to reconsider its rejection of the Ministry's Proposal. Similarly, I would urge the Ministry to not resile from its final offer."

PROCESS TO DATE

- The parties met in the post-conciliation phase of the Joint Process from December 16, 2014 to January 9, 2015, including the Ministry re-presenting its Offer dated December 5, 2014 that was referred to in the Conciliator's Report. The process has included over 60 face to face meeting days.

- On January 5, 2015, the OMA presented an alternate approach to achieving $580 million savings over Fiscal Years 14/15 and 15/16 that was a component of the Ministry's Offer.

- The Ministry considered the OMA's alternate approach and presented a modified version of the OMA's approach on January 7, 2015. The Ministry also presented its plan to implement its Offer dated December 5, 2014 if the OMA would not agree with the Ministry.

- On January 9, 2015, the Ministry revised its Offer for a PSA to include a modified version of the OMA's approach to achieving savings of $580 million in Fiscal Years 14/15 and 15/16, and, in doing so, replaced 26 specific proposals and the 1% payment discount.

- The purpose of this presentation is to update the Ministry's presentation of January 7 to illustrate how the Ministry could implement its revised Offer for a PSA dated January 9, 2015. This revised presentation also responds to questions asked by the OMA on January 9, 2015.

OVERALL APPROACH

With no agreement by the OMA, the Ministry would begin implementing its offer for a PSA as outlined in the Conciliator's Report and as revised on January 9, 2015

2014/15 & 2015/16 Initiatives

- 9 specific initiatives and payment discounts totalling savings of $580M would be implemented (see subsequent slides for specific implementation details).
- Because the reverse CANDI methodology has been a recent development in the negotiations for a PSA, unanticipated challenges may be encountered when implementing that methodology (such as allocating which payments are to be allocated to specialties thereby affecting the discount to be applied to the payment, and technical issues with applying different discounts to payments). The Ministry would therefore implement an interim solution on February 1, 2015: an across-the-board payment discount would be applied to the payments set out in the Offer. The Ministry esimates that to achieve approximately $320 million of the $580 million in savings the discount would be approximately 2.65% effective February 1, 2015 (the percentage would increase if implementation is delayed).
- To replace the interim solution, the Ministry would invite the OMA to participate in a working group reporting to the PSC to implement the reverse CANDI methodology. At the same time, OMA sections could propose savings initiatives through the MSPC and PSC processes described in the Ministry's Offer to replace the payment discounts. The Ministry may also propose to the OMA savings initiatives to replace the payment discount.
- Additional $70M in savings (14/15 to 15/16) – to be found by the Ministry.

OVERALL APPROACH

With no agreement by the OMA, the Ministry would begin implementing its offer for a PSA as outlined in the Conciliator's Report and as revised January 9, 2015

2016/17

- The PSB would be increased as per the Ministry's Offer and the savings initiatives from the previous fiscal years would continue into Fiscal Year 16/17.
- The payment discounts applied for Fiscal 14/15 and 15/16 would continue (except to the extent that they have been replaced with other savings initiatives as described on Slide 3).
- The benefits set out in the Ministry's Offer would not be implemented (an additional $32.7M in savings would be required and payment of $117 million would not be made).

Reconciliation

- The Ministry would balance to a fixed PSB (as per its Offer) for Fiscal Years 14/15 and 15/16, and Fiscal 16/17.
- If spending is higher or lower than planned, the payment discount would be increased or decreased accordingly.
- The Ministry would consider, in consultation with the OMA, alternate approaches to finding savings or alternate approaches to under-spending.
- Cost increases (or decreases) to the Ministry's subsidy for physician fees for the CMPA would not be included (as per the Ministry's Offer).

IMPLEMENTATION OF SAVINGS INITIATIVES FOR FISCAL YEARS 14/15 AND 15/16

The savings initiatives and payment discount outlined in Appendix A of the Offer require unique implementation activities in 3 categories:

A. **Regulatory Amendments**
   - The Ministry would seek approval from Cabinet for regulatory amendments.

B. **Contract Amendments**
   - Amendments to contracts would be proposed to affected parties (if an affected party would not agree, termination of a contract would be the alternative).

C. **Notification Letters**
   - Correspondence would notify affected parties of the termination of certain programs

A. REGULATORY AMENDMENTS (Cabinet approval required)

Regulatory Amendments - Schedule Of Benefits Adjustments

- Payment discount effective February 1, 2015 on fee for service payments to implement the interim solution

- 2 initiatives effective April 1, 2015
    - *Walk-In Clinics*
    - *Chronic Disease Assessment Premium*

B. CONTRACT AMENDMENTS

Contract Amendments – Changes to non-FFS Payments

- Propose amendments to apply the interim solution's payment discount on those payments described on Slide 3 (or terminate a contract if a party does not agree)

- 3 initiatives impacting primary care contracts effective 2015/16
    - *Enrolment*
    - *CME – Q code premiums (program separate)*
    - *Income Stabilization*
        - January 30, 2015 – agreement holders would be informed of the contract amendments
        - May 1, 2015 - payment changes would be implemented (or terminate a contract if a party does not agree)

C. NOTIFICATION LETTERS

Issue Notification Letters – Stop/Freeze Payments & Wind Down Programs

- 3 initiatives with fiscal impact in 2014/15 forward
  - *CME Program (Q Codes separate)*
    - January 30, 2015 – InfoBulletin, Update Email Account/Webpage/Phone Line would advise that program would no longer be available
  - *HOCC One Time*
    - January 30, 2015 – Hospitals, OHA & OMA would be informed that payments would not be made for 13/14, 14/15, and 15/16
  - *Acuity Modifier*
    - Notice would be given that payment will not be made for interim acuity modifier

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- 2 initiatives effective April 1, 2015
  - *HOCC Freeze*
    - January 30, 2015 – Hospitals, OHA & OMA would be informed that HOCC funding has been frozen.
  - *Managed Entry*
    - Notice would be given that entry will be reduced into capitated models

OMA CONSULTATION

The Ministry would continue to engage the OMA about the roll-out of the Ministry's implementation plan.

For example, the Ministry anticipates that it would consult with the OMA about:

- Communications with physicians as the roll-out occurs;
- The reverse CANDI methodology through a working group as proposed on Slide 3;
- Development of any other savings initiatives to replace the payment discount; and
- Approaches to applying reconciliation (both for achieving any further savings or distributing funding realized by over-achievement).

TAB 59

January 14 Amendment to January 9, 2015 Ministry Offer

Further to the offer presented to the OMA on January 9, 2015, the Ministry of Health and Long-Term Care has tabled the following revisions and explanatory notes to their final offer:

1) The Ministry will replace the following text from the offer of January 9, 2015

   4 e. At the beginning of Fiscal Year 16/17, the MOHLTC will make $117 million (i.e. 1% of the PSB for Fiscal 16/17) available for a one-time lump sum payment. Funding would be distributed as agreed by the Parties.

   With the following text:

   4 e. At the beginning of Fiscal Year 16/17, the MOHLTC will make $168 million (i.e. 1.4% of the PSB for Fiscal 16/17) available for a one-time lump sum payment. Funding would be distributed as agreed by the Parties.

2) As part of Appendix A 2(b) of the ministry January 9th offer, the ministry has identified a requirement to achieve savings of $247.5M over the 2 years. On January 14, the ministry revised this figure by stating that it will find system savings of $25M in 2014/15 and $25M in 2015/16, thereby reducing the savings requirement from $247.5M to $197.5M.

   Similarly the savings identified in Appendix A 1 of the ministry offer would increase from $259M to $309M to account for these system savings.

   The ministry will continue $25M of system savings into year 3. This would be used to reduce reconciliation for the final year of the agreement.

3) Finally, the Ministry would agree that should the agreement be ratified, further discussion would be undertaken to develop language acceptable to the parties to describe the terms of Schedules 1 and 2.

TAB 60

ONTARIO REGULATION 15/15

made under the

HEALTH INSURANCE ACT

Made: January 28, 2015
Filed: January 29, 2015
Published on e-Laws: January 29, 2015
Printed in *The Ontario Gazette*: February 14, 2015

Amending Reg. 552 of R.R.O. 1990
(GENERAL)

1. The definition of "schedule of benefits" in subsection 1 (1) of Regulation 552 of the Revised Regulations of Ontario, 1990 is amended by adding the following paragraph:

26. Amendments dated January 15, 2015 (effective April 1, 2015);

2. The Regulation is amended by adding the following section:

37.9 (1) Despite subsection 37.1 (2), the amount payable for an insured service rendered by a physician in Ontario, as set out in the schedule of benefits, shall be reduced by 2.65 per cent if the service is rendered on or after February 1, 2015.

(2) For greater certainty, the reduction under subsection (1) is in addition to, and not in place of, any other reduction provided for under this Regulation.

Commencement

3. (1) Subject to subsections (2) and (3), this Regulation comes into force on the day it is filed.

(2) Section 2 comes into force on February 1, 2015.

(3) Section 1 comes into force on April 1, 2015.

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TAB 61

Implementation Plan: Update for the OMA

January 29, 2015

STATUS and TIMELINE

- January 29: Update the OMA regarding the status of the MOHLTC's implementation of its proposals for the 2014/15 and 2015/16 Fiscal Years as described in the MOHLTC's slide deck dated January 12, 2015.
- January 29: A regulation will be filed implementing three proposals (see next slide).
- By February 2: OMA to provide feedback on the approach and draft materials listed on Appendix A.
- On February 3: The MOHLTC would send amendments to contracts to the OMA for execution, and those amendments would be sent to physicians and other contracting parties 7 days later (starting February 10).

A. REGULATORY AMENDMENTS

- Payment discount of 2.65% effective February 1, 2015 on fee for service payments under the Schedule of Benefits affecting professional and technical fees paid to physicians.

- Two changes to the Schedule of Benefits effective April 1, 2015:
    - *Walk-In Clinics:* Reduce payment for A888 from $35.40 to $33.70
    - *Chronic Disease Assessment Premium:* Eliminate premium for those with the following specialty designations: Internal Medicine, Nephrology, Gastroenterology & Cardiology

B. CONTRACT AMENDMENTS – Primary Care

- The MOHLTC has drafted an amendment to implement changes to primary care contracts:
  - Increasing the payment reduction on clinical service payments by 2.65% on May 1
  - Elimination of patient enrolment fee codes (except Q023 and Q043) on May 1
  - Per patient rostering fees set to zero but continue to use for managing enrolment on May 1
  - Elimination of Health Care Connects fees/ premiums (except Complex Vulnerable Patient fee code Q053) on May 1
  - Elimination of Continuing Medical Education fee codes on May 1
  - Limiting Managed Entry to 20 physicians per month in the priority stream on May 1
  - Limiting Income Stabilization Program eligibility on May 1
  - Notification that Interim Acuity Modifier Payments will not be paid

- The MOHLTC intends to present the amendment for execution to the OMA and, if the OMA does not execute the amendment, the MOHLTC will rely on section 7 of the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement (ORRJNDRA) to deem the OMA to have executed the amendment.

- One week later, the MOHLTC intends to send an INFOBulletin giving effect to and explaining the amendments to physicians. A physician would have the option of terminating a contract, as amended, in accordance with the termination provisions of the contract.

B. CONTRACT AMENDMENTS – Specialist APP Agreements

- The MOHLTC has drafted template amendments to increase the payment reduction to clinical payments by 2.65% affecting various specialist APPs effective May 1, 2015 (or April 1, 2015 for funding with hospitals affecting laboratory physicians).

- The MOHLTC intends to present amending agreements for execution by the OMA and, if the OMA does not execute the amendments, the MOHLTC will rely on section 7 of the ORRJNDRA to deem the OMA to have executed the amendment.

- One week later, the MOHLTC intends to send each amending agreement to each physician group (or each hospital for some agreements). All contracting parties would have two options:

  1. Accept the amendments: By not responding to the MOHLTC communication before May 1 (or April 1 in the case of Lab Physician agreements), other contracting parties would be deemed to have accepted the amendments; or

  2. Reject the amendments: Any contracting party can reject the amendments before April 30 (or March 31 in the case of Lab Physician agreements), which would be treated as notice of termination of the contract.

- The payment discount for agreements with hospitals for lab physician funding is being introduced on April 1 to align with hospital funding and the mechanisms for payment of annual salaries for lab physicians.

B. CONTRACT AMENDMENTS – HOCC and Other Hospital Funding Agreements

- The MOHLTC has drafted template amendments to freeze HOCC funding effective February 1 and to increase the payment reduction to clinical payments by 2.65% effective May 1 for the Hospital Paediatric Stabilization Program, Psychiatric Stipend Funding Agreement, and the Complex Continuing Care/Rehabilitation On-Call Program.

- The MOHLTC intends to present amending agreements for execution by the OMA and, if the OMA does not execute the amendments, the MOHLTC will rely on section 7 of the ORRJNDRA to deem the OMA to have executed the amendment.

- One week later, the MOHLTC intends to send each amending agreement to affected hospitals. All contracting parties would have two options:

  1. Accept the amendments: By not responding to the MOHLTC communication before May 1, other contracting parties would be deemed to have accepted the amendments; or

  2. Reject the amendments: Any contracting party can reject the amendments before April 30, which would be treated as notice of termination of the contract.

- Letters will be sent from the MOHLTC to affected hospitals, the OMA and OHA to explain that the HOCC program will be frozen effective February 1 and HOCC one-time payments will not be made.

- Implementation plans to address funding of certain programs have yet to be developed (e.g. programs funded through LHINs such as mental health sessionals or CHCs).

COMMUNICATIONS AND CONSULTATION

- The MOHLTC anticipates communications from physicians about these amendments.
  - The MOHLTC will not negotiate with physicians other than through the OMA.
  - Questions from physicians could be referred to the OMA.

- There is a continuing need to consult with the OMA regarding implementation and regular business. The PSC could be reconstituted to address this need:
  - Communications with physicians as the implementation continues.
  - Development of other savings initiatives to replace the payment discount.
  - Approaches to applying reconciliation.
  - Addressing funding requests by physicians to establish or expand specialist groups under alternate payment plans.

APPENDIX – LIST OF DRAFT MATERIAL PROVIDED TO OMA

- Primary Care Template Amending Agreement
- Template Letter for AFP/AHSC/EDAFA agreements, AFP/APP Template Amending Agreements (one version includes an extension to the agreement and one does not have such an extension), AHSC-AFP Template Amending Agreement and EDAFA Template Amending Agreement
- Lab Funding Amending Agreement with hospitals
- Template Letter for HOCC Amending Agreement and HOCC Template Amending Agreement
- Letters to OMA and OHA about HOCC program
- Template Letters and Template Amending Agreements for Hospital Paediatric Stabilization Program, Psychiatric Stipend Funding and Complex Continuing Care/Rehabilitation On-Call Program

TAB 62

INFOBulletin

Keeping health care providers informed of payment, policy or program changes

To: **Independent Health Facilities**

Published By: **Health Services Branch**

Date Issued: **February 12, 2015** **Bulletin #:2105**

Re: **Implementation of the 2.65% Payment Discount**

This INFOBulletin provides general information about the implementation of a 2.65% discount, effective February 1, 2015. A separate bulletin has been issued to physicians, hospitals and laboratories and is published at: http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/.

Implementation of 2.65% Payment Discount Effective February 1, 2015

Effective February 1, 2015 a 2.65% payment discount will be applied on all facility fees listed in the "Schedule of Facility Fees for Independent Health Facilities" (IHF Schedule). This discount is in addition to the existing 0.5% discount which will continue to be reported on the Remittance Advice. A separate INFOBulletin will describe the implementation details for the 2.65% discount provision.

If you require additional information please contact the IHF Program Unit at (613) 548-6637.

Ontario

TAB 63

INFOBulletin

Keeping health care providers informed of payment, policy or program changes

To: Physician Services

Published By: Health Services Branch

Date Issued: February 12, 2015 **Bulletin #:** 4646

Re: Amendments to the Schedule of Benefits for Physicians Services and Payment Discount of 2.65%

This bulletin describes the implementation of a payment discount as well as changes to the Schedule of Benefits for Physician Services (Schedule). The payment discount is effective February 1, 2015 and all Schedule changes are effective April 1, 2015.

Implementation of 2.65% Payment Discount Effective February 1, 2015

Effective February 1, 2015 a 2.65% payment discount will be applied on all fee-for-service physician payments. This discount is in addition to the existing 0.5% discount which will continue to be reported on the Remittance Advice. A separate INFOBulletin will describe the implementation details for the 2.65% discount provision.

Alternative Payment Plans, Alternative Funding Plans, and Alternative Funding Agreements

The clinical funding for Alternative Payment Plans (APPs), Alternative Funding Plans (AFPs) and Alternative Funding Agreements (AFAs) will be subject to the 2.65% across the board discount. Further details specific to each APP, AFP, and AFA will be provided to the Lead Physician and/or Administrator.

Changes to the Schedule of Benefits Effective April 1, 2015

Schedule of Benefits

1. Emergency department equivalent - partial assessment (A888). The fee is reduced from $35.40 to $33.70.
2. Chronic Disease Premium (E078) will no longer be payable for services provided by 13(Internal Medicine), 16(Nephrology), 41(Gastroenterology) or 60(Cardiology).

Ontario

Links to **Additional Information**

The new version of the Schedule is available at:
www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html

Hard copies of the Schedule will not be distributed. If you would like to order a paper copy or compact disk (CD) of the Schedule for a fee, please visit
https://www.publications.serviceontario.ca

Physicians without access to the Internet can contact ServiceOntario at 1-800-668-9938.

This bulletin is a general summary provided for information purposes only. Physicians, hospitals, and other health care providers are directed to review the *Health Insurance Act*, Regulation 552, and the Schedules under that regulation, for the complete text of the provisions. You can access this information at www.e-laws.gov.on.ca . In the event of a conflict or inconsistency between this bulletin and the applicable legislation and/or regulations, the legislation and/or regulations prevail.

TAB 64

INFOBulletin

Keeping health care providers informed of payment, policy or program changes

To: Primary Health Care Services

Published By: Primary Health Care Branch

Date Issued: February 12, 2015 **Bulletin #:11125**

Re: Changes to Primary Health Care Physician Payments

This INFOBulletin serves as notice that your current primary care alternative funding arrangement is ending effective June 1, 2015 and that you have the option to continue to receive funding under a new agreement if you are willing to accept the changes as set out below as applicable to your group.

Physicians Services – Compensation for Clinical Services

Under the 2012 Physicians Services Agreement (PSA), a discount of 0.5% was applied to all physicians' payments issued on or after April 1, 2013. The 0.5% discount was flowed through to payment for clinical services under the various primary care agreements, including physician payments by salary, sessional, per diem and capitation-based mechanisms.

Effective June 1, 2015, an additional discount of 2.65% will be applied to all physicians' payments for clinical services, including payments made pursuant to your new agreement.

Patient Enrolment Fee Codes

For patient enrolments that are effective June 1, 2015 or later, the following Fee Codes will not be payable under your new agreement:

Q013A 'New Patient Fee'
Q033A 'New Graduate New Patient Fee'
Q054A 'Mother and Newborn Fee'
Q055A 'Multiple Newborn Fee'

The following Patient Enrolment Fee Codes will continue to be payable under your new agreement:

Q023A 'Unattached Patient Fee'
Q043A 'New Patient Fee FOBT Positive/Colorectal Cancer (CRC) Increased Risk'

Ontario

Per Patient Rostering Fees

For patient enrolments effective June 1, 2015 or later, the following Per Patient Rostering fees will be reduced to pay at zero dollars:

Q200A 'Per Patient Rostering Fee'
Q201A 'GHC Per Patient Rostering Fee'
Q202A 'LTC Per Patient Rostering Fee'

Physicians should continue current enrolment processes and submit these Fee Codes in order to manage patient enrolment, but there will no longer be any payment associated with these Fee Codes.

Health Care Connect Program Fees

For enrolments effective June 1, 2015 or later, the following Health Care Connect Fee Codes will not be payable under your new agreement:

Q056A 'HCC Upgrade Patient Status'
Q057A 'HCC Greater than Three Months Fee'

The Complex Vulnerable Patient fee code (Q053A) will continue to be payable for the attachment of complex vulnerable patients through the Health Care Connect program under existing payment rules. However, the following payments associated with attachment of a complex vulnerable patient through Health Care Connect will cease for existing and new patients effective June 1, 2015:

- The *Complex Fee for Service Premium Payment* to Family Health Group (FHG) and Comprehensive Care Management (CCM) physicians.
- The *Complex Vulnerable Capitation Payment* to Family Health Organizations (FHO), Family Health Networks (FHN), Community Sponsored Agreement Blended Salary Model (CSA/BSM) physicians.

Note: The Health Care Connect program will continue to function as a tool to assist patients in finding a primary care provider; physicians are encouraged to continue using this program to reduce the number of unattached patients.

Continuing Medical Education (CME)

For CME activity on or after June 1, 2015 the following Fee Codes will no longer be payable under your new agreement:

Q555A 'Main Pro C'
Q556A 'Main Pro M1'
Q557A 'Other'

Managed Entry

The 2012 PSA established a Managed Entry process for the Family Health Network (FHN) and Family Health Organization (FHO) models through which controls were imposed on the number of physicians permitted to enter these models each month. The process permitted 40 new physicians to commence in the FHN and FHO models each month under two streams; 20 in a priority stream and 20 in a stream based on the date upon which the application was received.

For physicians commencing in FHNs or FHOs effective June 1, 2015 and onwards, monthly registration into these models will be limited to 20 physicians per month in areas of high need, i.e, within the priority stream only. This change is effective for commencement dates of June 1 and after, regardless of when the application/documents were submitted to the ministry.

Income Stabilization Program

For physicians commencing in the FHN and FHO models effective June 1, 2015 and onwards, participating in the Income Stabilization program will be limited to eligible physicians joining a FHN or FHO in areas of high physician need.

Physicians registered on Income Stabilization prior to June 1, 2015 continue under this program until the end of their one-year term, subject to the requirements of the program.

Acuity Modifier Payment

No Interim Acuity Modifier Payments, as set out in the 2012 Physician Services Agreement, will be made in 2014/15 or thereafter.

If you have any questions, please contact your primary care program analyst at 416-325-3575 or 1-866-766-0266.

TAB 65

INFOBulletin

Keeping health care providers informed of payment, policy or program changes

To: **Physician Services**

Published By: **Negotiations Branch**

Date Issued: **February 12, 2015** Bulletin #: **4647**

Re: **Continuing Medical Education Reimbursement Program for Course/Product Expenses Discontinued**

The Ministry of Health and Long-Term Care (ministry) and the Ontario Medical Association (OMA) regularly enter into Physician Services Agreements (PSA) that provide a framework for payments and initiatives related to physician services.

The last PSA expired on March 31, 2014 and the ministry and OMA commenced negotiations for a new PSA in January 2014 in accordance with the OMA Representation Rights and Joint Negotiations and Dispute Resolution Agreement.

To date, the ministry and the OMA have not reached an agreement.

In the absence of a PSA, and as recently announced by the ministry, the ministry is implementing a set of initiatives that will change the funding for certain physician services/programs.

This is to advise you that effective immediately, the Continuing Medical Education (CME) application-based reimbursement program for course/product expenses is discontinued. This change does not impact the Primary Care Continuing Medical Education program (fee codes Q555, Q556 and Q557).

- 2014 CME reimbursement applications for course/product expenses will not be accepted

If you have an inquiry regarding a 2013 CME reimbursement application, please submit a detailed question to cme@ontario.ca.

Ontario

TAB 66

OHA and OMA Analysis of the Government's Unilateral Action:

Ten-Point Plan for Saving and Improving Service

On January 15, 2015, the Ontario Medical Association (OMA) and the Ontario government failed to come to an agreement regarding the Physician Services Agreement. In response, the Ministry of Health and Long-Term Care (MOHLTC) announced its Ten-Point Plan for Saving and Improving Service, which outlines the government's changes to how physician services are remunerated in the province.

The Ontario Hospital Association (OHA) and the OMA are committed to supporting their members as the plan is implemented. In an effort to better understand the potential impact of the changes on hospitals and hospital-based physicians, the OHA and OMA have collaborated to develop a preliminary analysis of the MOHLTC's plan, which is included in this communication.

Additional information will be communicated to members as it becomes available. Information for OMA members can be viewed here. Information for OHA members can be viewed here.

OHA/OMA Analysis of the Government's Unilateral Action: Ten-Point Plan for Saving and Improving Service

Item	Implementation Date	Details of Changes	Potential Impacts on Hospital Sector
Payment discount of 2.65% on all fee for service payments under the Schedule of Benefits OHIP Bulletin (Feb. 12, 2015) OHIP Bulletin (Apr. 2, 2015) OHIP Bulletin (Apr. 8, 2015)	February 1, 2015	The discount will be applied to all fee-for-service payments (professional fees and technical fees) and clinical elements of non-fee-for service payments (e.g. primary care models, primary care specialized models, A/P/AFA agreements, salaried physicians receiving funding from the PSA and physician programs While the HOCC Program is excluded from this discount, other programs are impacted, including: • Complex Continuing Care (CCC) On-Call • Hospital Paediatric Stabilization • Physician On-Call (POC) in Long-Term Care • Psychiatric Supplement and Stipend • Rural Medicine Investment Program (RMIP)	Impact on physician morale. Impact on physician recruitment and retention. The OMA is urging members to stay focused on patients and to not take actions that will compromise patient care. However, it is anticipated that there may be less co-operation by physicians in the implementation of system initiatives (e.g. Health Links, QIPs, etc.).
Payment discount of 2.65% for non-fee for service payments and programs OHIP Bulletin (Feb. 12, 2015)	June 1, 2015		
A888 Fee Schedule Code	April 1, 2015	For physicians billing Fee-For-Service, there will be a reduction of the value of the A888 fee code, which is an assessment code rendered on weekends and holidays for seeing unscheduled patients for urgent medical problems. The fee will be reduced from $35.40 to $33.70. For physicians seeing unscheduled rostered patients on the weekend, the visit fee will also be reduced from $35.40 to $33.70. These physicians will continue to be able to bill the 30% premium for after-hours visits provided during scheduled after-hour blocks. The reduction to A888 applies broadly to family medicine, and is outside of the F340 and FHN 'basket' of services Note: As the value of A888 is reduced, the reduction will impact the amount payable from the FHG 10% premium and the 30% Q012 and	It is unclear how a decrease of $1.70 per visit will be received by the physicians, but this may have an impact on hospital Emergency Departments as patients may experience challenges accessing walk-in clinics after hours.

ITEM	IMPLEMENTATION DATE	DETAILS OF CHANGES	POTENTIAL IMPACTS ON HOSPITAL SECTOR
		Q016 premiums (which are after-hours fee payments for FHNs, FHGs, FHOs and other models).	
Chronic Disease Assessment Premium	April 1, 2015	Specialists in specific medical specialties benefitted from a 50% premium on chronic disease assessment. This premium is being eliminated for four specialties (internal medicine, cardiology, gastroenterology and nephrology).	This may result in less emphasis on physicians managing patients with chronic disease in the four specialties affected (internal medicine, cardiology, gastroenterology and nephrology). Note that Internal Medicine Specialists who practice in a subspecialty area, but bill under the General Internal Medicine (13) designation will be impacted. Some physicians may use this premium to hire allied health professionals to assist in the chronic disease management of their patients. Elimination of this premium may result in the withdrawal of services provided by these allied health professionals or closure of out-patient or community clinics
Enrolment Premiums	June 1, 2015	Physicians who treat a roster of patients are paid various premiums for accepting patients. Only premiums for the following fees will be maintained: • Q043 Fecal Occult Blood Test - New Patient Fee • Q023 discharged from a hospital • Q053 Health Care Connect Complex Vulnerable Fee	Impact on physician morale. The changes to the Enrolment Premiums in combination with the changes to Managed Entry in Capitated Models may influence the decision of new grads to enter into family practice.
Acuity Modifier	2014/2015	Additional payments were being made through an 'interim acuity modifier' to recognize the higher care needs of some patients on primary care physicians' rosters (beyond the age/sex adjusted capitation rates). Payments for this interim acuity modifier will not be made for at least two years until the MOHLTC implements a final acuity modifier to deal with patient care complexity.	Loss of the interim acute modifier may discourage physicians from taking on complex patients. There does not appear to be a timeframe for the MOHLTC to implement a final acuity modifier to deal with patient care complexity.
Managed entry in capitated models (FHOs and FHNs)	June 1, 2015	Ministry will reduce the net new number of physicians joining existing or starting new FHN or FHO groups from 40 to 20 per month (not including replacements); furthermore, physicians will only be eligible to join a FHN or FHO in an area of high need (unless they are replacing a physician who is leaving the FHN or FHO). Note: Criteria for 'high need areas' has not yet been determined.	Recognizing that primary care is viewed as the backbone of the health care system, these two changes raise concerns that the MOHLTC is moving away from these types of models of care. The changes may impact on the ability of the FHN or FHO,

OHA/OMA Analysis of the Government's Unilateral Action: Ten-Point Plan for Saving and Improving Service

Item	Implementation Date	Details of Changes	Potential Impacts on Hospital Sector
Income Stabilization	June 1, 2015	Income stabilization was introduced when the MOHLTC was encouraging movement of physicians into the capitation based models. It offers a fixed monthly payment to physicians joining a FHN or FHO as a way to provide a stable income until a practice is established. Participation in income stabilization will be limited to eligible physicians joining a FHN or FHO in an area of high need only.	in areas not designated as 'high need', to recruit additional physicians to see patients after hours or staff urgent care centres, potentially resulting in increased patient visits to hospital Emergency Departments. The changes to the Enrolment Premiums in combination with the changes to Managed Entry in Capitated Models and Income Stabilization may influence the decision of new grads to enter into family practice.
Continuing Medical Education Funding	2014/2015	The CME course and product (i.e. internet/laptops, hand held devices) reimbursements program will be discontinued. Premiums for CME available through primary care models will also be discontinued. The Ministry's perspective is that existing multi-program CME resources are not patient-focused, do not address health system needs/priorities and are not evidence-based.	Impact on physician morale. Possible impact on hospital budgets if physicians require upgraded skills to deal with change management, quality, leadership etc. With limited resources, hospitals may have to fund this training out of their global budgets as a recruitment strategy. Small, rural and northern communities include CME funding as a recruitment strategy. Hospitals in these communities may experience additional challenges related to recruitment and retention as a result of this change.
HOCC Funding Freeze	February 1, 2015	HOCC funding will be frozen at current levels. This means that new groups (including those waiting approval) will not be approved nor will additions to existing HOCC groups be permitted. Existing funding agreements will be amended to freeze approved funding at levels effective February 1, 2015.	There will be no flexibility to increase HOCC funding in the face of demonstrated need. Hospitals are continuing to operate and administer the HOCC Program and are facing a number of administrative challenges with processing the physician payments. Some palliative care groups in selected communities have received palliative on-call funding. It is unclear what the impact will be on the full implementation of this initiative. Regional HOCC has also not been addressed. The MOHLTC is currently refining its approach to implementing the HOCC freeze and information will be communicated as it becomes available.

Item	Implementation Date	Details Of Changes	Potential Impacts On Hospital Sector
HOCC Planned Funding Increases	2014/2015	Planned funding increases associated with the HOCC per diem initiative will be suspended until a new model is implemented. The per diem model was intended to increase physician accountability and decrease administrative burden of HOCC on hospitals	There is no timeline for implementation of the new model. In the interim, there is no incentive for HOCC groups of fewer than five physicians to increase coverage, or maintain increased coverage, which may result in increased wait times. Hospitals will continue to experience administrative challenges with the HOCC Program.
Reconciliation	2014/15 to 2015/16 will be subject to a reconciliation	The Ministry will ensure achievement of planned annual growth in the Physician Services Budget through a reconciliation process. If spending is higher or lower than planned, the payment discounts may be increased or decreased accordingly. It is also possible that funds are clawed back by the MOHLTC. (Note: methodology for reconciliation has not been finalized)	As the Physician Services Budget is fixed, and if expenditures, whether they are planned or not, approach this amount – there is the potential for further impacts on payments for physician services.

TAB 67

OHA Analysis of Ministry of Health and Long-Term Care's Additional Reductions to Funding for Physician Services

Item	Implementation Date	Details Of Changes	Potential Impacts On Hospital Sector
Payment reduction on fee for service professional fee payments >$1M	Retroactive to April 1, 2015	A 1% reduction will be applied to the professional component of fee for service claims for professional fees paid over $1M; to be calculated after all other payment discounts have been made.	Impact on physician morale, particularly in diagnostic imaging and ophthalmology specialties, which are likely to be most impacted. Overall the number of physicians impacted is relatively small. It is anticipated that there may be less co-operation by physicians in the implementation of system initiatives (e.g. Health Links, Quality Improvement Plans, etc.). Hospitals that recover technical fees on behalf of physicians have expressed concerns that this reduction may impact their funding for patient services.
Payment discount of 1.3% on fee for service payments	October 1, 2015	A 1.3% payment discount will be applied to all fee for service physician payments in addition to existing discounts. The 1.3 % discount will include both professional and technical fee claims. NOTE The 1.3% reduction does not apply to other contractual payments and physician programs in the same manner as previous reductions (i.e. Alternative Payment Plans).	
Professional fee codes for diagnostic imaging	October 1, 2015	The current P1-P2 fee structure will be converted to a single P code.	Impact on physician morale Diagnostic imaging services, such as Ultrasound, Nuclear Medicine studies, Echocardiography, with P1 and P2 fees will have the P2 fees deleted and P1 fees reduced to 80% of existing fee value (with a few exceptions). Where there exists only a P1 fee or only a P2 fee, fees will remain unchanged. The MOHLTC has not provided specific details about how the P1-P2 fee restructuring will be implemented. The requirement that the physician must be in the facility to bill the "P1" fee was eliminated as part of the conversion, however there may be circumstances where it is professionally required for the physician to be on site. Please review the Oct 1, 2015 Schedule of Benefits for specific details about the new professional fee payment requirements.
Point of care laboratory services Fee Changes Chart 1 Fee Changes Chart 2	October 1, 2015	Certain fee schedule codes have been removed and reduced for point of care laboratory testing, particularly drug abuse testing when done in the physician's office. Subsequent to the September 14, 2015 Bulletin #4657, the attached charges were revised to remove codes related to Point of Care Lab Testing for fertility-related issues.	As a result of these changes, results that may have been more readily available may now take more time.

OHA Analysis of Ministry of Health and Long-Term Care's Additional Reductions to Funding for Physician Services

Item	Implementation Date	Details Of Changes	Potential Impacts On Hospital Sector
Diabetes management incentive	October 1, 2015	For a physician to be eligible for the Diabetes Management Incentive (Q040), the physician must render a minimum of 3 Diabetes Management Assessments (K030) for the same patient in the same 12 month period to which the Q040 service applies.	In areas where diabetic care was provided by a multidisciplinary team, physicians and nurse practitioners often worked together to handle the management assessments and the physician was able to bill Q040. These assessments must now be provided by a physician for the physician to qualify to bill for the Diabetes Management Assessment (Q040). This may result in a shift away from the multidisciplinary approach to diabetes management as physicians must take a greater role as the primary caregiver for these patients.
Pre-operative consultations for low risk surgery	October 1, 2015	Unless the medical record demonstrates that consultation is medically needed, consultations are no longer eligible when billed solely for preparation of a patient: • undergoing low-risk elective procedures (cataract surgery, colonoscopy, cystoscopy, carpal tunnel surgery, arthroscopic surgery) under local anaesthesia and/or I.V sedation NOTE: Please review the Oct 1, 2015 Schedule of Benefits as the authoritative source.	'Medically necessary' as defined by the MOHLTC means that there must be a clinical indication requiring a consultation for the individual's specific circumstances related to the proposed surgery and anaesthesia. Routine pre-operative screening consultations for these procedures do not meet this requirement. The OMA has been advising its members that the new payment rule should only apply to the subsequent requests for pre-operative consultations to evaluate the patient's medical condition prior to surgery and not the initial consultation rendered by the physician performing the procedure, nor for any pre-operative assessment such as A903.
Echocardiography with cardiac doppler	October 1, 2015	Fee codes G577 and G578 for applying cardiac doppler will be discontinued Professional fee for cardiac doppler (G578), professional fee for a complete study (G570) and a stress study (G583) are combined. The technical fee for cardiac doppler (G577) will be combined with each of the technical fees for a complete study (G571) and stress study (G582) and both have been reduced by 5%.	New combined fees incorporate fee reductions to G571 and G583 resulting from the P1-P2 fee restructuring (i.e., G571 and G583 fees reduced to 80% of existing fee). Hospitals that recover technical fees on behalf of physicians have expressed concerns that this reduction may impact their funding for patient services.
Intravitreal injections	October 1, 2015	Fees for intravitreal injections (E147 and E149) have been reduced from $105 to $90.	This is the second decrease in fees for intravitreal injections this year, which may result in increased sensitivity among physicians.
Changes to Schedule of Benefits	April 1, 2016	New requirements must be met in order for echocardiography services to be eligible for payment:	The MOHLTC has not provided specific information about the implementation of these new requirements and plans

Item	Implementation Date	Details Of Changes	Potential Impacts On Hospital Sector
		• Facilities: Service must be rendered at a facility that has applied for accreditation by April 1, 2016 and whose application has not been denied. Accreditation body approved by MOHLTC is the Cardiac Care Network (CCN). • Physicians: Physicians performing service must be able to establish that they have: o Level III (advanced) echocardiography training; or o Level II (basic prerequisites for independent competence in echocardiography); or o Documented performance in an established laboratory, with interpretation of at least 400 Echo/Doppler studies/year for the preceding 3 years and at least 24 hours of accredited CME activities relevant to echocardiography over a period of 2 years for the preceding 3 years.	to issue a separate communication describing the implementation details Some physicians may be required to upgrade their training. The OMA section on Cardiology supported these recommendations so it is not expected that this will be a major concern.

TAB 68

INFOBulletin

Keeping health care providers informed of payment, policy or program changes

To: **Physicians, Hospitals and Long-Term Care Homes**

Published By: **Health Services Branch**

Date Issued: **February 17, 2015** **Bulletin #: 4648**

Re: Payment Discount – Non-Fee-For-Service Physician Payment Programs

The Ministry of Health and Long-Term Care (ministry) and the Ontario Medical Association (OMA) regularly enter into Physician Services Agreements (PSA) that provide a framework for payments and initiatives related to physician services.

The last PSA expired on March 31, 2014 and the ministry and OMA commenced negotiations for a new PSA in January 2014 in accordance with the OMA Representation Rights and Joint Negotiations and Dispute Resolution Agreement.

To date, the ministry and the OMA have not reached an agreement.

In the absence of a PSA, and as recently announced by the ministry, the ministry is implementing a set of initiatives that will change the funding for certain physician services/programs.

This INFOBulletin serves to advise that a 2.65% discount will be applied to the physician payment programs listed below effective June 1, 2015.

Affected Non-Fee-For-Service Physician Payment Programs

- Complex Continuing Care (CCC) On-Call
- Hospital Paediatric Stabilization
- Physician On-Call (POC) in Long-Term Care
- Psychiatric Stipend
- Rural Medicine Investment Program (RMIP)

Ontario

TAB 69

2015 Ontario Health Cut Backs: Overview and Specific Impact on Primary Care

Brittany Harrison[1], Merry Guo[1]

[1]Faculty of Medicine, University of Ottawa

ABSTRACT

On February 1, 2015, the Ontario government began implementing a series of unilateral cut-backs to health care in Ontario. These changes include a 2.65% decrease to physician fees across-the-board, restricting entry into Family Health Organizations (FHO) and Family Health Networks (FHN), discontinuing enrolment premiums, and restricting the Income Stabilization program. Without a doubt, family physicians are amongst the most heavily impacted physicians. In this commentary, we attempt to summarize the recent events leading to these cut-backs, and discuss the potential implications of these changes in relation to primary care in particular.

RÉSUMÉ

BACKGROUND

The Physician Services Agreement (PSA) is a contract that is negotiated every few years between the Ontario government and the Ontario Medical Association (OMA), the latter which represents the interests of the approximately 28,000 practicing physicians in Ontario [9]. The PSA is essentially a contract between employer and employee. It details not only how much physicians can bill for various services, but also health care financing on a greater scale, such as where health care funding should be invested, and where we can afford to cut back on certain programs and services. In recent years, the agreement has reflected a careful balance between the government's responsibility to operate within budget, and physicians' need for enough financing to serve an aging patient population.

The PSA ratified in 2012 reduced health care expenditures by making changes such as reducing annual health exams, reducing cervical cancer screenings and colonoscopies in accordance with new evidence-based cancer care guidelines, and implementing a 0.5% decrease to physician salaries [10].

Keywords: Family Practice; Family Medicine; Primary Care; Government; Ministry of Health

At the time, this contract was supported unanimously by the OMA board and by 81% of physicians in a referendum of Ontario physicians [11]. This PSA expired in March 2014, and for the past year the OMA and the Ontario government have been in negotiations for a new PSA [12].

NEGOTIATION CONFLICTS

The negotiations for the new PSA have been fraught with conflict, partly due to the government's goal of eliminating the province's deficit by 2017-2018 [13]. Ontario's deficit in recent years began with the global economic recession of 2008, which resulted in a provincial deficit of $6.4 billion in the 2008-2009 fiscal year, after three consecutive years of balanced budgets [14]. The subsequent years produced provincial deficits of $19.3 billion in 2009-2010 [15], $24.0 billion in 2010-2011 [16], $13 billion in 2011-2012 [17], $9.2 billion in 2012-2013 [18], and $10.5 billion in 2013-2014 [19]. With the projected deficit for the 2014-2015 fiscal year being $12.5 billion, the new government has inherited a large deficit that must, understandably, be eliminated [13]. Part of reducing this deficit is to reduce government spending, of which healthcare is a major portion.

Following months of negotiations, the government's final offer to the OMA was a 1.25% increase in budget for physician services. The OMA rejected this offer, citing that this increase would not be enough to cover the increasing healthcare needs of the aging population [12, 20]. Dr. Ved Tandan, president of the OMA, highlighted the fact that "Ontario's population is already underserviced for health care and our population is growing and aging. That increases the need for health services, but the government has decided to fund less than half of the additional care that will be required" [21].

This argument was refuted by Health Minister Eric Hoskins, himself a family physician, who insisted that physicians would be able to provide the same level of care as before despite the small budget increase proposed. "The OMA wants you to believe that doctors in this province can't provide the same level of care as last year unless they receive a pay raise and we simply don't agree... doctors can't just bill more and more and more. At some point they'll have to accept that they can do roughly the same amount of work as last year for roughly the same pay" [21]. Dr. Hoskins further stated that Ontario physicians on average make $360,000 in gross income, suggesting physicians should not complain on reductions to an already-handsome salary [21].

2015 HEALTH CARE CUTS

With both sides unable to come to an agreement after nearly a year of discussion, the government left the negotiations table and announced in January 2015 that it would unilaterally impose a series of health care cuts. The earliest cuts began on February 1st, 2015 with certain changes to become effective at later dates [1, 20, 22].

The new changes are enumerated below [1-7]. Numbers 1-11 impact family physicians directly.

1. 2.65% decrease to all physician payments
This is applied to all physicians across the board. It is effective February 1, 2015 for all fee-for-service payments, and May 1, 2015 for other models of payment.

2. Reconciliation
The ministry will impose a hard cap on spending on physician service. If physicians, as a whole, bill more than this amount, money will be taken back from physicians in 2-3 years' time. It has not been specified as to how these so-called clawbacks would occur.

3. Discontinue CME program
Physicians will no longer be compensated for Continuing Medical Education (CME) activities.

4. Managed entry into Family Health Networks, Organizations and Teams
Previously, 40 new family physicians per month were allowed to join or start a Family Health Network (FHN) or Family Health Organization (FHO). This occurred under two streams - 20 in a priority stream and 20 in a stream that was first-come-first served (based on date of application).

As of June 1, 2015, only 20 physicians per month will be allowed to join FHO or FHN, and only in areas of high need (priority stream only). By default, new family physicians who do not fulfill these criteria will only be allowed to join a Family Health Group (FHG), start a solo practice under the Comprehensive Care Model (CCM), or bill fee-for-service. The only way for physicians to practice under a FHO or FHN outside of the above parameters is to act as a locum for an existing group, or replace a departing physician (ex. retiring physician) [23].

Only practices that are under the FHO or FHN model can apply to become a Family Health Team (FHT). Essentially, the only way for a physician to join a FHT is to join the FHO or FHN that has been designated as a FHT. Therefore, by limiting entry into FHO and FHN practices, entry into FHT practices will be limited as well [24].

FHOs, FHNs and FHTs are considered to provide more comprehensive care than FHGs and CCM because they incorporate a team of allied health professionals. Furthermore, they offer after-hours telehealth advisory services every day of the week. There is evidence that FHOs, FHNs and FHTs are linked to higher patient satisfaction, more patient-centered care, and better learning environments for medical students (this has been one of the reasons more students are choosing family medicine as a career).

5. Discontinue enrolment premiums
These are one-time premiums paid to family physicians for accepting new patients [25]. Exception: There are three enrolment codes that will be continued, and those are for enrolling a patient previously without a family doctor (Q023), a Fecal Occult Blood Test positive patient (Q043), and complex or vulnerable patients from Health Care Connect (Q053).

6. Discontinue Health Care Connect program
This program helps unattached patients find a family physician. The program is currently still in effect; details on its discontinuation are pending.

7. Restrict Income Stabilization program
The Income Stabilization program helps new physicians entering FHN and FHO groups by ensuring stable monthly payments in

their first year of practice, thus acting as a source of financial stability [25]. This program provided around $200 000 - $220 000/year to new family physicians [23].

8. Acuity Modifier - delay
The acuity modifier is a $40 million/year payment given to physicians who practice under models in which patient enrolment is based on the acuity of patients. Payment for these services will not be delayed for two years.

9. Reduced fee for weekend or holiday assessment of urgent medical problem (A888)
The A888 fee is reduced to from $35.40 to $33.70. This change applies to many family physicians, since this is often what is billed at walk-in clinics [23].

10. HOCC one time (per diem) payment discontinued
The Hospital On-Call Coverage (HOCC) program pays physicians who work on-call at hospitals [26]. The HOCC One Time Payment will be discontinued for HOCC groups < 5 physicians - this is a stipend for working above their minimum call shift requirements.

11. HOCC freeze
Funding for the HOCC program will be frozen. No new HOCC groups/group members will be approved.

12. Chronic Disease Assessment Premiums (E078)
This premium is given for certain physicians who accept complex patients with certain chronic conditions [27]. It will be discontinued for internal medicine, cardiology, gastroenterology, and nephrology

POTENTIAL IMPLICATIONS TO PRIMARY CARE

Family physicians are directly impacted in many ways by the recent health care changes. Specifically, new family medicine graduates who are looking to start or join practices are heavily affected.

The restrictions to joining FHO, FHN, and, thus, FHT practices likely arose from the fact that these newer models are more costly than traditional models based on fee-for-service such as CCM and FHG. On average, a FHO costs the government $70 000/year more than a CCM, and $30 000/year more than a FHG [23]. (See Table 1 for differences between these family practice models). The popular FHO, FHN, and FHT models have been touted as the modern way to deliver primary care. Unlike the traditional fee-for-service models, physician income under these models does not rely heavily on the number of appointments in a day [25]. Physicians therefore feel less pressure to speed through appointments. Most recent family medicine residents have been trained under these new models, but for the most part will not be able to join these types of practices once they graduate [28-32]. Even if new family physicians commit to moving to "high need" areas in hopes of joining a FHO, FHN or FHT, they can only do so if the local quota for entry into these models has not been reached. The province-wide limit for joining these models is now only 20/year [23].

The discontinuation of enrolment premiums will affect new graduates as well. It is estimated that new graduates will lose $30 000/year, and that established physicians will lose $5000/year based on this cut alone. This cut affects all new graduates, even those that decide to relocate to high need areas. The discontinuation of the Income Stabilization program, except for in "underserviced areas", will also decrease starting salaries of new graduates. All in all, new family physicians stand to lose $30 000 - $100 000 compared to the starting salaries of their predecessors [23].

Established family physicians are affected as well. There will be a 2.65% across-the-board cut to all physician services. Recently the public has been told that Ontario physicians make around $360 000 a year. However, this is not the case for most family physicians. The average gross income for family physicians is in the range of $200 000 to $ 300 000 [34]. This gross income is used to pay the overhead costs of their clinic, which include rent, equipment costs, and staff salaries. These overhead costs consume roughly 30-40% of the gross income, resulting in an average net income of approximately $175, 000 [34, 35]. Reducing the gross income of family physicians not only affects their net income, but also may reduce available funding for their clinic and thus, the quality of patient care [29, 30, 33 -38].

Furthermore, while the government insists it won't limit how many patients physicians see, there will be a hard cap on the total amount the government will spend on physicians services. If physician billings exceed this hard cap, they must pay back the excess at a later date. Unfortunately, physician billing is often dependent on patient need for health services [30, 31]. Taking back money from physicians who work above and beyond the average in order to provide for their communities may, at best, be discouraging and, at worst, penalizing to these individuals.

Currently, 900,000 Ontarians do not have a family doctor, and there are an estimated 140,000 new Ontarians, both newborns and immigrants, expected over the next year [12]. Unfortunately, there is a feeling amongst new family medicine residents that Ontario is no longer an optimal region to practice. Many new Ontario family physicians may establish themselves elsewhere - perhaps out of province, or in the United States.

CONCLUSION

Fruitless negotiations between the Ontario government and the OMA have resulted in the government imposing unilateral cutbacks to health care in Ontario. Most of these cutbacks affect

family physicians. Channelling new graduates into fee-for-service practices, as well as reducing their starting salaries may encourage them to practice out of province. Furthermore, existing family physicians in Ontario may be faced with difficulty as they try to meet higher patient care demands with decreasing gross incomes.

REFERENCES

1. "Physician Services: ten-point plan for saving and improving service" [Internet]. Ontario Government Newsroom. 2015 Jan 15. [updated 2015 Jan 15; cited 2015 Mar 27]. Available from http://www.news.ontario.ca/mohltc/en/2015/01/physician-services-ten-point-plan-for-saving-and-improving-service.html
2. Summary of Government's Proposed Unilateral Action. OMA Media Release. 2014-2015.
3. Memorandum of Agreement between Her Majesty the Queen Right of Ontario, represented by the Minister of Health and Long Term Care and OMA. 2014 Dec 5 [updated 2015 Jan 9].
4. INFOBulletin – Payment Discount - Non-fee-for-service physician payment programs. Health Services Branch. 2015 Feb 17. Bulletin 4648. Available from: http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4648.pdf
5. INFOBulletin - Continuing Medical Education Reimbursement Program for Course/Product Expenses Discontinued. 2015 Feb 12. Bulletin 4647. Available from: http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4647.pdf
6. INFOBulletin - Changes to Primary Health Care Physician Payments. 2015 Feb 12. Bulletin 1125. Available from: http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/11000/bul11125.pdf
7. INFOBulletin - Amendments to the Schedule of Benefits for Physician Services and Payment Discount of 2.65%. 2015 Feb 12. Bulletin 4646. Available from: http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/11000/bul4646.pdf
8. MOHLTC Unilateral Action, by specialty. 2015 Jan 2015.
9. "Ontario slashes fees it pays to doctors following negotiations" [Internet]. Globe and Mail. 2015 Jan 15 [updated 2015 Feb 17; cited 2015 Mar 29]. Available from: http://www.theglobeandmail.com/news/politics/labour-talks-flounder-between-ontario-and-doctors/article22461657/
10. "2012 Physician Services Agreement between OMA and Her Majesty the Queen Right of Ontario, represented by the Minister of Health and Long Term Care". 2012 Physician Service Agreement. 64 p.
11. "New agreement between Ontario's doctors and government protects patient care" [Internet]. OMA Press Release. 2012 Dec 9. [updated 2012 Dec 9; cited 2015 Mar 28]. Available from: https://www.oma.org/Mediaroom/PressReleases/Pages/Newagreement.aspx
12. 17) "OMA stands up for patients and rejects government's offer as it will negatively impact patient care" [Internet]. OMA Press Release. 2015 Jan 15. [updated 2015 Jan 15; cited 2015 Mar 26]. Available from: https://www.oma.org/Mediaroom/PressReleases/Pages/OMArejectsgovernmentsoffer.aspx
13. "Mid-year Update on Ontario's Economic and Fiscal Performance", Ontario Ministry of Finance. 2014 Nov 17. [updated 2014 Nov 17; cited 2015 Mar 29]. Available from: http://www.fin.gov.on.ca/en/budget/fallstatement/2014/bk1.html
14. The Honourable Dwight Duncan - Minister of Finance. Public Accounts of Ontario 2008-2009. Annual Report and Consolidated Financial Statements. Toronto, Ontario. 2009 August. [updated 2010 May 14; cited 2015 Mar 27]. Available from: http://www.fin.gov.on.ca/en/budget/paccts/2009/09_ar.html
15. The Honourable David Onley - Lieutenant Governor of Ontario. Annual Report and Consolidated Financial Statements 2009-2010. Toronto, Ontario. 2010 August. [updated 2010 Sept 7; cited 2015 Mar 27]. Available from: http://www.fin.gov.on.ca/en/budget/paccts/2010/10_ar.html
16. The Honourable David Onley - Lieutenant Governor of Ontario. Annual Report and Consolidated Financial Statements 2010-2011. Toronto, Ontario. 2011 August. [updated 2011 Aug 23; cited 2015 Mar 27]. Available from: http://www.fin.gov.on.ca/en/budget/paccts/2011/10_ar.html
17. 17) The Honourable David Onley - Lieutenant Governor of Ontario. Annual Report and Consolidated Financial Statements 2011-2012. Toronto, Ontario. 2012 August. [updated 2011 Sept 30; cited 2015 Mar 27]. Available from: http://www.fin.gov.on.ca/en/budget/paccts/2012/10_ar.html
18. The Honourable David Onley - Lieutenant Governor of Ontario. Annual Report and Consolidated Financial Statements 2012-2013. Toronto, Ontario. 2013 September. [updated 2013 Sept 10; cited 2015 Mar 27]. Available from: http://www.fin.gov.on.ca/en/budget/paccts/2013/10_ar.html
19. The Honourable David Onley - Lieutenant Governor of Ontario. Ministry of Finance Public Accounts of Ontario. 2013-2014. Annual report and consolidated financial statements. Toronto, Ontario. 2014 September. [updated 2014 Sept 10; cited 2015 Mar 27]. Available from: http://www.fin.gov.on.ca/en/budget/paccts/2014/14_arcfs.pdf
20. "Ontario doctor's expect productive dialogue on important health issues as Legislature resumes" [Internet]. OMA Press Release. 2015 Feb 17. [updated 2015 Feb 17; cited 2015 Mar 22]. Available from: https://www.oma.org/Mediaroom/PressReleases/Pages/productivedialogue.aspx
21. "Ontario doctors reject the province's contract offer" [Internet]. CBC News. 2015 Jan 15. [updated 2015 Jan 19; cited 2015 Mar 29]. Available from: http://www.cbc.ca/news/canada/toronto/ontario-doctors-reject-province-s-contract-offer-1.2913779
22. "Ontario's doctors exploring all options to get back to the negotiating table" [Internet]. OMA Press Release. 2015 Mar 27. [updated 2015 Mar 27; cited 2015 Mar 28]. Available from: https://www.oma.org/Mediaroom/PressReleases/Pages/exploringalloptions.aspx
23. Impact of Government Unilateral Action on Family Medicine and Primary Care Physicians. OMA Media Release. 2015.
24. "Family Practice Models" [Internet]. Health Force Ontario. Last modified: May 9, 2013. Available from: http://www.healthforceontario.ca/en/Home/Physicians/Training_%7C_Practising_Outside_Ontario/Physician_Roles/Family_Practice_Models.
25. "Guide to Physician Compensation", Ontario Family Health Teams. 2009 September. Version 3.0.
26. Hospital On-Call Coverage Program [Internet]. Ontario Ministry of Health and Long Term Care. 2013 Apr 16 [updated 2013 Apr 16; cited 2015 Mar 28]. Available from: http://www.health.gov.on.ca/en/pro/programs/hocc/hocc_guide.aspx
27. Education and Prevention Committee Interpretive Bulletin. Chronic disease Assessment Premium: Code K078. Toronto, Ontario Ontario Medical Association. 2007 Jan. 3 p. Report no.: Volume 5, No 2.
28. "Fed-up doctors plan to use five-minute timer to make their case" [Internet]. Windsor Star News. 2015 Feb 16. [updated 2015 Feb 16; cited 2015 Mar 26]. Available from: http://blogs.windsorstar.com/news/fed-up-doctors-plan-to-use-five-minute-timer-to-make-their-case
29. Mulligan, C. "Docs want fair deal" [Internet]. Sudbury Star. 2015 Jan 25. [updated 2015 Jan 25; cited 2015 Mar 23]. Available from: http://www.thesudburystar.com/2015/01/25/docs-want-fair-deal
30. Flis, M. "Clawbacks to Ontario MDs: The absurdity of it all" [Internet]. Blog. 2015 Mar 15. [updated 2015 Mar 22; cited 2015 Mar 27]. Available from: https://drmarioflis.wordpress.com/2015/03/
31. Wooder, S. "Reconciliation – the Trojan horse of Ontario health cuts" [Internet]. Blog. 2015 Feb 4. [updated 2014 Feb 4; cited 2015 Mar 21]. Available from: https://drscottwooder.wordpress.com/2015/02/04/reconciliation-the-trojan-horse-of-ontario-health-cuts/
32. Ellis, M. "Ontario doctors vs. the Ontario government: we need better" [Internet]. Healthy Debate. 2015 Jan 21 [updated 2015 Jan 21; cited 2015 Mar 29]. Available from: http://healthydebate.ca/opinions/ontario-mds-vs-ontario-government-need-better
33. "Payments to Ontario Physicians from Ministry of Health and

Long-Term Care Sources 1992/93 to 2009/10". Institute for Clinical Evaluative Sciences. 2012 Feb [cited 2015 Apr 18]. Available from: http://www.ices.on.ca/~/media/Files/Atlases-Reports/2012/Payments-to-Ontario-physicians-from-MOHLTC-sources/Full%20report.ashx
34. "National Physician Survey, 2010. Results for Family Physicians by Certification, Sex, and Age". The National Physician Survey, 2010 [cited 2015 Apr 18]. Available from: http://nationalphysiciansurvey.ca/wp-content/uploads/2012/09/2010-FP-Q9.pdf
35. "Why Family Medicine?". The College of Family Physicians of Canada. 1996-2015 [cited 2015 Apr 18]. Available from: http://www.cfpc.ca/Why_Family_Medicine/
36. "Stop limiting where new physicians can practice, Ontario doctors tell government" [Internet]. OMA Press Release. 2015 March 25. [2015 March 25; cited 2015 March 27]. Available from: https://www.oma.org/Mediaroom/PressReleases/Pages/stoplimiting.aspx
37. Cargill, D. "Health care cuts will have lasting impact". [Internet]. Letter to the Editor, Windsor Star. 2015 Jan 20. [updated 2015 Jan 20; cited 2015 Mar 19]. Available from: http://blogs.windsorstar.com/open-newsroom/letters/health-care-cuts-will-have-lasting-impact
38. "OHIP billings do not equal salary" [Internet]. OMA Press Release. 2014 Dec 9. [updated 2014 Dec 9; cited 2015 Mar 26]. Available from: https://www.oma.org/Mediaroom/PressReleases/Pages/OHIPBillingsDoNotEqualSalary.aspx

Table 1. [Family Health Models in Ontario]. Description of the differences between types of Family Medicine Practice Models in Ontario

	Comprehensive model aka Fee for Service	Family Health Team	Family Health Group	Family Health Networks	Family Health Organization
Who it is for	Designed for solo family physicians	Work ininterdisciplinary teams	3+ physicians practicing together	3+ physicians practicing together	3+ physicians practicing together
Hours	Regular office hours + 3h/week extended hours	Regular and extended hours	Regular office hours + 3-5 session per week extended hours	Regular office hours + 3-5 sessions per week extended hours	Regular office hours + 3-5 sessions per week extended hours
Enrolment of Patients	Strongly encouraged	Strongly encouraged	Strongly encouraged	Commit to enrol patients	Commit to enrol patients
Allied Health		Already integral part of this team		Apply to Ministry of Health and Long Term Care to add other health professionals as part of a FHT.	Apply to Ministry of Health and Long Term Care to add other health professionals as part of a FHT.
After hours service for controlled patients	Variable	Variable	Nurse-staffed, Telephone Health Advisory Service	Nurse-staffed, Telephone Health Advisory Service	Nurse-staffed, Telephone Health Advisory Service
Pay	Fee for service	Blended capitation model [A] OR blended salary model [B] OR complement based remuneration [C]	Fee for service	Blended capitation model [A] – age and sex adjusted + bonuses and incentives	Blended capitation model [A] – complement based + bonuses and incentives

[A] Blended Capitation: Capitation based on a defined basket of primary care services provided to enrolled patients based on age/sex of each patient. Fee-for-service paid for other services [25].

[B] Blended Salary: Physicians are salaried employees of Community or Mixed Governance Family Health Teams: salary based on number of enrolled patients, plus benefits, bonuses [25].

[C] Complement based model: A base payment for a full-time equivalent "complement" in a given community/geographic area in addition to overhead payments, locum coverage, continuing medical education [25].

TAB 70

ONTARIO REGULATION 283/15

made under the

HEALTH INSURANCE ACT

Made: September 16, 2015
Filed: September 18, 2015
Published on e-Laws: September 18, 2015
Printed in *The Ontario Gazette*: October 3, 2015

Amending Reg. 552 of R.R.O. 1990
(GENERAL)

1. (1) The definition of "schedule of benefits" in subsection 1 (1) of Regulation 552 of the Revised Regulations of Ontario, 1990 is amended by adding the following paragraph:

28. Amendments dated September 1, 2015 (effective as of October 1, 2015);

(2) The definition of "schedule of benefits" in subsection 1 (1) of the Regulation is amended by adding the following paragraph:

29. Amendments dated September 1, 2015 (effective as of April 1, 2016);

2. The Regulation is amended by adding the following section:

37.10 (1) Despite subsection 37.1 (2), the amount payable for an insured service rendered by a physician in Ontario, as set out in the schedule of benefits, shall be reduced by 1.3 per cent if the service is rendered on or after October 1, 2015.

(2) For greater certainty, the reduction under subsection (1) is in addition to, and not in place of, any other reduction provided for under this Regulation.

3. The Regulation is amended by adding the following section:

37.11 (1) Despite subsection 37.1 (2) where, in respect of a fiscal year, $1,000,000 has already been payable from the Plan for the professional component of insured services rendered by a physician in Ontario after all the adjustments under this Regulation to the amount set out in the schedule of benefits have been applied, the amount payable to the physician for the professional component of insured services rendered in Ontario for the remainder of the fiscal year shall be reduced by 1 per cent.

(2) For greater certainty, the reduction under subsection (1) is in addition to, and not in place of, any other reduction provided for under this Regulation.

(3) In this section,

"fiscal year" means the period beginning on April 1 in one year, and ending on March 31 in the following year;

"professional component" has the same meaning as in the schedule of benefits.

Commencement

4. (1) Subject to subsections (2) to (4), this Regulation comes into force on the day it is filed.

(2) Subsection 1 (1) and section 2 come into force on October 1, 2015.

(3) Subsection 1 (2) comes into force on April 1, 2016.

(4) Section 3 shall be deemed to have come into force on April 1, 2015.

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TAB 71

INFOBulletin

Keeping health care providers informed of payment, policy or program changes

To: **Physicians, Nurse Practitioners, Hospitals and Clinics**

Published by: **Health Services Branch**

Date Issued: **September 14, 2015** Bulletin #: **4657**

Re: **REVISED - Payment Reduction on Fee-for-Service Professional Fee Payments of $1 Million or more, Payment Discount of 1.3%, and Amendments to the Schedule of Benefits for Physicians Services**

This bulletin describes changes to the Schedule of Benefits for Physician Services (Schedule) as well as the implementation of a payment discount and a payment reduction on fee-for-service (FFS) professional fee payments of $1M or more.

1. **Implementation of the Payment Reduction on FFS professional fee payments of $1M or more Effective April 1, 2015**

   Effective April 1, 2015 a 1% reduction will be applied to the amount payable for the professional component of FFS claims rendered by a physician who has been paid $1,000,000 or more for professional fees. This 1% reduction will be applied to the professional fees paid over $1,000,000 and will be calculated after all other payment discounts have been made. A separate INFOBulletin will be issued which describes the implementation details of this payment reduction.

2. **Implementation of 1.3% Payment Discount Effective October 1, 2015**

   Effective October 1, 2015 a 1.3% payment discount will be applied on all fee-for-service physician payments. This discount is in addition to the existing discounts. The discount will be reported on the Remittance Advice as a Physician Payment Discount.

3. **Changes to the Schedule of Benefits Effective October 1, 2015**

Effective October 1, 2015, a number of changes have been made to the Schedule. Charts detailing all fee code changes are available as attachments to this bulletin.

Professional Fee Codes for Diagnostic Imaging:

The current P1-P2 fee structure has been converted to a single P fee. The new fee amounts are available as attachments to this bulletin

Point of Care Laboratory Services

Changes have been made to remove fee schedule codes and reduce fees for point of care laboratory testing.

Diabetes Management Incentive

In order for a physician to be eligible for the Diabetes Management Incentive (Q040), the physician must have rendered a minimum of three (3) Diabetes Management Assessments (K030) for the same patient in the same 12 month period to which the Q040 service applies.

Pre-Operative Consultations for Low Risk Surgery

Pre-operative consultations when billed solely for preparation of a patient for low risk elective procedures, under local anaesthesia and/or I.V. sedation, are no longer eligible for payment unless the medical record demonstrates that the consultation is medically necessary. The low risk procedures are as follows:

- Cataract surgery,
- Colonoscopy,
- Cystoscopy,
- Carpal tunnel surgery, and
- Arthroscopic surgery.

Echocardiography with Cardiac Doppler

Fee codes G577 and G578 for applying cardiac doppler are discontinued. The professional fee for cardiac doppler (G578) and the professional fee for a complete study (G571) and a stress study (G583) are combined. The technical fee for cardiac Doppler (G577) has been combined with each of the technical fees for a complete study (G570) and stress study (G582) and both have been reduced by 5%.

Intravitreal Injections

The fees for Intravitreal injections (E147 and E149) have been reduced from $105 to $90.

4. Changes to the Schedule of Benefits Effective April 1, 2016

Effective April 1, 2016, new requirements must be met in order for echocardiography services to be eligible for payment.

Facilities - the service must be rendered at a facility that has applied for accreditation by April 1, 2016 and whose application to be accredited has not been denied. The accreditation body approved by the MOHLTC is the Cardiac Care Network (CCN).

Physicians - the physician performing the service must be able to establish that they have:

a. Level III (advanced) echocardiography training; or
b. Level II (basic prerequisites for independent competence in echocardiography); or
c. Documented performance in an established laboratory, with interpretation of at least 400 Echo/Doppler studies per year for the preceding three (3) years and at least 24 hours of accredited CME activities relevant to echocardiography over a period of two (2) years for the preceding three (3) years.

Indications - the indication must be one described in the document titled Standards for Provision of Echocardiography in Ontario found at http://www.ccnecho.ca/Standards/DownloadStandards.aspx and was in place on the date the service was rendered.

Physicians who have billed for echocardiogram services are encouraged to review the CCN standards found at http://www.ccnecho.ca/Standards/DownloadStandards.aspx to learn what the standards are both for facilities and for physicians working in the facility.

As the time for introduction of these proposed amendments is April 1, 2016, physicians are encouraged to advise the facility where they provide echocardiography services that accreditation will be mandatory for services to be paid by OHIP. Services will remain insured but payable at nil unless the facility is accredited and, the physician has the required qualifications.

A separate INFOBulletin will be issued which describes the implementation details of these requirements.

Links to Additional Information

Charts detailing all of the fee code changes referenced within are available as attachments to this bulletin at:
http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bulletin_4000_mn.html

The full details of the changes to the Schedule can be found at:

http://www.health.gov.on.ca/english/providers/program/ohip/sob/spb_mn.html

Hard copies of the Schedule will not be distributed. If you would like to order a paper copy or compact disk (CD) of the Schedule for a fee, please visit https://www.publications.serviceontario.ca

Physicians without access to the Internet can contact ServiceOntario at 1-800-668-9938.

This Bulletin is a general summary provided for information purposes only. Physicians, hospitals, and other health care providers are directed to review the Health Insurance Act, Regulation 552, and the Schedules under that regulation, for the complete text of the provisions. You can access this information at http://www.e-laws.gov.on.ca. In the event of a conflict or inconsistency between this bulletin and the applicable legislation and/or regulations, the legislation and/or regulations prevail.

TAB 72

Chart 1 - Fee Changes - Effective October 1, 2015

Fee Code	Existing Fee	October 1, 2015 Fee
E147	$105.60	$90.00
E149	$105.60	$90.00
G099	$2.59	$1.03
G040	$29.00	$15.00
G041	$7.25	$3.70
G043	$15.00	$7.50
G238	$89.64	$71.65
G141	$23.95	$19.25
G144	$23.95	$19.25
G147	$15.35	$12.30
G150	$24.00	$19.20
G251	$33.80	$27.05
G550	$89.45	$76.05
G851	$39.80	$31.85
G853	$33.80	$26.75
G854	$45.80	$38.50
G466	$117.50	$99.90
G857	$72.90	$61.95
G870	$70.95	$112.40
G871	$70.10	$96.20
G875	$47.45	$33.95
G562	$90.60	$127.85
G583	$81.55	$110.15
J102	$35.69	$28.80
J103	$47.55	$38.05
J105	$29.65	$23.70
J107	$23.55	$18.85
J108	$24.60	$19.70
J122	$29.65	$23.70
J125	$30.70	$24.55
J127	$16.40	$13.10
J128	$21.85	$17.55
J135	$33.20	$26.55
J138	$33.20	$26.55
J157	$21.95	$17.55
J158	$21.95	$17.55
J159	$33.20	$26.55
J160	$33.20	$26.55
J161	$20.30	$16.25
J162	$33.20	$26.55
J163	$21.95	$17.55
J164	$15.35	$12.30
J166	$27.80	$22.30
J168	$26.05	$20.85
J169	$20.45	$16.35

Fee Code	Existing Fee	October 1, 2015 Fee
J180	$23.65	$18.90
J182	$18.70	$14.95
J183	$29.75	$23.80
J185	$40.65	$32.50
J188	$28.65	$22.90
J189	$29.55	$23.65
J190	$26.40	$21.10
J191	$17.85	$14.30
J196	$12.05	$10.80
J197	$9.75	$7.80
J198	$12.35	$9.90
J199	$9.75	$7.80
J200	$26.75	$21.40
J201	$30.80	$24.65
J202	$32.75	$25.60
J203	$6.90	$5.50
J204	$6.90	$5.50
J205	$17.75	$14.20
J206	$17.75	$14.20
J207	$17.75	$14.20
J802	$48.40	$38.70
J804	$19.90	$15.90
J806	$57.80	$46.70
J807	$47.65	$38.10
J808	$26.80	$20.90
J809	$29.55	$23.65
J810	$47.40	$37.90
J811	$50.00	$40.25
J812	$46.10	$30.90
J813	$78.15	$62.50
J814	$41.21	$33.00
J815	$48.40	$38.70
J816	$48.40	$38.70
J817	$21.85	$17.50
J818	$48.35	$38.70
J819	$79.55	$23.65
J820	$66.35	$53.10
J827	$48.40	$38.70
J829	$48.40	$38.70
J830	$48.40	$38.70
J831	$48.40	$38.70
J832	$48.40	$38.70
J833	$48.40	$38.70
J834	$99.20	$31.10

Fee Code	Existing Fee	October 1, 2015 Fee
J835	$69.35	$55.50
J836	$48.40	$38.70
J839	$48.40	$38.70
J840	$48.40	$38.70
J847	$33.10	$26.50
J849	$26.55	$21.25
J849	$33.86	$27.10
J850	$59.65	$47.70
J851	$48.40	$38.70
J852	$64.60	$51.70
J853	$48.40	$38.70
J857	$54.95	$43.95
J858	$48.40	$38.70
J859	$43.25	$34.60
J860	$59.65	$47.70
J861	$65.75	$52.60
J862	$68.65	$54.90
J865	$48.40	$38.70
J866	$51.55	$41.25
J865	$48.40	$38.70
J866	$29.55	$23.65
J867	$27.65	$22.10
J868	$55.75	$44.60
J869	$59.65	$47.45
J870	$12.85	$10.30
J871	$48.40	$38.70
J872	$51.55	$41.45
J871	$17.80	$14.25
J875	$38.75	$31.00
J876	$48.40	$38.70
J877	$48.40	$38.70
J878	$48.40	$38.70
J879	$48.40	$38.70
J880	$21.40	$17.10
J881	$59.65	$47.70
J882	$48.40	$38.70
J884	$48.40	$38.70
J885	$54.95	$43.95
J886	$53.35	$42.50
J887	$43.25	$34.60
J888	$121.90	$97.50
J890	$121.90	$97.50
J895	$121.90	$97.50
J896	$121.90	$97.50

Chart 1 - Fee Changes - Effective October 1, 2015

Fee Code	Existing Fee	October 1, 2015 Fee
YB97	$111.90	$97.90
YB02	$57.01	$50.31
YB04	$25.88	$20.67
YB06	$67.74	$54.21
YB07	$61.94	$49.53
YB08	$33.93	$27.17
YB10	$61.53	$49.27
YB11	$70.37	$56.25
YB12	$33.01	$27.17
YB13	$100.53	$81.25
YB14	$53.60	$42.90
YB15	$62.93	$50.31
YB16	$62.93	$50.31
YB17	$18.41	$22.75
YB20	$86.27	$69.05
YB23	$12.60	$10.08
YB24	$12.91	$10.08
YB25	$12.66	$10.14
YB26	$12.91	$10.34
YB27	$62.93	$50.31
YB28	$62.93	$50.31
YB30	$62.93	$50.31
YB31	$62.93	$50.31
YB32	$62.93	$50.31
YB33	$62.93	$50.31
YB36	$62.93	$50.31
YB37	$12.91	$10.34
YB38	$12.91	$10.34
YB39	$63.01	$50.31
YB40	$62.93	$50.31
YB41	$14.01	$11.89
YB43	$14.01	$11.89
YB47	$43.04	$34.45
YB48	$34.52	$27.63
YB49	$44.08	$35.28
YB50	$77.56	$62.01
YB51	$62.93	$50.31
YB52	$83.91	$67.21
YB53	$62.93	$50.31
YB57	$71.41	$57.14
YB58	$62.93	$50.31
YB59	$56.26	$44.98

Fee Code	Existing Fee	October 1, 2015 Fee
YB60	$77.56	$62.01
YB61	$85.46	$68.38
YB62	$89.23	$71.37
YB64	$67.10	$53.63
YB65	$62.53	$50.31
YB67	$36.19	$28.98
YB68	$72.49	$57.98
YB69	$72.19	$57.79
YB70	$16.74	$13.39
YB71	$63.03	$50.5[illegible]
YB72	$72.10	$57.79
YB73	$23.16	$18.53
YB74	$12.60	$10.08
YB75	$50.29	$40.30
YB76	$62.53	$50.51
YB77	$62.53	$50.51
YB78	$67.93	$50.31
YB79	$62.93	$50.31
YB81	$77.56	$62.01
YB82	$62.93	$50.31
YB83	$76.02	$60.78
YB84	$62.93	$50.31
YB85	$71.45	$57.14
YB86	$69.38	$55.51
YB87	$56.26	$44.98

Chart 2 - Fee Code Deletions - Effective October 1, 2015

Fee Code
G139
G142
G145
G148
G161
G262
G263
G343
G345
G459
G460
G572
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G578
G584
J402
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Fee Code
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Fee Code
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Fee Code
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Fee Code
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TAB 73

Statement - Ontario Fee Cuts Will Result in Limited Access to Timely, Quality Patient Care: The Canadian Association of Radiologists

OTTAWA, Oct. 1, 2015 /CNW/ - The Canadian Association of Radiologists (CAR) is alarmed by the recent unilateral and arbitrary physician fee cuts in Ontario. We believe these cuts will result in limited access to appropriate, high-quality diagnostic imaging care for Ontarians. We ask the Ontario Government to rescind these changes and work together with Ontario radiologists to find solutions that will not jeopardize quality patient care or undermine patients' trust in our healt care system.

Among the fee changes affecting medical imaging is a 20 % reduction in all diagnostic ultrasound and nuclear medicine services that Ontario's patients rely upon for the diagnosis and follow-up of many diseases, including leading causes of mortality such as cancer and cardiac disease. Undermining the delivery of ultrasound services in community-based imaging clinics will delay patients' access to a timely diagnosis. Further, other life threatening conditions such as trauma and ectopic pregnancies are daily occurrences in many hospital emergency departments across the province where timely care is essential.

The potential impact of the cuts, among others, is that access to appropriate and timely medical imaging will be compromised; patients will have limited access to these specific imaging services, which will likely result in increased referrals for more costly MRI imaging, which in turn will increase wait times in hospitals for those services. MRI is not only more costly, but has significantly longer wait times in much of the province.

Dr. Willie Miller, President of the CAR, says, "We are concerned that these ill-informed, arbitrary fee cuts will negatively impact Ontarians' access to high-quality, appropriate and timely care. Patient care would be better served by the Ministry of Health working together with Ontario radiologists as recommended by Dr. Mark Priedlis, President of the Ontario Association of Radiologists, in his letter this past week to Health Minister Hoskins. Radiologists understand the implications of these changes on the front lines and are best suited to work collaboratively to find workable solutions that protect the healthcare of Ontarians."

The lack of consultation with Ontario radiologists denies the provincial health care system access to imaging expertise and understanding not available in the Ministry of Health. The Ontario Government's decision to reduce musculoskeletal and scrotal ultrasound by 63% and 74% respectively would have had serious patient care repercussions for approximately 800,000 patients annually. The CAR is encouraged that government followed the advice of the Ontario Association of Radiologists to reverse this decision, but is disappointed that there was no public acknowledgement from the Ministry of this important advice. The public has a right to expect that changes to the Ontario health care system should be made collaboratively by the Ministry with the physicians who deliver care daily. Clearly this is not what is happening.

The CAR urges the Government of Ontario to rescind all recently announced diagnostic imaging cuts and undertake a process which seeks to improve quality and sustainability in imaging through consultation with the Ontario Association of Radiologists. "Radiologists are willing and interested in working together with governments to improve the health care system," concludes Dr. Miller.

About the CAR

The CAR is the national voice of radiology committed to promoting the highest standards in patient-centered imaging, lifelong learning and research. Our physician members are respected as the experts in using diagnostic and therapeutic interventional imaging technology to promote safe, efficient and quality health care for Canadians. Radiologists are integral members of the healthcare team.

SOURCE Canadian Association of Radiologists

For further information: To coordinate an interview with a spokesperson from the CAR, contact: Canadian Association of Radiologists, Communications Department, 613 860-3111, ext. 203, info@car.ca

TAB 74

Court File No. CV-15539424

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

ONTARIO MEDICAL ASSOCIATION

Applicant

- and -

ONTARIO (MINISTER OF HEALTH AND LONG-TERM CARE) and LIEUTENANT GOVERNOR-IN-COUNCIL OF ONTARIO

Respondents

NOTICE OF APPLICATION

TO THE RESPONDENT:

A LEGAL PROCEEDING HAS BEEN COMMENCED by the applicant. The claim made by the applicant appears on the following page.

THIS APPLICATION will come on for a hearing on a date and time to be fixed by the Registrar at the place of hearing requested by the applicant. The applicant requests that this application be heard at the City of Toronto.

IF YOU WISH TO OPPOSE THIS APPLICATION, to receive notice of any step in the application or to be served with any documents in the application, you or an Ontario lawyer acting for you must forthwith prepare a notice of appearance in Form 38A prescribed by the *Rules of Civil Procedure*, serve it on the applicant's lawyer or, where the applicant does not have a lawyer, serve it on the applicant, and file it, with proof of service, in this court office, and you or your lawyer must appear at the hearing.

IF YOU WISH TO PRESENT AFFIDAVIT OR OTHER DOCUMENTARY EVIDENCE TO THE COURT OR TO EXAMINE OR CROSS-EXAMINE WITNESSES ON THE APPLICATION, you or your lawyer must, in addition to serving your notice of appearance, serve a copy of the evidence on the applicant's lawyer or, where the applicant does not have a lawyer, serve it on the applicant, and file it, with proof of service, in the court office where the application is to be heard as soon as possible, but not later than 2 days before the hearing.

IF YOU FAIL TO APPEAR AT THE HEARING, JUDGMENT MAY BE GIVEN IN YOUR ABSENCE AND WITHOUT FURTHER NOTICE TO YOU. IF YOU WISH TO DEFEND THIS PROCEEDING BUT ARE UNABLE TO PAY LEGAL FEES, LEGAL AID MAY BE AVAILABLE TO YOU BY CONTACTING A LOCAL LEGAL AID OFFICE.

Date October 29, 2015

Issued by _____
Local registrar

Address of court office: Ontario Superior Court of Justice
393 University Avenue, 10th Fl.
Toronto, ON M5G 1E6

TO: **Ministry of Health and Long-Term Care**
Legal Services Branch
56 Wellesley Street West, 8th Floor
Toronto, ON M5S 2S3

AND TO. **The Attorney General of Ontario**
Crown Law Office – Civil
720 Bay Street, 8th Floor
Toronto, ON M5G 2K1

AND TO: **The Attorney General of Ontario**
Constitutional Law Branch
720 Bay Street, 4th Floor
Toronto, ON M5G 2K1

AND TO: **The Attorney General of Canada**
Suite 3400, Exchange Tower
Box 36, First Canadian Place
Toronto, ON M5X 1K6

APPLICATION

1. The Applicant, the Ontario Medical Association ("OMA"), makes application for:

(a) A declaration that the failure to establish a binding dispute resolution mechanism to settle bargaining disputes between the Minister of Health and Long-Term Care (the "Minister") and the OMA in respect of physician compensation and related accountabilities, and/or the Minister's decision to refuse the OMA's request for such a mechanism, violate section 2(d) of the *Canadian Charter of Rights and Freedoms* (the "*Charter*"), and that these violations are not saved by section 1 of the *Charter*;

(b) A declaration that sections 1(1) and 37.9 of Regulation 552, made under the *Health Insurance Act*, R.S.O. 1990, c. H.6 (the "*HIA*"), as amended by Ontario Regulation 15/15, and/or the decision to unilaterally impose the reduction in fee-for-service and non-fee-for-service payments to physicians associated with this regulatory amendment, violate section 2(d) of the *Charter*, and that these violations are not saved by section 1 of the *Charter*;

(c) A declaration that sections 1(1) and 37.9 of Regulation 552, as amended by Ontario Regulation 15/15, and the associated payment reductions, are unconstitutional and of no force and effect;

(d) A declaration that sections 1(1), 37.10, and 37.11 of Regulation 552, as amended by Ontario Regulations 283/15, 302/15, and 303/15, and/or the decision to unilaterally impose the reduction in fee-for-service and non-fee-for-

service payments to physicians associated with this regulatory amendment, violate section 2(d) of the *Charter*, and that these violations are not saved by section 1 of the *Charter*;

(e) A declaration that sections 1(1), 37.10, and 37.11 of Regulation 552, as amended by Ontario Regulations 283/15, 302/15, and 303/15, and the associated payment reductions, are unconstitutional and of no force and effect;

(f) A declaration that the amendments dated January 15, 2015 and September 28, 2015 to the document published by the Ministry of Health and Long-Term Care ("Ministry") titled "Schedule of Benefits - Physicians Services under the *Health Insurance Act* (October 1, 2005)" (the "Schedule of Benefits"), and/or the decision to unilaterally make such amendments, violate section 2(d) of the *Charter*, and that these violations are not saved by section 1 of the *Charter*;

(g) A declaration that the amendments dated January 15, 2015 and September 28, 2015 to the Schedule of Benefits are unconstitutional and of no force and effect;

(h) A declaration that the Minister's decision to modify the "Managed Entry" process for Primary Care Patient Enrollment Models effective June 1, 2015 violates section 2(d) of the *Charter*, and that this violation is not saved by section 1 of the *Charter*;

(i) A declaration that the modifications to the "Managed Entry" process for Primary Care Patient Enrollment Models effective June 1, 2015 are unconstitutional and of no force and effect;

(j) A declaration that the Minister's decision to implement the "New Graduate Entry Program" (announced October 23, 2015) violates section 2(d) of the *Charter*, and that this violation is not saved by section 1 of the *Charter*;

(k) A declaration that the "New Graduate Entry Program" is unconstitutional and of no force and effect;

(l) A declaration that the Minister is required under section 2(d) of the *Charter* to engage in a process of collective bargaining with the OMA on behalf of Ontario physicians in respect of physician compensation;

(m) A declaration that the Minister has breached his agreement with the OMA called the "OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement" (the "Representation Rights Agreement");

(n) An order that the Minister establish a system of binding dispute resolution to resolve bargaining impasses between the Ministry and OMA in respect of physician compensation and related accountabilities;

(o) An order that the Minister establish a binding dispute resolution process to determine physicians' entitlement to compensation for their losses resulting from the Minister's unlawful conduct, or, in the alternative, damages or such

other relief under section 24(1) of the *Charter* as this Honourable Court deems just;

(p) The costs of this application; and

(q) Such further and other relief as counsel may advise and this Honourable Court deems just.

2. The grounds for the application are:

I. The OMA's Representation of Members of Ontario's Medical Profession

(a) The OMA is a not-for-profit corporation incorporated under the Ontario *Corporations Act*, R.S.O. 1990, c. C.38. It has represented the economic, clinical, and political interests of members of Ontario's medical profession since it was founded as a voluntary association in 1880. At present, the OMA has over 37,000 members, the majority of whom are practicing physicians;

(b) One of the OMA's primary activities and, in fact, one of its principal reasons for existence, is the negotiation and implementation of Physician Services Agreements ("PSA"). PSAs are negotiated agreements between the OMA and the Minister that establish many important working terms and conditions for the OMA's members. One of the most important terms that the OMA and the Minister negotiate and establish in PSAs is the funding to compensate physicians for providing services to the people of Ontario;

(c) Ontario physicians may only be compensated for providing insured services to insured persons by the Ontario Government, either directly by the Ontario Health Insurance Plan or indirectly by public hospitals;

(d) Notably, the Minister has negotiated every past PSA *exclusively* with the OMA. Historically, the OMA has also been Ontario physicians' exclusive representative in respect of issues related to the Schedule of Benefits, which establishes the price for physicians' service under the Ontario Health Insurance Plan, and the other programs under which payments are made to physicians for providing medical services to the public. The OMA established the original Schedule of Fees upon which the Schedule of Benefits was based;

(e) The OMA's status as the exclusive representative of Ontario physicians is recognized in the Representation Rights Agreement, the *Commitment to the Future of Medicare Act, 2004*, S.O. 2004, c. 5, and the *HIA*;

II. The Minister's Refusal to Negotiate with the OMA

(f) The OMA and the Minister entered into the Representation Rights Agreement in late 2012. Notably, this was prior to the Supreme Court of Canada's January 2015 decisions in *Mounted Police Association of Ontario v. Canada (Attorney General)*, *Meredith v. Canada (Attorney General)*, and *Saskatchewan Federation of Labour v. Saskatchewan*;

(g) The Representation Rights Agreement requires the Minister to consult and negotiate in good faith with the OMA for the purpose of entering into PSAs to establish physician compensation and related accountabilities;

(h) The Representation Rights Agreement also establishes a Joint Process of Facilitation - Conciliation in respect of bargaining disputes between the parties. In the Facilitation - Conciliation process, neutral third parties attempt to help the OMA and the Minister resolve their differences and reach an agreement. However, the process does *not* include a *binding* mechanism to resolve bargaining disputes;

(i) The last PSA expired on March 31, 2014 ("PSA 2012"). The OMA and Ministry representatives began meeting to establish a new PSA ("PSA 2014") in January 2014. However, the parties were unable to reach agreement on the basic elements of PSA 2014 in bilateral negotiations, and consequently they participated in Facilitation - Conciliation in Fall 2014;

(j) The parties were unable to reach an agreement in Facilitation - Conciliation. As a result, the Facilitation - Conciliation process ended and the Conciliator released a public report dated December 11, 2014 (the "Conciliation Report");

(k) On January 9, 2015, the Minister made a "final offer" to the OMA for a PSA with a three-year term, which it subsequently amended on January 14, 2015 (the "Final Offer"). The Final Offer had the following main elements:

(i) Total annual spending on physician services (the "Physician Services Budget") would be capped at a growth rate of 1.25% per year;

(ii) Over the course of the first two years of the agreement (2014/2015 and 2015/2016), the parties would implement specific measures to achieve $530 million in savings;

(iii) If total actual spending on physician services *exceeded* the capped Physician Services Budgets for 2014/2015 and 2015/2016, then the excess expenditure would be recovered from physicians in 2016/2017. On the other hand, if actual spending was *less* than the Physician Services Budgets, then the difference would be paid out to physicians in a lump sum in 2016/2017;

(iv) A similar recovery mechanism based on 1.25% spending growth would apply in the third year of the agreement (2016/2017), but the Minister would also make a $168 million lump sum payment available.

(l) The Final Offer ignored the fact that the *actual* annual growth rate in Ontario's Physician Services Budget is far greater than 1.25% as a result of a host of factors over which physicians have no control, including, but not limited to, the natural growth and aging of Ontario's population. The Final Offer also established an artificial "starting base" for the 2013/2014 Physician Services Budget that was *lower* than actual spending in 2013/2014;

(m) Taken together, these elements in the Final Offer contemplated a dramatic *reduction* in Ontario physicians' compensation over its three-year term;

(n) On this basis, the OMA rejected the Final Offer on January 15, 2015. But, in an effort to facilitate further negotiations, the OMA immediately offered a two-year freeze in the price of physicians' services. The Minister never responded to the substance of this offer;

(o) Instead, on January 15, 2015, the Minister announced that the Ministry would take unilateral steps to reduce spending in respect of physician services.

III. The Government Takes Unilateral Action to Reduce Physician Compensation

(p) On January 28, 2015, the Government enacted Ontario Regulation 15/15, which amended certain provisions in Regulation 552. This regulatory amendment unilaterally imposed:

(i) A 2.65% reduction to "fee-for-service" payments to physicians effective February 1, 2015; and,

(ii) Amendments to the Schedule of Benefits dated January 15, 2015 that reduced the fees payable under the Ontario Health Insurance Plan for certain physician services effective April 1, 2015.

(q) Notably, the Ministry also unilaterally applied the 2.65% payment reduction to other "non-fee-for-service" payments made to physicians under a variety of contracts and programs.

(r) However, these actions are at odds with the substance of the Conciliation Report and the Final Offer, and the Minister never engaged in good faith consultations or negotiations with the OMA in respect of this regulatory change or the associated payment reductions (which are described in detail in Ministry INFO Bulletins # 11125, 4646, 4648, and 4652).

(s) Furthermore, between January 2015 and October 2015, the Minister proceeded to unilaterally change many other working terms and conditions for physicians,

including other payments that physicians receive for providing services to the public. The Minister's unilateral actions in this regard include, but are not limited to:

(i) The Minister made unilateral changes (effective June 1, 2015) to the "Managed Entry" program that applies to primary care physicians entering Primary Care Patient Enrollment Models. The effect of these changes is to substantially reduce: (1) how many physicians can provide primary care services to the public; (2) the practice options of primary care physicians; and (3) the compensation of physicians who provide primary care services;

(ii) The Minister unilaterally announced and began to implement a "New Graduate Entry Program" that applies to new graduate primary care physicians. In combination, the elements of this program fundamentally change how new physicians are compensated; and,

(iii) The Minister made unilateral amendments to a variety of contracts and programs that set the terms on which "non-fee-for-service" payments are made to physicians, including "template agreements" and "ancillary agreements";

(t) All of these matters would normally be the subject of PSA negotiations. Furthermore, the Minister is expressly required to negotiate changes to all "template agreements" and some "ancillary agreements" with the OMA under the Representation Rights Agreement;

(u) However, the Minister undertook these actions without engaging in any good faith negotiation or consultation with the OMA;

IV. The Government Unilaterally Imposes Further Significant Payment Reductions

(v) On June 4, 2015, Ministry representatives advised the OMA that the Ministry was $339 million "over budget" for 2014/2015. This was several hundred million dollars more than any estimate that had previously been shared with the OMA. Despite this, the Ministry representatives advised the OMA that the Ministry planned to recover this increased amount from Ontario physicians;

(w) Moreover, the Ministry representatives advised the OMA that the Ministry would recover this amount from physicians in October 2015 despite the fact that the Final Offer stated that any recovery would not occur until 2016/2017;

(x) On August 5, 2015, the OMA sent the Ministry a detailed letter setting out its objection to the new recovery plan. The Ministry did not respond to the OMA's letter until September 8, 2015, at which time the Ministry simply confirmed that, effective October 1, 2015, it would impose an additional 1.3% reduction and other significant cuts to payments to physicians;

(y) Then, beginning on September 18, 2015, the Government enacted Ontario Regulations 283/15, 302/15, and 303/15, all of which amended Regulation 552. This regulatory change unilaterally imposed *additional* payment reductions on physicians, including:

(i) An additional 1.3% reduction to "fee-for-service" payments to physicians effective February 1, 2015; and,

(ii) Amendments to the Schedule of Benefits dated September 28, 2015 that further reduced the fees payable under the Ontario Health Insurance Plan for certain physician services effective October 1, 2015 and April 1, 2016.

(z) However, the Minister never engaged in good faith consultations or negotiations with the OMA in respect of these regulatory changes, or the associated payment reductions (which are described in detail in Ministry INFO Bulletin #4657);

(aa) Furthermore, the substance of Regulations 283/15, 302/15, and 303/15, and the associated payment reductions are at odds with the substance of the Conciliation Report and the Final Offer. In particular: (1) the Ministry has now recovered approximately $695 million from physicians, which is far more than the $530 million in its Final Offer; and (2) the Ministry implemented recovery measures effective October 2015, not in 2016/2017.

V. The Minister Seeks to Marginalize the OMA

(bb) Since January 2015, the Minister has also engaged in a course of conduct that seeks to (1) marginalize the OMA in respect of physician services issues and (2) undermine the OMA's ability to act as physicians' representative. In particular:

(i) Ministry representatives have made public statements that criticize and mischaracterize the OMA's conduct and positions in respect of its interactions with the Minister and physician compensation issues. Specifically, Ministry representatives have repeatedly stated that the

OMA has refused to engage with the Minister respecting physician services issues. On several occasions, the Minister has made such statements in the Legislature and in comments to the media. However, in fact it is the Minister that has refused to respond constructively to the substance of numerous OMA submissions;

(ii) Ministry representatives have bypassed the OMA to contact physicians and other physician groups (including various sections of members within the OMA) in respect of physician compensation and related issues that are normally the subject of PSA negotiations;

(iii) The Minister has begun to implement major reforms to the payment models in which primary care physicians practice. However, the Minister has not engaged in any consultations or negotiations with the OMA in this regard.

(cc) During this period, Ministry representatives have engaged in *pro forma* consultations with the OMA as the Minister unilaterally determines working terms and conditions for physicians that are properly the subject of PSA negotiations;

(dd) However, the Minister has never provided a meaningful substantive response to the numerous representations that the OMA has made concerning the Minister's course of conduct between January 2015 and October 2015;

VI. The Minister Rejects the OMA's Efforts to Correct the Power Imbalance

(ee) As the Minister has adopted this new course of action since January 2015, the OMA has made a number of efforts to strengthen its capacity to represent

Ontario physicians. However, Ministry representatives have obstructed all of the OMA's efforts in this regard. In particular:

(i) Beginning in April 2015, the OMA repeatedly requested that the Ministry grant it access to expenditure tracking data that would allow Ontario physicians to monitor and seek to control spending growth in line with the capped Physician Services Budget. However, Ministry representatives have refused the OMA's requests for such access;

(ii) On April 8, 2015, the OMA requested that the Minister appoint the Physician Services Payment Committee ("PSPC"), a bilateral OMA - Ministry committee mandated by the *HIA*. However, the Minister refused to appoint the PSPC. Further, in response to follow-up correspondence from the OMA, Ministry representatives suggested that the Government will amend the *HIA* to abolish the PSPC;

(iii) On May 19, 2015, the OMA asked the Minister to amend the Representation Rights Agreement to establish a *binding* dispute resolution mechanism for bargaining disputes over physician compensation and related accountabilities. The OMA made this request after the OMA Council overwhelmingly endorsed a resolution in favour of this amendment. However, the Minister refused to agree to a binding dispute resolution process for disputes over physician compensation.

(ff) Taken together, the Minister's actions since January 15, 2015 have had a significant detrimental impact on physicians' sense of security in their working lives and their ability to practice in Ontario;

(gg) The Minister's actions have also substantially undermined the OMA's capacity to represent its members;

VII. Violation of Section 2(d) of the *Charter* and the Representation Rights Agreement

(hh) The Minister's course of conduct in respect of physician services issues since January 15, 2015 has violated Ontario physicians' freedom of association under section 2(d) of the *Charter*. It has also violated the express terms of the Representation Rights Agreement;

(ii) More specifically, there is a significant power imbalance between the Minister and the OMA in respect of negotiations over physician compensation and related accountabilities. On numerous occasions, the OMA has informed the Minister of the urgent need to correct this balance. However, rather than work with the OMA to correct the imbalance, the Minister has sought to take advantage of it at every turn by taking the actions described above;

(jj) Furthermore, the Minister has expressly refused to agree to a process of *binding* dispute resolution in respect of bargaining disputes with the OMA despite the fact that Ontario physicians are unable to engage in "strikes" or similar job action;

(kk) Without access to a *binding* dispute resolution process for negotiation disputes, it is impossible for the OMA to have a meaningful process of collective bargaining with the Minister;

(ll) In fact, the absence of a binding dispute resolution mechanism has allowed the Minister to embark on a course of action that marginalizes the OMA as

physicians' representative and permits the Minister to determine the working terms and conditions for Ontario physicians unilaterally and without any meaningful negotiation or consultations with the OMA;

(mm) In doing so, the Minister has refused to engage in a process of meaningful collective bargaining with the OMA in respect of the changes to physicians' working terms and conditions that the Minister has unilaterally implemented since the expiration of PSA 2012. The main effects of the Minister's actions include substantially impairing physicians' ability to act collectively in respect of their working terms and conditions and imposing an immediate and significant reduction in physicians' income;

(nn) The Minister has also consistently marginalized the OMA in respect of physician services issues and has sought to bypass the OMA as representative of Ontario physicians.

(oo) The Minister's systematic efforts to diminish and deny the OMA's rights to represent Ontario's physicians, to publicly criticize the OMA, and to engage directly with the OMA's members and other physician groups in respect of physician compensation and related issues, have achieved their intended result, namely, to undermine the OMA's capacity to represent the collective interests of its members, and to make good faith dialogue between the Minister and the OMA impossible;

(pp) In combination, these factors have substantially interfered with Ontario physicians' right to associate and act collectively in furtherance of their workplace goals;

(qq) These violations cannot be justified under section 1 of the *Charter*;

(rr) The Minister's actions described above have also breached the Representation Rights Agreement's express requirements that the Minister: (1) recognize the OMA as the exclusive representative of Ontario physicians; (2) negotiate in good faith with the OMA for the purpose of entering into PSAs to establish physician compensation; and (3) consult with the OMA regarding significant healthcare policy and system issues that affect physicians;

(ss) *Rules of Civil Procedure*, R.R.O. 1990, Reg. 194, rules 14.05 and 38;

(tt) *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M.26;

(uu) *HIA*;

(vv) *Commitment to the Future of Medicare Act, 2004*, S.O. 2004, c. 5;

(ww) *Independent Health Facilities Act*, R.S.O 1990, c. I.3;

(xx) *Canada Health Act*, R.S.C., 1985, c. C-6; and

(yy) Such further and other grounds as counsel may advise and this Honourable Court may deem just.

3. The following documentary evidence will be used at the hearing of the application:

(a) The Affidavit of Dr. Atul Kapur, to be sworn;

(b) The Affidavit of Dr. Ved Tandan, to be sworn;

(c) The Affidavit of Dr. Jasmin Kantarevic, to be sworn;

(d) The Affidavit of Mr. Wojciech Roszuk, to be sworn;

(e) The Affidavits of such other individuals as counsel may determine to be appropriate; and,

(f) Such further material as counsel may advise and this Honourable Court may permit.

October 29, 2015

Fasken Martineau DuMoulin LLP
Bay Adelaide Centre
333 Bay Street, Suite 2400
Toronto, ON M5H 2T6

John D. R. Craig LSUC#: 41850V
Tel: (416) 865-4502
Email: jcraig@fasken.com

Christopher D. Pigott LSUC#: 59036A
Tel: (416) 865-5475
Email: cpigott@fasken.com

Fax: (416) 364-7813

Lawyers for the Applicant,
Ontario Medical Association

ONTARIO MEDICAL ASSOCIATION Applicant	and	ONTARIO (MINISTER OF HEALTH AND LONG-TERM CARE) and LIEUTENANT GOVERNOR-IN-COUNCIL OF ONTARIO Respondents	Court File No: CV-15539424

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT TORONTO

NOTICE OF APPLICATION

Fasken Martineau DuMoulin LLP
Bay Adelaide Centre
333 Bay Street, Suite 2400
P.O. Box 2400
Toronto, ON M5H 2T6

John D. R. Craig LSUC#: 41850V
Tel.: (416) 865-4502
Email: jcraig@fasken.com

Christopher D. Pigott LSUC#: 59036A
Tel: (416) 865-5475
Email: cpigott@fasken.com

Fax: (416) 865-5475

Lawyers for the Applicant,
Ontario Medical Association

TAB 75

PROVINCIAL POLITICS

Ontario doctors reject contract deal with province

Doctors reject contract with government, seek another round of negotiations in hopes of better deal

Aug. 15, 2016

"Members have made it clear that more is required from the Ontario government in order to best serve the interests of the profession and patients," OMA president Dr. Virginia Walley said Monday after the vote was

By **Rob Ferguson Queen's Park Bureau**

After weeks of nasty infighting, doctors have rejected a controversial four-year contract negotiated by the Ontario Medical Association and the provincial government.

Just over 63 per cent of doctors cast ballots against the pact, the OMA said Monday after votes were tabulated from Sunday's tense general meeting in Toronto.

"Members have spoken," OMA president Dr. Virginia Walley — who had stumped across the province urging doctors to approval the deal amid "vigorous debate" — said in a statement.

"More is required from the Ontario government in order to best serve the interests of the profession and patients."

Voter turnout was 55 per cent, meaning almost half the province's doctors did not vote on a contract that the association will now seek to renegotiate.

Health Minister Eric Hoskins said the government must still ensure "predictable annual increases" to the $11.5 billion annually now set aside for paying doctors.

"Although the government respects the outcome of the vote, the result is regrettable and will require all parties to reflect carefully on next steps," he added in a statement.

"I want to assure the people and patients of Ontario that their access to physicians and the health-care system will not be affected."

The contract would have boosted the pot of money for paying physicians by 2.5 per cent to $12.8 billion by 2020 and put a financial clamp on things like excessive urine testing by doctors at methadone clinics and fee-for-service billings over $1 million a year.

The pact was vocally opposed by two coalitions of doctors some highly paid specialists like radiologists, ophthalmologists and cardiologists, who said the increase would not keep up with demands for care from a fast-growing and aging population, leaving patients in the lurch.

A group called the Concerned Ontario Doctors had called the contract — which would trim $100 million from fees for medical procedures than can now be done faster given technological advances in techniques and equipment — a "complete surrender."

But the OMA said it was the best bet in tough economic times to secure stability for doctors — who twice endured unilateral cuts from the government in the last two years without a contract — while the association pursues a court challenge in hopes future contracts can be sent to binding arbitration.

Walley said she will "immediately" convene a meeting of the OMA's board and consult with members on their priorities for the next round of contract talks in hopes of "reuniting and re-engaging our membership."

Government officials said the pact was also structured to narrow the gaps between specialists like pediatricians who tend to be lower paid than radiologists and others.

The deal was endorsed by pediatricians, anesthesiologists and pathologists, among others, who applauded a provision in the agreement allowing doctors to co-manage the budget for paying physicians and have a strong voice in reforming the system.

"This notion that it's solely the job of government to ensure the sustainability of the health-care system has got to be over," Dr. Danielle Martin of Canadian Doctors for Medicare told the Star last week.

Jacobs countered that doctors are not interested in co-managing a budget they consider to be insufficient, leaving them to "ration" care to patients.

Last week, Progressive Conservative Leader Patrick Brown said he is open to settling contract disputes with doctors using a neutral third-party arbitrator if he is elected premier in 2018.

Previous Conservative leaders have raised concerns about binding arbitration for public sector contracts, saying the system is too expensive for taxpayers.

Rob Ferguson *is a Toronto-based reporter covering Ontario politics for the Star. Follow him on Twitter:* **@robferguson1**.