In the Matter of an Arbitration

BETWEEN:

ONTARIO MEDICAL ASSOCIATION

(the "OMA")

- AND -

MINISTRY OF HEALTH

(the "MOH")

(together, "the PARTIES")

REPLY SUBMISSIONS OF THE ONTARIO MEDICAL ASSOCIATION

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INTRODUCTION

1. The Ontario Medical Association ("OMA") provides the following in response to the Brief submitted by the Ministry of Health (the "Ministry" or the "government") and presented to this Board of Arbitration on May 7, 2024.

2. We would be remiss, however, if we did not note, at the outset, the profound impact the Ministry's submissions have had on physicians generally and on family physicians in particular. While claiming to have the highest regard for the most skilled and most well-trained health care professionals, the Ministry Brief is dismissive of the very real concerns advanced on behalf of the Ontario's doctors by the OMA and, in reality, is dismissive of the very role played by physicians. If the record is not corrected by way of this Reply, the Ministry's assertions may well promote the growing sentiment amongst family doctors to leave comprehensive longitudinal family medicine, and as well result in physicians in other areas of practice, who are working harder without commensurate compensation rate increases, to shift to less demanding work or to leave the profession and/or this jurisdiction to practice elsewhere.

3. In short, the tone and content of the Ministry Brief has only served to further demoralize physicians, and to exacerbate physicians' feelings of burnout, none of which is helpful for physician recruitment and retention.

4. This Reply Brief is intended, in fact, to clarify and correct the record before this Board of Arbitration, and to try to undo the harm inflicted on doctors and, as a result, on Ontarians who are reliant on their services. This Reply Brief will demonstrate that there is a crisis in medicine, that there is a path forward, and that the Board of Arbitration can begin moving doctors along that path to the benefit of all residents of this province.

REPLY TO TAB 1.3: PHYSICIANS CONTRACTUAL RELATIONSHIP WITH THE GOVERNMENT

5. At Tab 1.3 of its brief, the Ministry submits that physicians are not employees but have a contractual relationship with the government, and that their "independent contractor status" benefits them. While the OMA does not dispute the fact that doctors are not employees, it submits that physicians have few if any of the benefits accorded to traditional independent contractors, including most notably the ability to increase their fees in response to inflation and rising expenses.

6. The OMA recognizes that the independent practitioner role of doctors is at the heart of the Medicare compromise. On the one hand, Ontario and Canada have a single-tier publicly funded health care system in which physicians are precluded from billing privately for medically necessary services outside of the public systems; in turn physicians are independent contractors rather than salaried employees.

7. However, at paragraphs 20-32, the Ministry substantially overstates and misrepresents the degree of physician independence and autonomy in the Ontario health care system, ignoring the role played by hospitals, regulatory bodies such as the CPSO, professional and ethical responsibilities and the government itself in overseeing and determining the terms and conditions under which doctors provide their services. The Ministry's submissions ignore, as well, the critical role of the patients themselves in needing, requesting and/or demanding services.

8. In the 2019 Kaplan Arbitration Award, the Chair himself recognized that the government has a great deal of control over which physician services are publicly insured, and to what extent. As the Chair stated, "if the Ministry wishes to limit the insured physician services patients receive, it can readily do so" and that "it is entirely within the purview of the Ministry to delist inappropriate and medically unnecessary services."[1]

[1] Ministry of Health and Long-Term Care and Ontario Medical Association, (February 18, 2019, unpublished) ["2019 Kaplan Arbitration Award'] at p. 8, Tab 1 of OMA's Book of Authorities ["BOA"].

9. The Ministry's assertion at paragraph 22 that physicians "set their own total compensation" is completely false. Physicians, unlike other independent contractors, are unable to determine the fees for their services and normal market forces have no impact on their ability to raise those fees or their compensation. Similarly, hours of work are also set often by others, including hospitals or the terms of non-fee for service agreements (usually with no additional compensation provided where physicians exceed these hours).

10. Under Ontario's Medicare model, market forces are in fact largely replaced by government control when it comes to physician supply, and it is government policy that largely determines the numbers of physicians in the province. Similarly, the government has a large degree of control over the supply of other health care providers in the system, such as Nurse Practitioners, Midwives, Optometrists, and Physician Assistants, whose practices overlap to some extent with those of physicians. As well, as a result of deliberate government policy decisions, Ontario pharmacists can now give flu shots and other injections, refill prescriptions, make therapeutic decisions and prescribe drugs for 19 medical conditions.

11. The government also controls the volume of various physician procedures through the use of Quality Based Procedure (QBP) funding. These procedures include the following:[2]

- Cancer Surgery
- Cataract Day Surgery
- Chemotherapy - Systemic Treatment
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Corneal Transplant
- Degenerative Disorders of the Shoulder

[2] Ministry of Health, "Quality-Based Procedures" (December 14, 2023), OMA Reply Book of Documents ["Reply BOD"], Vol. 1, TAB 1.

- Gastrointestinal (GI) Endoscopy
- Hip Fracture
- Hysterectomy
- Knee Arthroscopy
- Non-Cardiac Vascular - Elective Aortic Aneurysm Repair
- Non-Cardiac Vascular - Elective Repair of Lower Extremity Occlusive Disease
- Non-Emergent Integrated Spine Care
- Pneumonia
- Primary Hip and Knee Replacement
- Stroke
- Tonsillectomy.

12. Effectively, QBP caps the number of procedures physicians can provide in a given time period.

13. Further limitations are imposed by the funding provided by the government for MRIs and CT scans. When the prescribed upper annual limits of hours are reached, MRIs and CT scans are cut back. Physicians are simply not able in these circumstances to offer more of these procedures, since it is the government, through its funding control, which determines the number of procedures that can be performed, regardless of either patient or physician preference.

14. Regulatory colleges also limit physician autonomy and play an important oversight role with respect to many aspects of patient care.

15. There are other system constraints which belie the Ministry's suggestion that physicians have very significant control and discretion over their work. For example, allied health human resource constraints frequently result in delayed and cancelled surgeries despite surgeons and anesthesiologists being available. Physicians are also often constrained in their ability to discharge patients to long-term care beds when no beds are available. Similarly, the ability of family doctors to obtain necessary diagnostic

investigations for their patients, such as biopsies, are often limited by the capacity of hospitals to perform those investigations.

16. Likewise, the government controls how many licenses are available to provide services such as MRIs/CTs, endoscopies, and orthopedic procedures in Integrated Community Health Services Centres (ICHSCs) (formerly Independent Health Facilities). The government has, for many years restricted the provision of new licenses and thereby limited physicians and others from setting up ambulatory care clinics in the community.

17. As well, contrary to paragraphs 22 and 28 of the Ministry's submission, it is a gross oversimplification to state that doctors are free to decide where they work and the hours they work. To provide necessary services, many physicians require access to hospitals and hospital-based equipment, as well as the assistance of other medical professionals, all of which are outside their control. By extension, maintaining critical hospital privileges also requires, amongst other things, that physicians commit to and perform a range of services, complete on call responsibilities etc. The Ministry of Health has also exercised control over physicians by limiting access to the number of new Family Health Organizations ("FHOs") that can be established, or by determining that certain Emergency departments are to be closed or downgraded to urgent care centres. For their part, hospitals base the provision of services on established business cases and implement HHR plans and restrictions, which materially affect and limit the ability of physicians to provide their services, including both procedural and diagnostic services.

18. Furthermore, in response to paragraphs 25-26, the OMA notes that the government can, in fact, indirectly "downsize" the number of working physicians by cutting hospital budgets, and in turn hospital boards can refuse, restrict or revoke physician privileges if there is a "lack of resources" or a "closing [of a] service" or no position available.[3] As well, physicians can have their hospital privileges refused, suspended, restricted or revoked in several other situations such as where there are concerns about competence, capacity or there is a conduct and/or performance review, or if the hospital

[3] Ontario Hospital Association, *Professional Staff Credentialing Toolkit* (September 2021) at p. 100, Reply BOD, Vol. 1, TAB 2.

closes. The CPSO can also revoke a physician's license thereby making them unable to practice medicine.

19. It is clear that there are a myriad of decisions and actors that can have significant financial, reputational, and resource impacts on physicians.

20. At paragraph 29, the government argues that "physicians enjoy a 'supply-based demand.'" There is neither validity nor any evidence cited by the Ministry to support such an argument. No doubt, patients and patient need affect physician autonomy. In fact, physician autonomy is less about making more money or "supply-based demand," and much more about ensuring necessary care is available and provided to meet patient needs and respond to patient concerns and requests. Indeed, in the current context, the suggestion that there are sufficient physicians available to meet patient needs is hardly credible. Moreover, the fact that a physician may work extra hours or provide additional services is typically based on their professional judgement that it is necessary to do so to meet unmet patient needs, and to provide appropriate patient care in a timely manner. Indeed, many physicians might well prefer working set hours with overtime paid when they work outside of normal hours. That is not the reality of their profession or of their professional and ethical obligations. Medicine is a 24/7 occupation; patients need care at all hours.

21. Indeed, the suggestion at paragraph 29 that physicians are advising patients to "undergo investigation, referral or treatment" in order to "contribut[e] to the overall incomes of physicians" is both highly offensive and inaccurate. Physicians are guided by their ethical and professional obligations not, as the government would suggest, improper financial motives. They follow guidelines and professional standards and exercise their experience and professional judgement when caring for their patients. Indeed, while the government brief points to patient convenience as an objective, this can conflict with physician clinical assessment of appropriateness and can also increase the cost to the health care system as a whole.

22. Fundamentally, the Ministry's submissions ignore that the real issue in this arbitration is the price to be paid for physician services and not their global income. Based on how the health system operates, if physicians do not provide services to patients, they cannot bill, and they do not earn any income. Thus, while it is true that the vast majority of physicians are not employees, the government has severely overstated the degree of autonomy physicians have to choose or not choose to perform services.

REPLY TO TAB 1.6: YEAR 1 PRICE INCREASE (THE "70/30") SPLIT)

23. Contrary to the Ministry's submission at paragraphs 43-61 of its brief, this Board must consider both the year 1 economic adjustments required, including catch-up and the general price increases (70% of the year 1 price increase), together with the OMA's submission in support of necessary targeted increases (30% of the year 1 price increase unless the parties agree otherwise). The determination of the year 1 price increase cannot be arrived at without consideration of the funding needed both for general increases and for targeted initiatives.

24. Indeed, the OMA notes that this is the first round of negotiations and arbitration where the OMA is in a position to meaningfully negotiate both general and targeted price and compensation increases free of the shackles of the imperative of seeking to undo previous unilateral action (2017 to 2021) or the constraints of Bill 124 (2021-24).

25. Moreover, contrary to the Ministry's suggestion at paragraph 58 that the targeted increases are merely an extension of the ordinary method for allocating general increases, the OMA is seeking (as addressed at length in its main brief) additional targeted funding, above and beyond the required general increases to the fee schedule (which general increases will then be allocated to each section or physician grouping for Schedule of Benefits adjustments based on a mix of across-the-board increases and relativity considerations). To be clear, these targeted compensation measures are very different than these ordinary allocations of price changes under the Schedule of Benefits. Targeted increases are intended to address systemic needs that require specific dedicated funding in addition to what might be secured through the general increase being sought. In the OMA's submission, it would be inappropriate —as well as wholly inadequate-- for the profession to have to fund these needed targeted investments from the professions' general increases, particularly since these are priority areas where additional funding is needed above and beyond any general increases. Indeed, targeted increases are necessary to address the many areas the government has neglected over the past two decades.

26. The OMA agrees with the Ministry's submission at paragraphs 45 and 61, that the year 1 increase, separate from catch up, must be determined by "taking all factors into account." However, the OMA submits that these factors must include an assessment of the OMA's position that additional targeted compensation increases are fair, necessary and appropriate.

27. Furthermore, the Ministry's submissions at paragraphs 48-55 completely ignore the fact that the setting of individual fees in the Schedule of Benefits results from a bilateral process in which the Ministry is an active and equal partner with the OMA, and where bilateral agreement between the Ministry and the OMA is required.

28. Until the early 2000s, the OMA was largely responsible for allocations of fee increases under the Schedule of Benefits. The OMA Central Tariff Committee (CTC), in consultation with the sections, was responsible for reviewing and updating the Schedule of Benefits to reflect, *inter alia*, changes in practice (e.g., new or different technologies or new or different surgical procedures) and to apply general fee increases to properly reflect the negotiated and allocated increases.

29. The 2004 PSA,[4] however, brought about a major change to this process with the establishment of a bilateral Medical Services Payment Committee ("MSPC"), which was tasked with making recommendations to the parties respecting amendments to the OHIP Schedule (as well as other physician payment mechanisms) to reflect the state of current medical practice and the needs of Ontario's healthcare system. The MSPC process is bilateral, and recommendations are made on the basis of consensus.

30. In September 2008, the parties entered into a new Physicians' Services Agreement[5] ("PSA") that applied a global professional fee increase to the OHIP Schedule, where half of the increase each year was to be allocated to OHIP Specialties based on a relativity methodology agreed to by the parties and the other half of the increase allocated

[4] 2004-2008 Physician Services Agreement between the OMA and MOH, TAB 48 of OMA's Book of Documents ["BOD"] VOL. 2.
[5] 2008 Memorandum of Agreement between the OMA and MOHLTC, TAB 50 BOD VOL. 2.

on an equal percentage basis to each OHIP Specialty. The process was intended to address and correct intersectional disparities within the medical profession in Ontario.

31. From 2012 until the 2017-21 PSA (largely the period of unilateral government action), there was no formal fee setting process (since there were no fee increases to allocate). During that time period, physicians providing new services not listed in the OHIP Schedule of Benefits had to find mechanisms for receiving remuneration which included billing under existing umbrella fee codes, billing under catch-all codes, submitting claims directly to OHIP medical consultants on an independent consideration (IC) basis, billing the patient directly where permitted, or securing payment from other sources such as academic funding for experimental programs. In many cases, the delay in payment adjustment affected the availability of new medical services.

32. In June 2017, the parties agreed to a Binding Arbitration Framework (BAF),[6] which established an independent consensually selected board of arbitration that was given the mandate to determine outstanding issues respecting the content of the 2017-2021 and future PSAs. Following the release of the 2019 Kaplan Arbitration Award, the MSPC was tasked with allocating the permanent fee increases based on the methodology agreed to by the Parties (a hybrid CANDI/RAANI model), with the five top-ranked specialties (Cardiology, Gastroenterology, Ophthalmology, Radiation Oncology and Radiology) "red-circled" (i.e. they were not eligible for any increase given their higher relativity position).

33. The Award also established the Appropriateness Working Group to discuss and recommend evidence informed amendments to payments by eliminating or restricting unnecessary physician services or physician payments.[7]

34. Subsequently, the 2021 Agreement established a new bilateral Physician Payment Committee (PPC) which absorbed the functions of and replaced the MSPC. The mandate of the PPC is to make recommendations on an annual basis to the Physician Services

[6] Binding Arbitration Framework ["BAF"], TAB 37 BOD VOL 1.
[7] 2019 Kaplan Arbitration Award, *supra*, Tab 1 BOA.

Committee (“PSC”) regarding amendments to the OHIP Schedule, as well as flow-through and any other financial changes to non-fee for service contracts and to other programs. In carrying out its mandate, the PPC is directed to take such steps as are necessary to achieve gender pay equity and to address advances in medical innovation/technology. Under the 2021-24 PSA, the PPC was also tasked with recommending the process for implementing each section’s or physician grouping’s allocated compensation increases to the OHIP Schedule, with one-quarter of the increase to be allocated on an equal percentage basis to each section or physician group and three-quarters of the increase to be allocated to each section or physician group based on the hybrid CANDI-RAANI score. These permanent increases took place on April 1, 2023 for years 1-2, and it is expected that they will be implemented prospectively on April 1, 2025 for year 3.

35. For each of the 2008 PSA, 2017 Kaplan Award and 2021 PSA MSPC/PPC fee allocation processes and, accordingly, the amount of funding available to each section or physician group has been stipulated in Agreement or Award and included a portion of the increase going equally across each section or physician group and a portion of the increase going to each section or physician group based on the methodology agreed to by the Parties (e.g., hybrid CANDI/RAANI model). Sections and physician groups have therefore been required to prioritize their fee proposals such that their full submission fits within their individual funding allocation, taking into consideration potential increases to cross-over fees i.e. those billed both by their members and other specialties that may impact their overall allocation.

36. However, contrary to the implication or suggestion in the Ministry brief that the OMA somehow has acted in a “sophisticated” way to game the system to the advantage of the profession, all of these changes and allocation to fees under the Schedule of Benefits have been made bilaterally on agreement by the both the Ministry and the OMA, and any disagreement between the OMA and Ministry over any of these allocations would be resolved by binding arbitration.

37. It is, again, offensive, but consistent with the entire theme underlying the Ministry brief, to suggest that a bilateral process ending in binding arbitration would or could be used to subvert or game the fee allocation process.

38. Furthermore, contrary to the Ministry's submission at paragraph 49 that the OMA determined in some cases that there were fees "not deserving of a fee increases", the reality has been that the 2017 Award and the 2021 PSA increases provided insufficient funding to increase all fees and required that sections and physician groups selectively target services identified as a priority by their members. There simply was not enough funding to apply any meaningful across-the-board increases to all fees. Indeed, some sections, including Anesthesiology and Ophthalmology, elected to cut some fees and to re-invest the savings to address priority areas identified by their members.

39. For example, at paragraph 53, the government highlights that the fee for a Papanicolaou Smear increased by 38%, whereas other fees increased by zero. Far from inappropriate, the decision to increase the fee for a Pap smear from $8.65 to $12.00 was based on consideration of such factors as time, intensity and relativity and a recognition of the need to incentivize the provision of this life-saving screening test. According to the Ontario Cancer Screening Performance Report, 2023, while the Ontario Cervical Screening Program Target is to screen 80% of eligible females, only 54.5% of eligible females were screened in 2019-21.[8] Thus, the fee increase for this service was much needed and entirely appropriate and was also a step in the direction of gender pay equity.

40. The fact is that the both the MSPC and now the PPC rely on core principles to establish a fee value and make recommendations on a joint OMA/Ministry consensual basis. The key criteria elements considered when evaluating a fee proposal include time, intensity and relativity to comparable codes. The following table describes each criteria element.

[8] Cancer Care Ontario, *Ontario Cancer Screening Performance Report 2023: Special Focus: Equity in Cancer Screening* at p. 89, TAB 3, Vol. 1, Reply BOD.

Criteria Element	Description
Time	Physician total time taken (pre-, intra- and post-service) by a typical physician to provide the typical service.
Intensity	Intensity of the service provided (1) Knowledge and judgment (2) Communications and interpersonal skills (3) Technical skills (complexity of the service) (4) Risk and stress
Relativity	Fee relativity with comparable services.

41. For each of the above criteria, the "*Averaging Principle,*" which evaluates each fee to reflect the work provided by the typical physician in the typical case, is also used.

42. When evaluating a fee proposal, the Committee uses information gathered from the Professional Fee Assessment Form (PFAF). Some key aspects contained in the form include:

- Description of the service
- Physician time required to perform the service
- Intensity of the service provided
- Relativity with similar services.

43. In addition, the committee has invited sections and physician groups to present their fee proposals and provide a narrative overview in support of their proposals. However, to reiterate, at the end of the day, any changes are made bilaterally, on agreement between the OMA and Ministry, and if there were disagreement by arbitration. To suggest that any of this results in some kind of fee-rigging by the OMA is completely unwarranted.

REPLY TO TAB 1.7: THE MINISTRY'S POSITION ON CATCH-UP

44. The OMA totally rejects the Ministry's position at paragraph 62, that this Board should award an increase of only 3% in year one and that there is no basis for "catch up." To the contrary, for the reasons set out in the OMA main brief and in oral argument (which the OMA will not now repeat), a 22.9% increase for Year 1 is needed and entirely justifiable. To reiterate, this increase includes a 10.2% increase in respect of catch-up, a 5% general price increase for 2024-25, and a 7.7% increase for additional targeted funding.

45. In the sections that follow, the OMA will reply to the Ministry's arguments that there is no issue with recruitment, retention, and physician supply. The OMA will describe the positive impact that increased compensation would have on recruitment and retention, suggest appropriate comparators, and describe the impact of patient complexity on compensation, among other factors. It is essential to note at the outset, however, that the Ministry's submissions fail to address or even take into consideration the overwhelming and compelling evidence of increasing intensity and patient complexity, as well as the undisputed evidence that family physicians are choosing to move out of comprehensive longitudinal care (from a high of 77.2% in 2008 to 65.1% in 2022),[9] contributing to an undeniable unattached patient crisis. The Ministry's brief is founded on a total failure to recognize or acknowledge that there is a crisis in medicine in this province which results in a fundamental inability or unwillingness of the government to use this arbitration process as one of the ways to begin to address this crisis.

46. At paragraph 63, the government argues that there is no basis for physicians to receive any catch up for the 2021-2024 period since Bill 124 did not apply to physicians and there were no restrictions on physician bargaining. The OMA submits that this

[9] Premji K, Green ME, Glazier RH, Khan S, Schultz SE, Mathews M, Nastos S, Frymire E, Ryan BL. Characteristics of patients attached to near-retirement family physicians: a population-based serial cross-sectional study in Ontario, Canada. BMJ Open. 2023 Dec 7;13(12):e074120. doi: 10.1136/bmjopen-2023-074120. PMID: 38149429; PMCID: PMC10711930, TAB 12, Vol. 1, BOD; K Premji, ME Green, RH Glazier, S Khan, SE Schultz, M Mathews, S Nastos, E Frymire, BL Ryan, Pandemic-era trends in patient attachment to an aging comprehensive family physician workforce in Ontario, Canada, TAB 4, Vol. 1, Reply BOD.

argument must be rejected and is one of form over substance. As submitted in the OMA main brief and in oral argument, Bill 124 significantly and materially informed and constrained bargaining and mediation, and any potential arbitration. Bill 124 also profoundly impacted the considerations of the membership during ratification. The impact of Bill 124 on the 2021-24 PSA was overwhelming; Bill 124 was not just a ghost at the bargaining table, but a dominant and overwhelming presence.

47. As to the year 3 construct, it simply reflected an agreement by the parties to determine price increases based on a consideration of the difference between what government calculated would have been spent but for COVID-19 in Year 3 and its actual expenditures, assuming the historic rate of utilization applied. As it turned out, because of, *inter alia*, unexpected population growth and delayed treatment during the pandemic, expenditures were ultimately much higher than had been anticipated by either party, leading the parties to agree to a 2.8% increase for Year 3. Nonetheless, the total price/compensation rate increase of 4.8% over the term of the 2021-24 PSA was profoundly affected and limited by Bill 124.

48. Now that Bill 124 has been found to be unconstitutional and has been repealed, various other health and broader public sector groups in the province, and particularly in the hospital sector, which the Ministry brief completely ignores, have negotiated or have had awarded significantly higher retroactive wage increases for the Bill 124 restraint years. These are compelling and significant changed circumstances that this Board must address by way of awarding the OMA's catchup request.

49. In addition, as outlined in our main brief, there is also compelling support for further catch-up price increases, above and beyond the impact of Bill 124 and inflation over the 2021-24 period, based upon the historic erosion of the price for physician services over the 2012-2021 period.

50. Furthermore, contrary to the Ministry's submissions at paragraph 63, the OMA is not seeking a Bill 124 reopener, which would entail a retroactive payment in respect of the 2021-24 period. Indeed, unlike every other health sector group in the province who

did receive Bill 124 retroactivity, the OMA accepts that this board cannot award retroactive payments in respect of the 2021-24 Bill 124 restraint years. Nevertheless, this Board is entitled to take into consideration the savings which the government has realized by the fact that there will not be any Bill 124 retroactivity payments to physicians when considering the amount to be awarded for Year 1 of the 2024 PSA.

51. Indeed, the government has had the benefit of those savings, and the OMA will never be able to recover those retroactive amounts for each of the years 2021-22, 2022-23 and 2023-24. Even assuming only an average of an extra 3% each year, the year over year cash-flow savings to government amounts to approximately 480 million dollars in year 1, a further 960 million dollars in year 2, and a further 1.44 billion dollars in year 3. This is the scope of the compensation losses to the profession, and compensation and funding savings for the government, resulting from the actual and very real practical impact of Bill 124 on the 2021-24 PSA.

52. Of course, the OMA has, for the reasons articulated in its main brief, proposed a 10.2% catch-up increase to match inflation, and to take into account other realities, including the losses suffered by the profession over the period 2012-2017, the reality of the context of the 2017-21 PSA, and the recruitment and retention and other challenges facing the medical profession.

53. At paragraphs 5 and 172 of its submissions, and elsewhere, the government also submits that Ontario Public Service (OPS) bargaining units, such as AMAPCEO and OPSEU, are appropriate comparators for the purpose of determining normative increases. The OMA simply notes that while the Ministry proposes the validity of that comparator for year 1, they conveniently ignore the fact that those same OPS groups received increases of 3%, 3.5% and 3% for the Bill 124 period which, if these are comparators as the government asserts, logic and fairness compels a consideration of what those groups ultimately received in the Bill 124 restraint period. Of course, for the reasons set out by the OMA in its main brief, the OMA submits that those OPS groups are much less relevant as a comparator than the hospital sector outcomes, where the

reopener awards were significantly higher, and included significant increases to address various health sector challenges in the hospitals including recruitment and retention.

54. Since the OMA's main brief was filed, there has been another health sector arbitration award of note. In *Participating Nursing Homes v Ontario Nurses' Association*, a central mediated consent award for nurses in nursing home/long-term care sector, the board awarded increases of 3% across the board in year 1. However, prior to the ATB being applied, a 5.5% increase was to be applied to each step of the grid, amounting to 8.5% in 2024-25 and then a further 3% in 2025-26, for a total 11.5% increase, and 11.9% compounded over those two years.[10] Notably, in the previous three years collective agreement, these nurses only received 1.75% each year. As a result, the ONA outcome provides for a substantial degree of catch up (albeit unlike other Bill 124 groups not retroactively), similar to what the OMA seeks in the present arbitration.

[10] *Participating Nursing Homes v Ontario Nurses' Association*, 2024 CanLII 44468 (ON LA), TAB 1, Reply BOA.

REPLY TO TAB 5: REPLICATION

55. At Tab 5 of their submissions, the Ministry references the arbitral principle of replication, referring, *inter alia*, to Paul Weiler's 1981 award for *65 Participating Hospitals and CUPE*.

56. While the OMA agrees that replication is a fundamental arbitral principle, it submits that the government has ignored the most relevant aspects of the 1981 Weiler award, namely his finding that replication includes protecting against inflation and providing real income gains. As he explained:[11]

> The ideal towards which interest arbitration aims is to replicate the results which would be reached in a freely-negotiated settlement. The negotiators at the bargaining table typically work towards a figure which will protect the worker against unanticipated inflation and provide real income gains to the extent these are permitted by rising productivity in the economy.

57. Consistent with this recognition, Weiler awarded a 12% increase in the first year and 24.8% increase overall, in order to "offset developing inflation." Similarly, the OMA submits that replication requires this board to offset inflation while also providing real price increases above and beyond inflation, including in Year 1 of the 2024-28 PSA gains.

58. Furthermore, the OMA submits that, contrary to the suggestions at paragraphs 84-89 of the Ministry's brief, replication does not require that demonstrated need be established in the context of seeking catch up and normative increases based on comparability. Rather the concept of demonstrated need is relevant to situations where something new or different is being proposed, most often arising in the context of non-monetary breakthrough proposals. As the Board explained in *Waterloo (City) v Waterloo Professional Fire Fighters Association Local 791, International Association of Fire Fighters*:[12]

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[11] *65 Participating Hospitals and CUPE, Re* 1981 CarswellOnt 3551 (Weiler) at para. 8, TAB 2 Reply BOA.

[12] *Waterloo (City) v Waterloo Professional Fire Fighters Association Local 791, International Association of Fire Fighters,* 2017 CanLII 57688 (ON LA), TAB 3 Reply BOA; see also *Ajax Professional Firefighters Association and Ajax (Town of)*, 2013 ONSC 7361, TAB 4 Reply BOA.

> [T]he requirement to show a demonstrated need for a change in the collective agreement applies primarily to those situations where the issue involves an emerging trend or a matter which is not addressed in the collective agreement; it does not apply, or is far less applicable, to situations where the change is justified by comparability.

59. Similarly, as the Board explained in *Independent Electricity System Operator v The Society of United Professionals*:[13]

> [T]he easier it is to characterize a proposal as the norm, then the more relevant comparability becomes and the less a party will be required to establish a demonstrated need. However, deviation from the norm makes establishing a demonstrated need that much more relevant and necessary for the party seeking such change.

60. In the present context, OMA's proposals for catch-up and general increases are focused on replication and comparability, the imperative to offset inflation and the challenges facing the medical profession including but not limited to recruitment and retention.

[13] *Independent Electricity System Operator v The Society of United Professionals*, 2023 CanLII 19309 (ON LA), at para. 33, TAB 5 Reply BOA.

REPLY TO TAB 6: RECRUITMENT AND RETENTION

61. At Tab 6 of its brief, the Ministry submits that "the recruitment and retention of physicians is not an issue" and that, as a result, this case is distinguishable from other recent health sector arbitral awards where recruitment and retention led to higher compensation increases.

62. This submission has been met with dismay and disbelief by OMA members, the media, and the public, shocked by the disconnect between the government's stated position in this arbitration hearing and the reality on the ground.[14] Contrary to the government's position, the OMA submits that recruitment and retention of physicians is a significant and growing issue. Respectfully, the government's analysis on this issue is wrong, belied by its own evidence, and lacking in any depth or understanding of physician workforce issues, capacity, or planning, and of specialty, regional, or demographic variations in population healthcare needs. As well, for family medicine, the government's analysis fails to take into consideration the undisputed evidence that the practice of comprehensive longitudinal care is on the decline, significantly contributing to the ongoing and growing unattached patient crisis.

63. In reply, the OMA reiterates and relies on its extensive submissions at part seven of its brief (pages 83-108 and paragraphs 235-296) on physician recruitment and retention. This evidence of a physician shortage crisis includes the following:

- Ontario still has a significant surgical backlog (paragraph 21).
- Wait times for priority procedures have increased in the post-pandemic period (paragraph 24).
- Ontario has an estimated shortage of 2,033 physicians (paragraph 243).

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[14] Barbara Patrocinio, "Ontario family physicians call for health minister's resignation," *QP Briefing* (May 13, 2024), TAB 5, Vol. 1, Reply BOA; Mohammed Adam, "Adam: It's ridiculous for Ontario to say it's not worried about 'diminished' supply of doctors," *Ottawa Citizen* (May 14, 2024), TAB 6, Vol. 1, Reply BOD; Ontario Legislature Hansard (May 14, 2024 Question Period: Marit Stiles to Nolan Quinn (PA, minister of Health): "The Minister of Health said that recruitment and retention of family doctors was "not a major concern." I want to say that again: "not a major concern." A quarter of patients in the Soo are without a family doctor. That's not a major concern for this minister? Some 30,000 patients in Kingston are without access to primary care—not a major concern?", TAB 7, Vol. 1, Reply BOD; David Helwig, "Shoemaker blasts province over doctor shortage," *Soo Today* (May 14, 2024), TAB 8, Vol. 1, Reply BOD; Isaac Callan & Colin D'Mello, "'Fire that minister': Ontario NDP calls on Ford to sack minister of health," *Global News* (May 13, 2024), TAB 9, Vol. 1, Reply BOD;

- Physician job vacancies have increased in the post-pandemic period (paragraph 249).
- 2.3 million Ontarians do not have a regular family doctor (paragraph 272).
- Attrition rates of physicians have increased in the post-pandemic period (paragraph 270).

64. Below, the OMA further addresses all the Ministry's recruitment and retention arguments regarding the number of medical students and residents, overall growth in family physician numbers relative to population, and the use of allied health professionals.

65. Just as in other recent health interest arbitration awards, recruitment and retention **is** a significant concern at present and the OMA submits that price/compensation increases should reflect this on the ground reality.

A. Ministry's Own Data Shows Evidence of Physician Shortages

66. As a starting point, it is worth highlighting that even some of the Ministry of Health's own documents are inconsistent with the position set out in the Ministry's brief and in fact support the OMA's position.

67. Prior to the second day of the hearing between the parties, the OMA requested a production order for documents that were the subject of a recent Freedom of Information ("FOI") request and order, as well as any other documents regarding physician shortages in the province.

68. Notably, according to the Order of the Information and Privacy Commissioner dated April 16, 2024, counsel appearing on behalf of the Ministry opposed the release of these documents in the context of the FOI request because "the disclosure of the withheld information would very likely be used by the OMA in upcoming negotiations to negotiate increases in physician billings through higher payment rates under OHIP, based on the economic principles of supply and demand", and because "It is reasonable that this information could be used by employees in government funded positions and/or their associations to achieve higher wages from the ministry, based on the economic principles of supply and demand, either through the collective bargaining or arbitration processes." This submission was in turn accepted by the decision-maker who accepted that "if the

withheld information relating to physicians is released it would be reasonable to expect it to be used by the OMA in upcoming negotiations to attempt to increase physician billing based on the economic principle of supply and demand."[15]

69. Indeed, the disclosed documents confirm physician shortages in various areas and throughout the province. For example, according to the *Health Human Resource Overview, May 2022,* the Ministry states that there is a need for "more family physicians and certain specialties like emergency medicine & anesthesia" and that there is a shortage of physicians generally in "rural, northern and remote" regions."[16] Furthermore, the data discloses that, with respect to Family Physicians, population growth is continuing to outpace the family medicine growth rate and the problem is only going to get worse. For example, whereas population growth was 1.6% in 2022 and the growth rate for family medicine physicians was 1.4%, by 2032 the population growth rate is projected to be 1.1% but the growth rate for family medicine physicians is projected to be only 0.5%. As the Overview recognizes, "family medicine growth [should] rest at or slightly above the population growth," not consistently under population growth as it has done for years.

70. Notably, the Ministry focus solely on the headcount of physicians categorized as "family physicians" itself fails to distinguish between those practicing focused family medicine in various "specialty" areas, as opposed to comprehensive, longitudinal family medicine where the need is increasingly dire.

71. The OMA further submits that the Ministry's projections significantly understate the real scale of the problem as they fail to take into consideration increasing complexity of care across the health care system generally, and, as we must repeat, in the case of family medicine, the fact that both new and established family physicians are increasingly choosing not to practice comprehensive longitudinal care (both discussed below).

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[15] *Ontario (Health) (Re),* 2024 CanLII 35289 (ON IPC), at paras. 18, 28, 53, and 61, TAB 10, Vol. 1, Reply BOD.
[16] Ministry of Health, *Health Human Resources Overview, May 2022,* at p. 3, TAB 11, Vol. 1, Reply BOD.

72. As well, according to the Ministry of Health's own "Physician Workforce Evidence & Analytical Modelling" Report from 2022, the problem is growing[17] and there are currently and will be physician shortages in multiple areas by 2030. Notably, in contrast to the Ministry's submission before this Board of Arbitration, this report recognizes that a growing and aging population presents additional health care complexity issues. As the report concludes, between 2020 and 2030, "Ontario population will increase by 13.2% from 14.8 million to 16.8 million" and that the "75+ population will increase by 54.3% from 1.1 million to 1.7 million" with "[s]eniors aged 75+ and infants [being] the highest cost users of the Ontario health system."[18]

73. While supportive of the OMA's position, as outlined in its main brief, on recruitment and retention, the same report itself notes its own limitations. For example, to arrive at its projections, "[d]emand at the base year (2020) was assumed to be zero, which may not accurately reflect the situation on the ground." As set out at paragraph 243 of the OMA's brief, this assumption results in a severe understatement of the estimated future shortage of physicians, given that as of 2021 there was already an estimated shortage of 2033 physicians in the province.

74. While the Ministry's own report finds that population growth will outpace the supply of physicians in 2030 by around 590 physicians (1.54%) (assuming a shortage of zero physicians in 2020), when one considers these findings by specialty and area of practice, the results are more concerning than even that one number would suggest.

75. Notably, the report projects physician shortages in the following practice areas by 2030 (assuming no shortages as of 2020, which as noted is a faulty assumption):

- Family Medicine – shortage of 429 family physicians or 2.6%
- Anesthesiology – shortage of over 300 anesthesiologists or 18.24%

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[17] Ministry of Health, "Physician Workforce Evidence & Analytical Modelling" Capacity & Health Workforce Planning Branch Nursing & Professionals Practice Division, November 2022, ["Physician Workforce Report"] TAB 12, Vol. 1, Reply BOD.

[18] Ibid. at p. 77

- Diagnostic Radiology – shortage of 160 diagnostic radiologists or 12%
- General Surgery – shortage of 64 general surgeons by 2030 or 7.6%
- Cardiac Surgery – shortage of 9 cardiac surgeons or 8.6%
- Internal Medicine – shortage of 287 or 7.2%
- Nuclear Medicine – shortage of 14 or 9.8%
- Obstetrics/Gynecology – shortage of 76 obstetricians/ gynecologists or 6.2%
- Ophthalmology – shortage of 95 ophthalmologists or 16.1%
- Orthopedic Surgery – shortage of 37 orthopedic surgeons by 2030 or 5.2%.

76. The report also finds that there "is significant unmet need for psychiatrists and mental health services across Ontario" and that between "2018 and 2019 the number of psychiatrist attritions increased by 80.7%."

77. Similarly, the report highlights that "Ontario is experiencing service disruptions in emergency departments" and that the "lack of physician staffing is...a key issue." These conclusions are consistent with and support the OMA's submissions at paragraphs 285-290 of its brief.

78. Other troubling trends are also noted, such as the "very high" and indeed growing number of anesthesiologists choosing to leave Ontario to practice elsewhere. As has been noted, a "shortage of an[e]sthesiologists...can have an outsized impact on patients and the ability to delivery medical services" by resulting in surgeries being postponed or cancelled.[19]

79. Thus, in addition to the evidence in the OMA's brief, the government's own data and reports, which it did not reveal even existed until pressed by the OMA, are inconsistent with its unsupportable position that "recruitment and retention of physicians is not an issue."

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[19] Carly Weeks, "Canada faces critical anesthesiologist shortage, causing backlog of surgeries" *Globe and Mail* (August 23, 2023), TAB 13, Vol. 1, Reply BOD.

B. Applications to Medical School and Residency CaRMS Data are a Red Herring

80. At paragraphs 105 to 115 of its brief, the Ministry submits that there is no problem with recruiting doctors because there are significant numbers of applicants to medical school relative to available spots, because many applicants choose Ontario for residency, and because Ontario fills its residency positions.

81. These submissions ignore the reality of the current physician workforce crisis and have limited to no bearing on the compensation issues currently being arbitrated in 2024, given that it takes a minimum of six years following an undergraduate degree to train a family doctor (which includes the medical school program and residency training), and at least nine years following an undergraduate degree to train a specialist physician. Indeed, the number of applicants to medical school tells us nothing about current recruitment and retention problems for *physicians* given that they will not be available to address shortages until one to two PSAs down the road.

82. The Ministry points to the number of applicants to medical school as somehow being a measure of the appropriateness of physician compensation today. While the OMA cannot fathom how that can be considered to be an appropriate measure of the need for compensation increases for established physicians, as a percentage of population aged 20-24 (a significant source of the medical school applicant pool), the number of applicants has actually remained flat or is even somewhat down since 2015.

Year	Pop Age Group 20 to 24	Ottawa	Queens	U of T	McMaster	Western	NOSM	Total Applicant	% of Pop
2015	948,922	4,298	4,683	3,488	5,270	2,479	2,132	22,350	2.4%
…									
2022	1,034,147	4,962	5,131	4,302	5,228	2,415	1,710	23,748	2.3%

83. To the extent that the number of undergraduate medical school spots is increasing by approximately 260 spots, it is worth noting that ground (metaphorical or actual) has not been broken yet on new medical schools. As noted, it takes a minimum of 6-7 years for the first cohort of new medical students (from whatever year they begin training) to

become family physicians, and an average of 9-10 years for the first cohort of new medical students (from the year they begin their training) to become specialists. It is also worth noting that new residency positions (449 by 2028/29) are in and of themselves less than the government's own estimate of the extent of the shortage of physicians in Ontario -- 590 physicians by 2030 -- even before increasing complexity and other factors are taken into consideration. Moreover, the OMA contends that its estimate of physician shortage is much more realistic: 2033 physicians (see paragraph 243 of the OMA's brief). It must also be recognized that, in order to prepare these new residents for practice, current physicians will need to devote more of their time to education, mentorship and teaching, taking them away from needed clinical time.

84. The OMA further submits that the Ministry's argument that Ontario is the province of choice for residency is flawed; Ontario merely has the most options available for potential residents. For example, when an applicant at Western doesn't match to Western, they can choose numerous other options within the same province. In Manitoba, Saskatchewan, British Columbia, Nova Scotia, and Newfoundland, there is literally no other in-province option, so obviously those numbers would be lower.

85. As well, according to the Ministry's own documents disclosed to the OMA, their data on filled residency spots combines both Canadian Medical Graduates (CMG) and International Medical Graduates (IMG). As the Ministry explains, "[t]o support Ontario's expansion and increase the role of IMGs in our training system, the ministry blended the 2nd iteration of the match. This opened more positions to IMGs."[20] Thus, as a result of this policy change, all positions unfilled after the first iteration are now blended into a single stream for the second iteration so that there is no longer a separated stream for IMGs. In other words, the second iteration is now easier to fill as it includes both CMGs and IMGs. As the following chart from the Ministry reveals, there have in fact been decreasing numbers of CMGs accepting Ontario residency spots and an increasing

[20] Ministry of Health, "Embargoed until May 5, 2023: ISSUE: To provide a summary of the results of the Canadian Medical Resident Matching Service (CaRMS) 2023 second iteration match," TAB 14, Vol. 1, Reply BOD.

reliance on IMGs 2023 to fill them. In fact, 2023 saw the most IMGs filling spaces and the lowest number of CMGs.[21]

	Ontario UG Graduating and PG CMG & IMG (MOH Funded)					Match Results			Ontario CMG Unmatched		
Year	MCU Funded Seats (Ontario Medical UG)	Ontario CMG Resident Positions	Ontario IMG Resident Positions	Total Positions Offered by Ontario	Ontario UG to PG Ratio	Filled by CMG	Filled by IMG	Vacancies (unfilled) Ontario Positions	Unmatched Current Year Graduates	Unmatched Previous Year Graduates (1)	Total Unmatched After Second Iteration
2023	952	1038	210	1248	1 : 1.09	962	286	0	15	16	**31**
2022	952	988	200	1188	1 : 1.04	973	200	15	4	6	**10**
2021	952	988	200	1188	1 : 1.04	984	200	4	10	5	**15**
2020	952	988	200	1188	1 : 1.04	978	201	9	8	7	**15**
2019	952	988	200	1188	1 : 1.04	983	200	5	7	2	**9**
2018	952	988	200	1188	1 : 1.04	986	200	2	32	21	**53**
2017	952	988	200	1188	1 : 1.04	975	211	2	35	18	**53**
2016	952	988	200	1188	1 : 1.04	984	202	2	19	29	**48**
2015	952	1,009	201	1210	1 : 1.06	1000	209	1	17	21	**38**

86. As well, if one looks solely at first choice same school match, Ontario schools do not do as well as schools in other provinces and that it is only the second choices within the same province that puts Ontario near the top:

2023 R-1 Main Residency Match - first iteration

Table 29: Match results by school of graduation

Province	School of graduation	Participants matched	Matched to same school	Matched to other school in same province	Matched out of province	% Same School
Newfoundland	Memorial University of Newfoundland	73	45	0	28	62%
Nova Scotia	Dalhousie University	113	76	0	37	67%
Quebec	Université Laval	233	142	84	7	61%
Quebec	Université de Sherbrooke	174	94	72	8	54%
Quebec	Université de Montréal	274	179	89	6	65%
Quebec	McGill University	164	81	30	53	49%

[21] Ministry of Health, "CaRMS Table Historic," TAB 15, Vol. 1, Reply BOD.

Ontario	University of Ottawa	161	61	62	38	38%
Ontario	Queen's University	104	28	39	37	27%
Ontario	NOSM University	63	11	33	19	17%
Ontario	University of Toronto	254	144	66	44	57%
Ontario	McMaster University	193	68	89	36	35%
Ontario	Western University	171	61	79	31	36%
Manitoba	University of Manitoba	105	75	0	30	71%
Saskatchewan	University of Saskatchewan	98	52	0	46	53%
Alberta	University of Alberta	156	96	20	40	62%
Alberta	University of Calgary	137	66	19	52	48%
BC	University of British Columbia	270	173	0	97	64%

87. Thus, what the government is pointing to as the evidence that Ontario is an attractive choice for residency program applicants, is in reality, *inter alia*, merely a result of the absolute number of positions in Ontario being the highest in the country and the policy decision to combine CMGs and IMGs into the same pool at the second iteration.

88. With respect to the CaRMs data referenced at paragraphs 113-114 of the government brief, the OMA submits that the fill rates for the four regions are not significantly different from one another (i.e. 99.8% is not meaningfully different from 99.2% or even 97%, in terms of highlighting Ontario's "superior ability" to attract medical students to residency programs), save perhaps for Quebec where there are language requirements that may explain a lower fill-rate, as acknowledged by the government itself at paragraph 109.

89. Furthermore, available CaRMS data for the last 5 years by region show that there is little fluctuation in fill-rates within each region year-to-year, and no meaningful difference in fill-rates between the regions, except for Quebec for the reasons noted. Excluding Quebec, the fill-rates for all regions over the last 5 years have been 97-100% and, in several cases, the fill-rates for other regions have been higher than Ontario's, but the OMA would submit not meaningfully different.

90. Thus, for all of these reasons, the OMA submits that the data presented at paragraphs 105-114 of the Ministry brief does not support the Ministry's claims, and in any event is completely irrelevant to meaningfully understanding current physician recruitment and retention challenges, and to determining appropriate compensation increases for established physicians for Year 1 of the 2024-28 PSA, having regard to the various considerations the OMA has submitted are relevant and controlling.

C. Population Growth Relative to the Number of Physicians is a Crude Measure of the Need for Physician Services

91. At paragraph 103, the Ministry further submits that there is no recruitment and retention problem because the growth in the total number of physicians outstrips population growth. In support of this point, the Ministry points solely to the number of family physicians, focusing in paragraph 115 on the projected number of family physicians in 2023-24. Neither the source of the population data nor of the family physician numbers is cited.

92. In fact, the Ministry's chosen measure (physician to population ratio) is a very crude measure of need for physician services and should not be used to determine the adequacy of physician supply in meeting the healthcare needs of the population. This ratio fails to account for such considerations as the diversity of patient care needs in an aging population with increasingly complex care needs and other patient need factors. Furthermore, physician-to-population ratios do not account for the many necessary activities in addition to clinical practice expected of, and engaged in, by physicians. These include teaching, administration, research, leadership roles, supervision or mentorship, and the burden of paperwork and administration. Nor does the overall physician-to-

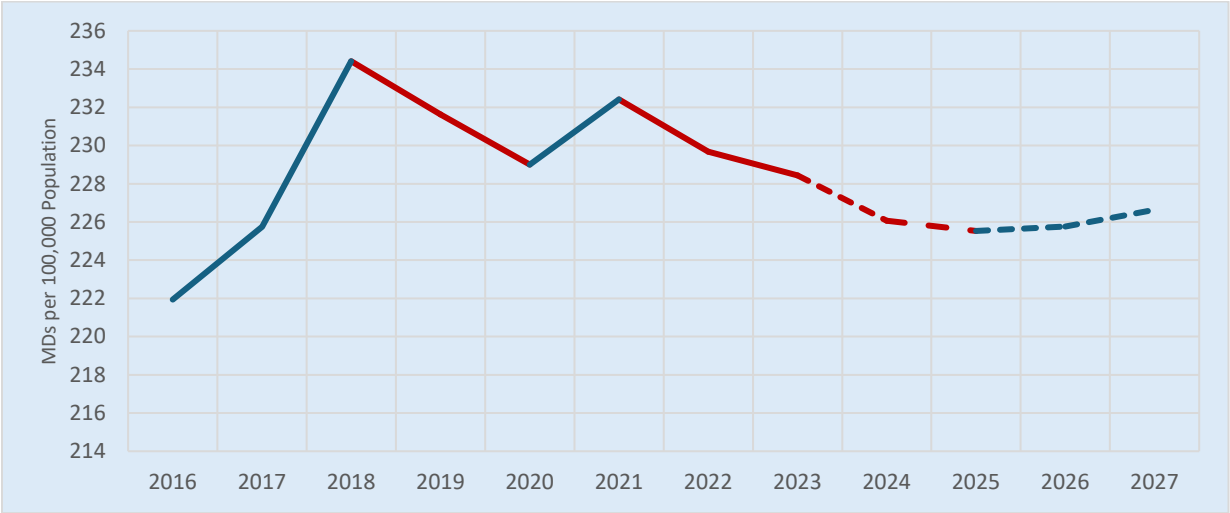
population ratio account for variation in population needs for different kinds of doctors (e.g. family physicians, pediatricians, gynecologists, etc.) at different points in time. Indeed, the Ministry itself recognizes some of the limitations with this measure in its "CIHI Release of Health Information 2021 Report" where it states at section 3 that "physician to population ratios do not consider many important factors such as the specific health needs of the population, the amount and type of services provided, and the geographic distribution of providers and patients."[22]

93. As the Ministry's comments recognize, looking solely at the number of physicians is an oversimplification that ignores highly relevant factors when determining the need for physicians, and the need for compensation increases for physicians. An increase in numbers of physicians, or even an increased rate of growth compared to population growth, is only one data point or metric. It reflects a "headcount" measure that does not take into account how many or what kinds of physician services are provided, where, when, and to whom. It fails to consider the population's current healthcare needs, which have increased in both volume and complexity, with a growing, ageing population, Ontario's welcoming of more international migration every year, and the evolving, specific and unique healthcare needs that physicians are expected to meet and service. Put bluntly, there is no way to match physicians to population on a mathematical basis without accounting for the complexity and other issues resulting from a growing, ageing and diverse population in this province.

94. As well, even using the government's measures, the number of physicians has not outpaced population growth, and the physician to population ratio in Ontario has worsened in the post-pandemic period, as is evident in the following table, based on CIHI and Statistics Canada data:[23]

[22] Ministry of Health, "CIHI Release of Health Information 2021 Report" at section 3, TAB 16, Vol. 1, Reply BOD.

[23] Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2022 — Historical Data. Ottawa, ON: CIHI; 2023; Statistics Canada, CANSIM Table 17-10-0009-01



95. Furthermore, as referenced above, even the Ministry itself has recognized in the disclosed *Health Human Resources Overview* document that there are physician shortages in various regions and specialties, and that population growth will in fact outpace physician supply in coming years.

96. Additional evidence of physician shortages is set out in detail at tab 7 of the OMA brief. This evidence is consistent with other independent reports, such as a report from RBC, which found that Canada currently has a shortage of 16,800 doctors and that without changes to working conditions, this will rise to 43,900 by 2028, 72% of which are family doctors.[24]

97. This shortage of physicians is also acute in areas such as Northern Ontario, which is currently actively recruiting to fill 384 full time vacancies, of which approximately 200 are for full time family physicians. Forty percent of Northern Ontario's family physicians are rural generalist family physicians (compared to Southern Ontario where the percentage is <5% (OMA 2021)) and 110 of the full-time equivalent vacancies are in rural settings.[25]

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[24] Ben Richardson, Yadullah Hussain, Naomi Powell, "Proof Point: Canada needs more doctors—and fast," RBC (November 23, 2022), TAB 17, Vol. 1, Reply BOD.
[25] Northern Ontario School of Medicine University, "Physician Workforce Strategy," TAB 18, Vol. 1, Reply BOD.

98. Notably, the Ministry submissions also focus solely on the number of family physicians, ignoring the countless other specialties where, as even the Ministry itself acknowledges in the disclosure documents cited above, there are supply and capacity challenges most acutely in psychiatry/mental health, anesthesia, obstetrics, emergency medicine, internal medicine and surgery.

99. Equally significantly, as the OMA has stated repeatedly, with respect to family medicine, mere headcount is not a useful metric, since it ignores increasing patient complexity, and the declining number of physicians practicing comprehensive longitudinal care is ignored. While the Ministry's data at paragraph 115 may show an increase in the total number of GPs from 2016-2023 of 14.2% (compared to population growth of 13.4%), when one breaks down those numbers to look at what these GPs are doing, as set out in the following chart, the number of physicians practicing comprehensive longitudinal care in a Patient Enrolment Model (PEM) has grown by only 7%, well below population growth.

	2016	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**% Change**
FFS - Non-descript	2,600	2,639	2,738	2,822	3,025	3,503	3,488	3,400	**31%**
GP Emerg	1,538	1,584	1,643	1,694	1,666	1,747	1,795	1,841	**20%**
Area of Focus	1,443	1,480	1,553	1,627	1,552	1,479	1,509	1,628	**13%**
Specialized Model	128	142	154	165	178	216	242	256	**100%**
PEM	8,736	8,926	9,024	9,083	9,123	9,189	9,232	9,332	**7%**
TOTAL	**14,445**	**14,771**	**15,112**	**15,391**	**15,544**	**16,134**	**16,266**	**16,457**	**14%**

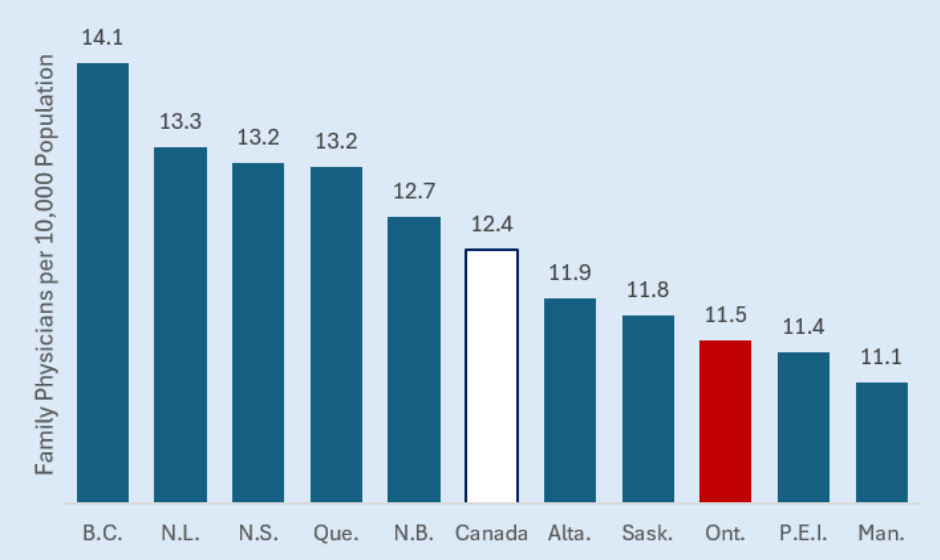
100. As peer-reviewed studies have concluded, while the overall family physician workforce may have grown, the proportion practicing comprehensive medicine has declined (2008: 77.2%, 2019: 70.7%).[26] As well, over time, an increasing proportion of the comprehensive FP workforce has neared retirement age, and an increasing proportion of patients are attached to near-retirement physicians. Moreover, at the same

[26] Premji "Characteristics of patients," *supra,* TAB 12, BOD.

time as mean patient age has increased, physicians must provide services to "increasing numbers of medically and socially complex patients." All of this has resulted in more and more unattached patients in Ontario as the "primary care sector faces capacity challenges as both patients and physicians age and fewer physicians practice comprehensiveness."[27]

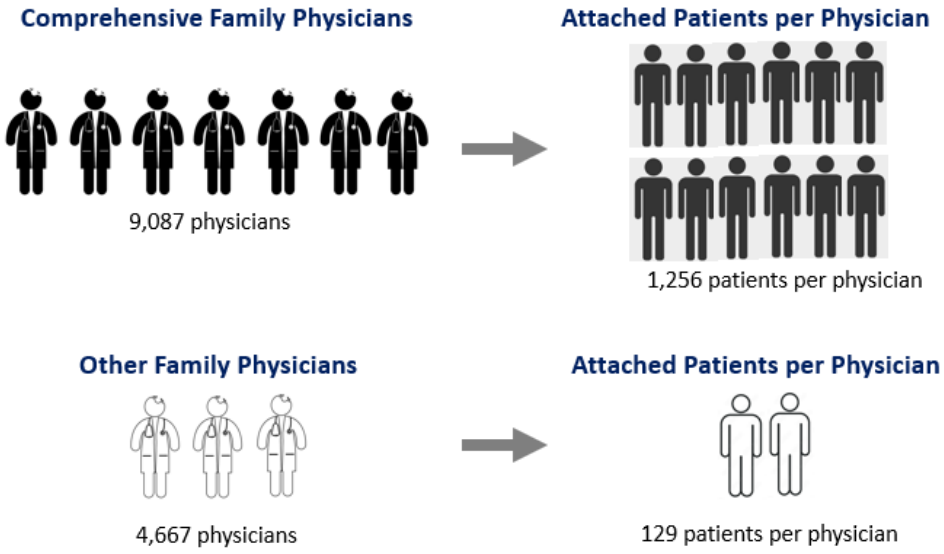
101. Furthermore, research has indicated that as a result of the COVID-19 pandemic, there have been additional negative impacts to the workforce due to comprehensive family physicians choosing to retire earlier or change their practice area or type.[28] Indeed, between 2008 and 2022, the proportion of family physicians in a comprehensive practice has declined from 77.2% to 65.1%. As well, according to Premji, since 2019, the growth in the overall comprehensive family physician workforce has stagnated.

102. Furthermore, it is notable that using headcount alone (as the Ministry proposes), in comparison to other provinces, Ontario has one of the lowest numbers of Family Physicians per capita in the country as set out in the following chart:[29]

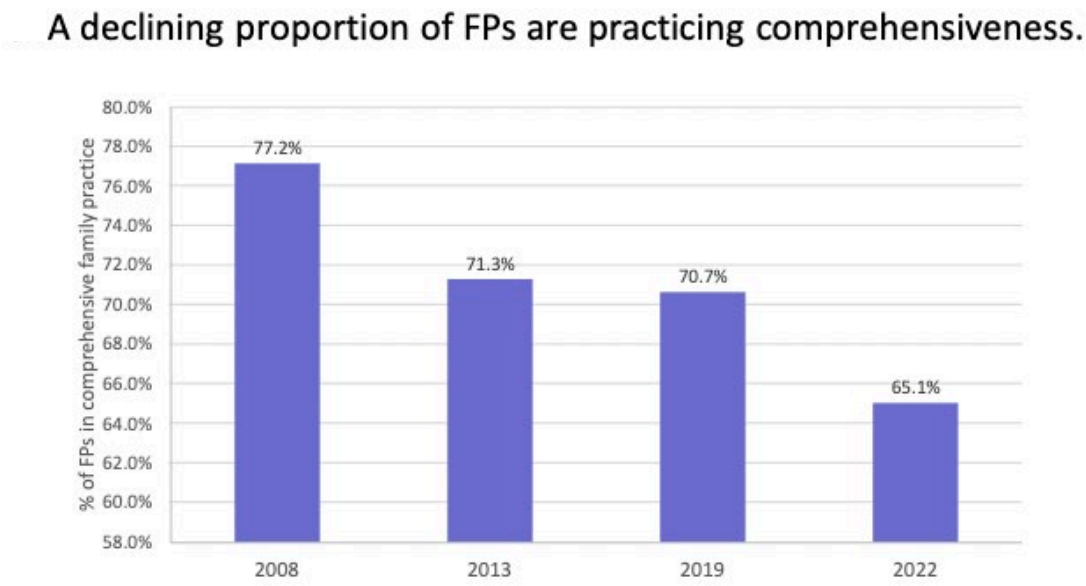


[27] *Ibid.*
[28] Premji, "Pandemic-era trends," *supra,* TAB 4, Vol. 1, Reply BOD.
[29] Canadian Institute for Health Information. *Supply, Distribution and Migration of Physicians in Canada, 2022 — Data Tables*. Ottawa, ON: CIHI; 2023. Table 23.1 Number and percentage change of family medicine physicians per 100,000 population, by jurisdiction, Canada, 1971 to 2022.

103. As well, as illustrated below, only about 2 out of 3 Family Physicians in Ontario currently provide comprehensive, longitudinal care:



Source: OHIP claims, Primary Care Architected Data, fiscal 2022-23.



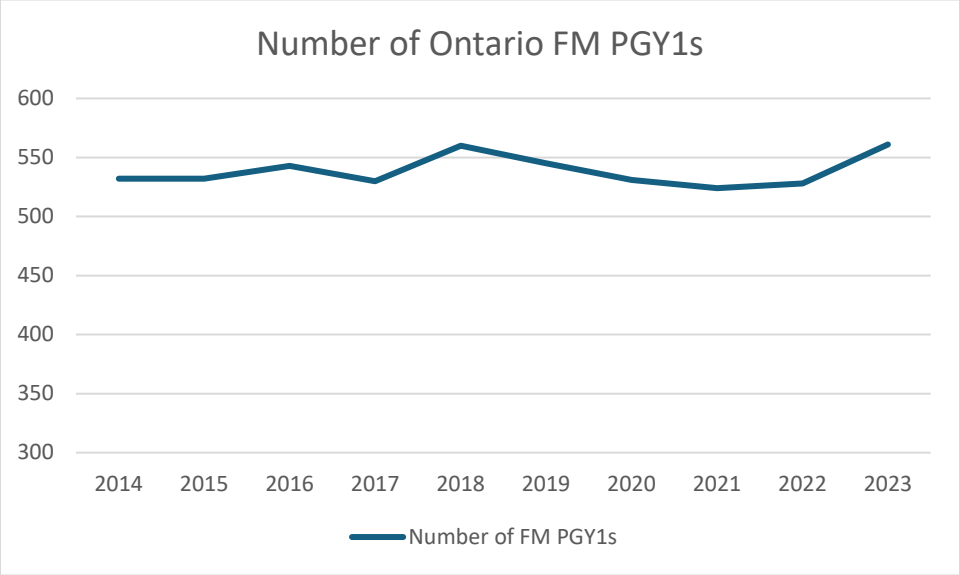
104. In fact, if as the OMA proposes there were to be additional targeted compensation rate increases aimed at comprehensive longitudinal family practice, and if these incentivized 2250 of those family physicians who are currently not practicing

comprehensive care to do so, it would mean an additional 2.7 million new patients becoming attached to a family physician (assuming a patient roster of 1200).

105. With respect to family medicine in particular, at paragraphs 116 to 118, the Ministry submits that the number of new family physician residents has remained constant at approximately 41%. Once again, the government fails to distinguish between family physicians choosing to work in walk-in clinics or specialized models of family medicine care, and those practicing comprehensive care.

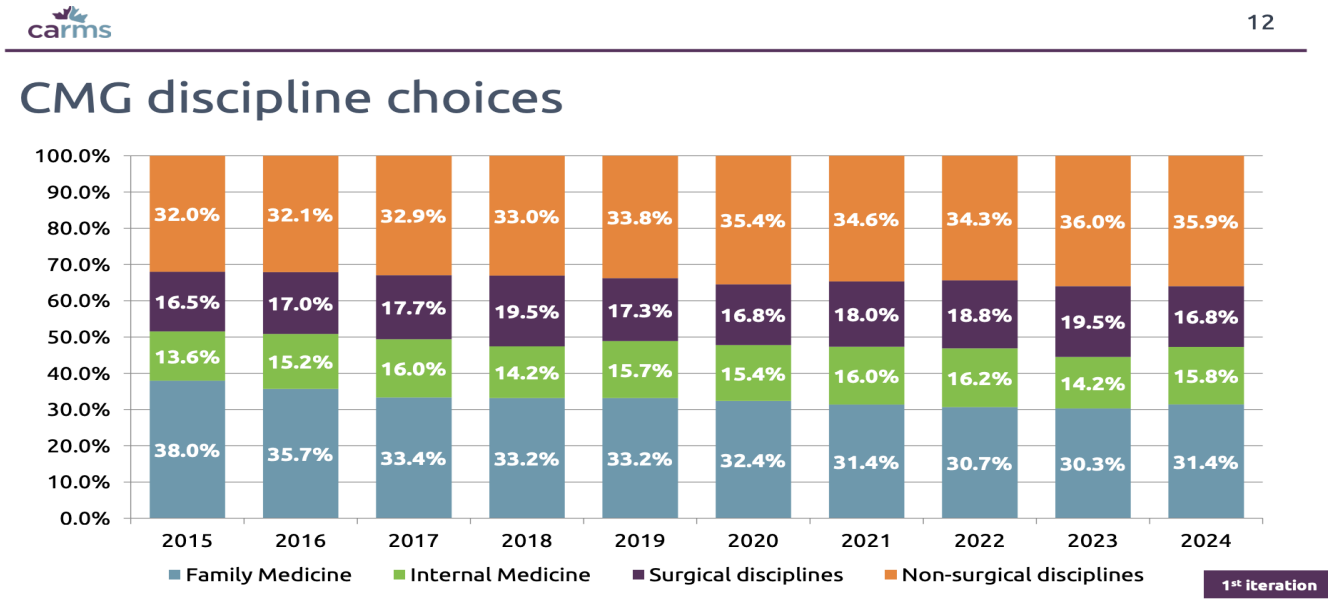
106. The 41% number is also a product of the number of residency spots available, which is solely within the Ministry's control. In fact, the OPRC historic data shows the following:

Year	Number of FM PGY1s	Total Trainees	%FM
2014	532	1283	41.5%
2015	532	1271	41.9%
2016	543	1286	42.2%
2017	530	1267	41.8%
2018	560	1329	42.1%
2019	545	1304	41.8%
2020	531	1281	41.5%
2021	524	1278	41.0%
2022	528	1290	40.9%
2023	561	1341	41.8%



107. Thus, while the proportion of residents choosing family medicine may have remained consistent, the population itself is growing, thus leaving a larger portion of the population unattached every year.

108. Furthermore, when one looks only at first CaRMs matches for family medicine, the evidence is striking that fewer residents are choosing family medicine (as demonstrated in the graph set out below), from a high of 38% in 2015 to 31% in 2024 (and this despite the fact that 44.7% of residency spots are allocated to Family Medicine). The OMA suggests, as a matter of logic and practicality, that those who have not chosen family medicine as their first choice will be less likely to choose and stay in comprehensive family medicine practice in future.



109. Notably, although the OMA persuaded the Ministry to open up managed entry to the FHO model in the 2021-24 PSA to more physicians, 40% of FHO spots remain unfilled.[30] This provides further evidence that physicians are not choosing to practice comprehensive longitudinal family medicine under the current circumstances, and that additional incentives are needed to attract them to it.

110. This data is also reflected in countless stories of family doctors who are choosing to leave family medicine or practice elsewhere. One such physician is Dr. Tristan Brownrigg, a family physician, practicing a mix of clinic, ER and inpatient care in the East Kootenays of British Columbia. A native of Ontario, he is a graduate of the University of Toronto Medical School, and did his residency at Queen's University in 2022, after which he worked in Ontario for six months. However, as he has watched the family medicine crisis in Ontario grow, he has chosen to move to British Columbia to practice there. As he explains:[31]

> Over the years I had watched my goal of working as a comprehensive rural family physician slowly become unsustainable amidst a collapsing system, decades of funding stagnation and poor planning, with a patchwork of good people on the ground trying to do their best in a system that doesn't seem to

[30] As reported to the OMA by the MOH "Managed Entry Data".
[31] Dr. Tristan Brownrigg, "*Perspectives on Ontario Health Care by a Recent Graduate*" (May 12, 2024), TAB 19, Vol. 1, Reply BOD.

> value their input. Day after day the insidious march of the family medicine crisis grew closer to the forefront of peoples' lives and garnered wider media attention, while the government either denied its existence or made no substantive changes that would realistically address it...
>
> Last year I moved to rural British Columbia to try something different for a year, cautiously optimistic about the significant changes to family practice on the back of the LFP model implementation in early 2023...
>
> My experience has been night and day. For the first time in my medical career I have felt hopeful about the future of family medicine and find my day to day life to be sustainable...
>
> Reading the recent government positions and negotiation briefs has been the final nail in the coffin for me. The disdain the Ontario government shows towards the hardworking family physicians who hold up the medical system is nothing short of repugnant. After more than a decade of training and education here, I will now be relinquishing my license to practice medicine in Ontario and stay in British Columbia.

111. As this narrative demonstrates, contrary to the Ministry's submissions, Ontario is far from the province of choice for family physicians.

D. Allied Health Professionals Cannot Replace Physicians

112. At paragraph 103, the government also submits that physicians are "part of a holistic team of primary care providers including Nurse Practitioners and Pharmacists...[who] will continue to be utilized to support and care for Ontario's patients."

113. The OMA submits, however, that the Ministry ignores the extent to which these "holistic teams" are ultimately led by physicians, such that any service or care that is provided by a team member must be integrated under the Most-Responsible-Physician's care. The physician is in almost all cases the most responsible provider who has overall responsibility for directing, coordinating care, and managing a patient at a specific point in time.[32] Indeed, a physicians' scope of practice is the broadest of the regulated health care professionals in Ontario. According to the legal definition found in the *Medicine Act*

[32]CMPA, "Collaborative Care: Working across disciplines to provide safe care" (April 2021 / Revised: December 2022).

1991, the practice of medicine is the "assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction."[33] This scope of practice of physicians includes thirteen authorized acts,[34] which no other regulated health care professional is authorized to perform. As a result, no other health care professionals hold an equal or comparable role to the physician, and as a legal and practical matter, the physician as the medical expert and the Most Responsible Provider cannot be substituted by any other professional, particularly since physicians are the only professionals who can undertake health assessment, diagnosis and therapeutic management without any restrictions.

114. Allied health professionals can place additional demands on physician services through increased prescribing, referrals, additional imaging and lab tests, etc. For example, if something goes wrong with the care provided by the pharmacist (e.g. adverse reaction to a medication that sends the patient to hospital), the issue ends up coming back to the physician to remedy even though they did not order/control/manage the original intervention/treatment. Conversely, if something goes wrong with the care provided by the physician, the responsibility lies with the physician themselves to determine how to redress it, including whether additional or other physician assistance might be required. Furthermore, the fact that AHPs alleviate low-value workload items from physicians, only serves to allow physicians to focus on the provision of higher value services i.e. services with greater intensity complexity and duration.

115. Thus, the OMA submits that, contrary to the government's suggestion, the increased use of allied health professionals cannot be and is not a realistic or sufficient solution to current *physician* shortages.

E. Increased Compensation is a Key Part of the Solution

116. In addition, contrary to the Ministry's submission at page 154 of its brief, price increases play a material and significant role in addressing physician shortages, including the unattached patient crisis in family medicine. Indeed, there are numerous examples,

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[33] *Medicine Act, 1991, SO 1991, c 30* at s. 3.
[34] *Ibid.* at s. 4.

both in Ontario and elsewhere, where increased compensation has been successfully used to address backlogs and problems in the health care system.

117. Some examples include the following:

- The creation of new remunerative family practice models including the FHG and FHO in 2000-2010 period, and the creation and expansion of numerous unattached patient codes in response to an unattached patient crisis. In response to these incentives, attachment grew by 1.47% annually from 2008 to 2014 when the government unilaterally eliminated many of these codes. (See discussion at paragraphs 562-563 of the OMA brief).

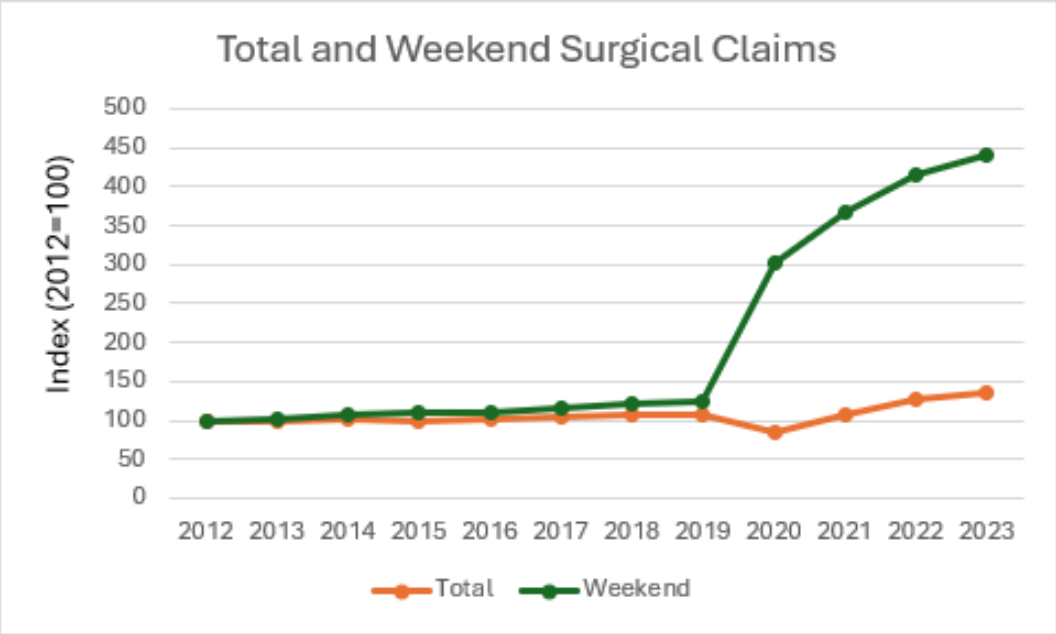
- The creation of EDAFA models in the late 1990s which were successful in stabilizing emergency services, initially in smaller community hospitals, then expanded to larger and academic hospitals, and which at the time provided an adequate supply of ED physicians through an improved compensation model (although funding levels have failed to keep pace). (See discussion at paragraphs 609-610 of OMA brief).

- The successful use of increased funding to address waitlists for procedures, Specifically, from 2004 onward, Ontario implemented its “Wait Time Strategy” and made substantial investments aimed at improving access to cataract surgery, MRI and CT scans, along with cardiac procedures, hip and knee replacements and cancer surgeries. These initiatives successfully enabled ophthalmologists, radiologists and others to provide more services – that is, to work harder and longer hours in order to satisfy previously un-met demand and thus decrease delay.[35]

- The introduction of after-hours premiums to help clear the backlog of elective surgery cases. The agreement allowed the after-hours procedure premiums (E409 and E410) to be billed when rendering an applicable service during evenings, nights, weekends and holidays, as defined in the Schedule of Benefits, and was intended to further support the government's response in addressing the backlog of surgeries and other procedures that were delayed due to COVID-19. The agreement came into effect November 28, 2020, and was initially to end March 31, 2021, but was subsequently agreed to be extended up until March 31, 2024, to further assist in reducing the backlog. There was a significant decline in surgical procedures being performed with the onset of COVID-19 and the measures taken, such as allowing after-hours

[35] D.A. Henry, S.E. Schulz, R.H. Glazier, R. S. Bhatia, I.A. Dhalla and A. Laupacis, Payments to Ontario Physicians from Ministry of Health and Long- Term Care Sources 1992/93 to 2009/10: ICES Investigative Report (Toronto: Institute for Clinical Evaluative Sciences, February 2012) at 1, 4, 14-15, TAB 20, Vol. 2, Reply BOD.

procedure premiums to be billed on elective cases on the weekend, increased the volume of procedures being performed in Ontario and thus reducing the backlog. As seen in the chart below, this compensation measure had its intended effect.[36]



- The creation in BC of the new Longitudinal Family Practice Model. Since its launch, 4,000 family doctors have enrolled, with an estimated 600-700 physicians returning to practice comprehensive longitudinal family medicine (see also discussion at paragraph 416 of main OMA brief). Similarly, in Manitoba, Nova Scotia, Newfoundland, Saskatchewan, and Alberta, significant investment in family medicine is being made to address the crisis in family medicine and to recruit and retain family doctors. (See discussion at paragraphs 516-553 of OMA brief).

118. Indeed, in its disclosure documents, the Ministry itself recognizes that it is currently using a number of financial incentives to recruit and retain physicians. These include:[37]

- **Northern and Rural Recruitment and Retention Initiative (NRRRI):** The NRRRI which began in 2010, offers financial initiatives to physicians to establish practices in rural and Northern Ontario. NRRRI grants range from $80,000 to $117,600, paid

[36] Source: MOH datafiles, FY2012/13 - FY2023/24 Fee-For-Service and Shadow Billing claims. Prepared by OMA Economics, Policy and Research, May 2024.
[37] Ministry of Health, "Issue: Physician Supply and Distribution" (September 19, 2023), TAB 21, Vol. 2, Reply BOD.

out over four years, while the physician establishes a practice. They are available in any community defined as rural, using the Rurality Index of Ontario (RIO); and, also in all five of Ontario's Northern Urban Referral Centers (Timmins, North Bay, Sudbury, Sault Ste. Marie, and Thunder Bay).

- **Northern Physician Retention Initiative (NPRI):** The Northern Physician Retention Initiative provides eligible physicians in northern Ontario with a $7,000 retention incentive, paid at the end of each fiscal year in which they continue to practice full-time in Northern Ontario beyond an initial four years.

- **Rural and Northern Physician Group (RNPG) Agreement:** This agreement is a comprehensive alternative funding agreement designed to strengthen the ability of designated communities to recruit, and retain, physicians to primary care group practices. It includes substantial enhancements, such as financial bonuses for preventative; prenatal; and palliative care; as well as a rural bonus recognizing the isolation and remoteness faced by physicians working in northern communities.

- **Locum Programs:** Locum programs, funded by the ministry, provide coverage for rural and northern communities experiencing shortages of physician services for a variety of reasons, including physician absences during vacations; educational and other personal leaves. The **Temporary Locum Program (TLP)** provides eligible hospitals in rural and northern Ontario with the opportunity to offer eligible physicians a temporary premium to maintain 24/7 Emergency Department (ED). In 2022-2023, over 593,573 hours of coverage have been provided through this program. 93 hospitals are participating in the program....

- **Rurality Gradient Premium (RGP)** consists of paying premiums to physicians having a practice address with a RIO score of 40 or greater. Payments range from $5,000 to $15,000 per year, depending on the RIO score of the practice community.

- **Hospital Premium for Rural and Northern Physicians:** Physicians with a practice location RIO score of 40 or more, who have provided $2,000 in eligible hospital services, are entitled to a $7,500 Hospital Premium payment. Once $6,000 in eligible hospital services is provided, an additional $5,000 payment will be made for a total $12,500 Hospital Premium.

119. As these examples demonstrate, increased compensation is a key part of addressing recruitment and retention challenges and promoting the provision of necessary physician services.

120. In addition, two systematic reviews clearly demonstrate that compensation is a key factor in the regional recruitment and retention of both permanent and locum physicians.[38] Specifically, Mohammadiaghdam et al. (2020),[39] based on the initial search of 2,312 relevant articles, found that "the desertion and retention of physicians in rural and underdeveloped areas [is] mainly based on financial factors, such as income, salary, loans and appropriate reimbursement. One of the major incentives for most of the physicians is their revenue…. Financial rewards and incentives have a significant effect on the desertion and retention of physicians....."

121. Similarly, Ferreira et al. (2024)[40], based on the initial search of 5,390 relevant studies, find that the "[m]ain strategies for facilitating locum tenens recruitment and retention included financial incentives (83%), education and career factors (67%), personal facilitators (67%), clinical support and mentorship (33%), and familial considerations (25%). Identified subthemes were desire for flexible contracts (58%), increased income (33%), practice scouting (33%), and transitional employment needs (33%)."

122. In Ontario, a joint study by the OMA and Ministry in 2005 examined the impact of the Northern Physician Retention Initiative (NPRI) on the recruitment and retention of physicians in Northern Ontario. NPRI provides financial incentive at the end of each year to physicians who remained and maintained full-time practices and held hospital privileges in Northern Ontario. The study concluded that "[t]here is strong evidence that the NPRI had a positive and significant impact on retention of physicians in Northern Ontario."[41]

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[38] Systematic reviews consist of a review of all research studies relevant to the question. Therefore, these systematic reviews synthesize information from typically hundreds of relevant studies and represent a comprehensive literature review of the topic.

[39] Nasrin Mohammadiaghdam, Leila Doshmangir, Javad Babaie, Roghayeh Khabiri and Koen Ponnet. "Determining factors in the retention of physicians in rural and underdeveloped areas: a systematic review." BMC Family Practice (2020) 21:216, TAB 22, Vol. 2, Reply BOD.

[40] Nathan Ferreira, Odessa McKenna, Iain R. Lamb, Alanna Campbell, Lily DeMiglio and Eliseo Orrantia. "Approaches to locum physician recruitment and retention: a systematic review". Human Resources for Health (2024) 22:24, TAB 23, Vol. 2, Reply BOD.

[41] OMA Economics. "Northern Physician Retention Initiative Study." October 2005. Report prepared at the request of bilateral System Management Committee, TAB 24, Vol. 2, Reply BOD.

123. Furthermore, a study by two researchers from Health Canada[42] examined if, and to what extent, expected income in a province plays a role in a physician's decision of where to practice. Based on their statistical analysis of the data from the Southam Medical Database (SMDB) obtained from the Canadian Institute for Health Information (CIHI) (which contains annual information on individual physicians in Canada for the period from 1974 to 2002), they conclude that the "effect of expected income in a province on the choice of province of residence is positive and statistically significant for physicians residing in Ontario and Saskatchewan…" In the model for Ontario, the parameter estimate for income in a province is significant and positive, suggesting that higher the income in a province, the more likely that province will be chosen by physicians residing in Ontario. With an additional $10,000 in annual income, the odds of choosing that province is 4.8% higher than choosing any other provinces."

124. As other researchers have observed, although increases in the supply of providers may be an important part of long-run policies, in the near term "the most effective means of increasing access would be to increase hours of work and service provision by the existing stock of practicing physicians."[43]

125. Indeed, this is confirmed by a recent survey conducted by the OMA Section on General & Family Practice (SGFP), which found that increased compensation is an important part of the solution to the unattached patient crisis. In this survey, 76% of its members answered yes to the question of whether an "increase in compensation [would] allow you to take on unattached patients and/or improve patient access to your practice?"[44] Moreover, when asked to describe how an increase in compensation would enable them to attach more patients and/or improve patient access, a large number of respondents reported that it would allow them to hire additional staff.

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[42] Sameer Rajbhandary, Kisalaya Basu. "Interprovincial migration of physicians in Canada: Where are they moving and why?" Health Policy 79 (2006) 265–273, TAB 25, Vol. 2, Reply BOD.
[43] Brian R. Golden PhD, Rosemary Hannam MBA, Douglas Hyatt PhD. Managing the supply of physicians' services through intelligent incentives. Canadian Medical Association Journal, January 10, 2012, 184(1), TAB 26, Vol. 2, Reply BOD.
[44] OMA "2024 SGFP Tariff Committee Survey for NTF/Arbitration" (April 19-22, 2024) and Text Analysis by OMA Survey Insights, TAB 27, Vol. 2, Reply BOD.

126. The OMA submits that, as outlined above and in Part Seven of its main brief, while the growing physician recruitment and retention crisis has unique and complex features and causes, compensation is an important factor in addressing that crisis, just as has been recognized in the case of nurses and other health care workers. As explained by the Chair in the CUPE/SEIU reopener award, "wage increases can reasonably be expected to keep people in the workforce, attract people who have left to return, and incentivize future employees."[45]

[45] *Participating Hospitals v CUPE/OCHU & SEIU (Bill 124 Reopener), 2023 CanLII 50888 (ON LA)*, TAB 6, BOA.

REPLY TO TAB 7: ECONOMY

127. In reply to Tab 7, the OMA relies primarily on its submissions at Part 6 of its brief on the Economy.

128. In response to paragraph 120 of the Ministry's submissions, the OMA notes that it is always the view of the government, in all contexts and before other arbitration boards that it must be fiscally responsible. However, in the face of that position. other broader public service employee groups have received significant increases, including most notably those in the health sector.

129. At paragraph 146, the Ministry submits that "there is no pattern to indicate that physician income tracks inflation." However, as set out at paragraph 313 of the OMA brief, there is evidence that while there have been periods (as in the current period) where the rate of physician price increases have fallen behind inflation, over the longer term, physician fee increases have historically tracked inflation, often catching up to it after trailing it (as the OMA notes is the case and result it seeks before this board).

REPLY TO TAB 8.1 to 8.3: THE DISTINCTION BETWEEN PRICE INCREASES AND EXPENDITURES ON PHYSICIAN SERVICES

130. Historically, the difference between price and income is a fundamental point of dispute between the parties. Whereas the government has sought to shift the issue to focus on income, the OMA has always taken the position that the appropriate measure is price, and, over time, the outcome of negotiations has indeed reflected the OMA's position. Thus, in the OMA's submission, the fundamental issue for this board is to determine, as provided for under the 2024-28 Procedural Agreement, what the overall price increase is for Year 1, including whether a case for catch-up has been made out by the OMA. Ultimately, this is not an arbitration about income but about the increase to price and other compensation increases that physicians should receive for providing a given level and type of medically necessary services.

131. It is also important to recognize that government payments to physicians are gross payments from which the significant "overhead" costs of operating a medical practice -- including malpractice insurance premiums, salaries of employees, office space, equipment and medical supplies, administrative and other small business costs -- must be deducted to arrive at a physician's net income before taxes. Accordingly, a physician's net real income is defined as gross clinical income adjusted for overhead and inflation. Of course, physician costs of practice are also subject to inflationary increases.

132. In contrast, employees in the OPS and BPS, unlike physicians, do not have to pay for staff or rent or other overhead costs, and, as a result, a 3.5% ATB wage increase for them, when providing the same level of services, equals an identical 3.5% increase to their income.

133. At paragraphs 159-161, the Ministry essentially accuses physicians of gaming the system to generate increased incomes even where fees have been frozen through "reasonably sophisticated techniques." As explained above in paragraphs 27 to 43, the Ministry's submissions are inaccurate, and ignore the fact that, as described above, the process for setting fees is a bilateral process.

134. In this respect, the Ministry's argument at paragraphs 22-24 and 32 of its main brief that physicians "have the **sole discretion** to increase their overall compensation should they choose to do so" (emphasis added) also erroneously implies that physicians have entirely unfettered access to the resources required to treat patients. As discussed above in paragraphs 5 to 22, this is simply not true. For example, in a hospital setting, access to resources such as operating rooms, endoscopy suites, cardiac catheterization labs, dialysis facilities, medical imaging facilities, in-patient and intensive care wards etc. is dictated by hospital budgets. Thus, hospital administrators, not physicians, control much of the access to the resources physician need to provide patient care. As well, several hospital specialists throughout the province have reported that hospitals are now charging them for rent or other expenses, part of a growing trend of hospitals downloading more costs to physicians, which negatively impacts their compensation.

135. Furthermore, as discussed more fully below in the OMA's response to Ministry tabs 12 and 13 of their main brief, any growth in billings above the growth in fee rate increases is not a great mystery, but is explained by the fact that physicians are increasingly providing more services per visit (intensity) and also providing a more complex mix of services (of a higher value, and so remunerated at higher rates), largely as a result of increased patient complexity.

136. At paragraph 168, the Ministry submits that "income" per physician has increased from 2019-20 to 2023-24 by 10%. Together with the OMA's fundamental disagreement with the Ministry premise of using income as a measure for determining the price for services provided, the OMA also disputes the Ministry's calculations. As discussed immediately below, since 2019-20, physician incomes have increased by about 6.5 rather than 10 percent (roughly equal to the price increases received over that same period).

137. In arriving at its physician "income" number, the Ministry uses the actual 2019-20 Physician Services Budget Expenditures and the forecast 2023-24 PSB expenditures, and then divides that by the number of physicians who had at least one fee-for-service or shadow claim in those two years. There are several difficulties with this methodology. First, the OMA estimate of 2023-24 PSB is about 1.2 percent lower. Second, the Ministry

includes items such as CMPA, Technical Fees and Benefits that are typically not included in measuring physician compensation for providing professional services. Third, the OMA relies on the more accurate record of the number of physicians in each year from the Ontario Physician Reporting Centre (OPRC), rather than relying on a mere headcount of the number of physicians with at least one OHIP claim[46]. For its part, the OPRC is "regarded as the key impartial source of information regarding physicians in training and in practice in Ontario." As well, they update "their data annually and presen[t] in a consistent and comparable format to allow in-depth time-series analysis."[47]

138. When these various factors are taken into account, the increase in average physician expenditure is 6.5 percent, rather than 10 percent, as set out in the following table.

Total and Average PSB Expenditures, Ontario, 2019-20 and 2023-24

	MOH	OMA
2019 PSB	$14,177m	$13,903m
2019 MDs	33,250	31,764
2019 Average PSB per MD	$426,382	$437,696
2023 PSB	$16,985m	$16,550m
2023 MDs	36,204	35,505
2023 Average PSB per MD	$469,144	$466,149
% Total Change in Average PSB per MD	10.0%	6.5%

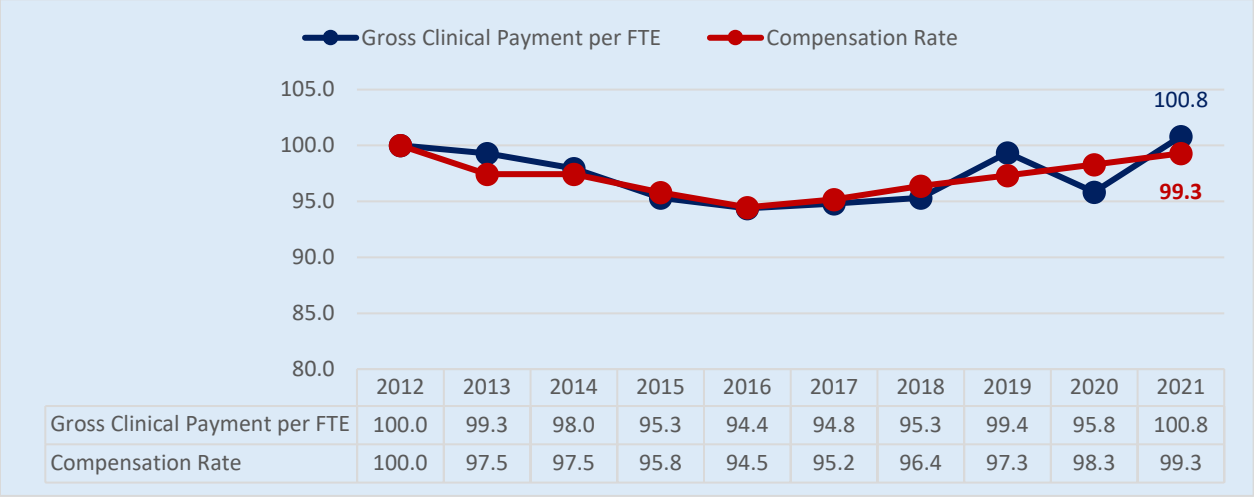
[46] OPRC is an independent institute that is government by the Ontario Ministry of Health, the College of Physicians and Surgeons of Ontario, the Council of Ontario Faculties of Medicine and the Ontario Medial Association. It is the definitive source of information on the number of physicians in practice and postgraduate medical training in Ontario.

[47] Ontario Physician Reporting Centre (OPRC), *Physicians in Ontario 2022 Report (Revision), TAB* 29, Vol. 2, Reply BOD.

139. The OMA further submits that a more appropriate and accurate measure of physician billings, widely used by provincial and territorial governments and medical associations in Canada, is the gross clinical payment per full-time equivalent physician, published annually by the Canadian Institute for Health Information (CIHI).[48] According to the CIHI data for 2012-13 to 2021-22 (latest available year), changes in the gross clinical payment per FTE and the physician compensation rate have been closely tracking each other. Therefore, based on these historical ten years of data, it is projected that the physician incomes increased by about 5.8 percent since 2019-20, again roughly equivalent to the compensation rate increases over this time period.

140. As well, as is apparent in the following chart, gross clinical payments per FTE for Ontario physicians, have remained relatively flat since 2012:

Gross Clinical Payment per FTE and Physician Compensation Rates, Ontario, 2012-13 to 2021-22



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Gross Clinical Payment per FTE	100.0	99.3	98.0	95.3	94.4	94.8	95.3	99.4	95.8	100.8
Compensation Rate	100.0	97.5	97.5	95.8	94.5	95.2	96.4	97.3	98.3	99.3

[48] CIHI is an independent institute funded by Health Canada and the provincial and territorial ministries of health. It is the most authoritative source in Canada for interprovincial comparison of the physician supply and remuneration.

REPLY TO TABS 8.4 AND 8.5: INCREASE FOR YEAR 1 OF THE 2024-28 PSA

141. In response to the Ministry's submissions at tab 8.4, and in particular paragraphs 171 to 179, regarding normative increases for Year 1 of the PSA, the OMA relies on its submissions at paragraph 318 to 370 of its brief. The OMA further notes that while the government purports to use broader public sector comparators in its analysis, they primarily focus their comparators at page 79 on the OPS (where, of course, there were no material recruitment and retention issues, although where there were OPS employees received targeted increases). Significantly and inexplicably, the Ministry completely ignores the increases received by hospital sector workers, even though these groups are in the OMA's submissions highly relevant given the similarities in their work environments and recruitment and retention challenges.

142. In fact, the Ministry's 3% proposal fails entirely to respond to the compensation increases received by other groups, most notably in the hospital sector, over the period where physician price increases were only 4.8%, as summarized immediately below:

Uncompounded	OMA	PARO	ONA	OPSEU	CUPE
2012-2023	8.8%	20.8%	27.45	25%	22.1%
2017-2020	4.0%	5.95%	6.3%	6.3%	6.1%
2021-2023	4.8%	9.25*	14.2%	11.75%	12.65%
2024			3.0%	3.0%	3.0%
2021-2024			17.2%	14.75%	15.65%

*PARO 9.25 is only for 2021 and 2022, bargaining 2023 forward now

143. By contrast, the Ministry's table at paragraph 175 of its brief is comparing apples to oranges, i.e. comparing physician billings (what the Ministry terms physician "income" but what is in reality the average billings per physician not accounting for such factors as overhead and expenses of practice), with OPS wage rate increases (which are also understated as the Ministry include only across-the-board increases) and not income (e.g. the comparison does not include increases to OPS employee income as a result of such factors as movement through the wage grid or overtime worked or premiums paid).

REPLY TO TAB 8.6: COMPARISON OF PHYSICIAN INCOME ACROSS CANADA

144. With respect to the limited family medicine focused cross-Canada comparators discussed in the Ministry brief at paragraphs 180-190, the OMA submits, *inter alia*, that, because of the unique impact of Bill 124 in Ontario, for the purpose of this arbitration, Ontario hospital and other BPS comparators are much more relevant than comparators in other provinces.

145. However, even if one looks at the Ministry's cross-Canada comparators, the OMA submits that the Ministry's analysis is flawed. The Ministry's analysis is based on estimating what a FHO physician with an estimated average workload would make in each of other Canadian jurisdictions. The three parameters required for this estimation are the physician's roster size, the number of visits, and the annual hours worked.

146. Specifically, the Ministry conducted this analysis using a 1,210-patient roster size; 2,998 visits per year; and 162 days (1,296 hours) per year (page 86 of Ministry brief). Using these parameters, the Ministry simulated that the compensation in the FHO model remains higher than in other Canadian jurisdictions, in the range of between $76K and $129K, concluding that "with current practice patterns, primary care doctors in the flagship capitated model for Ontario earn more than they would in any other comparable jurisdiction."

147. To examine the Ministry's claim, the OMA started by replicating the MINISTRY analysis. Next, the OMA conducted its own analysis adjusting three assumptions used in the Ministry analysis:

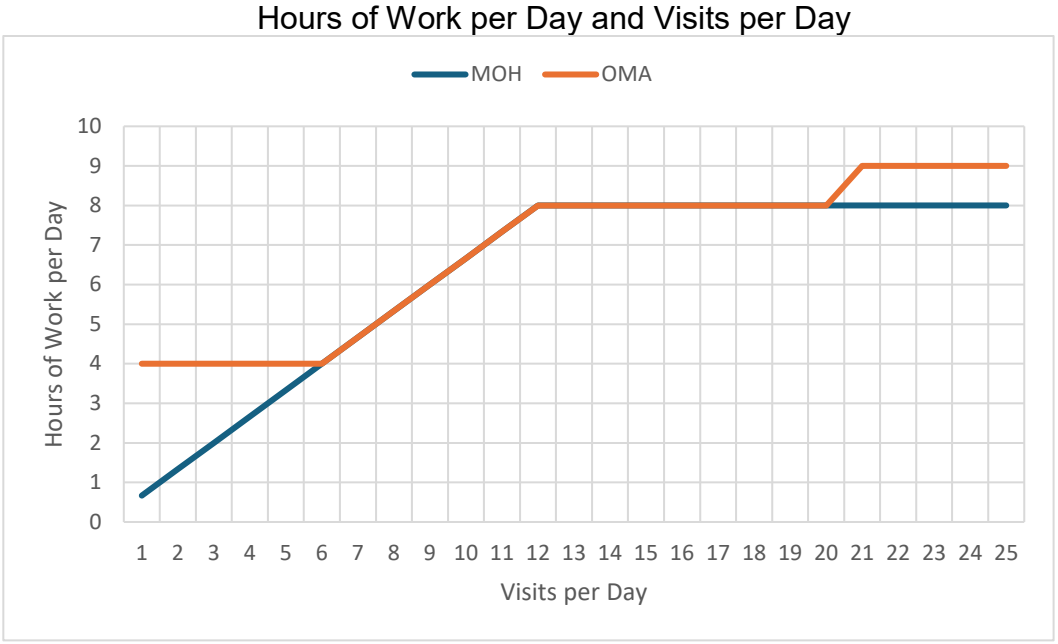
(1) The OMA compared the financial situation of FHO physicians in Ontario relative to other provinces at the individual level for each of 6,129 FHO physicians. In contrast, the Ministry analysis compares only the average for all physicians, which does not help to identify the actual number of physicians who would be financially better off (or worse off) elsewhere.

(2) The number of annual visits was adjusted by a factor of 1.5 to reflect the concern that shadow billings do not represent the full extent of services that FHO physicians in Ontario provide. This arises because several patient issues may be treated in the same visit, the physicians cannot submit fee codes for all services provided on

a single visit through the OHIP system, and physicians in a capitation model do not have the same disincentives to not provide multiple services to patients in one visit as in the fee-for-service model. By contrast, in the Ministry analysis, each visit counts as 1. Given that data is not available on this issue, the OMA also conducted a sensitivity analysis to simulate the impact when the number of visits is adjusted by a factor ranging for 1 to 2, in 0.1 increments.

(3) The number of hours per day is set at 4 hours (a half-day clinic) for any days with 6 or fewer visits and to 9 hours for any days with 9 or more visits. By contrast, in the Ministry analysis, the number of hours is set at 8 hours for any day with 12 or more visits and the number of hours is prorated for days with fewer than 12 visits. Given that data is not available on this issue, the OMA conducted a sensitivity analysis to simulate the impact of under- estimating the hours of work per day by a factor ranging from 1 to 1.25, in 0.05 increments.

148. The difference between the OMA and Ministry methodology with respect to hours of work assumptions is illustrated in the following chart:

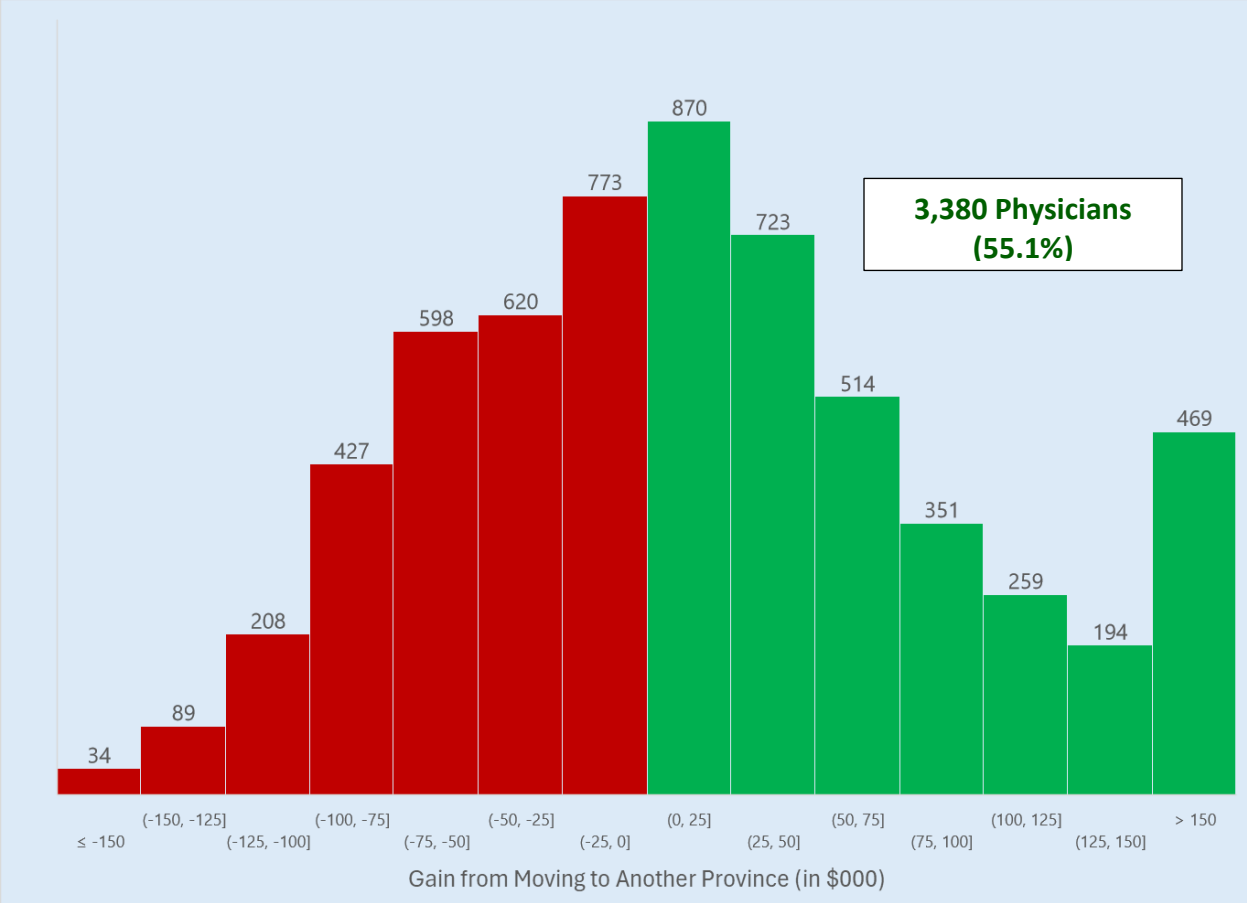


149. All other assumptions are the same in both methodologies (see Appendix A).[49]

[49] Appendix A, Tab 37, Vol. 2, Reply BOD.

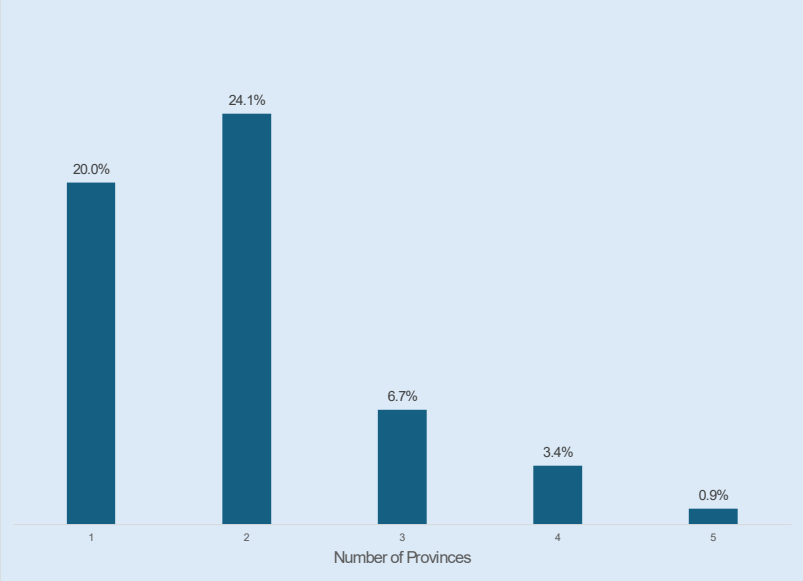
150. Using the more appropriate OMA methodology and assumptions, 3,380 FHO physicians (about 1 in 2) would be better off in another province. This finding is illustrated in the following chart:

Number of FHO Physicians Who are Better Off Financially in Another Province (OMA methodology)

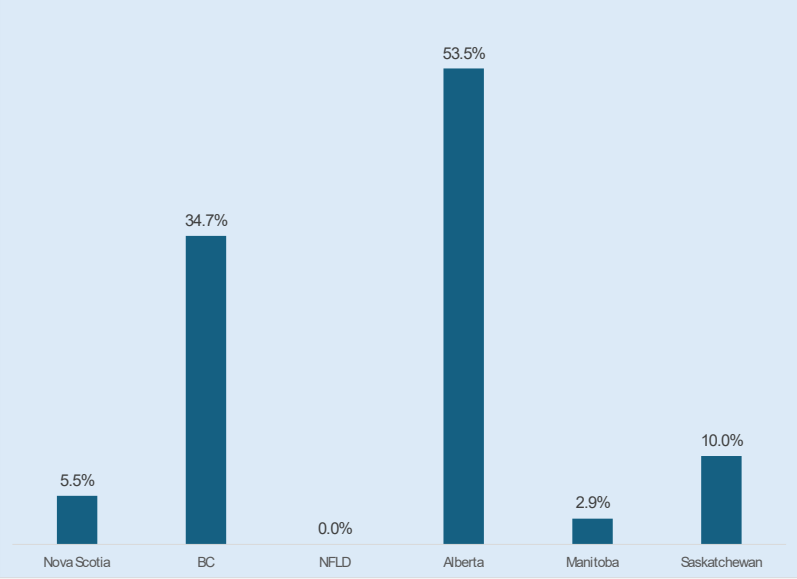


151. The average financial gain for these Ontario FHO physicians who would be better off is approximately $82,816 (or about 20 percent higher than the Ontario average). Further, this conclusion is not driven by a single province, as in fact there is a significant number of physicians who would be better off in more than one province. The following two charts presents these results for each province separately.

Percentage of FHO Physicians Better off in Any Other Province(s)



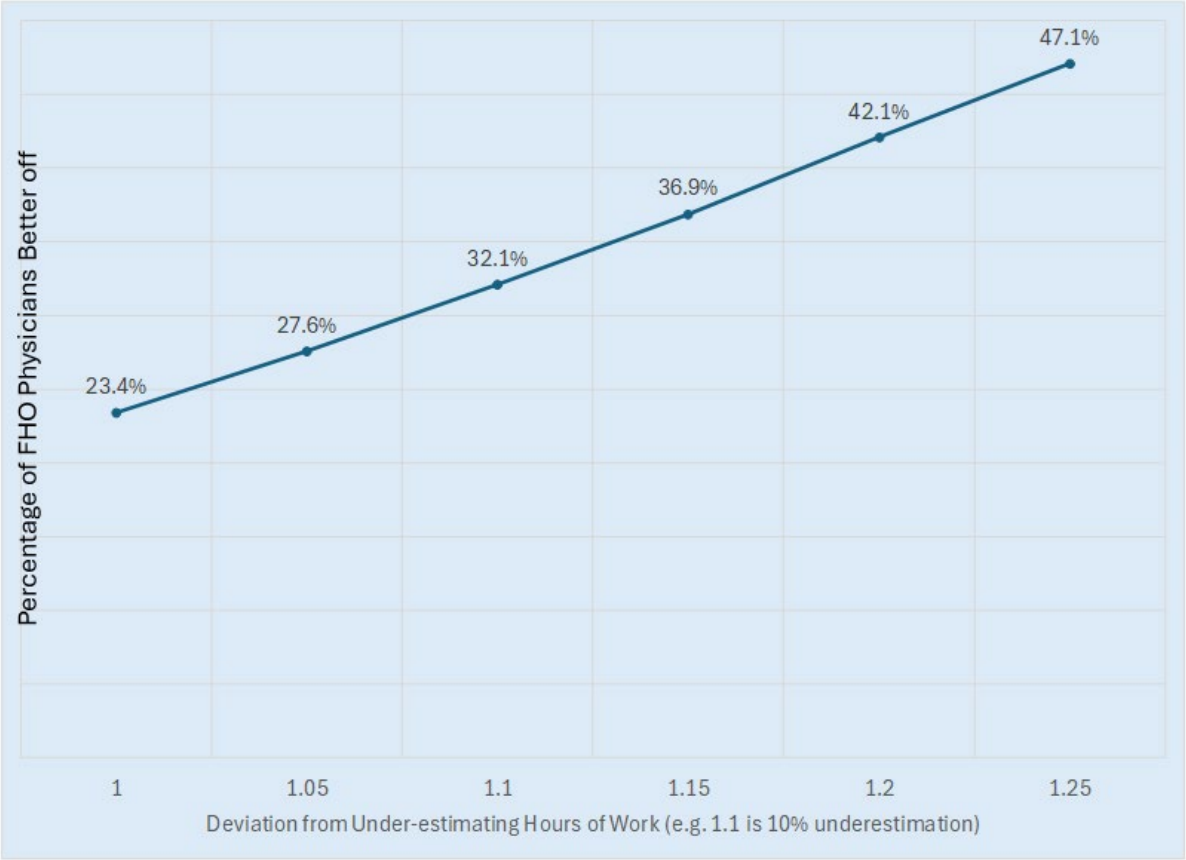
Percentage of FHO Physicians Better off in Each Province



152. The sensitivity of under-estimating the hours of work using the Ministry methodology is presented in following chart (all other assumptions of the Ministry methodology are kept the same). As can be seen, this can have a significant impact on the number of FHO physicians who would be better off outside of Ontario. For example,

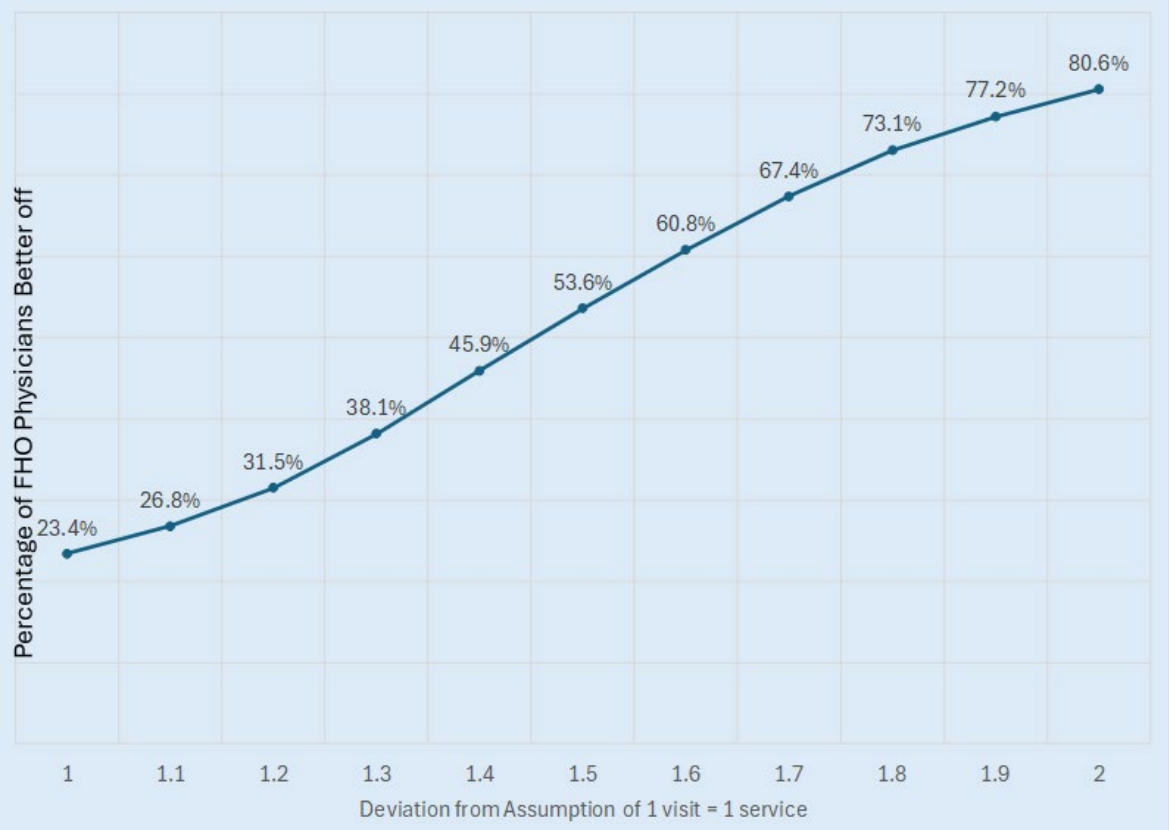
the assumption that a full-day work is 9 rather than 8 hours (a difference of about 12.5 percent) increases the percentage of FHO physicians who would be better off from 23.4 percent to 34.4 percent (i.e., from 1 in 4 to 1 in 3 physicians).

Percentage of FHO Physicians Better off in Each Province and Hours of Work



153. The following chart presents the sensitivity analysis of underestimating the number of services per each visit. Again, this underestimation can lead to a significant increase in the percentage of FHO physicians better off elsewhere. For example, if FHO physicians treat two conditions every 1 in 5 visits, the percentage of FHO physicians better off increases from 23.4 percent to 31.5 percent (i.e., from 1 in 4 to 1 in 3 physicians). A more realistic assumption of two conditions every second visit leads to about ½ of all physicians who would be better elsewhere.

Percentage of FHO Physicians Better off in Each Province and Annual Visits



154. In the following chart, the OMA summarizes the characteristics of FHO physicians based on whether or not they would be better off in Ontario or elsewhere in Canada.

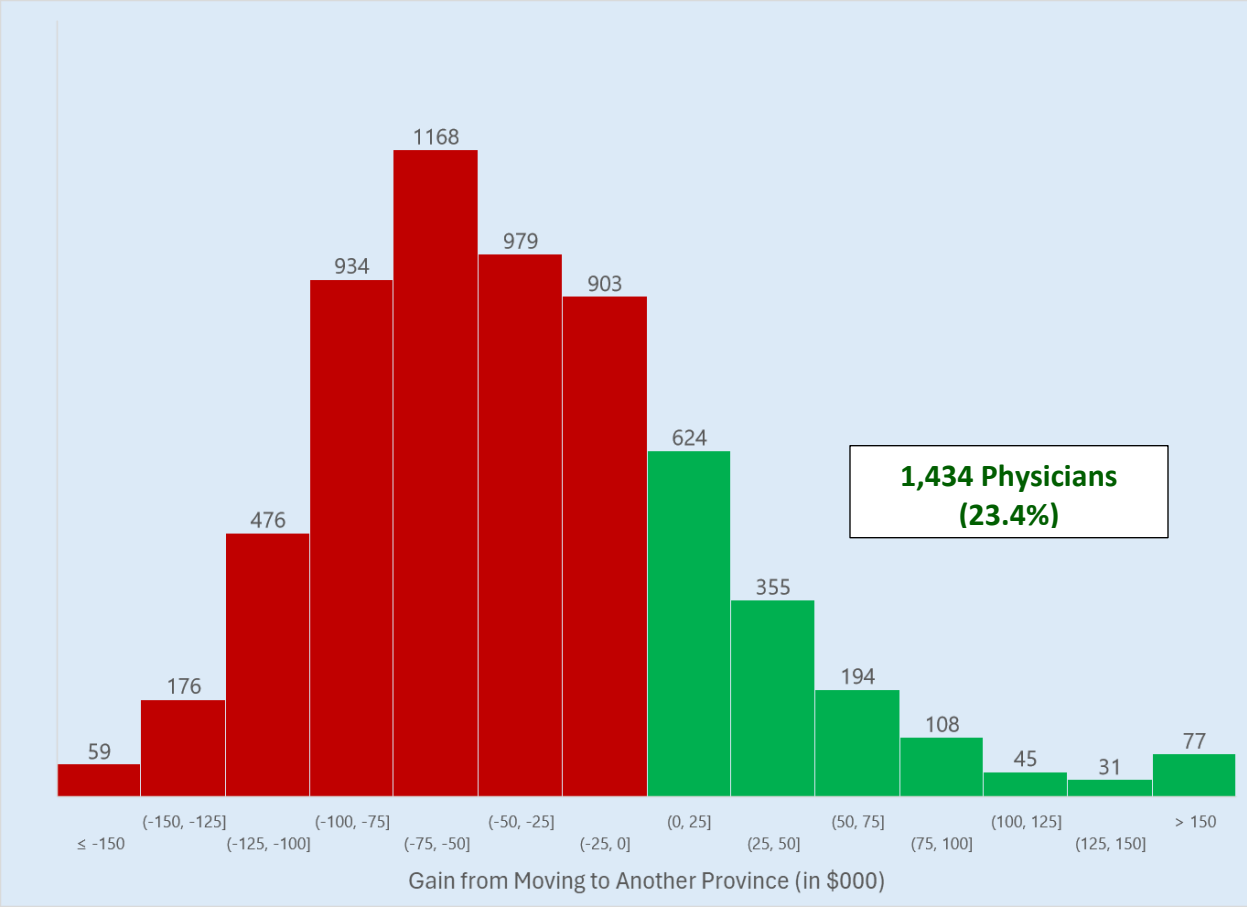
Characteristics of FHO physicians based on whether or not they would be better off in Ontario or elsewhere

	All FHO Physicians	Better Off Elsewhere	Better off in Ontario
MDs	6,129	3380	2,749
Roster Size	1,217	1,099	1,363
Annual Days	222	238	203
Annual Visits	3,506	4,123	2,747
Hours of Work	1,579	1,732	1,391

155. Notably, even using the less appropriate Ministry methodology, while the OMA was able to replicate the Ministry's results that the average income overall would be highest in Ontario, this comparison of average income hides the fact that even without adjusting

the Ministry's methodology on the basis and for the reasons set out in paragraph 146 above, 1,434 FHO physicians (about 1 in 4) would in fact be better off in another province (under the restrictive Ministry methodology and assumptions), as illustrated in the following chart:

Number of FHO Physicians Who are Better Off Financially in Another Province (Ministry methodology)



156. The OMA submits that its analysis is to be preferred over that of the government. The key difference is that the OMA examined the gain from migrating to another province for each individual FHO physician. In deciding where to practice, it is reasonable that physicians would consider their own practice style rather than some summary statistic for the province. Using the Ministry analysis, the average gross income for all FHO physicians appears to be higher on <u>average</u> in Ontario than in key other Canadian

provinces. However, at the individual physician level, a significant number of FHO physicians would experience a substantial financial gain from moving to another province. The magnitudes depend on how hours of work and visits are calculated, and range between 1,434 to 3,380 FHO physicians (23 to 55 percent of all FHO physicians), with an average financial gain between $48,991 and $82,816.

157. Put another way, the total roster size for FHO physicians who would be financially better off if they moved to another province is between 1.3 and 3.7 million patients. Even if a fraction of these physicians moved, the impact on Ontario health care system would be significant, adding to the already 2.3 million patients that are currently unattached.

REPLY TO TAB 10: ADMINISTRATIVE BURDEN IS AN URGENT PROBLEM THAT MUST BE ADDRESSED

158. At tab 10 of its brief, the government asserts that concerns about the growing patient care administrative burden facing physicians should not form the basis for price increases as this is a "new issue" that should be addressed through other initiatives such as "Patients Before Paperwork," the use of AI scribes, streamlining of forms and legislative changes.

159. In reply and as described at paragraphs 49 to 58 and 488 to 514 of the main OMA brief, the OMA submits that the growing administrative burden is a significant contributor to the current crisis in family medicine as family physicians have been required to take on more and more administrative tasks. Immediate steps must be taken to address this crisis. Providing physicians with increased compensation instead of requiring them to continue to do countless hours of unpaid administrative work will allow them to hire staff or invest in technological advancements and training so that they can, in fact, provide more direct patient care.

160. Furthermore, not only has compensation for administrative work been implemented in various other provinces, but unless government is required to pay for this work, it will have little if any incentive to actually put in place and implement real changes to reduce the unnecessary administrative burden on physicians.

161. Finally, even if partly successful, the Ministry's proposed solutions are many years away and do nothing to address the present crushing administrative burden that family physicians face today and over the course of the next PSA.

162. Moreover, not all administrative work can be done by others or done by AI but needs to be done by doctors. As chronic disease and multi-morbidity has been on the rise, combined with efforts to integrate health and social services, there are more forms to fill out and consults to be managed. Physicians rightly feel unvalued when required to perform this unpaid but necessary work.

163. The OMA acknowledges that paying for unnecessary administrative work may not be as desirable as eliminating it. However, paying for the work until such time as it is reduced or eliminated will at least demonstrate an acknowledgement of the very real concern over the growing administrative burden and will demonstrate that there is a recognition of the value of the work that physicians do. At the same time, it may well incent government to bring about needed changes to reduce the administrative burden on physicians.

164. The following submission from an OMA member expresses the reality of what family physicians are experiencing on this front:

> *With a full roster of 1,600 patients, I am doing at least 2 to 3 hours of paperwork each night. "Death by Inbox" is what I equate this to. "Admin burden" is not just about forms. The admin / inbox management we do each night is a clinical extension of our day that can't be done during our time with patients. Examples include complex referrals to determine where to send our patient, our HRM inbox that takes hours because of all the double/triple entries. Each lab report in our inbox creates a task such as updating the CPP, informing staff to call the patient with the result, or reminding ourselves to call the patient. Gone are the days where I would initial my paper lab results and they would be filed into the chart. The EMR itself, coupled with a very involved and informed patient population, creates more work for us.*
>
> *The CPSO rules on following up on test results puts the onus on us to track down and make sure we receive the CT scan or mammogram we ordered. All of these "reminders" end up in our inbox and they are "tasks" that we need to complete.*
>
> *Questions from patients all need to be answered and these are all done after clinic hours. Years ago, patients would not email or call in with questions. If they had a question they would book an appointment. Now in a FHO practice, we try to handle patients' questions without an in person visit. But they are still tasks that need to be handled. Patients now have access to their lab results and to their hospital charts/reports. All of this creates more "tasks" each night. If we are seeing patients all day and trying to ensure we allow for appropriate access, these 'tasks" end up being part of our evening work – all of which is still patient care, but indirect patient care that is not accounted for by the ministry in their one visit, one issue. I tell everyone I have a day job and a night job. This is what is killing family medicine.*

165. In addition, administrative burden is not solely a problem for family physicians. For example, the administrative burden has grown and is also significant for psychiatrists. Psychiatry consultation notes are detailed, and psychiatrists spend many hours on the phone getting collateral information from family members or community agencies and advocating for the homeless or poorly housed, disabled patients who are unable to advocate for themselves. Most of this work is not financially compensated, and often occurs in the evening hours and on weekends and leads to increased burnout. Another example is the need for physicians to obtain approval for medications including biologics and for certain tests e.g. PET scans outside of present indications such as neurologists for unexplained neurologic encephalopathies. Emergency room physicians have also seen their administrative work increase including searching through OntarioConnect for history of a patient presenting in the emergency department.

166. The OMA also agrees with Ministry's submission at paragraph 212 (i) that administrative work is taking away "precious physician time" from direct clinical care. However, much of this indirect patient care administrative work is often downloaded from other parts of the healthcare system. This is not a new problem but one that has been growing steadily and significantly and, when combined with the ongoing lack of appropriate compensation, has created another breaking point for family and other physicians who continue to be and to feel devalued.

167. The Ministry's inability to understand the gravity of the many factors that are contributing to this crisis, particularly in family medicine, is either willful blindness or a conscious decision to undervalue family physicians' contributions to the care of Ontarians - neither of which is either acceptable or a responsible position for the government to take.

168. The OMA further submits that the Ministry's statements at paragraph 212(v) that the "fee system should not incent [administrative] work" ignores the realities of modern medical practice, in which technology has become permanently embedded, and trivializes the changes to medical practice and efforts to have physicians use provincial digital health tools to support patient care and provincial priorities. It creates the illusion that many of

these tasks can somehow be separated out from necessary patient care. The reality is that using technology tools and providing integrated interdisciplinary care adds an administrative burden which cannot be separated from the provision of appropriate care. These tools require that physicians develop technology training, invest in systems, security and privacy infrastructure, ensure that there are necessary backups, develop data analytics skills, privacy training and the ability to manage growing data sets, engage in complex negotiation of vendor agreements, and understand and comply with new regulatory obligations. It is disingenuous to suggest that a physician can simply provide care without undertaking and being fairly compensated for these required and related patient care activities.

169. At paragraphs 213-214, the government suggests that the Patients Before Paperwork (Pb4P) initiative will reduce administrative burden and has already done so in the short-term. While these concepts sound good on paper, in reality there has been very little progress in getting them off ground either quickly, or in a way that will create meaningful results. Indeed, the action plan is vague and without any firm commitments or timelines.[50]

170. As well, the Pb4P tools chosen were based on priorities of the government and were not validated by physicians for their utility or for their impact on workflow. These are provincial priorities, not physician priorities, and the greatest value in their adoption would be realized by the healthcare system and not physician practices. There is no evidence that the program will result in concrete reductions in administrative work as the program does not have an objective evaluation framework to measure the hours of administrative burden that could be reduced. Indeed, the OMA has not even been provided with general updates about the project plans at the Digital Health Advisory Table.

171. As well, the specific initiatives identified at paragraph 213 of the Ministry's submissions have not, at this time, actually created any measurable digital improvements and have not reduced administrative burden. For example, regarding the reduction of the

[50] Ontario, "Ontario Helping Family Doctors Put Patients before Paperwork" (April 24, 2024), TAB 30, Vol. 2, Reply BOD.

use of faxes, there is no evidence that reducing the use of faxes will result in a corresponding reduction in the clinician time spent on tasks. In fact, the OMA has raised concerns with the Ministry regarding the implementation of “Axe the Fax.”

172. As well, it is incorrect to say that the “Hospital Report Manager” (HRM) has been accomplished. While a pilot is underway, the system level impact that it will have on administrative burden is unknown at this time. As well, there have been so many barriers with respect to implementing the recommendations of the HRM task force that a new task force has had to be struck.

173. With respect to the launch of a provincial procurement process for e-referral solutions, while an RFP has been issued, it is not expected that this initiative will have any impact until a number of years out and it is unclear if the results will decrease administrative time. As well, if a different e-referral solution is selected than the one currently in use (OCEAN), there will be an additional administrative burden entailed for all the physicians that will have to change over to the new system.

174. Contrary to the Ministry’s statement at paragraph 228, there is no indication or current outcomes that demonstrate that anything proposed under the PB4P initiative will reduce administrative work for physicians; rather, it will only further digitize some processes and, in fact, may well increase administrative burden in some cases.

175. At paragraphs 215 to 225, the Ministry suggests that a new AI scribe pilot will be a panacea to all administrative burden problems. The OMA notes that while the AI scribe pilot is welcome, it is still a long way from being rolled out at scale. As well, the results described at paragraph 219 are preliminary only and have been assessed by a small number of physicians in a lab setting with standardized patients. Work is currently underway to validate the use of AI scribe in clinical settings. Moreover, as described by the government, the AI scribe role is limited to the administrative work involved in the direct physician/patient interaction, but there are many other administrative tasks involved in patient care.

176. The government has also not committed to providing any funding for the AI scribe tool, or any technological infrastructure to support and maintain the use of AI scribe, and as a result, the costs of using it will have to be borne by the family physician--yet another cost to running a practice.

177. At paragraph 226, the Ministry makes further reference to its efforts to simplify 12 government forms. Of the 12 priority forms identified, none have been successfully implemented to date. With respect to the only one that was "completed" (for hearing aids), it was implemented incorrectly and spawned a range of new issues which cannot be properly solved without new and further long-term work. Indeed, this initiative with respect to forms is evidence of the extent to which working with the Ministry of Health to address the administrative burden is both time consuming and laden with delay and frustration. In the interim, physicians will continue to be required and expected to undertake a significant portion of unpaid administrative work over the course of the current PSA, for which they should be compensated.

178. Similarly, with respect to proposed legislative changes, it appears that the prohibition on sick notes will only apply to the maximum of three legislated sick days per calendar year in the *Employment Standards Act.* As a result, it will have a minimal impact on administrative burden related to any other sick notes, given that workers are absent on average 9.5 days (private sector) to 15.8 days (public sector) per year.[51]

[51] Statistics Canada, "Work absence of full-time employees by public and private sector, annual" (January 5, 2024), TAB 31, Vol. 2, Reply BOD.

REPLY TO TABS 12 AND 13: PHYSICIAN CLINICAL ACTIVITY AND PATIENT ACCESS AND EVIDENCE OF PATIENT COMPLEXITY

179. At Tab 12.1, the government picks a handful of isolated data points, which it then takes out of context, to support its view that there are more physicians earning higher incomes but working less and providing fewer services. To support what they put no higher than their "hypothesis", they also selectively rely on a few articles which either have significant limitations or which they mispresent, as discussed below.

180. The OMA submits that the hypothesis that the government advances from these isolated data points is wrong and that its analysis is unsophisticated and completely ignores the overwhelming evidence of the impact of increasing complexity, chronicity and multimorbidity. The Ministry's analysis also makes no allowance for more indirect patient care that is not counted in absolute visit numbers, including the indirect care resulting from increased coordination of care requirements by family physicians (e.g. responding to emails from patients, reviewing labs, managing referrals, and reviewing, following up on and coordinating consult reports).

A. Growth in the Number of Physicians Relative to Population

181. The Ministry's first premise is that the number of physicians has increased at a greater rate than the population has.

182. The OMA has already replied to this argument above in our response to the Ministry's Tab 6, Retention and Recruitment. However, it is helpful at this point to reiterate some key conclusions.

a. The physician to population ratio in Ontario has in fact worsened in the post-pandemic period, falling from a high of 234 physicians per 100,000 people in 2018 to currently 225.5 physicians per 100,000 people.[52]

[52] Canadian Institute for Health Information. Supply, Distribution and Migration of Physicians in Canada, 2022 — Historical Data. Ottawa, ON: CIHI; 2023; Statistics Canada, CANSIM Table 17-10-0009-01

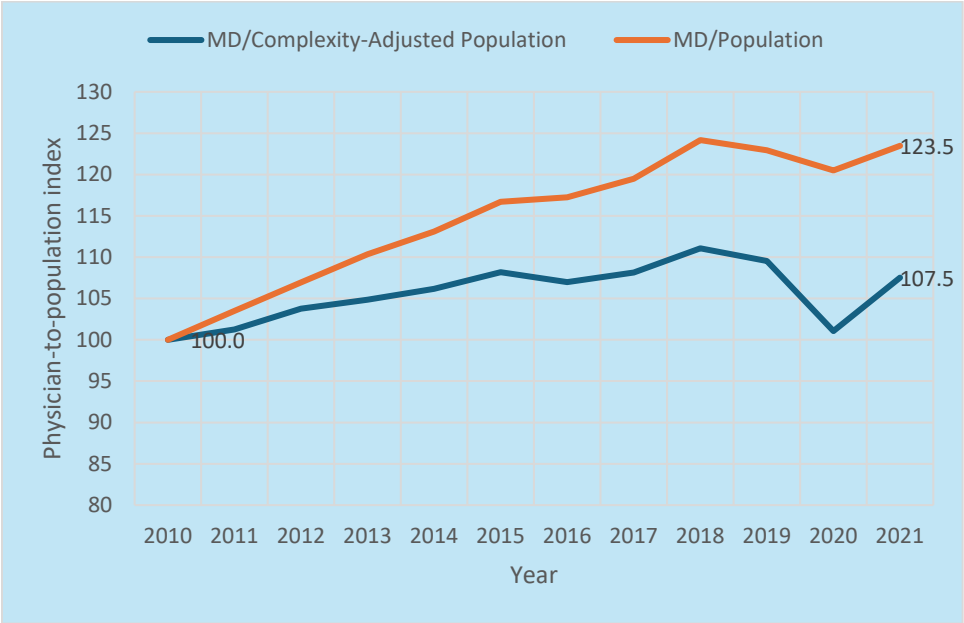
b. Looking solely at the total "headcount" of physicians is an oversimplification that does not take into account the healthcare services provided, where and when and to whom, and does not recognize that the population's current healthcare needs, which have increased in both volume and complexity, with an ageing population.

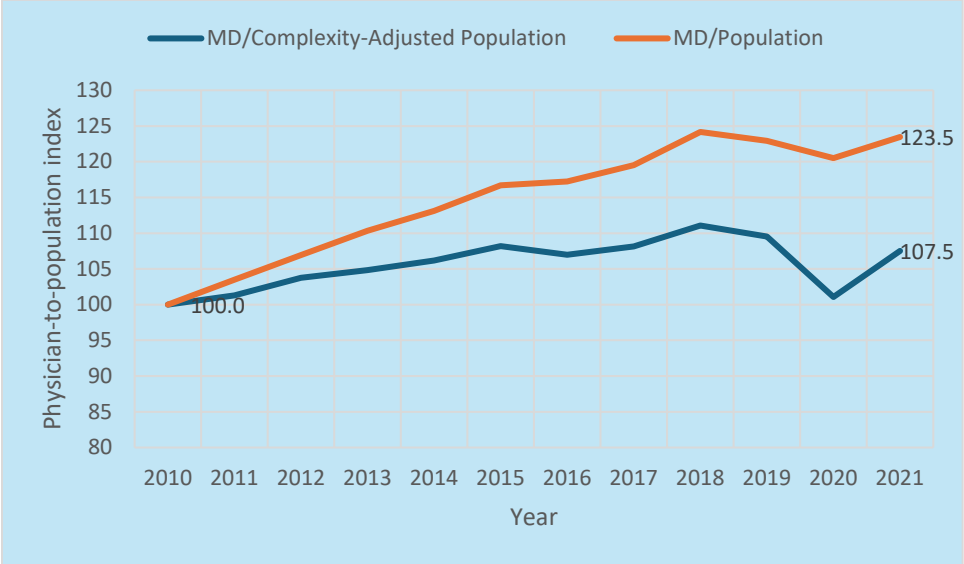
c. As set out above and in the OMA's brief and the Ministry's own documents, there is significant and compelling evidence of physician shortages, including in the north and rural regions and in practice areas such as comprehensive longitudinal family medicine, emergency medicine, psychiatry/mental health, anesthesia, obstetrics, internal medicine and surgery.[53]

d. If one looks at family medicine alone, headcount is not a useful measure given increasing patient complexity and the declining number of physicians practicing longitudinal care. From 2016 to 2023, the growth in the number of physicians practicing comprehensive longitudinal care has only been 7%, well below the population growth of 13.4% during the same time period. These findings are consistent with the government's own *Health Human Resource Overview, May 2022*[54] document, which confirms that population growth is in fact outstripping the growth in the number of family physicians.

183. In fact, when the physician to population ratio is adjusted for complexity, any absolute increase in the numbers of physicians (indexed) is offset by increased patient needs and the number of physicians-per-population it is significantly smaller, as illustrated in the following graph:[55]

[53] Physician Workforce Report, *supra,* TAB 12, Vol. 1, Reply BOD.
[54] Ministry of Health, *Health Human Resources Overview, May 2022,* at p. 3, TAB 11, Vol. 1, Reply BOD.
[55] Canadian Institute for Health Information data on physician and population and CIHI Grouper data on complexity.





184. Contrary to the Ministry's hypothesis, this data supports the view that absolute numbers are an inaccurate measure to indicate true physician supply, such that case complexity needs to be incorporated into these measures.

B. Growth in Physician "Income"

185. The Ministry's second contention is that physician income has grown more than across-the-board increases since 2021. This conclusion is also flawed.

186. Again, the OMA has already addressed this argument above in our reply to the Ministry's Tab 8, in the discussion of the difference between price vs income. However, we reiterate here some key findings:

- Based on the OMA's analysis, since 2019-20, physician income has grown by either 5.8% or 6.5 %, depending on the data source used, which is close to the compensation rate increase over this time period, not the 10% suggested by the government at page 116.

- The Ministry's calculation contains the following flaws:

    - The estimated 2023-24 PSB number that it uses is 1.2 % higher than the OMA estimate.

    - The government has included items such as CMPA, Technical Fees and Benefits in their calculations which do not reflect changes to physician compensation for professional services provided.

    - The government has calculated the number of physicians using the number of physicians with at least one OHIP claim in a year instead of the number of physicians in each year from the Ontario Physician Reporting Centre (OPRC),[56] which is an independent and definitive source of information on the number of physicians in practice and postgraduate medical training in Ontario.

- When these errors are addressed, the increase in average physician expenditure is 6.5 percent, rather than 10 percent.[57]

- Another source of data for physician income is CIHI data regarding gross clinical payment per full-time equivalent physician. This is widely accepted

[56] OPRC is an independent institute that is governed by the Ontario Ministry of Health, the College of Physicians and Surgeons of Ontario, the Council of Ontario Faculties of Medicine and the Ontario Medial Association. It is the definitive source of information on the number of physicians in practice and postgraduate medical training in Ontario.
[57] See table at paragraph 138 above.

as the most appropriate and accurate measure of physician incomes According to the CIHI data for 2012-13 to 2021-22 (latest available year), changes in the gross clinical payment per FTE and the physician compensation rate have been closely tracking each other. Using 10 years of historical data, it is possible to project that physician incomes will increase by about 5.8 percent since 2019-20, close to the compensation rate increase over this time period.

C. Billings and Patients Seen

187. The Ministry's third contention is that growth in price adjusted fee-for-service and shadow billings and rate adjusted expenditures has exceeded growth in patients seen and that the number of patients seen, and patient encounters has declined, with the Ministry hypothesizing that this means physicians are working less overall, and that patient access is decreasing. Once again, this superficial analysis does not withstand careful review.

188. The OMA has already explained above that looking solely at patients seen encounters is the wrong measure because it ignores completely evidence of complexity. Nonetheless, in their analysis, the government uses a simple count of patient encounters and distinct patients as a measure of physician productivity. However, this does not account for the fact that the type of patient encounters as well as the acuity of patients has changed over time.

189. Since 2004, the OMA and the Ministry of Health have measured utilization as the fee-weighted sum of physician services to account for exactly this fact. Given that fees for each service are set through a bilateral process (MSPC until 2021, PPC thereafter) based mainly on time and complexity of each service, this approach to measuring productivity recognizes that some services may take more time or are more complex than others, and that the case-mix of services may change over time.

190. Contrary to the Ministry's simplistic analysis, when the patient encounters and the number of patients per physician are weighted by the fee (i.e., time and complexity) for

services provided, the total value of physician services has in fact increased over time. This is because the average visit fee and average fee per patient have increased more than the decrease in the number of visits per physician and the number of distinct patients per physician. This data is set out in the following table:

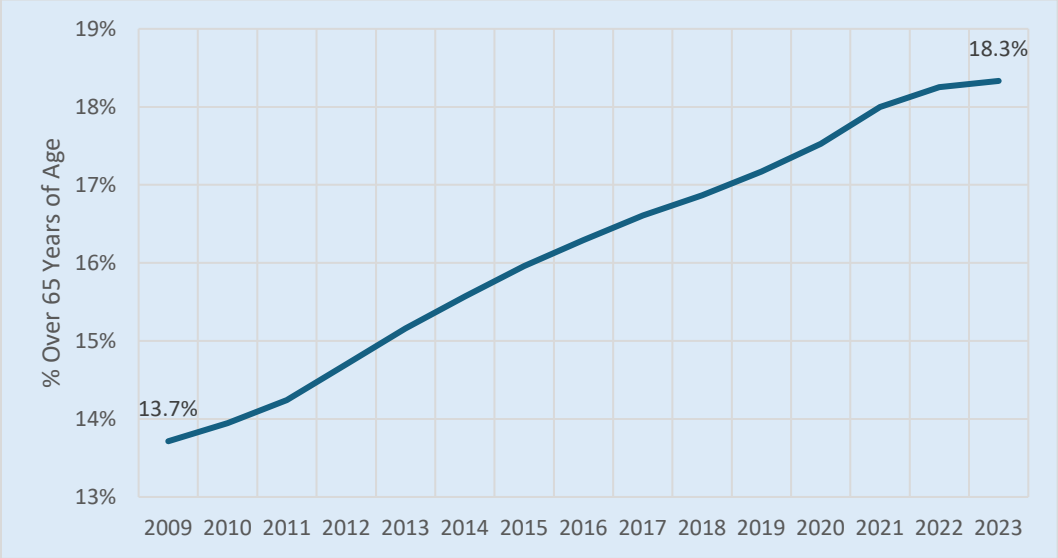
Value of Physician Services, Visits, and Patients

Year	Value of Physician Services	Visits per Physician	Average Visit Fee	Distinct Patients per Physician	Average Fee per Patient
2008	$295,760	4,459	$66.33	2,057	$143.81
2016	$296,562	3,954	$75.00	1,989	$149.09
2019	$298,318	3,786	$78.79	1,934	$154.22
2022	$306,557	3,694	$82.98	1,828	$167.66
Percent Change					
2008 - 2022	3.7%	-17.1%	25.1%	-11.1%	16.6%
2016 - 2022	3.4%	-6.6%	10.6%	-8.1%	12.5%
2019 - 2022	2.8%	-2.4%	5.3%	-5.5%	8.7%

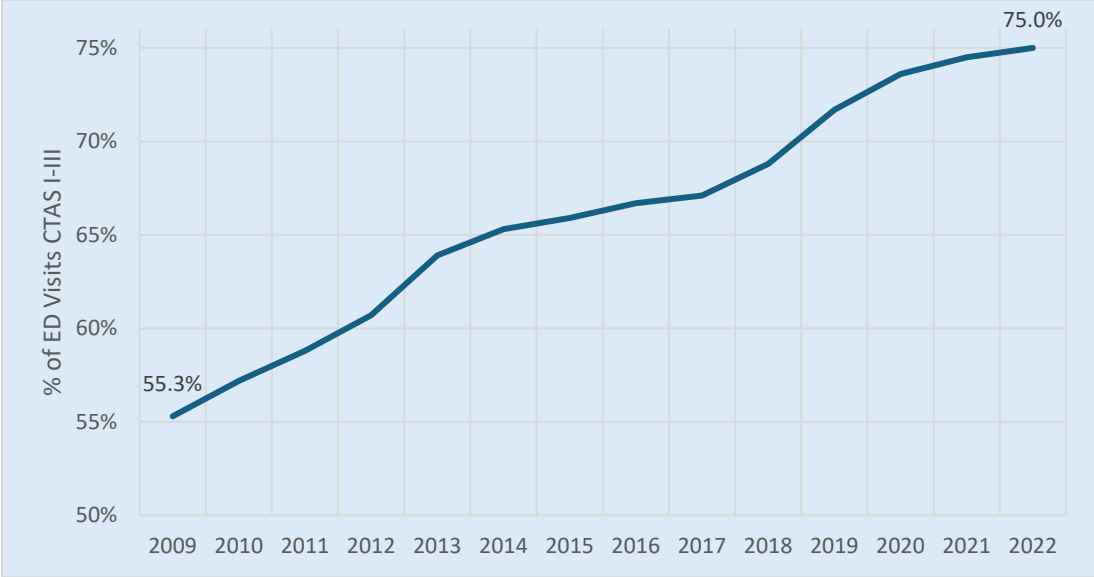
191. The fact that both the value of services provided to each patient and the values of services provided during each visit have been increasing can be explained by increasing complexity of patients. Indeed, there are numerous indicators that the average patient complexity is increasing.

192. These indicators of increasing complexity include the following:

i) The proportion of Ontario population over the age of 65 has been increasing over time, from 13.7 percent in 2009 to 18.3 percent in 2023.



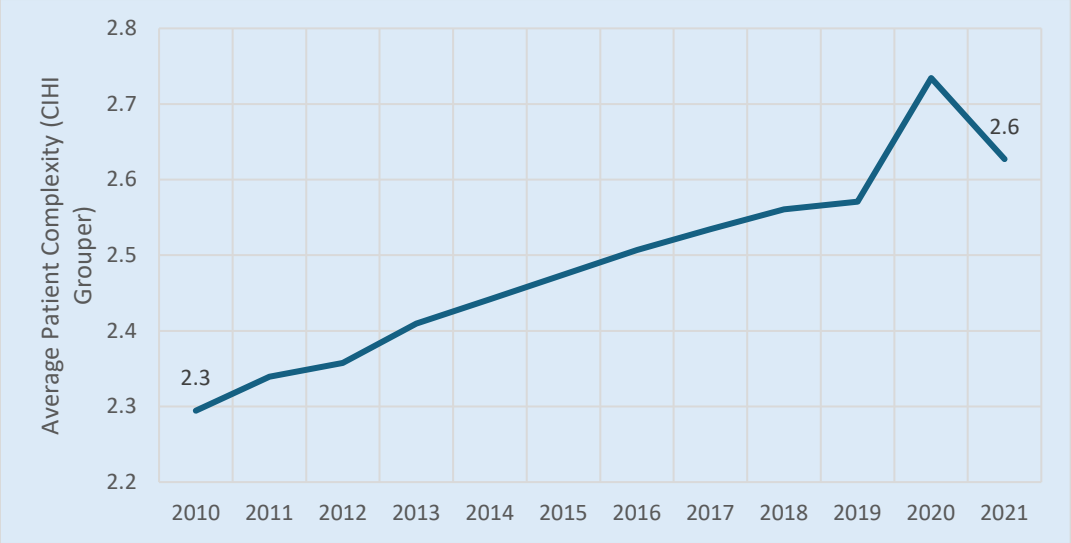
ii) The proportion of Emergency Department visits that are more complex (CTAS levels I-III) has been steadily increasing over time, from 55% in 2009-10 to 75% in 2022-23.



iii) The average resource intensity for patients, as measured by the CIHI Population Grouper[58] (the most reliable and comprehensive risk-adjustment system in Canada developed over several years by CIHI with support from

[58] Canadian Institute for Health Information. Population Grouping Methodology. Accessed May 28, 2024, TAB 32, Vol. 2, Reply BOD.

clinical experts, ministries of health, and other experts) has also been steadily increasing over time.



iv) This increase in complexity is also documented by Steffler et al. (2021), which the government cites but misrepresents at Tab 13 of its brief. The authors find that, by accounting for a patient's full health profile using the CIHI Population Grouper, "[t]he average concurrent [Resource Intensity Weight] RIW for the age- and sex-standardized population increased by 4.6% over the study period."[59] The government, however, completely ignores this key finding in its analysis.

v) The proportion of surgical procedures that are more complex (ASA Levels III – V and ASA E)[60] has also been steadily increasing over time, as a proportion of all surgical procedures.

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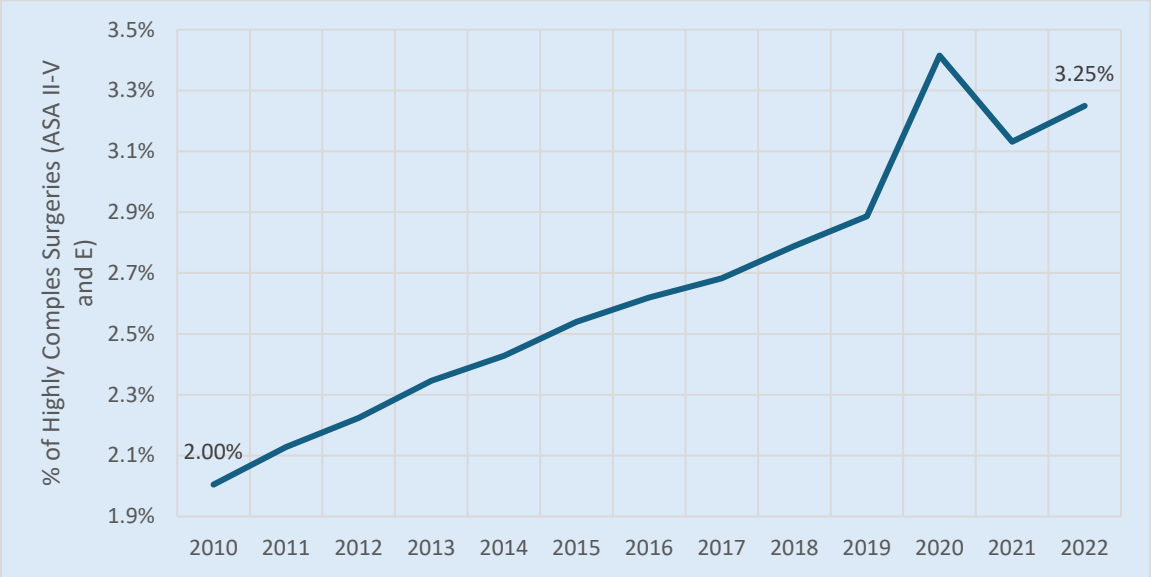
[59] Steffler M, Li Y, Weir S, Shaikh S, Murtada F, Wright JG, Kantarevic J. Trends in prevalence of chronic disease and multimorbidity in Ontario, Canada. CMAJ. 2021 Feb 22;193(8): E270-E277. doi: 10.1503/cmaj.201473. PMID: 33619067; PMCID: PMC8034347, at page E275, Exhibit 18, MOH Exhibits.

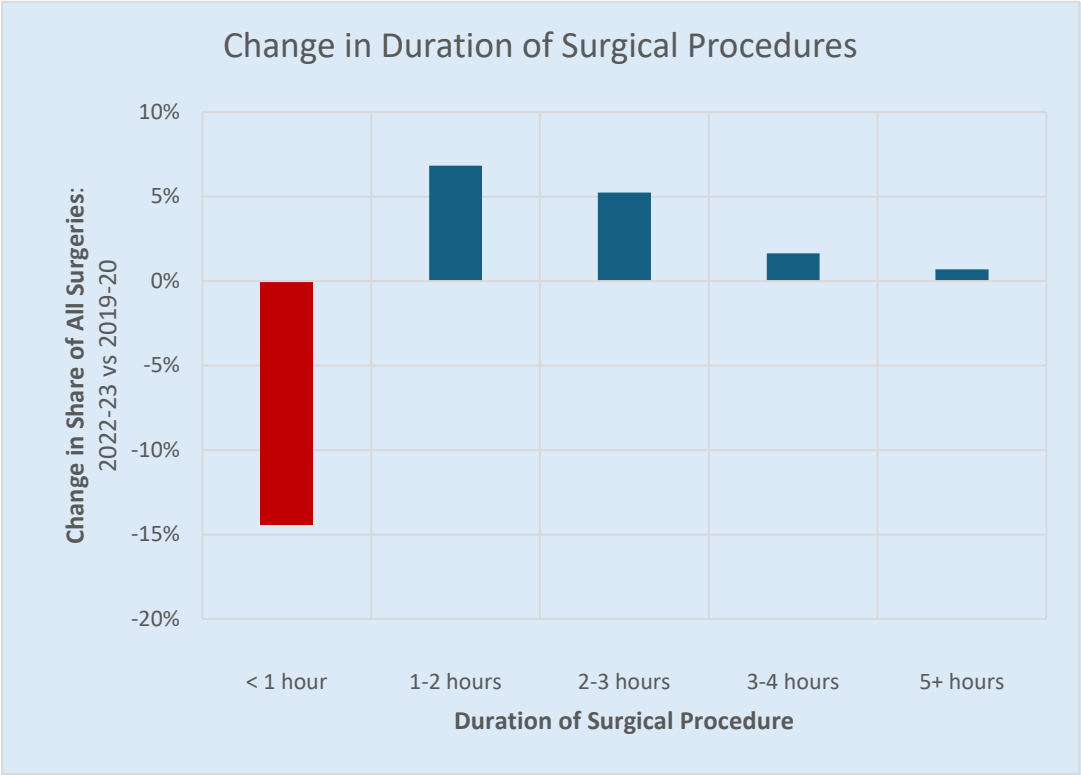
[60] ASA score refers to the "America Society of Anesthesiologists' score that is simple but reliable and predictive of outcomes in patients undergoing surgery. ASA 1 is a normal healthy patient, ASA 2 is a patient with mild systemic disease, ASA 3 is a patient with severe systemic disease, ASA 4 is a patient with severe systemic disease that is a constant threat to life, ASA 5 is a moribund patient who is not expected to survive without the operation. ASA 6 is a declared brain-dead patient whose organs are being removed for donor purposes, ASA E identifies emergency surgery. II is stable mild disease



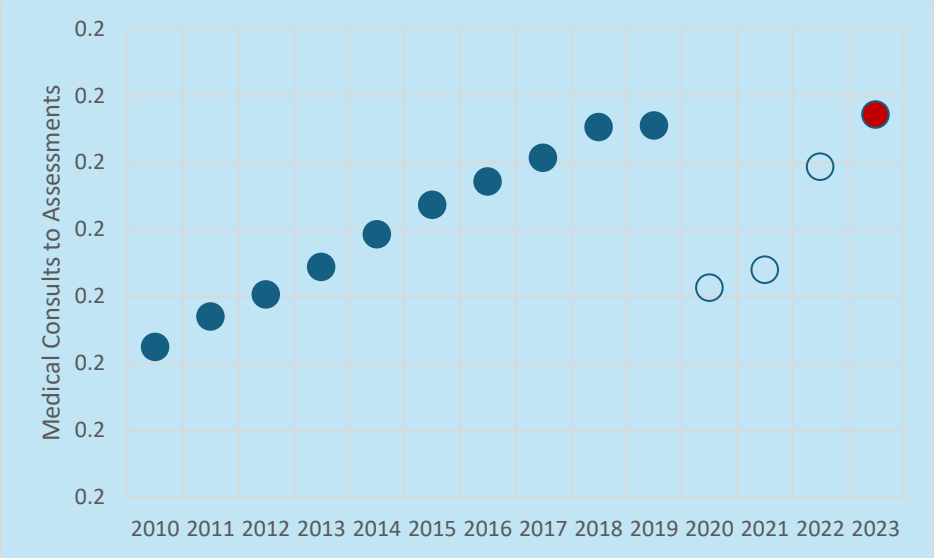
vi) The average duration of surgical procedures has also increased from the pre-COVID period, from the average of 87.6 minutes in 2019-20 to 102.3 minutes

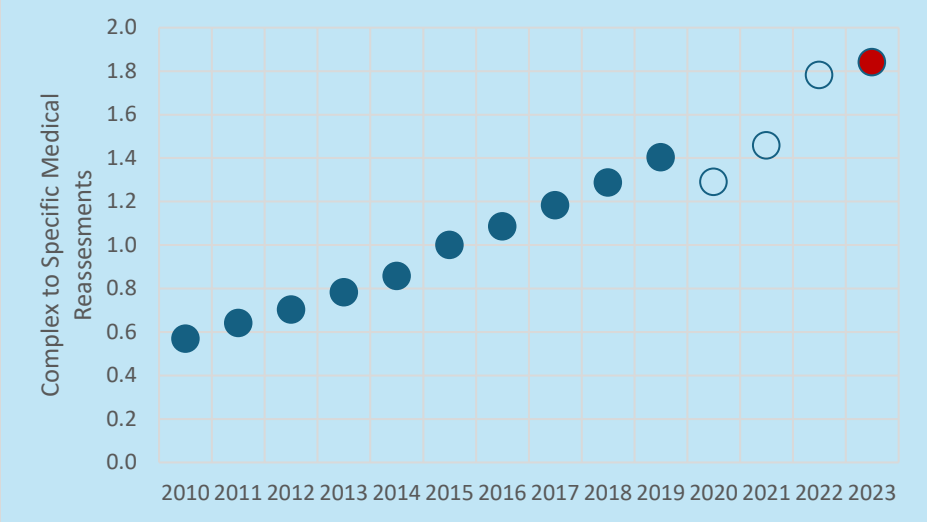
(smoker, controlled high blood pressure), III is stable chronic disease (COPD, chronic angina) with IV being a constant threat to life (e.g. dialysis). See American Society Anesthesiology, ASA Classification System Physical Status, Last amended: December 13, 2020, TAB 33, Vol. 2, Reply BOD.

in 2022-23.

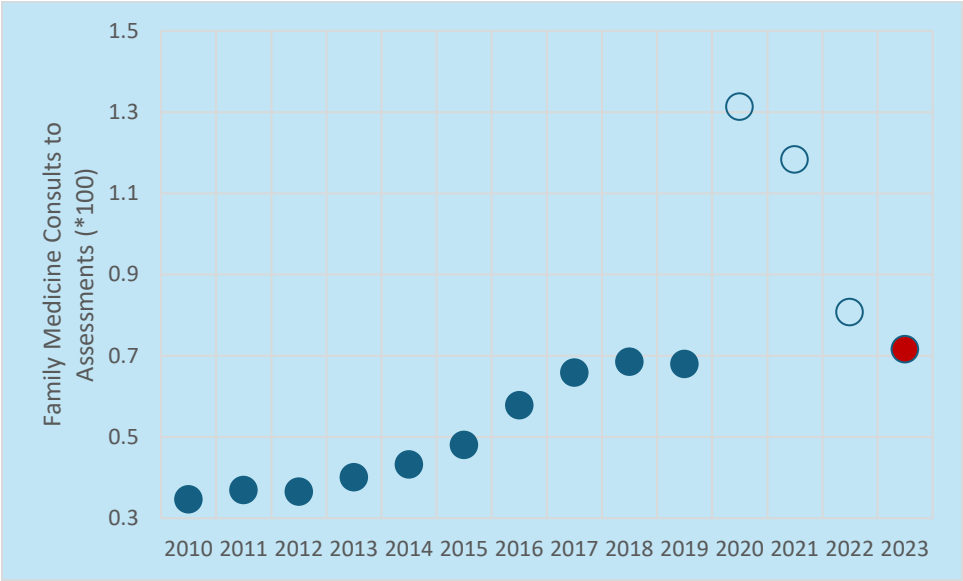


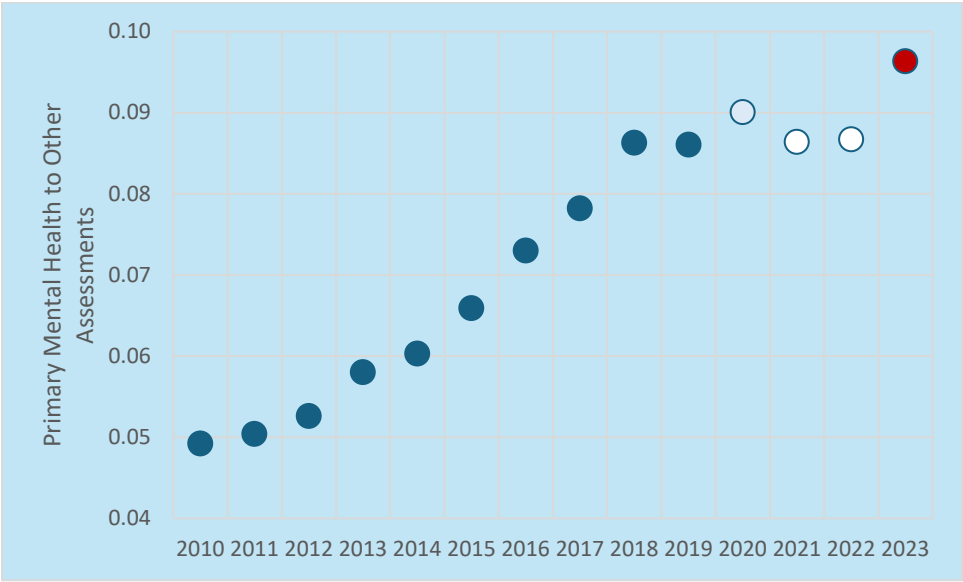
vii) For Medical Specialists, the ratio of consults (more complex) to assessments (partial and specific, less complex) has been increasing over time. The same is true about the ratio of complex re-assessments to specific reassessments. [Note: Prior to 2020, the circles in blue represent all visits. The unshaded circles for 2020 to 2022 include only in person visits, because while the COVID K codes were in place, they did not distinguish between different types of visits, including between consults and assessments or between different types of assessments. For 2023, the data (the red circles) reflects a full comparison as it includes both virtual and in-person visits].





viii) Similarly, the ratio of consultations to assessments has also increased over time for Family Medicine, as has the ratio of primary mental health care to other assessments.





ix) Older populations typically have higher healthcare needs due to age-related conditions such as cardiovascular diseases, arthritis, and dementia. The increase in the population of seniors places additional demands on healthcare resources, including primary care, long-term care, and specialist/acute care. The government recognizes this which is why the 2024 budget included funding for increasing long-term care beds.

x) Patients with multimorbidity present challenges for physicians managing their care and, as the proportion of these patients in the population increases, for health care system planning. The prevalence of multimorbidity and chronic disease has been strongly associated with primary care use, specialist consultations, number and intensity of inpatient hospital admissions and other types of care.

193. In its overly simplistic analysis, the Ministry ignores this evidence of increasing patient complexity, which provides a compelling and convincing explanation for why the number of patient encounters and number of distinct patients seen has decreased and why it is not in any way a meaningful measure of workload. This increase in complexity also explains why physician billings may increase as the value of services increase with increasing complexity.

194. Rather than analyze the multitude of complex factors at play, the Ministry chooses instead to adopt an overly simplistic approach that supports its false narrative of a lack of productivity among family and other physicians, citing increased numbers of physicians, but not increased visits. This is an unsophisticated argument that fails to recognize the impact of chronicity, complexity and multimorbidity, and an aging population, all of which requires more time per visit. It also ignores the reality that family physicians, as well as various specialists, are routinely dealing with multiple issues per visit, but the OHIP billing system has no functionality to document the number of issues per visit. As discussed in the main brief, and above, there is also more indirect patient care including increased coordination of care requirements, responding to emails from patients, reviewing labs, and managing referrals.[61]

195. Thus, the OMA submits that, when the Ministry's cherry-picked data is analyzed more closely, it does not support the Ministry's narrative that physicians are working less

[61] Lavergne R, Peterson S, Rudoler D, Scott I, Mccracken R, Mitra G, Katz A. Productivity Decline or Administrative Avalanche? Examining Factors That Shape Changing Workloads in Primary Care. Health Policy. 2023 Aug;19(1):114-129. doi: 10.12927/hcpol.2023.27152. PMID: 37695712; PMCID: PMC10519339, TAB 34, Vol. 2, BOD.

and earning more—but rather this is a misleading and disrespectful narrative ("hypothesis") that the government has deliberately chosen to put before this Board.

D. Ministry Tab 12.2: The Lee paper

196. In support of their contention, the Ministry also cites three papers. However, the OMA submits that the cited evidence is either severely limited or grossly misinterpreted.

197. In Section 12.2, the Ministry cites extensively from an article entitled "The Induced Productivity Decline Hypothesis" by Lee et al. in an attempt to substantiate its claim that Ontario has more physicians who receive higher compensation but provide fewer services.

198. First, the Lee et al. article looks at the period 2007 to 2018, using national data. It is not specific to Ontario and says nothing about Ontario, nor Ontario family physicians. Second, and more importantly, the author uses the simplistic measure of the number of patient services provided per physician per year to define productivity, which as discussed above is a highly problematic approach. As well, the author uses CIHI fee-for-service (FFS) counts of services, which exclude NFFS (non-fee-for-service) work. While Lee claims this approximates NFFS work, even Lee admits that this may be inaccurate. Lee also makes no adjustments to the numerator (service counts), or the denominator (physician counts). In effect, Lee is assuming that a service provided in 2007 is the same throughout their study period to 2018. This is a serious limitation as it fails to account for observed changes in patient complexity and changes in service mix over time. Furthermore, the Lee article ignores changes not only in the demographics of the broader population but also of physicians.

199. The Lee article also lacks any rigorous statistical analysis and ignores the severe limitations of the data used. While the authors list the many limitations of their own study, they do not attempt to address any of them. For example, they state that:

- As the population ages and comorbidities increase, the patients' needs become more complex and require more time.
- Changing demographics of the medical profession (gender, ageing) are not accounted for.
- NFFS/APP service assumptions may be inaccurate.
- Many physicians are excluded from the CIHI data (anesthesia, imaging).
- CIHI data does not capture Alberta or the Territories.
- Overhead costs were not available.
- The productivity measure is impacted by the value and mix of service provided and this changes over time.
- Patient complexity is not measured in any of the databases used.
- CMA survey sample sizes and response rate vary greatly over time and may not be representative of all physicians.

200. A simple counting of services, even if the count was accurate, does not reflect the quality or length of care provided, or the intensity or complexity of cases handled by physicians. Under this approach, if one just takes a raw count of visits, two visits by healthy patients would be better (more productive) than one visit by a complex cancer patient. Quality takes time and more complex patients take more time to provide care to and to service.

201. For example, a typical visit to a family physician may take 15 minutes, however, as the patient population ages and gets more complex, this average may increase (for example, by 3 minutes) to 18 minutes (over a period of 10-15 years a very conservative assumption) Those 3 minutes represent a 20% change. It would take 20% more time to service patients than before, or for a fixed period such as an 8-hour day, you would end up serving fewer patients. The Lee paper makes no attempt to include any such

adjustments in their calculations or conclusions. Indeed, this simple example alone would offset the alleged 21% decline in services reported for family physicians by Lee.

202. As well, Lee reports a decline in services per physician (his sole measure of 'productivity') as captured by aggregate CIHI data. However, service counts are greatly impacted by the type of payment (i.e., FFS, capitation, salary). Lee reports that the data he uses only captures FFS-based services but not NFFS services, yet he claims to 'estimate' these NFFS services which are not observed.

203. As noted above, patient complexity is an important factor that Lee also ignores. As discussed, complexity is related to the age, presence of co-morbidities, chronic conditions, and other patient factors. More complex patients require more physician time. There are various measures available to gauge how complexity has changed over time. These range from simple measures such as the share of the population that is elderly to more sophisticated measures such as the CIHI Case Mix Grouper and John Hopkins ACG measures of case-mix. As set out above, all measures point to rising complexity.

204. The data Lee relies on respecting hours of work is for different groups of physicians (a sample) and for a different period. For example, the CIHI services data is for 2007-2018 and Lee looks at hours worked data for 1998-2019 from CMA sample surveys. The authors themselves acknowledge that their results may not be generalizable: "Response rates for the CMA National Physician Health Surveys averaged 40% of a random sampling of 8,000 physicians across the country from 1998 to 2004 and 20% of all physicians between 2004 and 2019 and <u>may not be generalizable</u> to all physicians."

205. In addition to the variation in sample size and response rates, there are additional issues with the use of CMA surveys beyond those that Lee acknowledges. The CMA used a variety of distinct annual survey instruments with surveys administered in many but not all years. Between 1997 and 2003 it used its Physician Resources Questionnaire; in 2004, 2007, 2010 and 2014 it used the National Physician Survey, which was a joint effort of the CMA, the College of Family Physicians of Canada, and the Royal College of Physicians and Surgeons; and in 2017 and 2019 it used the CMA's Physician Resource

Survey. These were all retrospective surveys soliciting the average hours per week usually spent on various activities. This introduces the possibility of recall bias issues in the data.

206. The authors report that average hours have declined, since 1998, by 11% for men and 2% for women. However, they do not discuss the data during the time that corresponds to their service data – 2007-2019. It appears from Figure 3 that there has been no decline for female MDs at about 46 hours/week in both 2007 and 2019, and a slight decline for males from about 50 hours to about 47 hours. We are not given any information on the sampling designs nor sample size of the data used. So, it appears to be a 5% decline overall, or 0.4% per year.

207. There is no statistical analysis of any of the results presented in the Lee article, no confidence intervals, no statistical significance testing (t-tests) or modelling of any kind in any of their 'analysis'. Indeed, describing this paper as a' research paper' is a misnomer; rather, it is at best an opinion piece that pulls together disparate descriptive readily available data sources to make apples to oranges comparisons.

208. Furthermore, the government selectively omits the acknowledgment by the article authors of a significant increase in physician work for "indirect patient care", defined as "reports, charting, patient or family phone calls."[62] Even though the analysis from this paper is dated and does not reflect indirect patient care currently in a post-pandemic environment, this measure does suggest that there had been a dramatic increase in the "administration" of medicine which is supportive of the experience noted by many physicians.

209. In summary, the Lee article falls short in providing a robust, statistically sound, and comprehensive examination of physician productivity. Any policy recommendations or assessments derived from this article, particularly by this Board, can only be made with

[62] Lee SK, Mahl SK, Rowe BH. The Induced Productivity Decline Hypothesis: More Physicians, Higher Compensation and Fewer Services. Health Policy. 2021 Nov;17(2):90-104. doi: 10.12927/hcpol.2021.26655. PMID: 34895412; PMCID: PMC8665726, at page 97, Exhibit 16, MOH Exhibits.

extreme caution due to the article's substantial limitations, the simplistic nature of the productivity measures used, and the on the ground real world experience of physicians, some of which is further detailed below.

E. Reply to Ministry 12.3: The Kralj paper

210. In Section 12.3, the government cites selective excerpts from the paper “Long-Term Trends in the Work Hours of Physicians in Canada” to support its claim that doctors are working less, despite receiving higher incomes over time.

211. However, the OMA submits that the conclusions that the Ministry draws from the paper are not supported by the paper at all. In fact, the Ministry draws conclusions (that unsurprisingly align with its misleading and faulty narrative) that are above and beyond what could be reliably inferred based on the data analysis in the article.

212. Specifically, the paper is based on self-reported responses to a survey. Therefore, these results are subject to some well-known potential survey deficiencies such as the sampling and nonresponse biases. The survey question also does not allow direct patient care to be disaggregated from other work such as administration, teaching, and research, which may lead to a response bias due to the question ambiguity. This is not surprising given that the data source (Labour Force Survey) is not designed, nor targeted, specifically for physicians.

213. Apart from the fact that the paper focused on Canada and not Ontario, the sample size is too small prior to 2007 to make any reliable statistical inference. In fact, for the period where the sample size reached 1,000 observations (14-year period spanning 2007 to 2021), so that potentially more reliable statistics could be produced, hours worked by Ontario physicians remained unchanged, at about 46.5 hours per week. This is higher than physicians in most other provinces (BC, Manitoba, Saskatchewan, Alberta, and Quebec) and significantly higher than any other Canadian workers.

214. Most notably, the study authors explicitly reject the explanation that increased compensation leads to decreased hours of work, stating that they “found no evidence that

increased physician payments and the resulting income effect contributed to reduced work hours."[63] Therefore, the Ministry claim respecting its target income hypothesis (that higher remuneration leads to lower hours of work) is completely unsupported by the study it relies on.

F. Reply to Ministry tab 13.1: Increasing Patient Complexity

215. Finally, at tab 13.1 of its brief, the government relies on an article entitled "Trends in prevalence of chronic disease and multimorbidity in Ontario" to support its contention that there is an absence of evidence of increasing patient complexity. As discussed above, there is in fact considerable evidence of increasing patient complexity. Moreover, in the OMA's submission, the government has misrepresented the results of the article, relying on selective excerpts taken out of context to support a conclusion that is entirely opposite to that of the authors. For clarity, it is not that the study results permit different interpretations; rather, the Ministry draws conclusions from it that are utterly wrong. Specifically, the article examined trends in chronic diseases and multimorbidity by examining:

(a) Crude prevalence of chronic conditions and multimorbidity (increasing);
(b) Age-sex adjusted prevalence and multimorbidity (decreasing);
(c) Changes in type and severity of chronic conditions; and
(d) Overall patient complexity.

216. The Ministry presentation of the study focuses on the first two points (a) and (b) only. However, the declines in age-sex standardized chronic illness and multimorbidity rates are concentrated among minor and moderate health conditions, while the prevalence of major chronic diseases were decidedly on the rise. In short, the article concludes that there has been a shift away from more minor chronic disease and toward

[63] Boris Kralj, Rabiul Islam, Arthur Sweetman, "Long-term trends in the work hours of physicians in Canada"
CMAJ Mar 2024, 196 (11) E369-E376; DOI: 10.1503/cmaj.231166 at page E374, Exhibit 17, MOH Exhibits.

more severe disease in Ontario's population, resulting in higher average patient complexity (as measured by the CIHI's Population Grouper).

217. In particular, and contrary to the position of the government, the study authors conclude that[64]

> "*The average patient complexity for the age-sex standardized population increased by 4.6% over the 10-year study period*."
>
> "*Rising resource intensity in the age-sex standard patient population indicate that the mix of health conditions in Ontario requires increasing amounts of health system resources to treat, beyond what would be expected with population aging. Further, the increasing burden measured among the highest cost cases indicates that the costliest cases are becoming increasingly complex*."

218. The OMA is at a loss to understand how the government brief failed to mention these key and most relevant conclusions from the study.

219. Overall, the OMA submits that Ministry's conclusions at Tabs 12 and 13, namely that physicians are working less but earning more and that there is no evidence of increasing complexity, are unsupported by the academic literature and based on a flawed and selective reading of isolated data points.

G. Real-World Physician Experience

220. The fact that physicians are continuing to work very hard and long hours and that patient complexity is increasing is also supported by countless real-life on the ground reports from physicians in a variety of practice areas. Since the Ministry's arbitration brief was released, the OMA has received a large number of submissions from its members practicing in a range of specialties or in family medicine, some of which are excerpted below.

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[64] 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. CMAJ. 2021 Feb 22;193(8): E270-E277. doi: 10.1503/cmaj.201473. PMID: 33619067; PMCID: PMC8034347, at page E275, Exhibit 18, MOH Exhibits.

221. While written from a variety of perspectives and coming from across the province, these submissions are united in their disbelief at the government's position that there is no physician shortage, physicians are working less, and there is no evidence of increasing patient complexity, all of which are not supported by their lived experiences, nor as detailed above the evidence.

222. A number of common themes also emerge from these submissions. These include the following:

- Physicians are experiencing increased workloads, extended OR times/blocks, increased waitlists, increased complexity, and longer surgeries due to increasing patient complexity, staff turnover etc.
- Physicians have unpaid teaching responsibilities. which must be added on top of full clinical hours as they cannot afford to take 'time off' clinical hours to teach.
- Physicians are doing more care coordination than ever before.
- Patient care takes longer due to language barriers, and increased access to data (EMR, OLIS, diagnostics), which require more reviewing time for patient data, greater treatment and diagnostic options, and which takes more time to consider, discuss with patients and treat than before.

223. Illustrative excerpts from just some of these submissions are set out below from different practice areas.

i) Anesthesiology/Surgery

224. Anesthesiologist and surgeons report that they are doing more complex cases in the community with less specialty resources, stretching scope of GP-anesthetists in settings and cases not previously used, use of more anesthesia assistants to address shortages, and long hours to cover shortages.

225. One Anesthesiologist writes as follows of long hours and increasing complexity:

> *Overall, in hospitals, patients are presenting with more comorbidities including higher BMIs than ever and are having longer, more complex surgeries...Case complexity has become an important contributor to increased time spent either directly with the patient or with the coordination of care- extra meeting or collaboration with other physicians or allied health professionals.*
>
> *OR cases that involve more complex cases take longer to organize, setup and do the surgery and require more complex postoperative management EMR documentation, retrieval of information, and administrative/additional legal/safety requirements slow the function of the OR, inpatient services and outpatient clinic visits.*
>
> *...In AHSCs, the OR days have been getting longer and longer and there is also increased elective work on weekends in many hospitals to catch up on the backlog.*
>
> *At Toronto General Hospital, most of the elective ORs run routinely until 17:00 or 19:00. The Anesthesiologists have 8 levels of call for all of these elective late rooms every day. Many other AHSCs also have many rooms that routinely run long. At Mount Sinai, nearly half of our ORs are staffed to 17:00 or more every day.*

226. An Anesthesiologist from a hospital in Sudbury similarly reports long hours and increasing complexity:

> *As an intensivist, our patients are increasing in complexity. We are the referral center for Northeastern Ontario, where there is a severe shortage of family physicians. Critically ill patients often present with complex, unmanaged diseases, with a lack of access to primary care. There is also an opioid crisis in Northern Ontario, leading to very complex medical conditions, multiple system diseases and prolonged hospital admissions...This invariably increases workload.*

227. Another Anesthesiologist from a hospital in Kingston shares similar concerns and notes in particular the increasing number of highly complex surgery cases that they are seeing at what was traditionally an ambulatory surgery:

> *Hotel Dieu Hospital is a site traditionally for ambulatory surgery and has no critical care. Our patient population has changed, previously we would say "not a candidate for Hotel Dieu" including ASA 4 patients but now anything*

goes. We have fully embraced doing any kind of patient - babies (Hotel Dieu has no pediatric capacity), BMI 80 patients as well as complex and comorbid patients. Our workaround is that we pre-arrange ambulance transfers for high-risk patients, and they are transferred postoperatively via ambulance from Hotel Dieu to Kingston General.

Just last week my colleague did yet another ASA 4 patient - renal failure, recent pneumonia/COPD, CAD, obesity/OSA etc. for head and neck extensive skin cancer resection. Two anesthesiologists said, "Not a candidate for Hotel Dieu." There was no other OR time at Kingston General available for this patient. Basically, he had to have his surgery at our "ambulatory" center or he would die from his cancer. His surgery occupied the whole day and when frozen sections were needed they had to be taken by taxi across the city to pathology at our acute care hospital. He had an art line, insulin and norepi infusions; not a typical ambulatory surgery case.

228. Another Anesthesiologist shares this perspective, noting that numbers of procedures hardly tell the whole story regarding how hard doctors are working:

In my hospital, when the goal started to be catching up with the backlog of surgeries created by the pandemic, the hospital kept saying we were working at 70% or 80% capacity from pre-pandemic levels. It felt odd as we were collective tired and feeling we were working way more. For instance, we created one more list on Saturday and Sundays.

When we dissected the data more, what we realized is that in fact we were doing 70 or 80% of the OR blocks pre-pandemic levels, but when we looked into hours worked, we saw that we were in fact working more than 100% from pre-pandemic levels. The summary of this story is that there is more than one way to measure things. Number of surgeries, number of OR blocks, average wait period etc. But bottom line, for us, it is how many hours working that truly counts.

[As well,] we are offering surgery to people that we would have never offered it before- people with complex comorbidities/psychiatric/developmental challenges that require additional time and consideration.

There are human resource and flow challenges in the hospitals that continually slow things down. Fewer nurses, PACU delays, fewer OR attendants to clean rooms, and instrument delays also contribute to decreased efficiencies. Also, increasing use of minimally invasive approaches to surgery including robotic surgery has contributed significantly to longer procedure times but are much better for patient recoveries. Many hospitals are still recovering from the HHR impacts of the pandemic and have ongoing challenges in reopening all of their operating rooms. Ironically, that is partially keeping the anesthesiology shortage from being the rate-limiting factor in getting more ORs opened.

> *...Another aspect to this is that bed flow issues, particularly during flu season, result in medical overflow into surgical beds, resulting in cancellations of elective surgeries. Sicker surgical patients also stay in hospital longer which also contributes to bed flow issues. All of the bedflow issues also back up into the recovery room (PACU) preventing them from flowing patients out and accepting new ones from the operating room thus prolonging the surgical times as the OR team is stuck in the room waiting to come out.*

229. Another example from a physician in Hamilton:

> *We are doing lists on Saturday and Sundays in the OR and have been requested by the EP lab to do Saturday cases and a weekday list that goes until 7pm. We keep doing more lists with the same amount of people, so my impression is that we are working more.*
>
> *Additionally, it is VERY common in my department for anesthesiologists who are on a day off to come with short notice to the hospital due to an emergency case, but all other in house anesthesiologists are already busy with their own cases. This has been happening more and more because we have been doing more non-OR cases, so it increases the pool of emergency that may need us, particularly in Neuro-DI.*

230. With respect to surgery, it is also important to note that there has been an increasing trend to use minimally invasive surgery. One study has found an increase from 9% to 52% of surgeries between 2004 and 2014.[65] This results in much better outcomes for patients, but it also takes much longer, which accordingly has an impact on the total number of surgeries that can be performed.

231. One surgeon reports as follows:

> *Patients are more complex, older, and often sicker by the time we see them. The Canadian life expectancy was 79 in 2000, 81 in 2010 and is now 83. The average age similarly climbs aggravated by the demographic bulge of the baby boom. Whereas once there were understood age thresholds for care, we now are actively treating older patients (e.g. the 87 year old kidney transplant recipient at St. Mike's from 2023).*
>
> *Lack of access to primary care, particularly access to good primary care with a professional who has a level of comfort in managing system specific illness,*

[65] Hoogerboord, Marius, James Ellsmere, Antonio Caycedo-Marulanda, Carl Brown, Shiva Jayaraman, David Urbach, and Sean Cleary. "Laparoscopic colectomy: trends in implementation in Canada and globally." Canadian Journal of Surgery 62, no. 2 (2019): 139, TAB 35, Vol. 2, Reply BOD.

only results in more work for the specialists, through their offices, and ultimately through the ER and in patient wards.

The pandemic led to slower surgical times, mainly due to stringent respiratory precautions. Add to that nursing shortages, and other resource limitations. At my institution it is extremely common to have to wait in the OR after the surgery is done, to transfer the patient to recovery room, due to lack of capacity. We should be returning to pre pandemic surgical times, however surgery itself, perhaps with some exceptions, has not become faster. There is greater use of regional anesthesia which takes time. The investment in time for these things in the OR translates to benefit elsewhere including better pain control, less narcotic usage and shorter hospital stays. Also due to advances in preventative care and non-surgical management, surgery may be deferred or never needed. That should be perceived as a good thing. The government should be investing in surgery, it is being done with more stringent indications, better technique and that results in better patient outcomes and savings elsewhere.

Fewer and longer surgeries do not result in greater income to the surgeon, in fact very much the opposite.

232. An Otolaryngologist from Durham region writes as follows of recruitment challenges:

There's a dramatic shift in the job market. Too many jobs, too few residents. We are unable to secure a permanent hire at one of the branches of our hospital for 4 years now. People come and go, or no reasonable candidate to start with.

The population of Durham region was 608K in 2011 (year of the census), and there were 6 hospital-based ENTs here (4 at Lakeridge Health, 2 at the Ajax branch of Rouge Valley Health System). The region is now more than 700K, likely close to 725K. We should have 7 ENTs. We have one hospital corporation now in the region, LH, and we're down to 5 people.

Situation is worse further east out of here. Cobourg can use 1 extra person, PRHC at least 2, Belleville 2, Napanee likely 1, Brockville 1. Kingston likely can use 3-4 people, as the head and neck program their imploded and they face significant shortages and are having a hard time covering their usual catchment area.

Speaking of complexity, we've built a completely subspecialized team here at LH. So based on a foundation of great general ENT work, now we also do advanced otology, rhinology, laryngology and community head and neck. It's not about the case numbers, but what we do here! It's never been as complex

in this region. All used to go downtown, and only cancers now go, which we're not allowed to do anyway per CCO.

233. A cardiac surgeon reports as follows:

> *We are all doing more cases and still earning less than our compatriots in other provinces and all around North America. This also doesn't even count for cost-of-living. we have had to increase our workload in the operating room as best, we could both accommodate the increasing population in the office to see patient sooner. Patients were dying on our waitlist as well documented and the ministry knows this very well. I could provide you with a list of cardiac surgeons that have left the province. They are not coming back.*
>
> *In the meantime, with the patient population growing, there are documented monthly deaths on the cardiac surgical waitlist...Whether this is capacity or Hospital staffing or surgeons' availability, all of it plays a role.*
>
> *There is no question the only thing keeping the system working on the cardiac surgical point of view is that the cardiac surgeons continue to work hard days nights weekends all the time.*

234. A neurosurgeon from Toronto similarly notes that surgeries are longer and more complex:

> *Personally, I find that I am working much harder and my office is struggling to keep up with the number of consults received.*
>
> *I am not at all surprised to see the number of surgeries has decreased and the length of each case has increased. The duration of each case has increased noticeably simply because of staffing shortages in all aspects of patient care. The average room turnover as reported by EPIC (our EMR at the hospital) is documented at over 65 min per case. If I am doing 3 cases a day, I loose almost 200min in a 7-hour elective OR day just on room turn over. There are not enough personal to clean and turn over the rooms... Finally, the cases are more complex as we are seeing the disease process at much later stages of clinical presentation as patients have been waiting so long to get to the OR. These factors add significant delays which translates to less cases being done.*
>
> *Furthermore, because patients are sicker (have waited so long to get to the OR), their length of stay has increased which translates to bed shortages and ultimately cancelled cases. We are seeing this happen so frequently in our specialty. I am sure this ultimately translates to fewer overall surgical*

cases being completed. The system simply does not have the capacity to care for post patients.

Hospital bed capacity is absolutely 100% the biggest hurdle to getting cases done aside from getting actual access to the OR. Every day we deal with CODE gridlock and emails telling us to discharge patients or else cases will be cancelled. Personally, I have actually blocked these emails because it is a source of stress and I feel it is not fair to the patients to be literally pushed out of the hospital so I can do another case.

I feel that post pandemic, I am working more hours but truthfully the output and efficiency is significantly reduced as the system simply cannot provide the resources to care for patients. Whether it is staffing shortages, bed crunches, new staff, etc, etc, it has become harder to get things done. Efficiency for the most part has disappeared.

235. A vascular surgeon from Kingston also confirms increasing case complexity:

The case-complexity in vascular surgery has surged in the last 5-8 years, especially for patients with critical limb ischemia. Multimorbidity is common in our practice settings, and these patients are the most resource-intensive. The majority of Vascular practices, in both communities and academic settings, have had to take on wound care management services. This requires frequent (usually every 2 week) visits to ensure a wound is progressing and making fine adjustments accordingly. The proportion of diabetic/ESRD patients has also increased, and as a result, we deal with chronic wounds of mixed etiology, and become primary points-of-contact for these patients, as family doctors ill-equipped to handle this high-volume practice pattern. Vascular surgery practices are bombarded by communications from community wound care nurses, which are often time-sensitive updates. Therefore, the office-day of a Vascular surgeon has become a weekly exercise in risk management.

The volume of urgent output consults has increased (for multi factorial reasons), and therefore, there is an equally proportional number of non-urgent consultations that are displaced. As a result, the elective wait time for consultation for something like varicose veins, or claudication, is greater than 2 years for most practices. In Ottawa, the current waitlist is 5 years, though, back in 2018, it was 2 years. This goes to show the troubling trend of displaced non-urgent consultations. My personal example, I started practice in 2019, and had only a 3 month waitlist for vein consultation, now its 1.5 years over the span of 4 years of practice.

Our technology is rapidly evolving, to the patients benefit. However, we are having to hybridize our practice to perform both open Surgery and minimally

> *invasive surgery in one OR setting. This can result in an operation that is 4-6 hours long for one patient...*

236. Another surgeon reports on the increasingly long hours they are working, as a result of administrative burdens, surgical backlogs, and increasing complexity:

> *For twenty-five years I have taken call every Tuesday. I used to set the goal of getting home by 7 PM to have dinner with my family. Now I am never home. On Mondays I am in the operating room. If we are lucky we have enough staff and resources to finish the list. If not I have to tell someone that their surgery is cancelled. That just re-burdens the patient and my staff to find another time. After the OR I make phone calls. Patients now expect to be phoned. I then try to get on top of some "paperwork" to get the week started on a good footing. I come in at 7 AM to my office every morning. That allows me some time to do some office work such as review results, do an EAP application or respond to some emails before the clinical day starts at 8. On Wednesdays I see patients in my office. I see patients continuously through the day without a break. After the patients are done I go back to "paperwork" and won't leave the office until after 7. Usually at home I do more work remotely. I also round on my patients in the hospital daily. Thursdays and Fridays follow the same pattern. I then take call one in five weekends.*
>
> *This work has become all-encompassing for the reasons we already know. Patients are older, sicker and more complex. The population grows steadily each year. Patient expectations are greater, and patients aren't always good stewards of their own health. An absence of quality primary care means patients come to us in worse shape and lack medical support in the community. Technology, despite benefits, slows us down. The surgery we do is more complex. Cases that we would have operated on previously like small renal masses and low risk prostate cancer are now relegated to non-operative management.*
>
> *I'm proud to say the patients get their surgical care despite these challenges. This happens not because the system facilitates it, but because a relatively small number of surgical providers commit literally their lives to making it happen.*

ii) Emergency Medicine

237. Emergency Department (ED) physicians similarly report that increasing patient complexity and shortages are adding to their workload. They report seeing patients in

chairs and waiting rooms, which affects the quality of an assessment, stable patients becoming unstable while waiting in overcrowded ED, prolonged stays in ED after admission, and pressure to discharge patients or admit fewer patients. A common theme is that more care and coordination/administrative work is being done in the ED which, previously, would have been a referral to an admitting service and done by them once the patient was admitted. This is due to an increased push to find alternatives to admission (a government direction), increased access to information on other databases which are now accessible, leading to an obligation to review (e.g.: ConnectOntario); localization of certain specialties at particular hospitals, leading to increased work to arrange transfer to facility which can take care of the patient's condition; delays in care in the community, leading to, e.g., cancer diagnosis in the ED. All of these require the emergency physician to spend more time, decreasing "productivity."

238. One Emergency Physician explains the additional time it takes to access electronic medical records as follows using a real-life example from their practice:

> *A 75-year-old male comes in short of breath, with wheezing throughout. Oxygen level is 65% on room air and the patient is working very hard to breathe. He is regularly on both puffers and lasix. He lives just out of town but was visiting his daughter when he became all of a sudden very short of breath and they called an ambulance – all his records are at his home hospital. The patient has both a lung and heart specialist but doesn't recall the names of his diseases. He left all his meds at home and did not bring a list to his daughters for lunch*
>
> *In the past an ED doc would have treated this patient with only whatever information the family could remember. It took too much time to get records from another hospital. They would take a kitchen sink approach with puffers, steroids, lasix, nitro and bipap – never knowing if they were treating COPD or heart failure. CXR, bloodwork, ecg, ICU referral.*
>
> *With connecting Ontario and records online a doctor might now spend 15-20 minutes reading about this patient to provide more tailored care. We would learn that he has a cardiomyopathy by finding old echos and a cardiology consult. We would read that he has a recent admission for cardiogenic shock and might need early tailored pressors. We would learn that his lasix dose is very high and increase our initial IV lasix dose. We can also access his baseline bloodwork (which in the past was not available).*

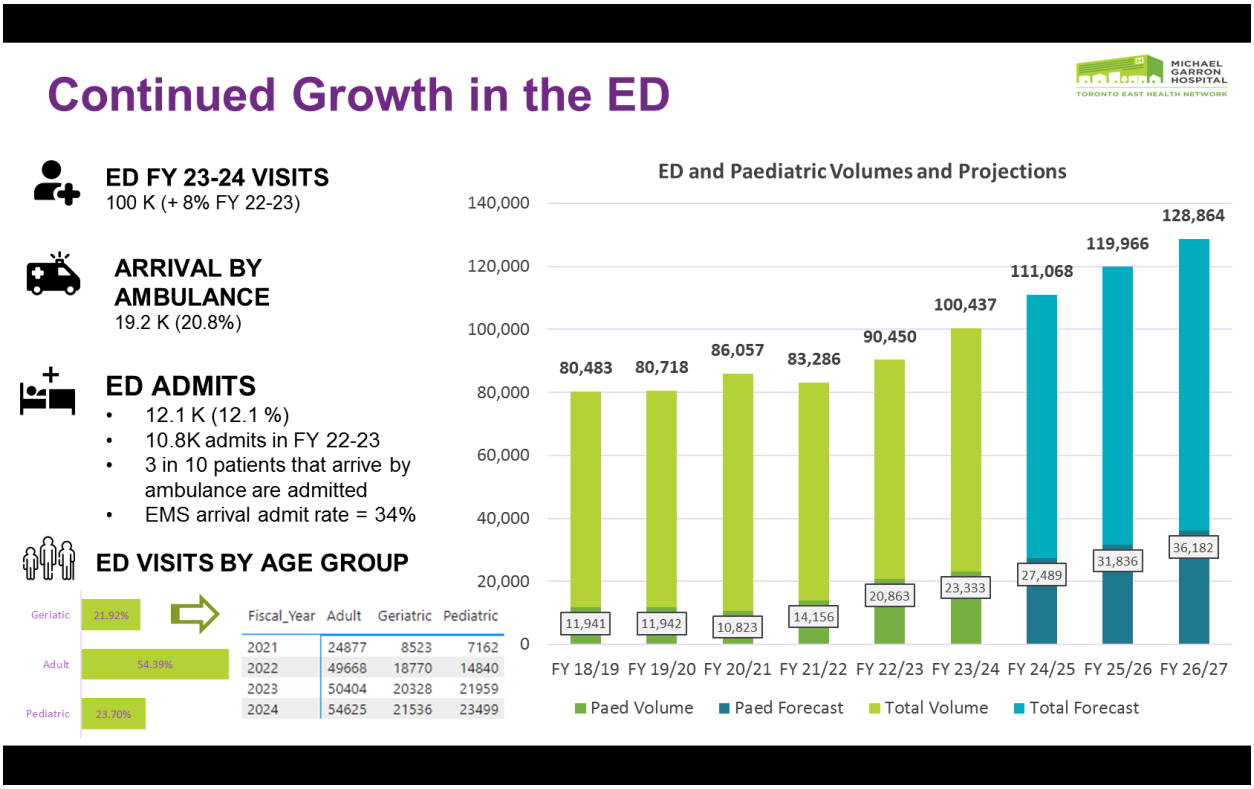
> *Access to past medical history takes a long time to read but definitely can make a real impact to the quality of patient care. It is time well spent, even though again – the ED physician has less direct patient encounters – these minutes spent save money on investigations, days in the ICU and can even save patient lives.*

239. Another Toronto Emergency Physician writes about the large numbers of patients overwhelming their emergency department:

> *We are at record high volumes. We are now the busiest single site emergency department in the city. We see the most EMS volumes after Humber, which is an amalgamated site.*
>
> *Last year we saw 100,400 patients we have the highest acuity in the city based on CTAS data. This was recently published in the Toronto Star. Average visits ranging from 275-310 routinely with some days as high as 350+ visits.*[66]
>
> *Admission rate has remained approximately 12%. We are providing care routinely to critically ill patients in the hallway and waiting rooms. Surge level 2 and 3 are on the rise and a bad sign.*
>
> *Recent modelling suggest we may see a 10% increase in our growth this year which would put us at 110,000 visits for 2024."*

240. The increasing volume of patients facing this emergency room is reflected in the following chart:

[66] Megan Ogilvie, "Patients are 'routinely' being diagnosed with cancer in busy Canadian emergency rooms, doctors warn," (May 16, 2024), TAB 36, Vol. 2, Reply BOD.



iii) Pediatrics

241. Pediatricians also report a shortage of doctors and the fact that they are facing increasing complexity.

242. Comments from pediatricians in the province include the following:

- *"Most patients do not have a family doctor, so when I get referred patients from other sources, such as the ER, the inpatient ward, a walk-in clinic, or Children's Aid, I have no choice but to continue to follow them as most patients do not have a family doctor"*

- *"During COVID, most patients didn't visit their doctors and fell out of their cycle of routine visits with their primary care provider. York region public health sent out notices to families whose kids did not have up to date vaccines with a deadline of April 10th or they would be suspended. We received a flood of phone calls with parents panicking to book an appt. When they came for visits for vaccines, other medical issues were uncovered which required more appointments to deal with. Complex mental health issues and academic issues that require frequent visits."*

- *"I see a mixture of consultations, follow up for medical or behavioural issues, and primary care well baby care and sick visits. I follow many complex*

patients for "primary care"-ex-prems, severe autism or behavioural disorders, ADHD, medical complexity, technologically dependent to name a few. These complex patients take up a lot of time, which means I am often running behind on my schedule..."

- *"I am seeing 10-15 EXTRA patients per day on top of my already full schedule because so many patients are sick and trying to avoid the emergency room. Then I return phone calls of parents demanding to speak with me about various issues...even though my remuneration for this is now down to 85%."*

- *"As a pediatric respirologist, my private practice patients are often more complicated patients that have struggled with ongoing respiratory complaints, despite management by other specialists, like pediatricians or allergists. Additionally, due to the long wait lists at tertiary care centers, I also have very complex patients redirected to my clinic. As a result, the patients that I see in my typical consulting practice are of high complexity with multi factorial, comorbidities and contributions to respiratory complaints. These patients are very fragile and difficult to diagnose, requiring frequent reassessment and therapeutic trials with a keen and critical eye and coordination with multiple other specialties. In particular, these consultations and follow ups take much longer than a typical patient with a single, milder complaint."*

- *"While I would typically spend about eight hours in my clinic seeing patients, there's usually 2 to 3 hours' worth of documentation and paperwork to review tied to that single day. As a result, I'm usually working between 50 to 60 hours per week with clinical work, and this excludes educational activities for the university as well as for local providers to improve the baseline of respiratory care locally. There are also many administrative tasks related to hospital work which is uncompensated and reflects at least an additional 2h per week. "*

- *"We have a severe shortage of family physicians, so we have nowhere to send patients when they graduate Pediatric care. We have a severe shortage of OHIP-covered mental health supports, so we are left dealing with these complex patients on our own in the community.*

  The waitlist to see a Pediatric Psychiatrist can be up to 2 years.

  We used to have a clinic that would accept unattached babies, but it closed down due to lack of funding, as it was a non-profit. The pediatrician group has been approached by a family medicine group who does OB to help these unattached babies, but again, we are all too full, just as the family physicians are.

> *The result is having to tell new parents that they need to take their newborn to a walk-in clinic for their first checkups and weigh-ins. This breaks my heart, and every week I am on call, I end up accepting several babies into my practice, even though I am beyond full. The babies that are still unattached often end up in the ER for minor issues because they have nowhere else to go."*

243. A pediatrician from Timmins notes the additional challenges facing pediatricians in the North:

> *A full-time pediatrician in this district is currently expected to be on call/provide hospital service for 24 hours x 6 days a month. However, when our locum fails to present or struggles with advanced skills, we are still called back in to help. We are on call 365 days a year.*
>
> *Because of our remoteness and poor access to locum coverage, calls are usually covered consecutively without any break. We can both recall numerous instances when we have been in hospital for sometimes 48-72 hours without any sleep. The reason is that we manage critically ill neonates and children until they can be transferred to the nearest tertiary care center (around 800 km away).*

244. Another pediatrician writes as follows, expressing a sense of desperation:

> *Many days, we both think that it will be impossible for either of us to continue to sustain a practice under such conditions. We invite any who believe that 'Ontario is fine doctor wise', to come and work with us for anywhere between 4-7 consecutive days. The exact amount it takes most of our locums to decide never to come back. We invite those who believe that there are enough pediatricians in Ontario to state this fact directly to the guardians of our most psychiatrically/medically fragile children. Such a meeting could take place in our underfunded hospital and offices. Unfortunately, by the time you get here, pediatrics in our district will have likely burned to the ground.*

iv) Psychiatry

Psychiatrists share concerns about increasing complexity. For example, one psychiatrist reports as follow:

> *Patient complexity has been very high. Psychiatrists often work with patients with multiple co-morbid conditions which is not captured in reports to the Ministry where for billing purposes only one diagnosis is*

> *reported. In addition, many of our patients are refugees with severe trauma history and language barriers.*

245. Another Psychiatrist reports as follows:

> Psychiatrists have been working more to meet increased post-pandemic demands (expansion of virtual care has helped meet some of the increase in demand) in the setting of our workforce growing older and retiring early due to burnout.
>
> Additionally, due to difficulty accessing/finding a family physicians and other specialists some patients are seen in longer than planned follow-up.
>
> Number of community psychiatrists work long-term with highly complex cases which in the eyes of the Ministry may be seen as these psychiatrists are not seeing enough patients, not working hard enough. However, by seeing these patients and caring for them the psychiatrists are, in many cases literally saving their lives as well as keeping them out of emergency rooms and inpatient beds which leads to tremendous cost savings.

v) Family Medicine

246. Family physicians report increasing patient complexity, increasing administrative burdens, and managing patients waiting for specialty care as the patient condition deteriorates while waiting. Indeed, family physicians are taking on more risk treating/managing diseases at more advanced stages.

247. A family physician from Northern Ontario shares her challenges around workload as follows:

> *There are so many layers of the workload problems when one is working shorthanded. And it is not just post pandemic, it is a chronic issue now that has been an issue in rural N. Ontario for some time but is worse now.*
>
> *I will start by saying that without locum support we would not be able to provide any semblance of reasonable service to the community and it would not be bearable to stay in the community any longer.*
>
> *Having said that, locums are not the answer to our current situation (and I suspect for all others in similar situations). They are a bandaid solution as they don't provide the needed continuity of care and the benefits to patients and community when a doc lives and works locally.*

...
Inbox Management: *Additional time spent managing our inboxes—scripts, lab and consults for all the patients who are no longer, but who are part of the community and have seen locums. These patients still need care, so even though we haven't rostered them to ourselves, we end up managing all of this, as we don't have enough "locum days" to have locums cover all of this. I would estimate for each of us this adds another 1-2 hours to an already busy day.*

Sicker patient load: *Sick patients need not only care but need continuity of care—my partner and I have taken on all the "unattached" patients with serious illnesses (cancer, advanced CHF, COPD, frail elderly etc). This disproportionally adds to our work, both in the inpatient and outpatient realm. The locums, as a result, are managing a "less sick" population.*

Because we have been here for several years, when specialists have seen a patient from our community who they think is going to need follow up – for post-surgical care, cancer care, palliative care, etc – they call one of us to get us to take that patient on… they know us and they know we will do the work and provide the care, but the load is becoming unmanageable now.

Locum ER support: *A big time sink for us is locums requiring support in the ER—there is an expectation that help will be available 24/7 for things like intubations, procedures, help with managing sick patients and random questions. While I can appreciate this from their end, it's an unreasonable expectation when there is no cushion in the system. ...*

Picking up ER shifts: *When locums cancel or are delayed by weather, we take their ER shifts and still try and meet our clinic obligations. This winter, it was an issue as it seemed many of our locums were booked to arrive on days when Highway 17 was closed for weather. We collectively feel a moral obligation to keep the ER open and if ER shifts need to be covered, we do it.*

Other Admin Work: *The hospital and clinic admin work is now divided among the two of us. Our new recruit is going to gradually pick some of this up, but he's only been with us for a few months, and we don't want to overwhelm him. I think this is an unrecognized burden, especially in rural settings, where it's the same docs who manage the clinic admin and hospital admin. All hospital committees and all clinic admin issues come to us. Again, I would say this adds at least 1-2 hours extra per day (when averaged out)...I now come in at 07:00 in order to do my inbox and round on my inpatients before clinic starts*

Managing the ER schedule has become a very time-consuming job as we're juggling our own needs plus various locums

There are roughly 10 hospital/medical committees that we share between the two of us. Outside of MAC, I don't think any individual should be sitting on more than one other hospital committee.

...
It's hard to put numbers on things but I would say I now work a minimum of 10 hours days when not on for ER and am still doing some additional work in the evening. This doesn't include getting called out to help when we're not on call and the "hard to quantify hours". Locums are picking up more call so when we have good locum support, I am doing much less call, but paradoxically seem to be working more hours.
...

Primary care visits for mental health conditions has risen significantly since the pandemic. These visits can make up to 50% of a clinical day in Family Medicine. Despite the care provided during the pandemic by virtual services and in-office visits, many adult and pediatric patients are coming in to discuss mental health concerns that originated during the pandemic. To care for these patients, time is needed to address these concerns and this can add hours to a clinical day when urgent medical concerns must also be addressed. There are very few resources available to support patients with mental health conditions in our community and Northern Ontario. Consequently, that care and support falls on the shoulders of Family Physicians in our community. We had to cut our counselling program at the Centre years ago due to a lack of funding. This has only increased the workload on our Family Physicians who continue to fill that void in lack of mental health supports for our patients.

Family physicians in our community had a significant increase in workload due to the shortage of specialists in our community. Hours of work are done to locate specialists in neurology, gynecology, plastic surgery (to name a few) only to have those consultation requests declined as the patient doesn't live in that region or that waitlists are 6 months or longer (most waitlists in Northern Ontario already far exceed that). I had one case whereby I had to try consulting 5 Gynecologists in Ontario to see a patient who needed gynecologic care. Sault Ste Marie has had no Gynecologist available to see non-emergent cases in at least two years. This work is unpaid and contributing to burnout in Family Medicine. There is a significant back log of consults as a result of the pandemic and this is downloading hours of unpaid work to find a specialist willing to see a patient from Northern Ontario.

...

***Specialist challenges:** I am now spending a significant amount of time trying to find specialists for various services. Where I cannot find those specialists, I am using econsult for information, but what would usually have*

> *been explained/managed/supported by the specialist, I now have to explain to the patient and manage on my own. (I am in an RNPGA community and there is no funding for using econsult in our contract, so I do those referrals after hours and without payment).*
>
> ***Mental health issues have increased** – in our ER, and in our office setting. We have few resources for helping to manage these patients and it is not the usual mild depression or anxiety for which we can certainly use virtual tools, but rather the drug induced psychosis, the complicated grief with parallel substance, use disorder, and depression with limited resources and living in poverty. All of these come back to me as the family physician and in my small community, I cannot simply say "not my scope, not my problem". I see these people in the grocery store and out and about in town. Sometimes my only option seems to be leaving altogether to be able to manage the press of work on my time.*

248. Another small-town family doctor Southwestern Ontario reports of feeling overwhelmed and contemplating leaving family medicine for his own well-being:

> *I am a small town family doctor SW Ontario and I have never been closer to suicide as I am today.*
>
> *I felt completely overwhelmed 20 or so years ago, when my wife and I (she is also a family doctor) started our careers in Moose Factory in July, only to have all the other 6 physicians that already worked in Moose Factory leave by the fall of that year. The region called for complement of 10 physicians, but we were the only two full time docs left to care for the whole coast – quarterbacking few locums and residents to make it work. We learned a lot, but it was hell and we felt trapped.*
>
> *20 years later I have an option that I didn't have before: to quit medicine. I don't want to, as I think I am good at what I do, and I have intended to work for another decade, retiring on my terms, … but it is an option that I will take if needed to save myself.*
>
> *I have been looking to the outcome of the new contract with the Ministry to help me decide. It's a retention issue for me.*

249. The above examples are just a handful of the type of feedback that the OMA received from its members, including in response to the Ministry's initial brief and its contention that physicians are not working as hard, and that there is no evidence or experience of growing patient complexity. These statements provide a compelling

narrative of the reality for physicians on the ground, directly countering the Ministry's simplistic and misleading "hypothesis" and articulated position.

CONCLUSION

250. As stated at the outset of this Brief, the intent of the OMA, in its Reply, has been to address various assertions, including misstatements and misinformation, contained in the Ministry's submissions, including the aspect of the Ministry's brief that were disrespectful and cynical in relation to the contributions of physicians to the welfare of their patients and the Ontario health care system. We trust we have done so and that this will go some way to demonstrating the need for and appropriateness of the compensation rate increases sought by the OMA in this Year 1 arbitration.

251. The OMA reserves the right to amplify on these submissions at the oral hearings and is, of course, prepared to provide any additional assistance it can to this Board of Arbitration.