In the Matter of an Arbitration

BETWEEN:

ONTARIO MEDICAL ASSOCIATION

(the "OMA")

- AND -

MINISTRY OF HEALTH

(the "MOH")

(together, "the PARTIES")

SUPPLEMENTARY REPLY BOOK OF DOCUMENTS OF THE ONTARIO MEDICAL ASSOCIATION

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4.	OMA response to Ministry reopener charts
5.	Collective Bargaining Highlights 2024
6.	Ontario Physician Reporting Centre, Physicians in Ontario Longitudinal Dataset (2009-2022) - Hamilton, ON: OPRC; 2024 (excerpt)

TAB 1

MOH MONTHLY REPORT RE NUMBER OF PHYSICIANS IN PATIENT ENROLMENT MODELS

Primary Health Care Status Report: Summary (as of April 1, 2024)				
Model	**Aff. Type**	**No. of Groups**	**% of Grand Total**	**No. of Phys.**
Harmonized and Non-Harmonized Models (B28/B29)				
Blended Salary Model (CSA)	B28			83
	B29			3
	TOT	**14**	**1.56**	**86**
Family Health Network (FHN)	B28			134
	B29			1
	TOT	**12**	**1.34**	**135**
Family Health Organization (FHO)	B28			6,293
	B29			99
	TOT	**600**	**67.04**	**6,392**
GP Focused: Care of Elderly (Enrolment)	B28	6	0.67	12
GP Focused: HIV	B28	5	0.56	23
Group Health Centre	B28	1	0.11	36
Rural & Northern Physician Group Agreement (Group 1): Northern Group Funding Plan (NGFP)	B28	14	1.56	68
Rural & Northern Physician Group Agreement (Group 2): Community Sponsored Contracts (CSCs)	B28	22	2.46	36
Sioux Lookout Regional Physicians Services Inc.	B28	1	0.11	120
St. Joseph's Health Centre	B28	1	0.11	19
Weeneebayko Area Health Authority	B28	1	0.11	13
Harmonized Model Total		**677**	**75.64**	**6,940**
Comprehensive Care Model	B28			332
Family Health Group (FHG)	B28	218	24.36	2,143
Non-Harmonized Model Total		**218**	**24.36**	**2,475**
Grand Total		**895**		**9,415**

NUMBER OF FAMILY PHYSICIANS NEEDED TO ACHIEVE 97% ATTACHMENT AT 1300 ROSTERED PATIENTS

	OMA	MOH
Number of Family Physicians	15,327	17,814
% Comprehensive Care	65%	65%
Number of Comprehensive Care FPs	9,963	11,579
Average roster size	1,300	1,300
Number of attached patients	12,951,678	15,052,830
Ontario Population	15,380,575	15,380,575
Percent attached	84.2%	97.9%
Percent unattached	15.8%	2.1%
Number unattached	2,428,897	327,745
Gap in Family Physicians (97% Target)	**1,513**	0

INSPIRE DATA – PERCENTAGE OF UNCERTAINLY ATTACHED

Year	Attached (%)	Attached (#)	Uncertainly Attached (%)	Uncertainly Attached (#)
March 2017	89.1	12,399,025	10.9	1,516,828
March 2018	89.0	12,545,529	11.0	1,550,571
March 2019	89.0	12,737,955	11.0	1,574,354
March 2020	87.9	12,862,033	12.1	1,770,542
March 2021	87.4	12,863,444	12.6	1,854,455
March 2022	85.3	12,758,757	14.7	2,198,754
March 2023	84.7	13,062,948	15.3	2,359,659

HCES DATA, PERCENTAGE OF UNATTACHED

Year	Attached (%)	Attached (#)	Uncertainly Attached (%)	Uncertainly Attached (#)
2019	93.3	13,353,384	6.7	958,925
2022	89.7	13,416,887	10.3	1,540,624

COMPOUNDED ANNUAL GROWTH RATE IN PHYSICAIN VISITS SINCE 2004-5 PSA

Fiscal Year	Annual Visits per Physician
2004	4,542
2005	4,623
2006	4,551
2007	4,467
2008	4,459
2009	4,514
2010	4,365
2011	4,310
2012	4,156
2013	4,046
2014	4,003
2015	3,982
2016	3,954
2017	3,906
2018	3,841
2019	3,786
2020	3,389
2021	3,637
2022	3,694

2004 to 2022	-18.7%
CAGR	**-1.1%**

CIHI GROSS CLINICAL PAYMENT PER FTE ONTARIO RANKING FOR 2021-22

Specialty	Ontario Rank (out of 10)	% FFS
Family medicine	7	41%
Medical specialists		
Internal medicine	6	84%
Cardiology	6	91%
Gastroenterology	4	82%
Neurology	7	72%
Psychiatry	9	69%
Pediatrics	9	54%
Dermatology	9	91%
Physical medicine	6	84%
Surgical specialists		
General surgery	9	86%
Thoracic/cardiovascular surgery	4	80%
Urology	9	83%
Orthopedic surgery	9	90%
Plastic surgery	9	86%
Neurosurgery	1	76%
Ophthalmology	10	95%
Otolaryngology	6	83%
Obstetrics/gynecology	9	80%

SOURCES: Canadian Institute for Health Information. National Physician Database Historical Payments — Data Tables. Ottawa, ON: CIHI; 2023.) "% FFS" data comes from ICES for 2022-23. NFFS includes AHSC, APP, EDAFA, PC Models and All Others (Kim E, Schultz S, An D, et al. Physician Compensation Update: 2005/06 to 2022/23, Applied Health Research Questions (AHRQ) # 0866 010 006. Toronto: ICES; 2024.

TAB 2

The Changing Family Physician Workforce:

Trends in focused primary care practice, Ontario, 1993-2021

21st May 2024 | INSPIRE-PHC Research Rounds

Hina Ansari, PhD, MSc; Richard H. Glazier, MD, MPH; Susan E. Schultz, MSc;
Michael E. Green, MD, MPH; Kamila Premji MD, PhD; Eliot Frymire, MA;
Maryam Daneshvarfard, MScCH; Liisa Jaakkimainen, MD, MSc; Tara Kiran, MD, MSc

MAP Centre for Urban Health Solutions

INSPIRE-PHC

Funding and Disclosures

The study was supported by the INSPIRE Primary Health Care Research Program which is funded through the Ontario Ministry of Health.

This study uses one of several approaches to measure focused practice. **This approach is not specifically endorsed by Ontario Health.**

H.Ansari is funded through the CIHR-IHSPR HSIF Postdoctoral Fellowship, and Ontario Health.

The funders had no role in the design and conduct of the study.

No endorsement is intended or should be inferred.

Background and Rationale

- Primary care workforce crisis
  - 20% (Canada) and 15% (Ontario) without access
  - 15% loss to impending retirement
  - Burnout and retention challenges
  - Aging population
  - Increasing multimorbidity and complexity
- Concerns that family physicians are opting out of comprehensive, longitudinal practice
- Understand workforce trends to inform health human resource planning and supports

Lavergne et al 2023; Premji et al 2023; Kone et al 2021; Ontario College of Family Physicians 2023

Objectives

1. Compare the characteristics of family physicians in focused practice relative to family physicians overall and other practice types.
2. Examine trends in uptake of focused practice between 1993 and 2021.
3. Examine the most prevalent types of focused practice, and how this has changed over time.

Methods

Design:	repeated cross-sectional
Population:	all family physicians in Ontario
Study period:	fiscal years 1993/94 – 2021/22
Data sources:	health administrative data at ICES
Measurement:	practice type
	Schultz & Glazier 2017 (1) comprehensiveness; (2) focused practice (FPA codes, setting, procedures); (3) worked < 44 days; (4) n/a = no billings; (5) other
Analysis:	descriptive methods, graphical analysis

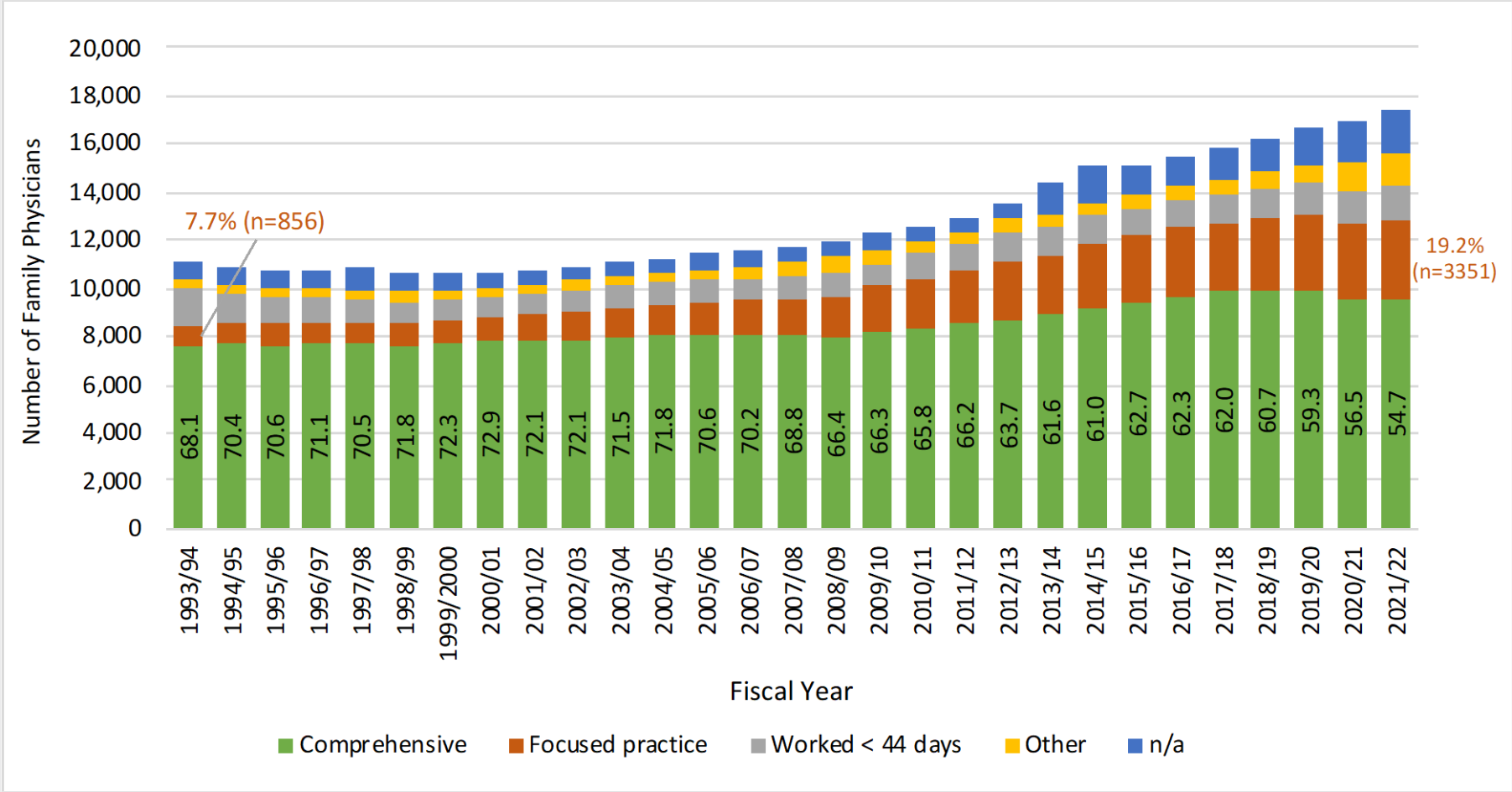
Schultz & Glazier 2017

Study cohort characteristics

	1993 N=11,103	2021 N=17,413	Absolute Δ +6,310
Female (n,%)	3,124 (28%)	8,490 (49%)	+ 5,366
Mean age (mean, SD)	43 (13)	49 (14)	+ 6 years
Mean days worked (mean, SD)	170 (100)	151 (90)	- 19 days
Rurality (n,%)			
0	6,309 (56.8%)	8,536 (49%)	
1-9	2,125 (19.1%)	4,591 (26.4%)	
10-39	1,774 (16.0%)	2,906 (16.7%)	
40+	816 (7.3%)	1,303 (7.5%)	

↑ 6,310 physicians
↑ Age
↑ Female
↓ Mean days worked
↑ Suburban

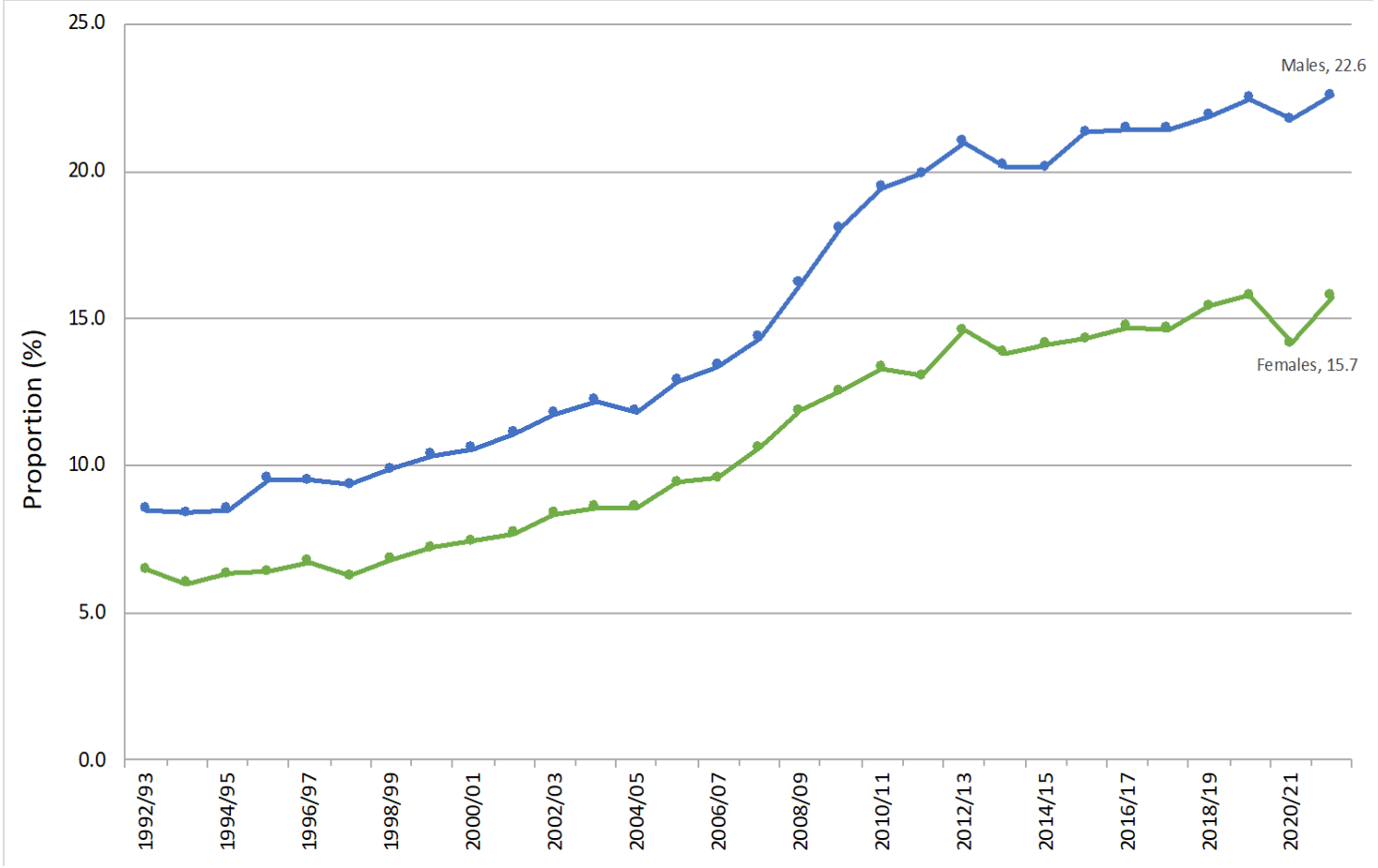
Approximately 20% of family physicians in 2021 were in a focused practice, an increase from 8% in 1993



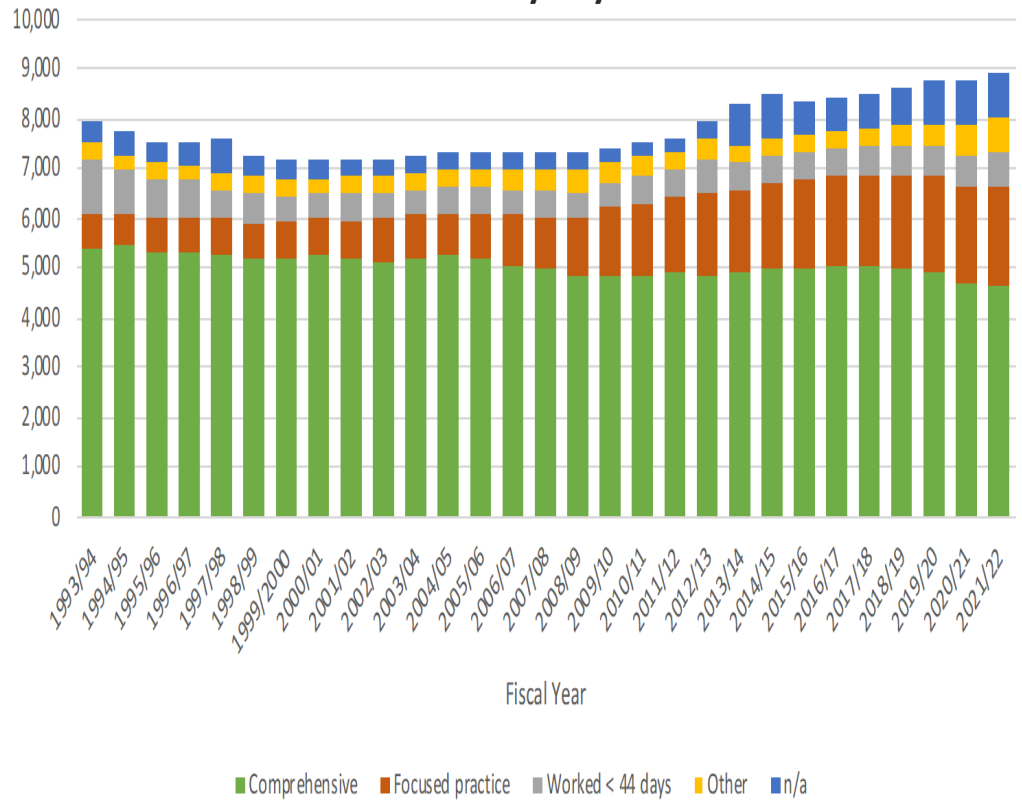
40% of the growth in the primary care physician workforce was attributable to focused practice

	1993 N=11,103	2021 N=17,413	Absolute Δ + 6,310
Focused	856	3,351	+ 2,495
Comprehensive	7,562	9,522	+ 1,960
< 44 days, other, n/a	2,686	4,540	+ 1,854

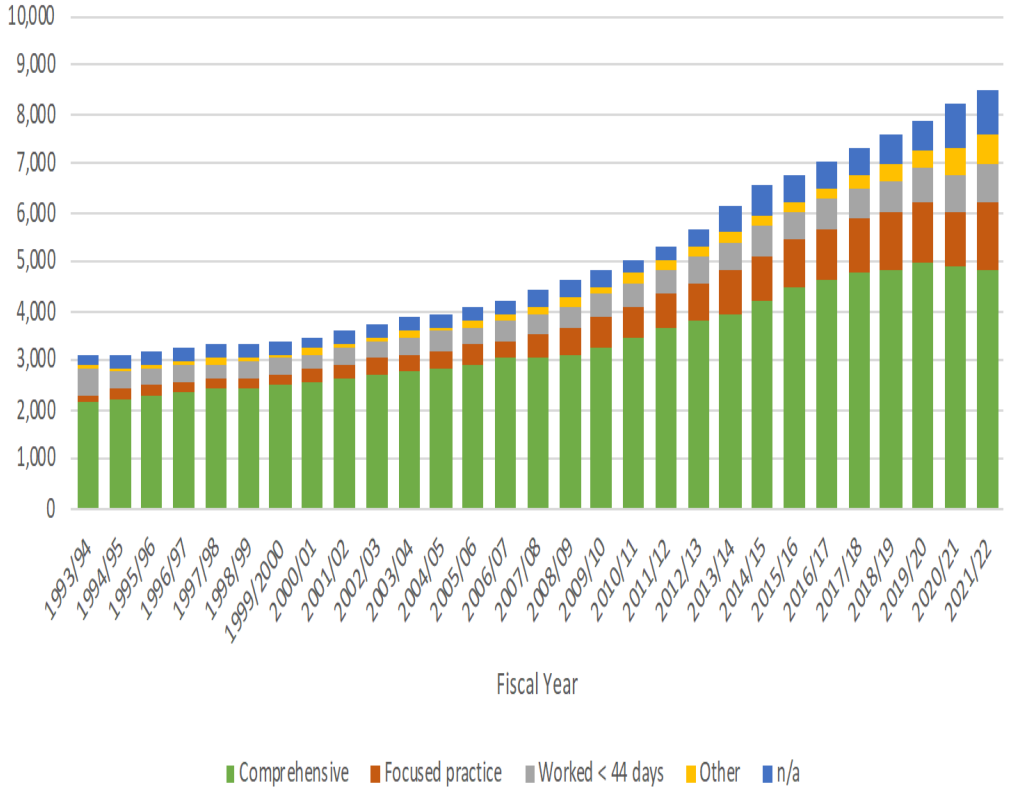
The proportion of family physicians in focused practice increased among both males and females



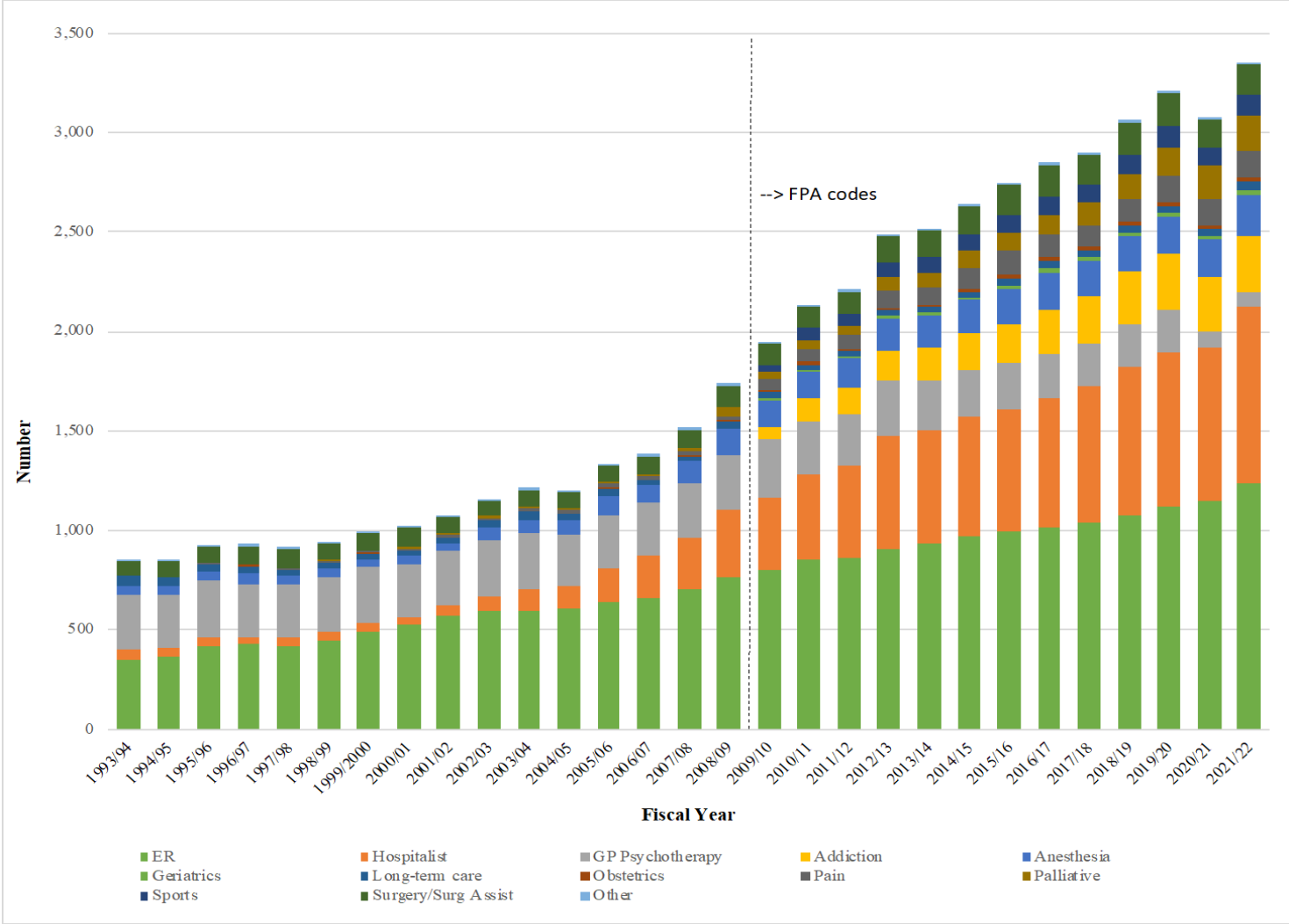
Male family Physicians



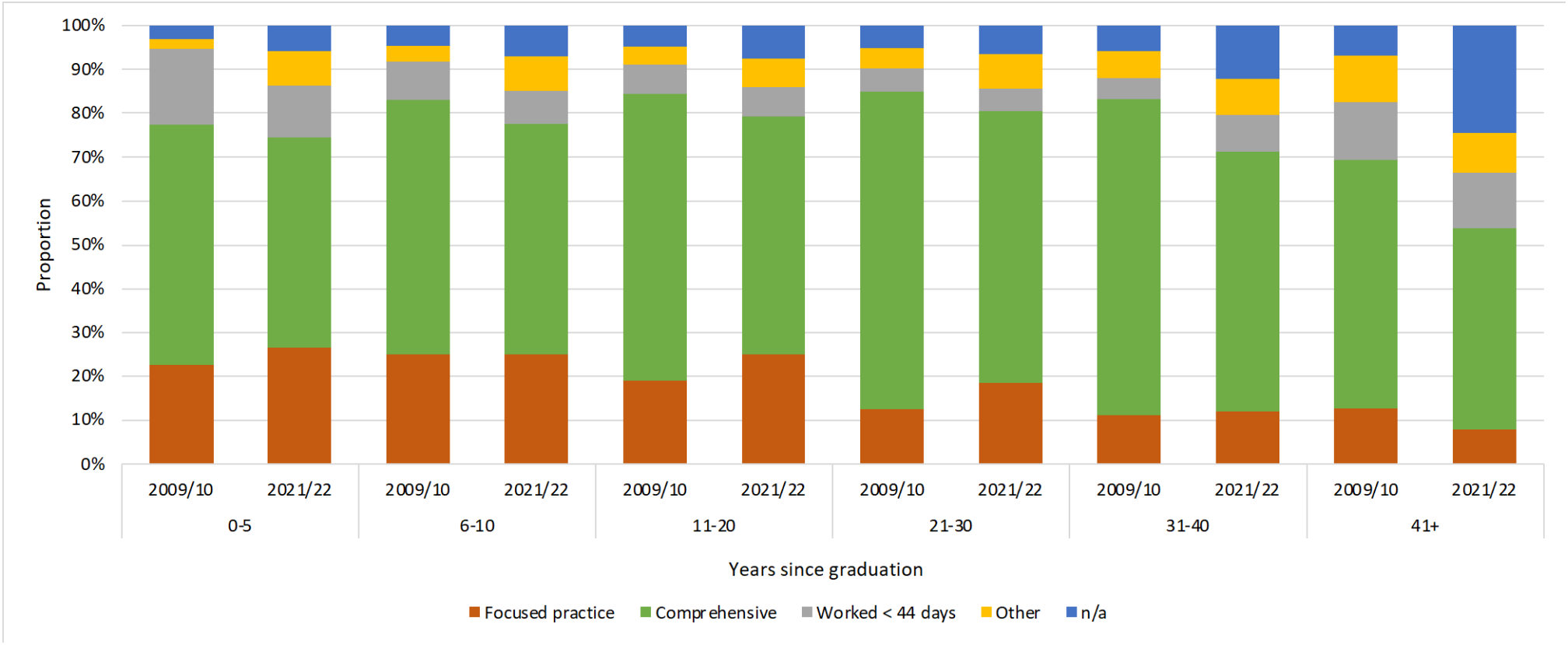
Female family Physicians

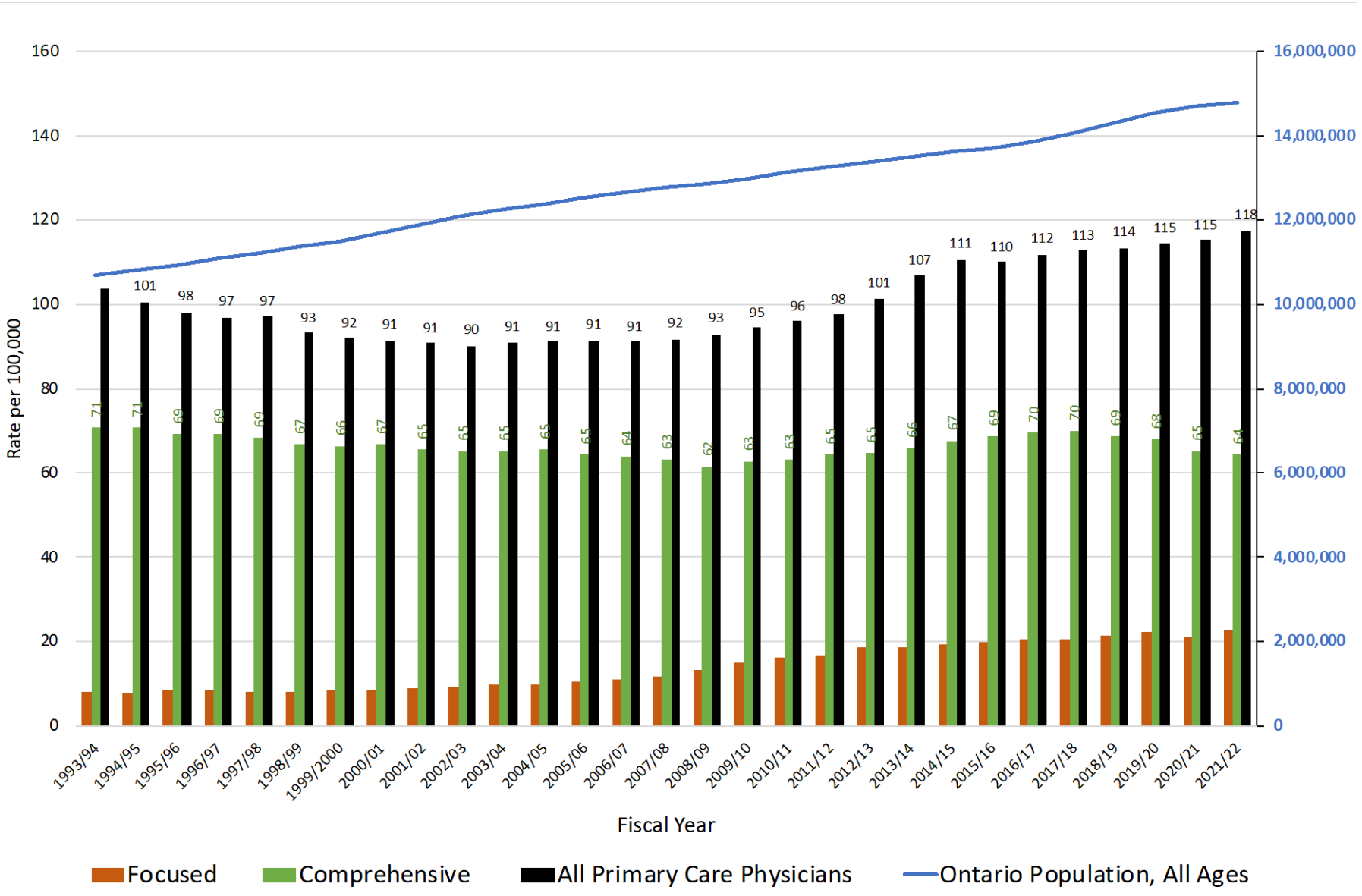


The growth in focused practice was driven by emergency, hospitalist and addictions medicine



The relative growth in focused practice between 2009-2021 was not limited to recent family medicine graduates



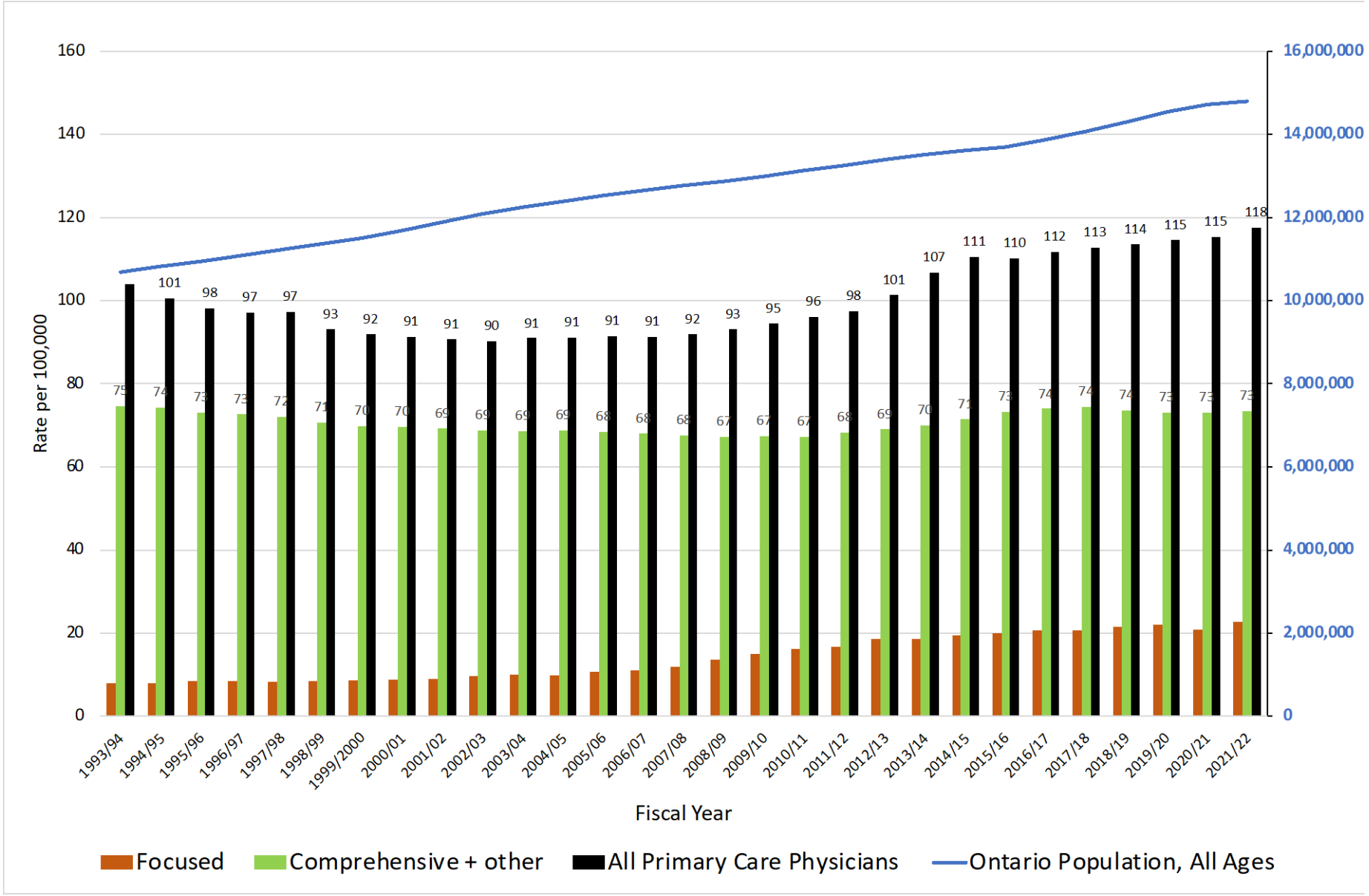


Increase

- ✓ Ontario's population
- ✓ Family physicians per capita
- ✓ Focused practice family physicians per capita

No increase

X Comprehensive family physicians per capita



Sensitivity Analysis

Summary of results

Overall ↑ family physicians, ↑ family physicians per capita, ↓% comprehensive, ↑ % focused practice

- 20% of family physician workforce in 2021 was in focused practice, up from 8% in 1993.
- Of the 6,310 family physicians added to the workforce, 40% had pursued focused practice.
- Focused practice trends were driven by uptake of emergency, hospitalist and addictions medicine.
- The proportion of focused practice physicians was greatest in early- or mid-career physicians.

  However, the decrease in comprehensive practice over time held true across all career stages.

Interpretation

- Absolute numbers and per capita rates suggest that the family physician supply is thriving compared with previous years.
- However, this needs to be interpreted within the following context
  - Focused practice comprised 40% of the increase
  - Decrease in mean number of days worked
  - An aging workforce
  - More female family physicians

Important considerations for workforce estimation and planning

- Multifaceted reasons behind these evolving trends:
  - System-level: Funding/payment models; team-based care
  - Physician-level: Work-life balance; financial considerations; administrative burden

Aggarwal et al 2024; Kralj et al 2024; Ganguli et al 2020; Premji et al 2023; Jin et al 2022; Ontario College of Family Physicians 2023.

Limitations

- Varying definitions of primary care clinicians, comprehensiveness and focused practice across different jurisdictions
- Claims data representative of those with provincial health insurance coverage
- Other practice types (‘other’ and ‘n/a’) require further investigation
- Did not include nurse practitioners, physician assistants, and many physicians at CHCs who are salaried
- Diagnostic coding in administrative data has been shown to
- The dichotomous ascertainment approach (instead of scales or scores) was designed to inform health human resource planning but did not include part-time focus practice provided by physicians who spend their time in multiple settings and may therefore have underestimated the total amount of focus practice.

Future directions

- To understand impact of these trends on the health system's ability to meet the population's need for comprehensive longitudinal primary care
- To understand contributing factors at various levels
- To establish policy levers and supports that can encourage sustainability of comprehensive primary care

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Wong E, Stewart M. Predicting the scope of practice of family physicians. Can Fam Physician 2010;56

Appendices

Appendix A: Identifying the primary care pool

1. the physician's "main specialty" classified as general practitioner/family physician, or family physician/emergency medicine

2. the physician's "functional specialty" (i.e. practice pattern defined by their fee-for-service billings) closely matched that of a general practitioner or family physician

Schultz SE, Glazier RH. Identification of physicians providing comprehensive primary care in Ontario: a retrospective analysis using linked administrative data. CMAJ Open. 2017;5(4):E856-E863

Appendix B: Core Primary Care Services

- **Core primary care services** are identified as those feecodes that meet the following criteria
  1. 80% or more of all billings for the code had to be submitted by family physicians
  2. The total primary care billings for the code had to represent at least 0.1% of all billings by family physicians for that year
- A separate list for what constitutes core primary care services is generated for each year.
- Core primary codes grouped into approx. 22 activity areas

Bazemore A, Petterson S, Peterson LE, et al. More comprehensive care among family physicians is associated with lower costs and fewer hospitalizations. Ann Fam Med 2015;13:206-13

Wong E, Stewart M. Predicting the scope of practice of family physicians. Can Fam Physician 2010;56

Appendix C: Comprehensiveness algorithm

- To be comprehensive, physicians must
  - be in the PC pool;
  - have worked at least 44 days during the year;
  - have more than 50% of billings for core primary care and
  - have billings in at least 7 activity areas.

- Physicians who do not meet the above criteria are focused, other, n/a or <44
- <44 = those who worked less than 44 days in the year
- N/a = those with no billings
- Other = Do not qualify as comprehensive, focused, <44 or n/a

Schultz SE, Glazier RH. Identification of physicians providing comprehensive primary care in Ontario: a retrospective analysis using linked administrative data. CMAJ Open. 2017;5(4):E856-E863

Appendix D: Focused practice algorithm

FP assessment billings

- A917 Sport medicine FPA
- A927 Allergy FPA
- A937 Pain management FPA
- A947 Sleep medicine FPA
- A957 Addiction medicine FPA
- A967 Care of the elderly FPA

IPDB variable-based

- anesthesia
- hospitalist
- surgical assisting
- obstetrics
- emergency department
- long-term care
- psychotherapy/counselling

Fee code categories

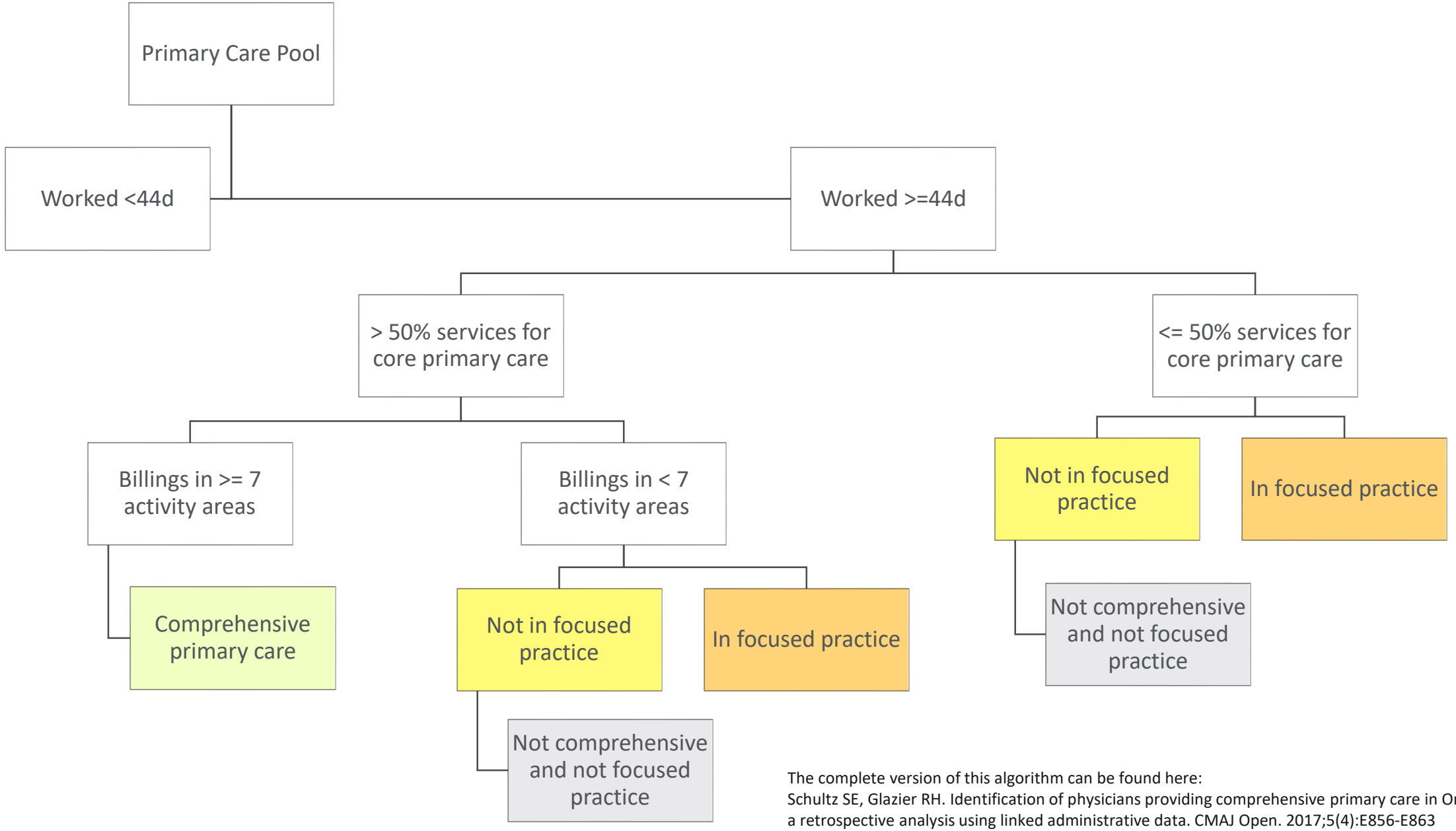
- palliative care
- psychotherapy/counselling
- critical care
- cardiac care
- dialysis
- allergy
- pain management
- radiology
- ER

(CFPC) Focused practice defined as commitment to one or more specific clinical areas as major part-time or full-time components of their practice.

1. FPA codes: Physicians who are eligible to bill these fee codes have met criteria set out by the ministry for focused practice in these areas.

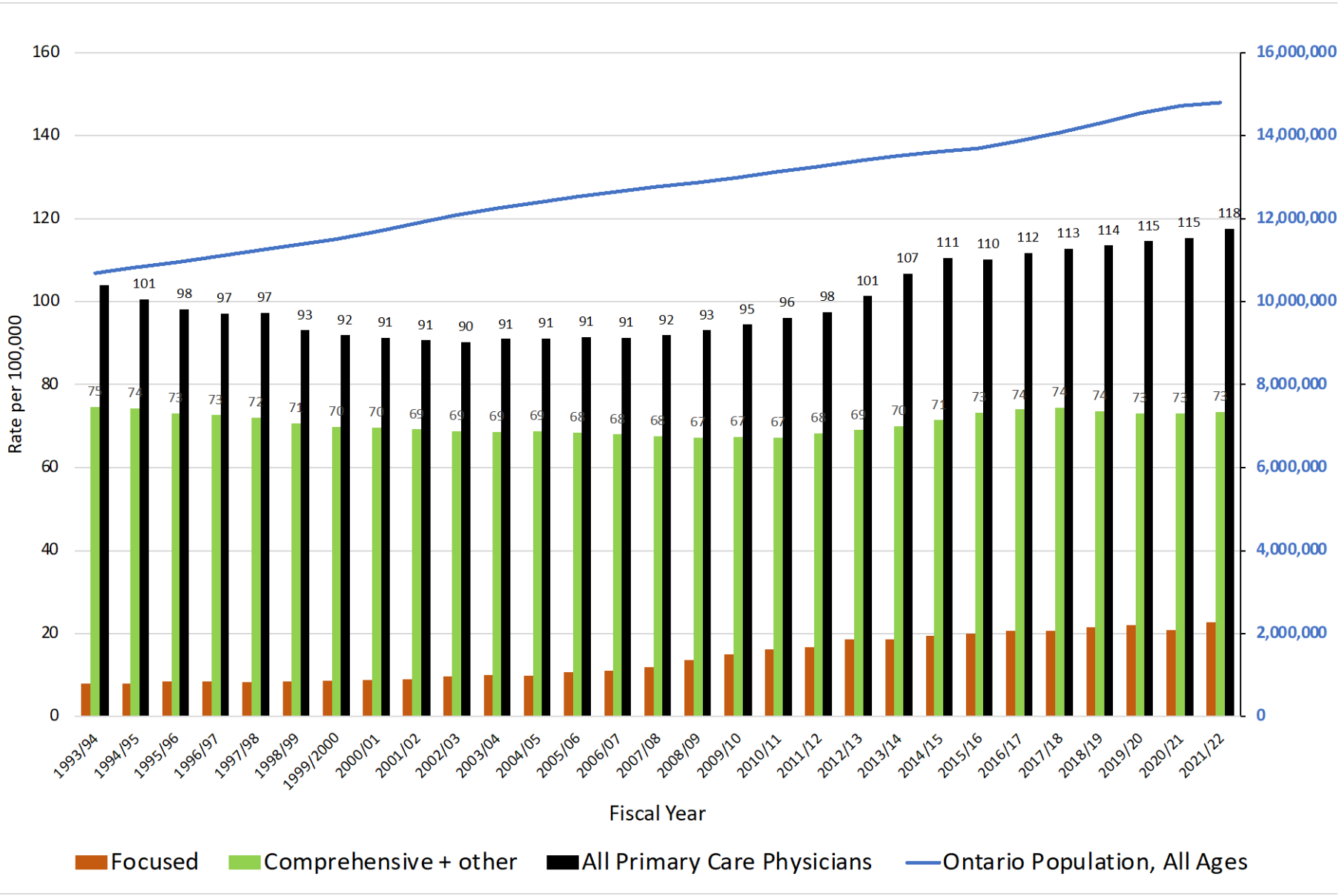
2. IPDB counts: Focused practice defined as having more than 50% of visits in one location or more than 50% of payments for one type of service.

3. Fee code categories includes procedures when determining the proportion of a physician's service or billings that are focused in one area.

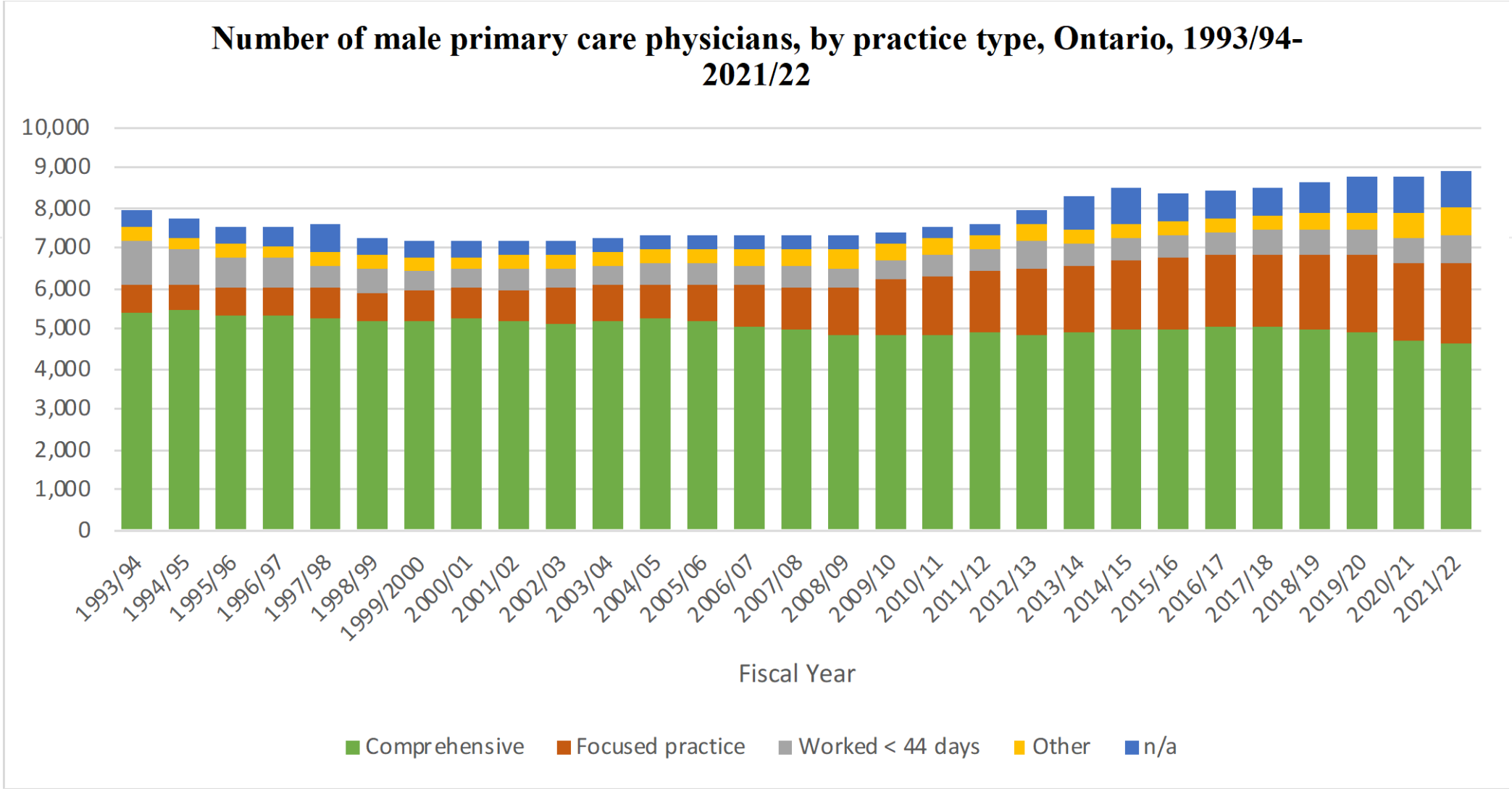


The complete version of this algorithm can be found here:
Schultz SE, Glazier RH. Identification of physicians providing comprehensive primary care in Ontario: a retrospective analysis using linked administrative data. CMAJ Open. 2017;5(4):E856-E863

Sensitivity Analysis

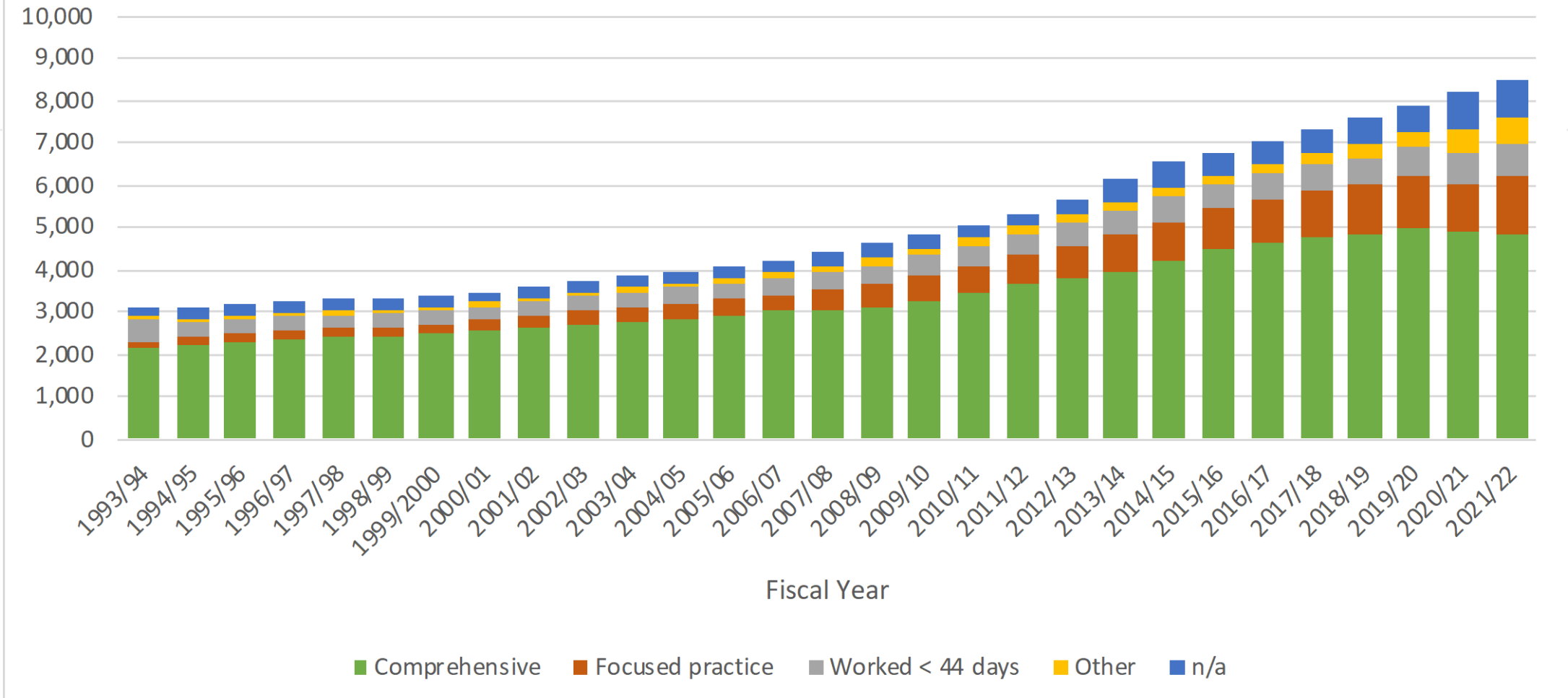


Archived slides (the gender-specific story)

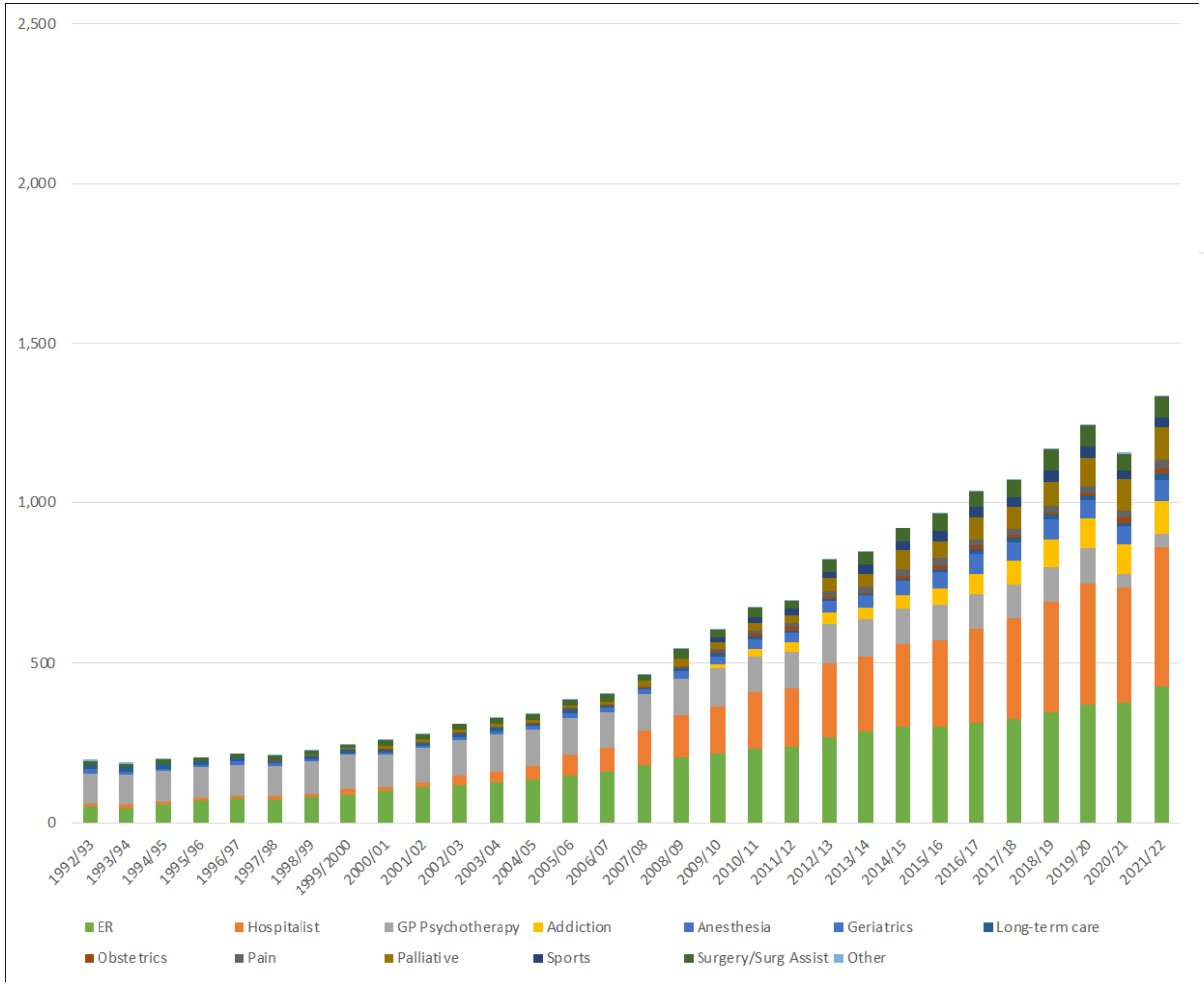


The number of male family physicians has not increased significantly, but the proportion of male physicians going into focused practice has (previous slide)

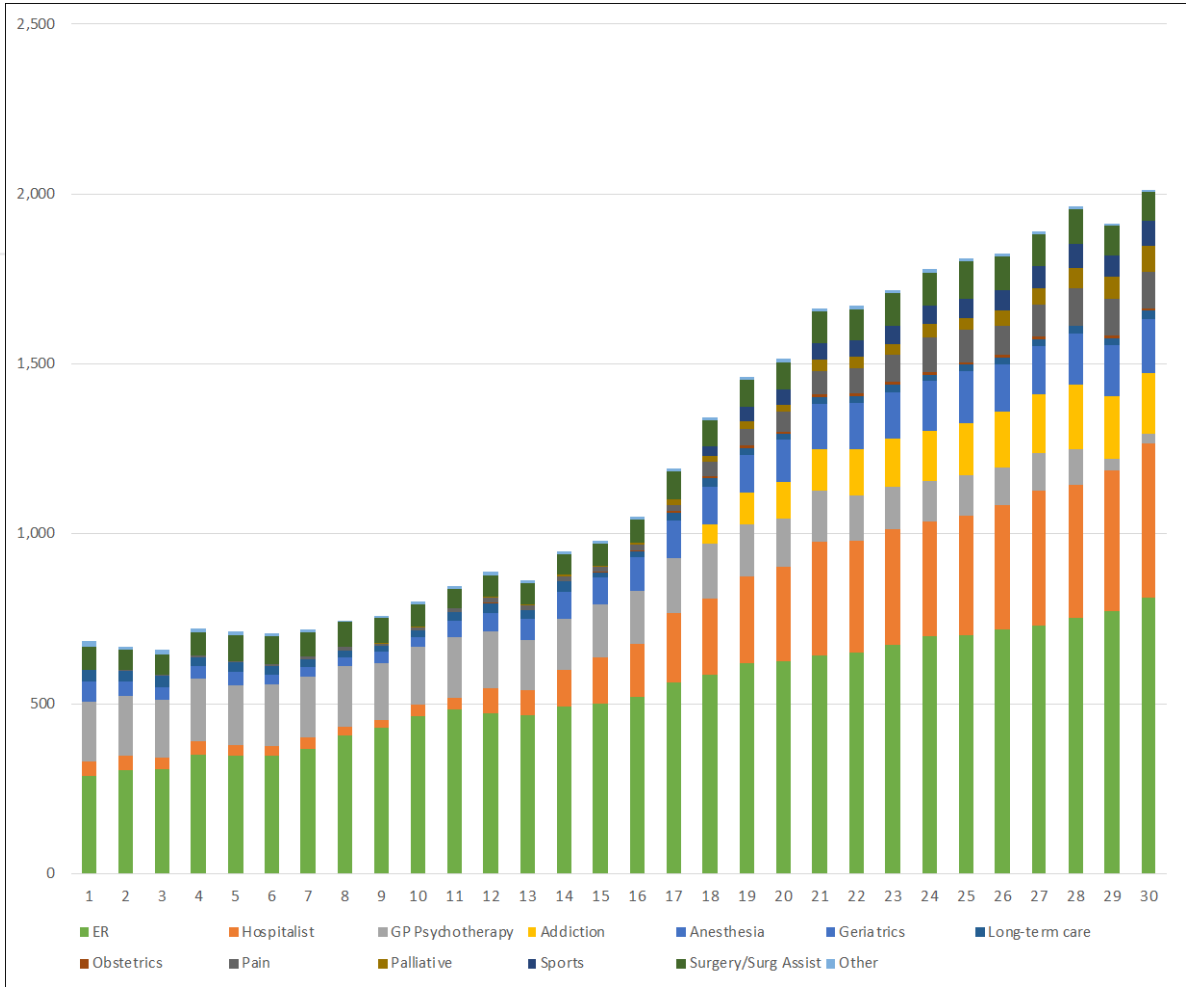
Number of female primary care physicians, by practice type, Ontario, 1993/94-2021/22



Female



Male



INSPIRE-PHC

MAP Centre for Urban Health Solutions

TAB 3

OurCare

EN / FR **Survey Data Explorer**

OurCare is a pan-Canadian project to gather input from the public on how to rethink the future of primary care–the type of care usually delivered by family doctors and nurse practitioners (NPs). The survey was online from September 20th to October 25th, 2022. Over 9000 people in Canada completed the full survey, sharing their perspectives and experience. You can view the data below.

All Data | Québec Data | Ontario Data

Click here to learn about how to use this tool

All Questions | Those with a family doctor or NP | Those without a family doctor or NP

Those looking for a family doctor or NP | What is important when it comes to primary care

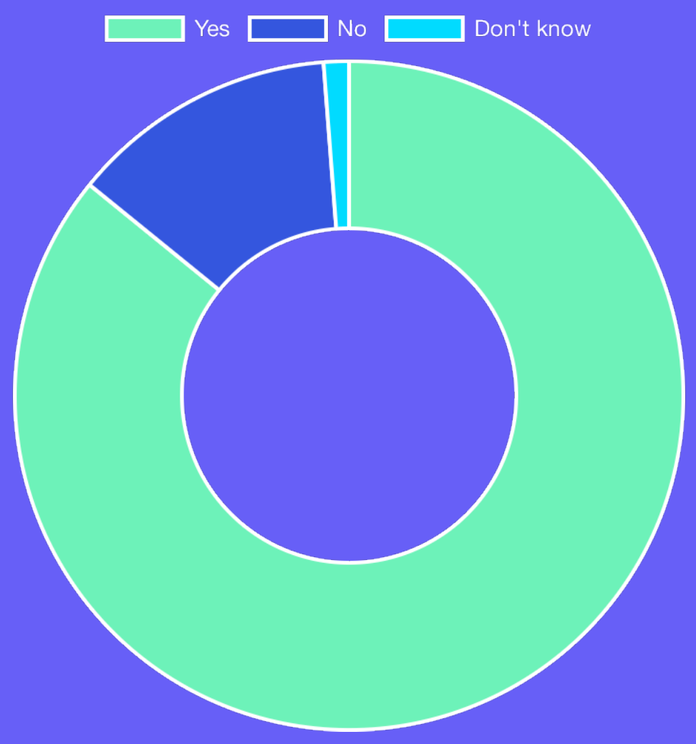
In-person and virtual walk-in clinics | Virtual care and team-based care | Access to medical information | Reimagining care

Who responded (Weighted Data) | Who responded (Unweighted Data)

Select a question:

1 - Do you currently have a family doctor or nurse practitioner that you can talk to when you need care or advice about you...

Do you currently have a family doctor or nurse practitioner that you can talk to when you need care or advice about your health? N= 4036



The OurCare project is led by Dr. Tara Kiran at MAP Centre for Urban Health Solutions, Unity Health Toronto. Learn more at OurCare.ca.

Click here to read about Survey Methods

Demographic definitions

You can view the full survey that respondents took in English or French.

TAB 4

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Our File No. 22-910

January 24, 2024

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Dear Sirs:

Re: The Crown and OPSBA and ETFO – Hearing Date: January 16, 2024

Please accept the following supplemental submissions of the Elementary Teacher's Federation of Ontario (ETFO) in response to the Crown's "Wage Reopener Decisions" table, which was submitted at the conclusion of last week's hearing, and in response to the Crown's letter of January 22, 2024 regarding the recent OPSEU unified mediated settlement.

The Ministry's Chart

With respect to the Crown's "Wage Reopener Decisions" table, which was submitted at the conclusion of last week's hearing, ETFO makes the following points:

- The chart does not account in any way for size of bargaining unit. As a result, in the Crown's table central awards that applied to 45,000 employees, such as the *CUPE/SEIU v, Participating Hospitals (Bill 124 Reopener)* award, or 12,000 employees, such as the *Participating Hospitals v OPSEU* award, are treated and weighted the same as an award affecting only 142 employees, such as the *Salvation Army Ottawa - Grace Manor v Canadian Union of Public Employees (CUPE), Local 4592* award. This has the effect of overstating the impact of the LTC sector awards in the overall average and underplaying other sectors, such as the hospital sector.

- The chart excludes numerous memoranda of settlements from the hospital and power sectors. For example, OPSEU has approximately 48 non-participating hospital bargaining units. These units also had reopeners and all have largely settled for the pattern set in the central award (4.75%, 3.5%, 3%). The same is true for the CUPE and SEIU non-participating hospital bargaining units. (For example, there are approximately 15,000 CUPE hospital workers at non-participating hospitals where the central pattern has subsequently been followed). However, none of these settlements are included in the Crown's table, which artificially lowers the overall average in the Crown's table.

- This chart is not actually looking at a weighted sample, it's just looking at an average wage increase across the sample unions listed in the data for the contract year period. A weighted sample is equal to the sum of weight of each data point multiplied by value of each point then divided by the sum weight of each data point.

- The chart includes errors. For example, it lists a University of Toronto MOS for the 2021-2023 time period, but it is unclear who the union is. However, the Gedalof interest arbitration award in *University of Toronto v University of Toronto Faculty Association* addressed the contract period July 1, 2020 to June 30, 2023 and included increases totalling 1%, 1%, and 8 %, which does not line up with what was included in the Crown's table. Subsequently, the USW Local 1998 bargaining unit at the University of Toronto, which includes 5800 members, followed the pattern set in the Gedalof award and negotiated a 12.8% increase over its contract, with a 9% increase front-loaded in the first year.

- Other relevant settlements from the post-secondary sector have been excluded. For example, the chart does not include the Queen's University and Queen's University Faculty Association's settlement for a three-year renewal agreement, effective from July 1, 2022 to June 30, 2025 that includes wage increases of 3.5% in the first year and 3% in each of the subsequent years.

- The Crown's table gives undue weight to the long-term care sector awards, which as noted in ETFO's reply brief is not an appropriate comparator. Historically, increases in the sector have been lower than other sectors and they do not provide any real basis for comparison. As well, frequently there are adjustments to wage grids made at interest arbitration and as a result ATBs do not reflect the full amount of compensation increases awarded. This is particularly the case in recent rounds where the government's permanent wage increase for PSWs in 2022 has resulted in frequent upward adjustments to wage grids in response.

- As well, LTC workers have lower educational requirements than do teachers. Comparing a job that requires high school education to a job that requires an undergraduate degree followed by an education degree is not an appropriate comparator.

- Further, teachers are best compared to other professional higher paid workers (such as power workers and hospital professionals), all of whom received larger increases in their reopener negotiations/awards than employees in the LTC sector.

For these reasons, ETFO submits that the Board cannot rely on any of the so-called averages contained in the Crown's table, nor the conclusions that the Crown attempted to draw from it at the close of the hearing. Rather ETFO encourages the Board to look at the awards and outcomes themselves, particularly those from other professional groups, such as Power, Hospital and Post-Secondary sector. Those settlements and awards include amounts in the 3.5% (see for example Queens) to the 4.75% (OPG, Hospital) range. Thus, in ETFO's submission, the appropriate comparator "reopener range" for the Board's consideration is 3.5 to 4.75%.

Significantly, this does not account accounting for the documented recruitment and retention concerns which justify and require additional increases to be awarded. As this Board is well aware, there were, beyond the normative increases identified above, also significant additional compensation increases awarded throughout the health care sector – in the form of benefit, premium and grid adjustments -- in order to respond to its specific recruitment and retention crisis.

ONA RESULTS

Finally, by way of example regarding the continuing problems with the Crown's supposed averages, with respect to the Crown's health sector average number, ETFO notes that this number is again artificially skewed downward, this time by the inclusion of the ONA numbers from the 2021-2022 year when ONA only requested 2 and 3 percent in bargaining and before Arbitrators Stout and Gedalof. As explained by Arbitrator Kaplan, in the ONA and OHA award, from a replication point of view these numbers are of limited comparative value

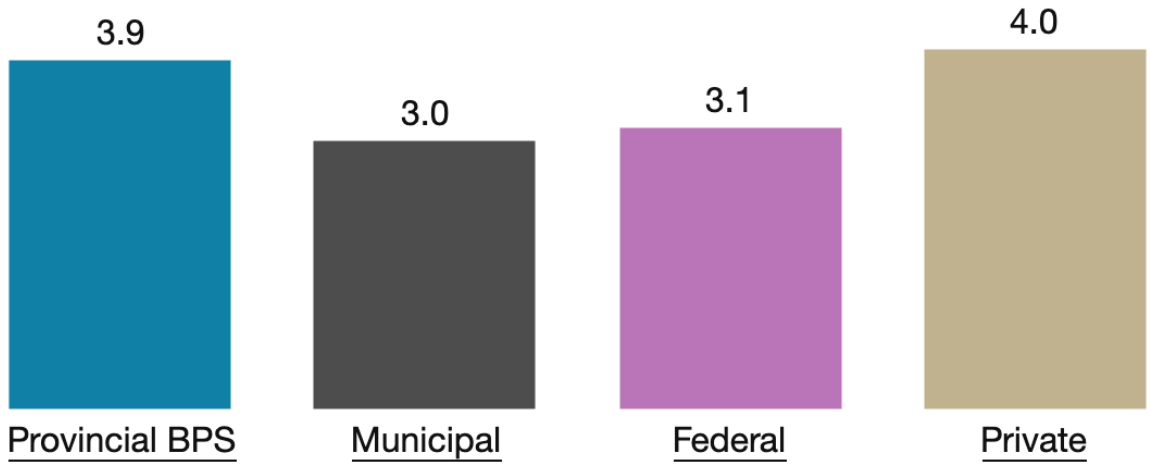
Before the Stout and Gedalof Boards, ONA resurrected earlier asks that had been formulated at a time when inflation had not yet taken root. However, in the meantime, annual inflation hit 3.5% in 2021 and 6.8% in 2022. The fact that ONA did not change its proposals to reflect intervening events does not make this change in circumstances any less material. The fact that ONA relied on its earlier asks cannot mean that the unions are somehow bound to follow reopener awards that failed to address relevant interest arbitration criteria such as the state of the economy and recruitment and retention. Following either of these reopeners would not be replication since the overall settlement trend is completely contrary to either of these outcomes.

At the same time that it has included the ONA numbers, the Crown has continued to exclude the many OPSEU, CUPE, and SEIU non-participating hospital bargaining units that also had reopeners and that have all largely settled for the pattern set in the central awards (4.75%, 3.5%, 3%), which again artificially lowers the overall hospital average in the Crown's table. These are just but a few examples of the continued problematic nature of the Crown's table and calculations and why ETFO continues to reiterate that the averages found in it are not reliable.

TAB 5

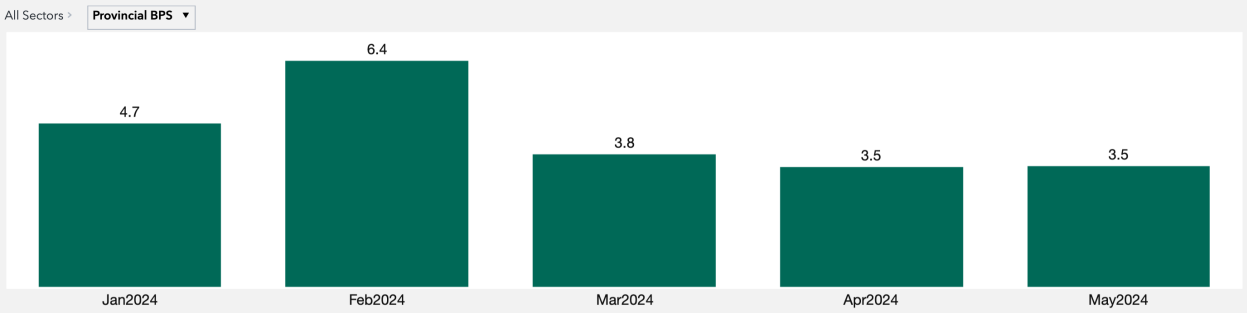
Collective Bargaining Highlights, Overview of Wages
Ministry of Labour, Ontario
https://www.lrs.labour.gov.on.ca/en/index.htm

All Sectors 2024



Sector Group	Ratification	Number of Settlements	Number of Employees	Avg. Annual Increase (%)
Subtotal: Provincial BPS		152	78,440	3.9%
Provincial BPS	Jan2024	3	787	4.7%
Provincial BPS	Feb2024	6	9,549	6.4%
Provincial BPS	Mar2024	7	6,561	3.8%
Provincial BPS	Apr2024	135	61,389	3.5%
Provincial BPS	May2024	1	154	3.5%
Subtotal: Municipal		17	8,282	3.0%
Municipal	Jan2024	6	1,985	3.2%
Municipal	Feb2024	3	883	2.6%
Municipal	Mar2024	5	1,381	3.2%
Municipal	Apr2024	3	4,033	2.9%
Subtotal: Federal		1	1,301	3.1%
Federal	Jan2024	1	1,301	3.1%
Subtotal: Private		7	3,953	4.0%
Private	Jan2024	1	1,300	3.4%
Private	Feb2024	3	1,824	4.2%
Private	Mar2024	2	426	4.3%
Private	Apr2024	1	403	4.6%

Provincial BPS 2024



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Provincial BPS	Apr2024	135	61,389	3.5%
Provincial BPS	May2024	1	154	3.5%

TAB 6

RESET

Specialty: Yearly Details

PAGE NAVIGATION

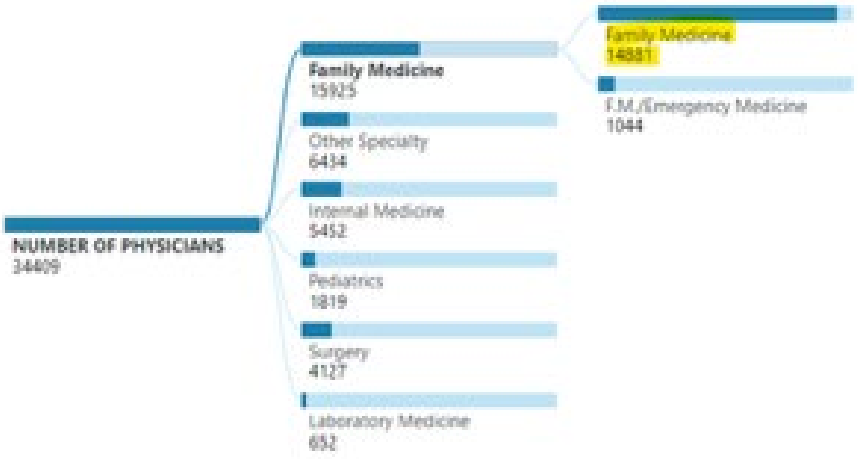
YEAR 2022

LHIN All LHINs

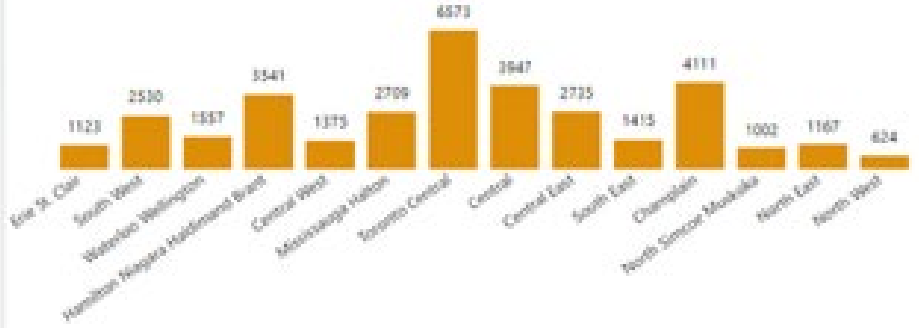
GENDER All

TOTAL PHYSICIANS SELECTED

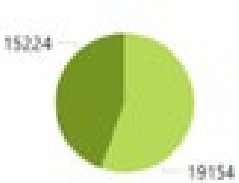
34409



NUMBER OF PHYSICIANS BY LHIN



AGE DISTRIBUTION OF PHYSICIANS BY GENDER

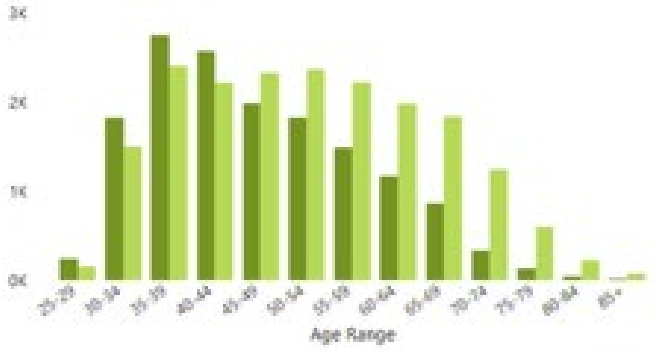


Female

See detail

Male

See details



Footnotes

Refreshed April 4, 2024

OPRC