IN THE MATTER OF AN ARBITRATION

BETWEEN:

The Ministry of Health and Long Term Care

And

The Ontario Medical Association

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

Appearances

For the MOHLTC: Robert Reynolds

Craig Rix
Hicks Morley
Barristers & Solicitors

Bob Bass
Michele White
Bass Associates

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

Goldblatt Partners
Barristers & Solicitors

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

Introduction

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

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

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

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

Criteria for Decision-Making

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

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

(a) The achievement of a high quality, patient-centred sustainable publicly funded health care system;
(b) The principle that compensation for physicians should be fair (in the context of such comparators and other factors that the arbitration board considers relevant) and reasonable;
(c) Such comparators as the arbitration board considers to be relevant, including but not limited to, physician compensation;
(d) The economic situation in Ontario;
(e) Economic indicators that the arbitration board considers relevant, including, but not limited to, the cost of physician practice;
(f) Evidence-based relativity and appropriateness considerations; and
(g) Data sources agreed to by the parties to be reasonable, or otherwise the most reliable data available.

Discussion

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

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

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

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

Award

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

Ministry Proposal for Hard Cap on PSB

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

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

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

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

OMA Response to Ministry Proposal for Hard Cap on PSB

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

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

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

Decision - PSB

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

Decision - Appropriateness

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

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

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

AWG

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

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

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

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

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

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

Redress – The OMA Position

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

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

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

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

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

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

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

The OMA – Fee Increases

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

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

Redress – The Ministry Position

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

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

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

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

The Ministry – Fee Increases

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

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

Decision – Redress and Fee Increases

Redress

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

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

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

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

Fee Increases

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

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

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

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

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

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

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

(1) Effective April 1, 2017

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

(2) Effective April 1, 2018

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

(3) Effective April 1, 2019

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

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

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

(4) Effective April 1, 2020

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

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

Other Compensation Matters

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

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

Primary Care

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

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

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

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

Accordingly, we award the following:

Multi-Stakeholder Primary Care Working Group

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

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

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

Academic Health Sciences Centre and NOSM Proposals

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

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

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

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

Technical Fees Proposals

The parties are also directed to continue discussions regarding the OMA's additional technical fees proposals.

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

It is our hope that discussion, mediation and fact-finding during this mediation process will set the stage for efficient and productive future processes.

Conclusion

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

Dated at Toronto this 18th day of February 2019.

"William Kaplan"

William Kaplan, Chair

"Dr. Kevin Smith"

Dr. Kevin Smith, Ministry Nominee

"Ron Pink"

Ron Pink, QC, OMA Nominee

APPENDIX - APPROPRIATENESS WORKING GROUP (AWG) AND PROCESS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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