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July 26, 2016

MEMORANDUM
To: General Surgeons of Ontario
From: Ontario Association of General Surgeons & Section on General Surgery
Re: OMA-MOHLTC Tentative PSA
Date: July 25, 2016

On July 11, 2016, Ontario physicians were surprised to hear that a tentative Physician Services Agreement (PSA) had been reached between the OMA and the Ministry of Health and Long-Term Care. The agreement came about very quickly and was based on high-level closed discussion between the OMA Negotiations Committee Chairs and the Ministry. The full OMA negotiation team was not fully involved until late in the process. The PSA is short on specifics, instead setting the framework for bilateral discussions regarding details and implementation. So, for the past 2 weeks, the OAGS/Section Board has worked to gather as many details as possible regarding the potential scenarios, if we either ratify or reject the PSA.

What is clear is that the tentative agreement is imperfect, and so the question before us is not whether we like the agreement, but rather whether it is better than the likely alternatives. We need to ask ourselves: "Is the tentative PSA acceptable in the current political and economic environment and against the backdrop of the ongoing unilateral government action?"

There is no question that our ability to reach favourable agreements has been largely dictated by the economic and political climate in the province. We had very difficult agreements in the 1990's, followed by a decade of very favourable agreements, before being faced now with a challenging negotiations environment, as well as unilateral government action. I am optimistic that our ability to reach negotiated agreements with significant fiscal infusions will improve if economic conditions in the province recover over the next few years.

Last week, the OAGS/Section Board discussed the PSA and were unable to come to a consensus regarding its acceptability. The Board discussed the likely outcomes of a yes or no vote, and in the end decided to present a summary of the PSA, and the potential wins and losses as a result of this agreement, in the hope that the information will help each of you to decide whether or not to support or reject the tentative agreement.

Highlights of the tentative PSA

1. **The agreement spans 4 years** between April 1, 2016 - March 31, 2020.
2. The **Physician Services Budget (PSB)** would be based on the actual 2015-16 expenditures with an annual 2.5% increase. In addition, annual one-time payments of $50M, $100M, $120M and $100M would be provided for the duration of the agreement. **If PSB expenditures exceed these monies**, a co-management process will be used to address excess utilization, and reconciliation may include payment reductions. **If utilization is less than projected**, monies will be available for increased payment. The Schedule of Benefits will be modernized to include a total of $200M in permanent fee reductions.

3. The **OMA and the Ministry will co-manage** the task of maintaining expenditures within the planned PSB. Co-management acknowledges the joint responsibility of physicians and the Ministry to attain the goals of the PSA. Principles of relativity, appropriateness and value for money will be used to guide fee adjustments. The co-management process will include the OMA, the Ministry and a neutral 3rd party facilitator who has the ability to make binding decisions if needed. Co-managed decisions will include the modernization of the Schedule of Benefits, fee adjustments and the development of a health human resources strategy. Co-management may also include fee code increases/decreases, progressive discounting of billings in excess of $1 M, monitoring of data on expenditures, utilization, practice patterns and billing profiles.
4. **Changes to the primary care physician agreement** will include ensuring improved access to after-hours primary care services and increasing the number of managed entry positions. These changes will not affect general surgeons directly.
5. **If the PSA is ratified**, the Ministry has agreed that no future unilateral action will be taken during the course of the agreement. This gives the OMA additional legal channels to challenge government action, including the ability to seek interest arbitration in disputes. Furthermore, the government has committed to not undertake unilateral action at the expiry of the PSA if the OMA has won the right to binding arbitration in the lower courts, even while such a decision may be under appeal.
6. The **OMA Charter Challenge** will continue - even if we ratify the PSA. The OMA Charter Challenge seeks to order government to establish a binding dispute mechanism. It is expected that it will take two years before a decision is rendered in the lower courts, and about 5-6 years if it is appealed all the way to the Supreme Court. Ratification or rejection of the tentative PSA does not affect this Charter Challenge.

Impact of the PSA on General Surgeons.

The bottom line is that this is not an agreement where General Surgeons stand to gain anything, but we may be able to stop ongoing losses. Clawbacks to date will not be reversed, and the planned 2.5% PSB increases together with the one time payments only cover expected growth; in other words, one should not expect any fee increases. However, under the current unilateral actions we face, ongoing fee cuts total $1.12B over the next four years (for the entire profession). Having a ratified PSA will bring stability and predictability to our practices, but no gains.

It is important to acknowledge that with the tentative PSA, **the government has shown some movement for the first time in years**. The ability of the two sides to come up with an agreement was hardly a foregone conclusion. There is an acknowledgement that physicians are essential partners for health system transformation. It is true that we did not achieve binding arbitration and that the PSA came about without a robust negotiations process. The question is whether these details are deal breakers. An arbitrated deal would likely look fairly similar to what is currently before us – a fixed PSB, growth that accounts for demographic changes, and a plan for health system design reform.

Right now, the unilateral action has a fixed PSB with 1.25% growth. The PSA would double the growth to 2.5%. When one adds in the annual one-time monies, the OMA economics department calculates that the annual PSB will grow by roughly 3.1%. **A growth rate of approximately 3% has been pretty much stable for the past decade. There is no reason at this time to imagine that it will change substantially over the next four years.** In fact, health care utilization growth due to demographic changes (population growth and aging) represents only ~ 1.9% of growth. The demographic pressure for general surgery services is even lower than this. The remainder of growth is due to an increased number of practicing physicians. So, although none of us like the idea of a fixed PSB, the PSA demonstrates that the government is willing to fund more than just demographic growth.

Now as part of the agreement, there will be **$200M in planned permanent fee reductions**. Where these fall will be decided using a co-management process that includes the OMA, the Ministry and a neutral facilitator. Since principles of relativity and appropriateness will be used, this will probably target the high billing groups; Cardiology, diagnostic imaging, and ophthalmology are at the top of this list. Gastroenterology is also on the "relatively over-valued" side, and as a result endoscopy fees may be targeted, which would obviously affect general surgeons as well. OAGS/Section would advocate for ways to mitigate this action. Otherwise, under the OMA's relativity formula, **general surgery is considered neither over-valued nor undervalued**, and it is unlikely that the government position would be that general surgery income otherwise needs to be disproportionately targeted.

You have probably received some **emails from specialty groups** who vehemently oppose the tentative PSA. Many of us have received emails from diagnostic imaging, gastroenterology and cardiology sections, who came out in opposition to the tentative PSA almost immediately. One must wonder how serious the deliberative process could have been that allowed them to come to a decision so quickly. It is also worth noting that these groups are amongst the top billing groups in Ontario, and thus, are the ones that are most likely to be targeted for permanent fee reductions. Many of us might even agree that these groups should have fee reductions. This fact is worth keeping in mind when one reads their solicitations. The question to be asking yourself is whether other specialist groups represent your interests as a General Surgeon. So far, the emails received seem rather detached from the reality that most of General Surgeons encounter in our own clinical practices.

Many of us are worried about the **co-management process,** in particular the ability of the OMA to appropriately represent the needs of General Surgeons during this process. Principles of relativity, appropriateness and value for money will be used to guide decisions made. However, **the issue of relativity** has been a thorn in our relationship with the OMA for a long time. It is not clear that the OMA is able or willing to tackle the question of relativity in a fulsome way. Also, the OMA continues to support the use of the CANDI methodology to establish relativity even though they are aware of how deeply flawed the CANDI methodology and data are. This is an area in which it is very much in our interest, as General Surgeons, to press for changes.

If we accept the PSA, it will require trust that the co-management process will work. At this time, most of us are pretty short on trust of either the OMA or the government to make decisions that reflect the interests of General Surgeons. This may be the 'devil in the details' that makes or breaks your decision. You will have to reflect on how much trust you have in the process when you consider how you will vote.

For those who desire **binding arbitration**, it's vital to realize that government remains unwilling to enter into binding arbitration with the OMA at this time. Binding arbitration is primarily a tool used to encourage the parties to reach a negotiated settlement, rather than as a means to settle ongoing conflict. It will likely take the OMA Charter Challenge to settle this question. The OMA lawyers tell us that this is years away. If we wait it out, we are likely to suffer ongoing clawbacks during the interim. Unfortunately, even if the OMA Charter Challenge is successful, physicians are unlikely to recover the loss of income suffered to date as a result of the unilateral government action. Consequently, each of us will have to balance the prudence of waiting years for binding arbitration vs. accepting a settlement that is available today.

Hopefully, this email will give you some more information regarding the impact of the tentative PSA on General Surgeons. You should take a few minutes to review the PSA on the OMA website or attend an information session before deciding whether to support or reject the tentative agreement. **The OAGS/Section executive encourage each and every one of you to vote on the PSA.**

SPECIAL NOTE: As of July 25, the planned referendum at the end of July has been CANCELED due to a petition demanding an OMA General Meeting prior to member voting. At this time, details of the OMA General Meeting and voting process are forthcoming. Please follow the OMA and OAGS websites for updates on when and how you will be able to vote on the PSA. **It is vital to ensure that the opinions of General Surgery are represented in the final decision.**

Sincerely,

Dr. Alice Wei
President, Ontario Association of General Surgeons

Dr. Chris Vinden
Chair, OMA Section on General Surgery

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