Motions – potential responses

Concept	Response
Data is incomplete / not accurate	• If you believe there is an equity issue, move forward with BEST current data • No the data is not complete and adjustments likely will need to be made • Yes there are some pieces missing • But the gap is so great, that the resulting change in variance with correction will still allow for a lot of movement • The gap isn't 1.5:1, or even 2:0.1, it is 3.1:1 • Even if we assume that the OH of the highest earners are not quite accurate and you change that OH quite dramatically, the variance will only move minimally, for example from 3.1:1 to 3:1 • The process is iterative • Analysis / paralysis • Precedent with fee equity process – same arguments through that process
Overhead calculation is not accurate	• Yes additional work is needed on the OH • This is a continuing process • Even if we assume that the OH of the highest earners are not quite accurate and you change that OH quite dramatically, the variance will only move minimally, for example from 3.1:1 to 3:1
Negative allocation should not be on the table	• It will take 972 years otherwise • If we don't address these issues with extreme high earners, someone else could
RF should not be making these decisions – should go to full membership	• Role of the RF is the authority of the association • Voice of the membership is through the RF • All delegates have been elected by their constituents • Contracts such as agreements or amending agreements go for ratification to the membership but when you are working within a ratified contract, that is the job of the RF and the RF advises the board what to do • Allocation decisions are owned by the board and they are presented to the RF
Specialists' training is much longer than GPs	• This adjustment is already in the ANDI • Risk is already compensated thru CMPA

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Specialist groups with higher utilization rates are due to patient demand and should not be harmed	• Utilization should be reflected in hours worked – there should be a correlation • ANDI does not restrict the number of patient encounters and should not impact access
Data does not reflect complexity/risk and intensity of work done by higher income specialist sections	• There is a complexity adjustment in ANDI already • Cognitive vs procedural – what is the value of procedures, where is the evidence that this is a higher level cognitive task • There is cognitive load of physicians across the spectrum of income • in fact evidence to suggest in ambulatory assessments it is higher than SC
Data does not reflect the harder work done by specialists, i.e., longer work days	• There are all variations within every section as to the length of a workday for all their members – some FP may have briefer days while others may be working 12-14 hours days • The same applies to specialists • Hours of work can be applied to iterations of the model as we work towards equity
GP have had higher percentage increases in the recent agreements	• Agree • And even after those increases, they are still the lowest end • Even with those increases the ANDI gap has become wider • There has finally been recognition that primary care is the nucleus of the healthcare system
GP income from PCN funding has not been included in the ANDI data	• PCN payments that contribute to family physician clinical compensation is minimal • Vast majority of funds flow to hire allied health providers • At most, factored across all GPs there is a 1-2% increase to gross clinical income • Even with this addition, the GP ANDI line will not move on the graph
Some sections have already taken a significant hit from the PCC changes	• True, including GPs