POLICY BRIEF · END THE WAIT ONTARIO

Built for the Back End

How Ontario's autism program concentrates money — and profit — at the intensive tier children wait years to reach.

The finding in one sentence

Ontario's autism system is arranged like an insurance market, not a health system: a free, universal "front end" that delivers parent coaching rather than child therapy, an intensive "back end" where per-child funding and provider revenue concentrate, and a registration-date queue — not needs-based triage — that meters access so spending never exceeds the budget.

The documented facts

ACCESS

Of **88,175 children registered** in the OAP (FOI, Dec 2025–Mar 2026), only **~23% (20,666)** hold active Core Clinical funding; **~67,509 wait** — confirmed by CBC.[3,4] Three-quarters receive only the free front-end services.

THE QUEUE

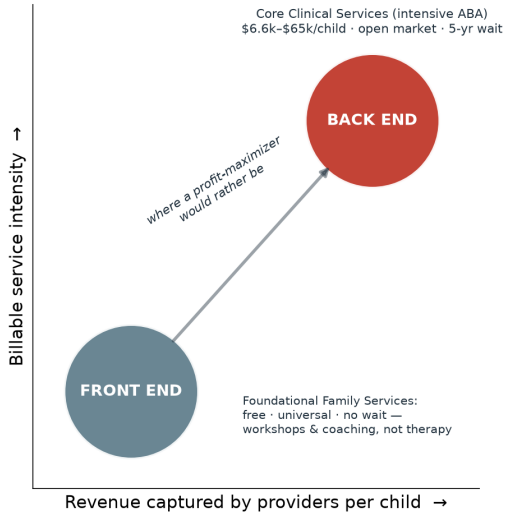
Children enter Core Clinical Services **strictly by registration date, not severity of need**.[1] Waits exceed **five years**; FOI records show periods where the funded count *fell* as more registered.[4] This is demand management, not a backlog being triaged.

THE MONEY

Core funding scales from **~$6,600 to ~$65,000 per child** with assessed need,[2] paid direct-to-family into an **unregulated open market**. Intensive ABA also authorizes far more billable hours (20–40/week) than allied services, making the back end the most revenue-productive tier. The 2026–27 budget of **$965M** still falls ~$385M short of the FAO's own estimate of need.[4,5]

Why the money — and the profit — pools at the intensive back end

Two tiers, opposite economics



The same design, read from a boardroom

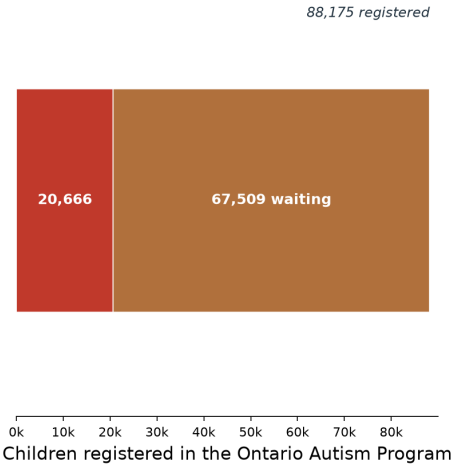
	FRONT END	BACK END
Cost to system	Low	High
Revenue to provider	Minimal	Up to ~$65k/yr/child
Billable hours	A few sessions	20–40 hrs/week
Share of children	~77% (waiting)	~23% (funded)
Wait to access	None	5+ years
Clinical impact	Low	High
Profit attractiveness	Low	**HIGH**

Schematic of the documented OAP structure (dollar figures per the funding charts). 'Share of children' uses the 23%-funded / 77%-waiting split. Profit-attractiveness is the article's inference from these documented economics, not an official OAP metric.

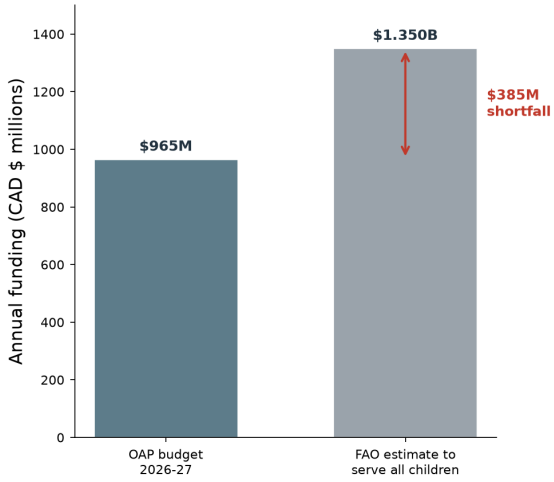
Figure 1. The same design, read from a boardroom. Every attribute that makes the front end cheap to the treasury also makes it unprofitable to deliver; every attribute that makes the back end valuable to a provider is what the system rations behind the queue. “Profit attractiveness” is inference from the documented economics.

The universal promise, and the gate behind it

Only 23% of registered children get funded therapy



A ~$385M shortfall against Ontario's own estimate



Ontario Autism Program, FOI counts Dec 2025–Mar 2026 (88,175 registered; 20,666 funded). Budget: 2026-27 Ontario Budget. Need estimate: Financial Accountability Office of Ontario.

Core clinical funding (23%)
Waiting — free 'front-end' services only (77%)

Figure 2. The universal promise, and the gate behind it. 77% of registered children are held in the free front-end tier; even the current budget falls ~$385M short of the province’s own FAO estimate.[3,4,5]

The corroborating evidence

WHAT A MATURE FOR-PROFIT AUTISM MARKET LOOKS LIKE (U.S.)

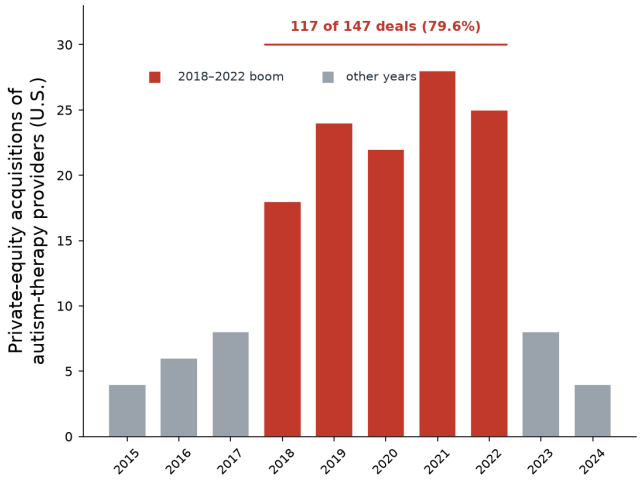
A 2026 *JAMA Pediatrics* study found **574 autism-therapy sites acquired by private equity** across 42 states (147 deals; 79.6% in 2018–2022), with PE **more likely to enter high-prevalence, generous-mandate states**.[7] CEPR found PE completed **~85% of all autism-sector M&A (2017–2022)** — a concentration seen in no other health segment.[8] The mechanism: intensive ABA out-bills allied services, so consolidators **strip speech/OT/feeding** to concentrate on high-intensity ABA. Ontario's intensity-based funding builds in the same price signal.[8]

A KNOWN FAILURE MODE OF 'CHOICE' MARKETS

Thirty years of quasi-market research is consistent: routing public care money through individualized-funding markets **shifts risk onto consumers, advantages well-resourced families and providers, and can widen inequalities** — Le Grand (1991),[10] Spall et al. (2005),[11] and NDIS/English-social-care studies.[12–15] Markets in care fail in a predictable direction: toward the provider, away from the person the funding was meant for.

What a for-profit autism market looks like once it matures: the U.S.

A private-equity feeding frenzy, 2018–2022



The scale of the roll-up

574
provider sites acquired by private equity, 2015–2024

42 states
the roll-up concentrates where autism prevalence is highest

+24 pts
more likely to buy into the highest-prevalence states

~85%
of ALL autism-sector M&A (2017–2022) was private equity

Arnold et al., JAMA Pediatrics 2026 (DOI 10.1001/jamapediatrics.2025.5443): 574 sites, 147 deals, 42 states. Sector M&A share: CEPR, 'Pocketing Money Meant for Kids' (2023). Yearly split anchored to the study's 79.6% figure.

Figure 3. Private equity follows prevalence and payment. Capital flows to where billable need is densest and reimbursement most generous — the same gradient Ontario builds in from the start. Source: Arnold et al., *JAMA Pediatrics* 2026;[7] CEPR 2023.[8]

The inference — clearly labelled

OUR READING OF THE FACTS

A rational profit-maximizer handed Ontario's autism budget would build exactly this: a cheap universal front end that satisfies "everyone gets something," spending concentrated in the high-revenue back end, and a queue that keeps the obligation inside the appropriation. **We do not claim documented intent.** We show that the structure's incentives point one way with unusual consistency — the most profitable tier is the most rationed, the free tier has the least clinical substance. It is the inversion of the universal-care principle that allocation follows need. Functionally, it was built in the image of what an insurance company would want.

What would change the diagnosis

- **Triage the queue by clinical urgency**, not registration date — the single change that would most distinguish a health system from a demand-management scheme.

• **Fund to the FAO's estimate of need** (~$1.35B), closing the ~$385M gap rather than managing it through the waitlist.

• **Restore clinician-led needs determination** and publish provider-concentration and ownership data before Ontario's market consolidates the way the U.S. market has.

Sources

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