Health Policy 120 (2016) 732–738

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Health Reform Monitor

Primary care in Ontario, Canada: New proposals after 15 years of reform☆

Gregory P. Marchildon [a,*], Brian Hutchison [b]

[a] *Institute of Health Policy, Management and Evaluation, University of Toronto, Canada*
[b] *Departments of Family Medicine and Clinical Epidemiology and Biostatistics, McMaster University, Canada*

ARTICLE INFO

Article history:
Received 3 December 2015
Received in revised form 13 April 2016
Accepted 15 April 2016

Keywords:
Primary care
Health care reform
Fee-for-service payment
Capitation
Salary
Rostering
Policy development
Health system reform
Primary care physicians
Canada
Ontario

ABSTRACT

Primary care has proven to be extremely difficult to reform in Canada because of the original social compact between the state and physicians that led to the introduction of universal medical care insurance in the 1960s. However, in the past decade, the provincial government of Ontario has led the way in Canada in funding a suite of primary care practice models, some of which differ substantially from traditional solo and group physician practices based on fee-for-service payment. Independent evaluations show some positive improvements in patient care. Nonetheless, the Ontario government's large investment in the reform combined with high expectations concerning improved performance and the deteriorating fiscal position of the province's finances have led to major conflict with organized medicine over physician budgets and the government's consideration of an even more radical restructuring of the system of primary care in the province.

© 2016 The Author(s). Published by Elsevier Ireland Ltd. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

1. Medicare and constraints on primary care reform in Canada

For historical and structural reasons, primary care has been extremely difficult to reform in Canada. When universal medical care coverage was introduced in Canada, for the first time in the province of Saskatchewan in 1962, organized medicine was highly opposed to the policy, considering it a potential threat to clinical decision-making and professional autonomy over patient billing. A 23-day doctors' strike ensued and was only terminated with a compromise known as the Saskatoon Agreement that protected the status of doctors as independent contractors paid on fee-for-service (FFS) within the new system. A corollary of the compact is that, henceforth, doctors would negotiate for fee increases directly with the provincial government and would have considerable influence in deciding which new health services or procedures should be included in the basket of universally covered medical care services. Ensuring the privileged position of physician services, the Saskatoon Agreement became the template on which general tax-based universal "medicare" was introduced in the rest of Canada when the federal government provided some national standards in return for sharing provincial medical care expenditures [1].

For the rest of the twentieth century, primary care was largely delivered by physicians working in solo practice or in small physician groups sharing premises and overhead expenses. The focus was on basic medical services with

☆ Open Access for this article is made possible by a collaboration between Health Policy and The European Observatory on Health Systems and Policies.

* Corresponding author. Tel.: +1 14169782067.
E-mail addresses: greg.marchildon@utoronto.ca (G.P. Marchildon), hutchb@mcmaster.ca (B. Hutchison).

http://dx.doi.org/10.1016/j.healthpol.2016.04.010
0168-8510/© 2016 The Author(s). Published by Elsevier Ireland Ltd. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

few incentives for illness prevention and health promotion. After hours care was variable, limited and sometimes absent, forcing patients with minor illnesses into hospital emergency departments off hours and on weekends. The restriction of coverage under medicare to physician and hospital services and FFS physician payment strongly discouraged the involvement of other health professions in the delivery of primary care.

By the beginning of the 21st century, the lack of progress of primary care reform in Canada was obvious to experts in the field as well as decision-makers. Although there has been renewed interest in reforms over the past 15 years, these efforts have remained incremental and have not resulted in any major system changes in terms of governance, in particular, how primary care policy is formulated and implemented and how resources are allocated to primary care providers and organizations [2,3]. Moreover, based on patient assessment of selected primary care indicators and attributes used in the Commonwealth Fund's surveys of international health policy, Canadian performance relative to other OECD countries has been consistently weak, particularly in timely access to care and primary care infrastructure (clinical information systems, interprofessional teams, performance measurement and feedback, and quality improvement support) [4–6].

Canada is a decentralized federation and primary care policy is largely within the legislative purview of provincial governments, even if some of the conditions for universal coverage are under a federal law known as the Canada Health Act [7]. As a consequence, primary care reform is more usefully evaluated at a provincial rather than a national level. Compared to other OECD countries, the depth of primary care reform has been limited by the constraints of the Saskatoon Agreement.

2. Background: primary care reform in Ontario since 2002

Although still best described as incremental in approach, one province – Ontario – stands out in terms of the provincial government's single-minded focus on primary care. The pace of these reforms has been remarkable and the content of the reforms have begun to break with the constraints of the original Saskatoon Agreement. Since 2002, the Government of Ontario has launched a number of primary care models to increase access and improve the quality and delivery of primary care services. Ontario's investments in primary care reform were partly enabled by federal government funding provided through the Primary Health Care Transition Fund (2000–2003) and the Health Reform Fund targeting primary health care, home care and catastrophic drug coverage in 2003.

The provincial government has relied heavily on changes in physician remuneration and the provision of performance incentives and bonuses to achieve its aims [8]. Between 2007 and 2009, total payments to primary care physicians increased by 32% (compared to a 23% increase in overall provincial government health care expenditures), related mainly to the introduction and spread of the new reimbursement models [9]. The primary care share of health care expenditures rose from 7.5% to 8.1% during this period [9]. Mean payments per full time equivalent primary care physician (unadjusted for inflation) increased by 31% between 2005 and 2009, compared to an increase of 25% for all Ontario physicians [10]. An important result of the introduction of new remuneration models and increased payments to primary care physicians has been to reverse the sharp decline in graduating physicians entering primary care that occurred during the 1990s.

However, relative to the substantial public investment made, the reforms have not yet produced the level of improvement in access and quality of care that the provincial government originally expected. As a consequence, the provincial government agenda is now focused on containing costs while potentially broadening the reforms to include potential structural changes that could require more direct accountability of primary care teams to the provincial government as discussed in the final section. This article reviews the original reforms and the rethinking spurred by mixed assessments of the results, and a potential major recalibration of the reforms that could have a substantial impact on primary care reform throughout Canada.

Prior to 2002, Ontario was almost identical to all provinces in that primary care was dominated by FFS doctors in solo and small group practices. The only exception to this was the proportionately small amount of primary care delivered by salaried practitioners working in government-owned but community-governed health centres targeting poor and marginalized populations. Beginning in 2002, the Ontario government introduced a number of new models of care based on three predominant forms of remuneration – fee-for-service (FFS), capitation and salary as illustrated in Table 1 [11].

To offset the incentives produced by any one system of remuneration, the predominant form was blended with elements of the other systems. In addition, bonuses and pay-for-performance targeted financial incentives were offered in all the models in order to encourage certain desired behaviours, in particular, the provision of after hour coverage for rostered patients, the provision of targeted services (e.g. mental health care, palliative care, cancer screening), and the establishment of key primary care infrastructure including the implementation of electronic medical records.

Uptake of the new models by primary care physicians has accelerated during the past decade. In 2002, 94% of Ontario's primary care physicians were remunerated through FFS [11]. By 2015, less than a quarter remained in traditional FFS and almost half of those FFS physicians provided specialized services (e.g., palliative care, sports medicine, hospitalist care, psychotherapy) rather than full-service primary care.

The capitation- and team-based models have disproportionately attracted physicians serving more affluent, healthier and lower-cost populations, raising equity concerns [12–14], not surprisingly given the lack of case-mix adjustment in the age-sex based capitation formula. However, Rudoler et al. found no evidence that physicians in capitation-based models are reducing the care they provide to sick and high cost patients [14]. In addition, although primary care physician density has increased substantially

Download English Version:

https://daneshyari.com/en/article/6238892

Download Persian Version:

https://daneshyari.com/article/6238892

Daneshyari.com