Intelligence MEMOS

From: Åke Blomqvist and Rosalie Wyonch

To: Christine Elliott, Ontario Minister of Health

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Re: **ONTARIO HEALTH TEAMS: PRIMARY CARE SHOULD BE KEY**

The Ontario government is reorganizing healthcare, from the Health Ministry to the doctor's office. To meet the goals of reducing wait times, constraining costs, and ensuring patients have access to high-quality healthcare, the government should address fundamental challenges in primary care and how family doctors are paid.

Ending hallway medicine was one of the government's signature promises in the campaign and it has proposed a system reorganization, featuring a network of Ontario Health Teams with responsibility for supplying "integrated" healthcare to all residents.

We now await the government response to the hundreds of OHT proposals it has received. We do not yet know the details, but the government says it has received many interesting suggestions.

Many proposals are likely to be from groups of professionals who deal with specific health problems, or who already have developed informal networks in their local communities. The government should keep in mind, however, that the ultimate objective is to transform the entire system to provide higher-quality coordinated care. To do so, it must strive to bring all sectors into the process, starting with the family doctors, nurse practitioners, and family health teams who supply the primary care that is its foundation.

A key element in several high-performing healthcare systems in other countries has been a well-established relationship between each patient and a primary-care provider, who is the healthcare adviser and manages the care and drugs patients receive from all providers – that is, a primary-care provider whose practice is the patient's "medical home." This has been the model in the U.K. National Health Service, in the Netherlands, and in several of the more successful parts of the US managed-care sector. Ontario should draw lessons from these models.

It should also build on the evidence from the experiments with enrollment-based methods of compensating primary-care providers that have been running in Ontario since the late 1990s. The experiments have used the principle of capitation, a compensation method under which a doctor is paid in part on the basis of the number of patients who have signed up with his or her practice, and who have agreed that they will use the enrolling doctor's practice as their first point of contact with the system.

Capitation is like a lawyer's retainer. It is paid every month whether or not a patient actually has used any services, but in return the doctor agrees to see the patient if he or she needs care, to ensure that there are arrangements for after- hours care, and to bill the provincial insurance plan for "core services" at a discounted rate.

The Ontario capitation experiments were started in part because many patients had trouble finding a physician who was willing to take on the role as family doctor. In that respect, they have had some success: In surveys, most Ontarians today will say that they have a family doctor who usually is willing to see them on short notice. But while some had also hoped that capitation would help contain healthcare costs, there is no evidence that the experiments have had this effect. Aggregate payments to primary-care providers have continued to grow at a healthy pace. While economic theory suggests that capitation gives primary-care doctors an incentive to focus more on preventive care, there isn't convincing evidence that has happened to a significant extent in Ontario so far.

On balance, the evidence on the effectiveness of primary-care payment reforms in Ontario so far may not seem encouraging, and the government's apparent desire to strike out in new directions is understandable. In our recent C.D. Howe Institute report, however, we argue that rather than abandon the new models for compensation and production of primary care at this stage, the government should take them further.

The idea that in a well-functioning healthcare system, patients must have an accountable provider serving as their medical home is more convincing than ever, and a patient enrollment model based on capitation is by far the most logical basis for such a system. Moreover, one should keep in mind that the Ontario capitation schemes were very watered-down versions of methods elsewhere. The right way for the Ontario government to go at this point is to continue moving in the direction of stricter versions of capitation as the basis for compensating primary-care providers, and to use capitated primary-care providers as the backbone of the new OHTs.

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