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HEALTHCARE POLICY

## Accountability and Access to Medical Care: Lessons from the Use of Capitation Payments in Ontario

by

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- Over the last decade, the province of Ontario has reformed primary care to pay family doctors more on a capitated, or per patient, basis and less on a fee-for-service basis. This has been coupled with an emphasis on patient enrollment with a specific family doctor, or group of doctors, to improve both access and the relationships between family doctors and patients.
- While it is debatable whether Ontario has achieved good value-for-money with reforms, these efforts seem to have improved timely access to continuous primary care and created an incentive structure for providers that is more consistent with the system's access and cost-control objectives.
- However, even with greater access to family doctors in Ontario than in the past, there were over 1.7 million visits by enrolled patients to outside doctors in 2011/12. A cursory review of claims data suggests that visits outside of one's family doctor are largely due to patient choice based on convenience of care.
- Ontario's healthcare system could realize better value-for-money were fewer patients to seek such outside care. One area for reform would involve better designed incentives for patients that complement the existing incentives for providers.

An established relationship between individual patients and a regular family doctor, or other primary-care provider, is a valuable feature of a well-functioning healthcare system (Nabalamba and Millar 2007, Freundlich 2013). For providers, having familiarity with patients' medical

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histories improves their ability to treat patients appropriately, and can reduce the cost of care because it decreases the need for repeated diagnostic tests and for trying different treatment strategies. For patients, an implicit commitment from a familiar primary-care provider to see them quickly when they have health problems is also valuable. Some years ago, many patients in Ontario who did not have a regular family doctor complained of reduced access to timely care, since they had difficulty finding a doctor who was willing to see them on short notice.

In Ontario, the objective of improving patients' access to care from a regular family doctor has triggered comprehensive primary-care reform over the last decade that centers on: i) patient enrollment; and ii) a move away from fee-for-service toward per-patient, or so-called "capitation", physician payments.

In the new system, primary-care practices can establish a roster of regular patients, agreeing to supply them with care on a timely basis as needed. Patients join this roster by signing a written commitment to consider these practices as their regular providers, to whom they will turn in the first instance when they need care.

Payment by capitation, in turn, is used partially as an incentive for providers to take responsibility for many regular patients. Under capitation, the government pays providers a lump sum, which is a fixed, age-sex adjusted, annual amount based on the number and type of patients on the practice's roster. In return, the physicians provide a "basket" of services such as assessments, diagnosis, treatment, primary mental health, coordination and referral, and patient education and preventative care, at discounted rates.<sup>1</sup> This E-Brief examines the improvements in access achieved by reforms in Ontario and then discusses ways to better design incentives for patients and providers to ensure cost-effective primary care – the need to do so is an important lesson for other provinces considering similar reforms.

## Results of Ontario's Reforms

Primary-care reform in Ontario has introduced a variety of payment models, such as blended capitation models. A blended payment model sees most income earned on a capitated, or per patient, basis with a small share of income coming from fee-for-service payments. Physicians and care providers organized in so-called Family Health Organizations and Family Health Networks can take advantage of this model. There are also enhanced fee-for-service models, which combine the fee-for-service payment with additional performance incentives such as chronic disease management.<sup>2</sup>

Today, over 8,000 family physicians and about 10 million patients participate in these new models.<sup>3</sup> The most popular model for patient enrollment – Family Health Organizations (FHOs) – had 5.6 million patients and 4,200 family physicians participating in 2012. While a complete cost-benefit analysis of the reforms would

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- 1 In a pure capitation system, providers receive no additional payment for providing the services included in this basket. In a "blended" system, such as that in Ontario, doctors are paid additional amounts for each service provided, but at rates that are only a fraction of the regular fees paid for these services to doctors who practice purely on the basis of fee-for-service. Emergency Department services are not in the basket, and patients can access them without financially impacting the family doctor with whom they are enrolled.
  - 2 These fee-for-service payment models are known as Family Health Groups and the Comprehensive Care Model.
  - 3 The remaining family physicians (about 4,000) practice in Emergency Departments, Focused Practices, and traditional fee-for-service models.

have to include their fiscal costs, which have come under scrutiny (Ontario 2011), the reforms have likely led to other forms of cost savings, such as reduced referrals and hospital length of stay, among others.<sup>4</sup> There are also indicators they have had a significant positive impact on patient access to healthcare: Since 2004, for instance, there has been a major increase in the number of patients formally enrolled with family doctors (Kralj and Kantarevic 2012a).

Although Ontario's blended plans pay doctors partly by capitation, patients still are allowed to seek care from any provider, not only from the provider on whose list they appear, at no out-of-pocket cost. In similar enrollment models in other countries, patients are either restricted to seek care from their designated provider (e.g., in the Health Maintenance Organizations (HMOs) that are common in the US) or have to bear all or part of the cost if they receive services from an outside doctor (e.g., the United Kingdom). This is a common feature in primary-care systems abroad because it encourages a single access point to care, improving providers' familiarity with individual patients, and allowing for a more cost-effective use of public resources.

While patients in the Ontario model may value the ability to seek primary care from any provider without penalty, allowing them to do so weakens the rostering approach. Most obviously, it can be costly to the public purse since the provincial plan pays both the capitation amount to the regular provider and the full fees charged by outside providers. In addition, the outside use may cause some of the problems with fragmented care from multiple providers that the capitation approach was supposed to address in the first place.<sup>5</sup> To counter these problems, Ontario has introduced a number of incentives to limit outside use, such as financial penalties for providers when their patients seek care elsewhere,<sup>6</sup> formal requirements on capitated providers for scheduled after-hours operations, and disincentives to enroll too many patients.

However, these incentives focus on the providers only – there are currently no effective policies in place to limit outside use initiated by patients, even though the roster agreements they have signed oblige them to seek treatment first from their designated doctor or provider group. That is, patients are free to seek the most convenient source of care, even if their regular provider is available, because they are not financially sanctioned in any way for doing so.<sup>7</sup> As a result, many enrolled patients are still going to walk-in clinics or other outside providers to receive primary-care services. Under the FHO model, enrolled patients accounted for over 14 million family doctor visits in fiscal 2011/12, but over 1.7 million visits were with outside physicians for in-basket services (i.e., outside use), exposing their regular doctor (with whom they are enrolled) to a financial penalty.<sup>8</sup>

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4 See Kralj and Kantarevic (2012b) and Kralj and Kantarevic (2013) for more information on the additional impacts of reforms.

5 For example, in fiscal 2012/13, the value of outside use services was close to \$115 million, about 60 percent of the maximum possible access bonus (Source: Calculations by authors based on OHIP data).

6 A portion of the capitation payment to the regular providers is designated as an access bonus. If an enrolled patient seeks outside care, the access bonus is reduced by the full amount of the fee paid by the provincial plan to the outside provider. While this reduces the cost to the provincial plan, it does not completely eliminate the possibility of double payment since the access bonus cannot be reduced below zero.

7 There may be other, non-financial deterrents to outside use. For example, the physician may de-enroll patients with excessive outside use, but this is clearly not a preferred solution for either the physician or the patient.

8 The Auditor General of Ontario suggested that the level of outside use was even higher than the figure stated here (Ontario 2011). Outside use excludes Emergency Department services and certain other focused practice services and includes only comprehensive care services that could in principle have been provided by the enrolling physician rather than the alternative provider.

Allowing patients to seek care from outside providers may make sense if the ‘outside use’ is due to behaviors by the enrolling physician. However, a review of the Ontario Health Insurance claims data suggests that outside use is largely due to patient choice based on convenience of care.

### What Causes Outside Use of Primary Care in Ontario?

A number of factors can cause Ontarians enrolled in capitation plans to access outside providers. For instance, there may be a preference for receiving care on weekends or non-work hours, at a location near home or work, and there may also be limited office hours available in a patient’s primary-care group.<sup>9</sup> A cursory analysis of these factors in Ontario shows the following:

- The vast majority (about 93 percent) of outside use occurs during weekdays, not on weekends (see Figure 1a).<sup>10</sup>
- Younger patients have higher outside use than older patients (Figure 1b).<sup>11</sup>
- The travel time, from the patient’s home address, to providers where they received outside use service is longer than the travel time to their regular enrolling physician (Figure 1c).
- In at least one-half of the cases of outside use, the enrolling doctors’ group was available to provide services, as evidenced by the fact that doctors provided services to other patients during that day or evening (Figure 1d).
- Outside use visits are no different than other visits in terms of type of assessment and condition diagnosis. The vast majority of visits are minor or intermediate assessments associated with diagnosis such as the common cold, hypertension and anxiety.

The travel time finding noted above is interesting, and at first glance puzzling, since it is not clear why a patient would travel twice as far to seek outside care. After all, it is unlikely that these patients are unhappy with their enrolling physicians, given they still receive most of their care from them and given that they can change doctors twice a year. However, the puzzle disappears if it is recognized that many patients may seek care not from their home – from where travel time in our data is measured – but from places where they are spending most of their time, such as work or school. From these locations, the travel time for outside care is often faster than a trip to their regular doctor. Anecdotally, and consistent with the other data presented, the patients seek outside care near their employer and their children’s school.

### Conclusions and Recommendations

Ontario has made bold reforms to primary care. While debate on the cost-effectiveness of these reforms remains, these efforts seem to have improved timely access to continuous primary care, and created an incentive structure for providers that is more consistent with the system’s objectives in primary care than the traditional fee-for-

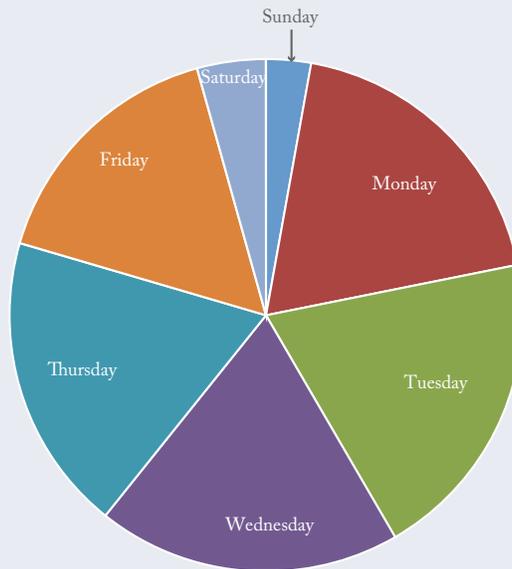
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9 Clearly, there may be a myriad of other factors that influence patient choice that are beyond the scope of this paper, such as the proliferation of walk-in clinics, accessibility during regular hours, the type of medical condition, etc.

10 In interpreting the data, one limitation is that the data do not allow us to observe the hour when the outside use occurred.

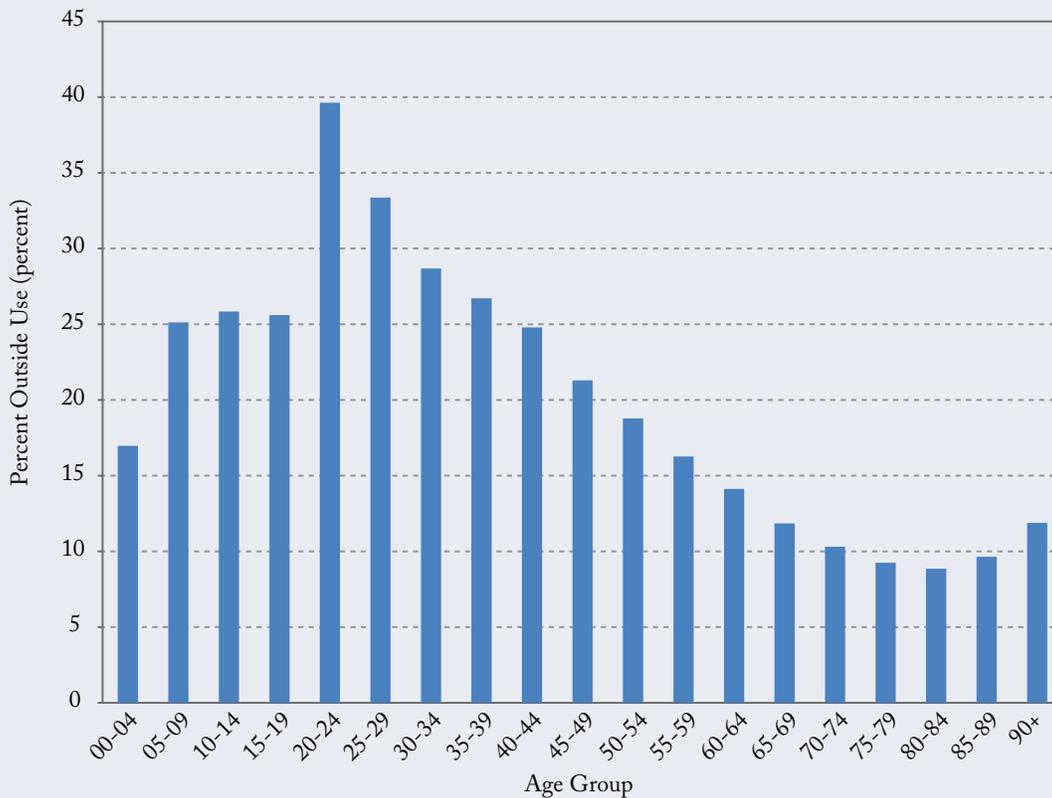
11 The percent outside use in this Figure represents the visits for in-basket services provided by the non-enrolling physician as a percentage of the total number of visits for in-basket services that the patient received from both enrolling and non-enrolling providers.

Figure 1a: Outside Use by Day of Week, Fiscal 2011/12



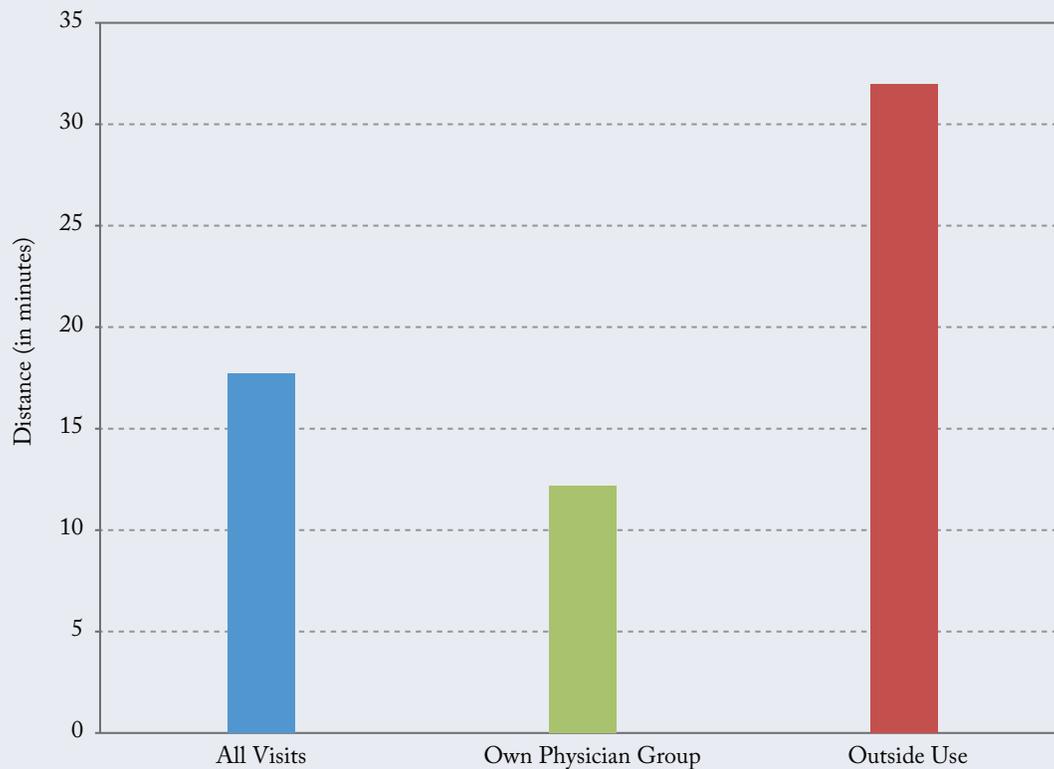
Sources: OMA Economics Department based on OHIP data.

Figure 1b: Percent of Services Received Outside the Enrolling Physician Network, 2011/12, by Patient Age



Sources: OMA Economics Department based on OHIP data.

Figure 1c: Mean Travel Time by Type of Visits, 2011/12



Sources: OMA Economics Department based on OHIP data.

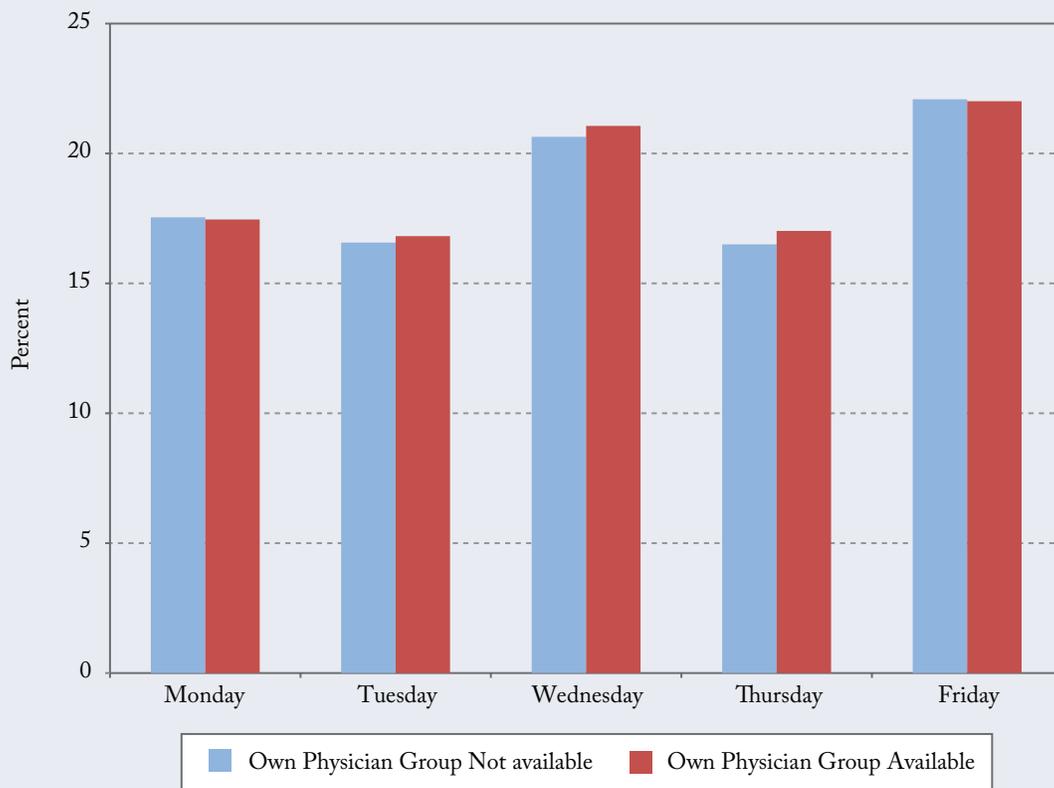
service model (Blomqvist and Busby 2012). In our view, other provinces should consider adopting a similar model while learning from Ontario's challenges.

Better value-for-money for Ontario's health system could be achieved were fewer patients to seek care outside the doctor or family physician group that enrolls them. One area for reform would involve better designed incentives that target patients – complementing the existing incentives that target providers. If Ontarians – like citizens in many other advanced countries – value greater patient flexibility in seeking care from any provider then it should be recognized that this flexibility has a cost. Attempts to reduce this cost by targeting providers only will have limited success; ensuring that enrolled patients are similarly held accountable for their behavior seems a promising way forward.

As a start, we believe doctors should be encouraged to explain more clearly to patients that by signing the rostering agreement, they have agreed that they will only seek care from an outside provider when they have a good reason for doing so. As well, the Ministry of Health and Long-Term Care could expend more effort to explain the rationale for the rostering model, and that it does imply some obligations on patients as well as on providers.

Even though we recognize that it would be highly controversial, we also think it reasonable to ask patients to pay part of the cost of their care out-of-pocket if they chose to go to an outside provider purely for reasons of

**Figure 1d: Percent Outside Use by Day of Week and Whether Enrolling Physician Group was Available during After-Hours, 2011/12**



Sources: OMA Economics Department based on OHIP data.

convenience. Leeway could be given to patients who work long distances from home – all patients with a greater than one-hour commute to work could be permitted one or two outside visits per year before charges begin, for instance. Further flexibility could be given for patient visits during off-regular hours of care as well as for same-day needs or for repeat visits in a short time horizon.

If a pattern of outside use is common for a specific patient, he or she could be encouraged to choose a family physician closer to their place of work. Of course, any financial charge option would require amendments to the Physician Services Schedule of Benefits via regulation changes to the *Health Insurance Act* deeming such services uninsured. It would also require a thoughtful implementation approach, with caveats like those mentioned above, to achieve its objective of reducing unnecessary outside use without compromising access to quality care.

Better patient education and provider accountability on quality of care received are other avenues for improvement. Patients under the current system can choose to switch provider groups where they are enrolled – and thereby reduce the income of the group they are leaving and raise the income of the group they join. Greater effort to measure primary-care quality, including the availability of after-hours care for time-crunched patients, would put more incentives on physicians to improve service quality and keep their patients.

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