Primary care reform: Is it time for population-based funding?

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Résumé

LA RÉFORME DES SOINS MÉDICAUX PRIMAires au CANADA attire de plus en plus d’attention, surtout de la part des gouvernements préoccupés par les coûts imprévisibles et la mauvaise répartition des médecins. La mise en œuvre d’un mode de financement fondé sur la population suscite beaucoup d’intérêt. La capitation et l’inscription sont répandues dans certains pays d’Europe, mais les données probantes relatives à leur efficacité sont difficiles à interpréter à cause des différences entre les systèmes de soins de santé. Même si les résultats signalés par les Drs Truls Østbye et Steinar Hunskaar dans ce numéro (page 45) indiquent que la capitation et l’inscription peuvent être efficaces et acceptables dans certains pays, elles ne sont pas nécessairement applicables au contexte canadien. Il est néanmoins probable que l’on implantera bientôt au Canada un mode de financement fondé sur la population, ce qui permettra de mieux évaluer les systèmes de paiement.

Although the restructuring of hospitals is capturing most of the media attention as provincial health systems across Canada undergo reform, issues surrounding the provision of primary care are also drawing the interest of policy-makers and health professionals. Half of Canada’s physicians are engaged in primary care, and most health care episodes start and end with the family physician. However, the most significant aspect of primary care is its position as an entry point into the health care system. By providing first-contact care that is accessible, comprehensive, coordinated and continuous, primary care ideally serves not only the individual patient, but also—by promoting appropriate patterns of utilization—the health care system as a whole.

In Canada, most primary care is provided by physicians who are paid on a fee-for-service basis. Alternative payment mechanisms have been used for many years but are still uncommon. Physicians in community health centres (CHCs) are salaried. However, except for CLSCs (centres locaux de services communautaires) in Quebec, they serve only a small part of the population. Newfoundland has salaried district medical officers, and there are alternative payment plans for practice in remote areas in several provinces. Alternative funding plans for academic health science centres provide a defined budget that is used to pay physicians by any of a variety of methods. Ontario’s HSOs (Health Service Organizations) are the only structures that use payment by capitation. The comparison of fee-for-service with alternative funding methods is complicated by other variables that may characterize the agencies involved, such as range of services, patient population, use of nonphysician staff and style of medical practice.

At the national level, much of the policy discussion on primary care has arisen from the issue of physician resource policy, beginning with the Barer–Stoddart report1 and developing through Birch and associates’ Paying the Piper and Calling the Tune,2 the Kilshaw report3 and other documents. In Ontario, similar efforts also arose from questions of human resources policy.4 The National Forum on Health has identified primary care as a key element in the restructuring of health care systems, and several important papers have been published by groups representing family physicians.5–8

At the centre of most plans for reform is population-based funding, whereby each patient would be registered, or rostered, with 1 practice, where they would obtain all primary care (except in an emergency). The obligations on the part of the practice would be to provide a comprehensive range of diagnostic, therapeutic and preventive services and to be available to respond to patients’ needs at all times. These obligations can be defined in contracts between the funder and the practice, and between the practice and the patient. Population-based funding is already being developed as a basis for a wide range of services within the regionalized system in western Canada.
and would be a component of the integrated health care systems being considered in Ontario.

In a capitation system of population-based funding, periodic payments are made to physicians in return for the provision of a defined range of services to a rostered population, independent of the volume of services actually consumed. Payment is made for each person on the roster and can be adjusted for age and sex to allow for differences in predicted utilization. Thus, payment is driven by the needs of the population served rather than by the physician’s level of activity. Medical associations in Alberta and Ontario have endorsed capitation for primary care — at least in principle — as one of several options. However, if physicians are to be allowed to choose their method of funding, then one might suppose that the share of the funding pool allocated to each funding option should be proportional to the population served. In practice, capitation would most likely be combined with 1 or more of base funding, fees for specified services, special allowances and incentive payments. Such blended funding systems are already in place in the UK and several other countries.

The goals of primary care reform include the promotion of quality care, greater continuity, encouragement of effective preventive care, consumer choice, increased accountability, better distribution of physicians and more predictable costs. There is a broad consensus among health care professionals with regard to these goals; the challenge, however, is to assess the available evidence to find policies that will achieve the intended outcomes.

Canada’s only experiment to date in capitation, Ontario’s HSO program, failed — at great expense — to achieve its objectives. However, it would be rash to attribute this failure to capitation per se rather than to the poor design of this particular program. The pilot system of rostered and capitated primary care in Norway described by Drs. Truls Østbye and Steinar Hunskaar in this issue (page 45) had more positive outcomes. The finding of a small reduction in the use of emergency departments and walk-in clinics is of interest, as is the absence of an increase in referrals to specialists (although there is conflicting evidence elsewhere). The study was too limited to demonstrate any effect upon the geographic distribution of physicians.

Although the outcomes of rostering in Norway may provide some lessons for us, they are pointers rather than hard evidence. In the Norwegian pilot the public component of funding changed from a combination of salary and fees for service to a combination of capitation payments and fees for service. The inclusion of user fees in both systems constituted a clear difference from the Canadian situation. Also, patients who consulted a medical specialist without referral or another general practitioner without sufficient reason had to pay higher user fees as well as the fees for service that the government would normally pay. Introducing such policies in Canada would require some political courage and might be interpreted as a violation of the Canada Health Act.

Some of the goals of medical reform will bear fruit only in the long term, and therefore there is little evidence so far to guide policy decisions. Nevertheless, provincial governments are impatient to deal with the continuing maldistribution of physicians, and it seems likely that the provision of services will in future be governed by the needs of populations rather than by physicians’ preferences. This means population-based funding, but not necessarily by capitation. An option that would achieve some of the objectives of reform (but might be more acceptable than capitation) is the “reformed fee-for-service” option proposed by the Ontario Medical Association, in which physicians would charge a fee for services up to an amount equal to that payable under capitation for the same size and composition of roster. Another option might be CHC practice.

The Norwegian study is nevertheless another indicator that population-based funding and rostering can be effective and acceptable in many countries. The evidence that this is also the case in Canada’s health services system must come from our own experience. Primary care reform in Canada still has far to go, but to enable policy-makers to evaluate options for payment mechanism, type of provider and practice organization, we should implement population-based funding, rostering and contracts for comprehensive care very soon. There is no reason to delay any longer.

References


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