Features

Chroniques

Michael OReilly is a freelance writer living in Marathon, Ont.

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Ontario's attempt at primary care reform hits another snag

Michael OReilly

In brief

ONTARIO IS THE LATEST PROVINCE to step into the health care reform spotlight. Proponents hope its proposed series of primary care pilot projects, built around the concept of patient rostering, will improve the delivery of care. If the project goes ahead, doctors in 5 participating sites will be paid under a capitation system, with payments starting at $70.29 annually for men aged between 25 and 35.

En bref

L'ONTARIO ENTRE À SON TOUR sous le feu des projecteurs de la réforme du système de santé. Les défenseurs de la réforme espèrent démontrer, grâce à une série de projets pilotes, que la formule des listes de patients peut améliorer la prestation des soins. Si la proposition de projets pilotes est acceptée, les médecins des cinq sites participants seront rémunérés à la capitation, à compter de 70,29 $ par année pour les hommes de 25 à 35 ans.

Dr. Rudy Gasparelli feels like the groom who is always left at the altar. In a never-ending search for new ways to pay family physicians, he has twice agreed to participate in trials involving alternative payment plans (APPs). And once again, he says, the Ontario government's chequebook has failed to match the rhetoric coming out of Toronto.

"We are ready and willing to try new things, but the government appears unwilling to put up the funding needed to make this work," says Gasparelli, who practises in Wawa, a town with 4500 residents about 200 km north-west of Sault Ste. Marie, Ont. "It would be an advantage to have an APP, but not at the price they want us to pay."

Last spring the Ontario Medical Association (OMA) and the provincial government announced plans for primary care reform (PCR). As part of the initiative, patients in 5 pilot communities were supposed to be rostered with networks of physicians.

The participating networks would meet all primary care needs of these patients and also provide a wide range of health-promotion services that are not currently insured. From the physician's perspective, the biggest change is that services would be paid for via capitation, in which an annual fee is paid to cover services for each patient on a roster, rather than via the more common fee-for-service payments. The annual capitation fees vary according to patients' age and sex.

"This is not about saving money, it's about improving access," explains Jeremy Adams, a Ministry of Health spokesperson. "Whatever we can do to improve access to services, to improve the range of services, to improve the focus of the health system to be on wellness rather than illness — anything we can do to move along those lines needs to be looked at."

Gasparelli is sceptical. He says the government's financial offer is simply inadequate and would mean an income cut for Wawa's doctors. "We're reasonably happy with the way things are right now," he explains. "Primary care reform is asking physicians to do what we're already doing. This [is supposed to] make the funding more appropriate for the service we're already providing."

$340.87 a year

Under the latest primary care reform offer, Gasparelli would be paid $340.87 a year to provide care to men aged 85 to 89. When the patients are aged 15 to 19, the stipend would drop to $73.85 a year, while the lowest payment, $70.29 annually, is reserved for men aged between 25 and 35. He will also be paid up to $100 an hour to take courses that have been approved by the Ministry of Health and will receive a financial bonus for reaching set goals for vaccinating patients.

These numbers were drawn from province-wide averages that are highly skewed towards urban practices, says Gasparelli. With the ministry refusing to recognize the added challenges — and costs — faced by rural family doctors, Gasparelli says he was forced to walk away from the talks.

Dr. Rudy Gasparelli: Too high a price?

But Wawa may not be the only place where PCR is a hard sell. According to Gasparelli, physicians in the other pilot sites have not yet signed on, and some of the smaller ones share the Wawa physicians' financial reservations. The other pilot locations named were Hamilton, Chatham and Paris, and the Kingston area. Despite repeated attempts, Ministry of Health officials were unavailable to comment on physicians' developing reluctance to participate in the reform effort. A spokesper-son did say that negotiations "are ongoing."

The reform effort developed following more than 2 years of study by a committee headed by the OMA's Dr. Wendy Graham. The committee, which comprised physicians, academics, hospital staff and consumers, was created by the minister of health in 1996. Members were told to design a new model for delivering patient services in Ontario.

Graham says Canada's public health care system looks considerably different now than it did 2 years ago, when the work began. She said it is now faces serious threats, and her committee's job was to find ways to help save it.

"When I was at the CMA annual meeting in 1996, we voted on whether we were in favour of two-tiered health care. This would have been the death of our system, so I think rescue isn't too strong a word [for this primary care reform package], given that background."

When Graham and her team began considering reforms, the twin goals were to improve service while getting better control over costs. The first step was to consider systems in the US, UK, New Zealand and Scandinavia. Graham thinks the model that emerged is a synthesis of the best the world has to offer.

Under the primary care reform package, patients are voluntarily rostered to groups of family physicians, with each rostered patient having a set amount of money attached to them each year according to their age and sex.

Family doctors commit to providing an expanded level of care. This includes expanded on-call and weekend services, enhanced preventive and wellness efforts, and improved use of networking technology. This last feature will help doctors build practice networks and rationalize the use of resources through improved sharing of patient and clinical information.

"A pivotal shift"

"This is a pivotal shift away from individual sickness intervention to looking at the broader aspects of health promotion and wellness in the population," said Graham. "In the long run this will decrease the rate of increase in health care spending, which is why governments are willing to invest now."

Each pilot project will run for 2 to 3 years, and then a joint OMA-ministry committee will examine the results and consider whether the system should be expanded into other parts of the province.

Graham says their voluntary nature and level of choice are key features of the pilot projects. Patients must choose

to be rostered, they are allowed to change their minds twice and they can always seek service from outside doctors without penalty. This is an important difference from the rostering systems found in the US and the UK, where patients have far less flexibility.

One of the more visible results of rostering is the use of telephone triage. The physician network in each of the 5 pilot sites is supposed to develop an after-hours telephone advice line for rostered patients. This is to enhance contact with them and reduce costs to the system by limiting visits to emergency wards and walk-in clinics.

In the past, some physicians have offered this kind of service without being compensated. These, and additional services provided by nurses or nurse practitioners within a practice, would be funded directly under the pilot projects.

Gasparelli says Wawa, which has 6 physicians, has long been at the forefront of medical innovation. Local doctors have always taken a group-practice approach, and they already offer telephone triage and employ a nurse-practitioner, and cover all on-call work at the local hospital.

Years ago the province launched an initiative called the comprehensive health organization (CHO), which called for a local body to manage all local health care needs and not just primary care services. However, it had limited success.

"What we're into now is interesting and certainly a move in the right direction," says Gasparelli, "but it's not nearly as far reaching as the original CHO plan. This is basically a physician-funding model. I think it offers advantages over fee for service but I think it will have a limited impact on the quality of service delivered.

"The most important factor in the quality of service is the physician himself, not the method of payment."

Adams stresses that PCR is "revenue neutral" and will not increase physicians' incomes. However, Graham says additional money will have to be spent at the outset to cover start-up costs for new computers and rostering procedures. On top of this, additional billing codes will allow physicians to charge for new services mandated under these reforms.

The expanded use of computers and electronic networks is key to PCR because it will allow for the electronic transfer of the files of rostered patients and improved access to current clinical information. Improved technology will also let the government track rostered patients' use of the medicare system accurately so that any services delivered by family doctors outside the pilot projects are accounted for.

100 FPs, 300 000 patients?

Graham said PCR poses tricky questions that these pilot projects would help answer. Are patients willing to have their use of the health care system tracked this closely? More important, are patients willing to take on some responsibility for the health care system?

"I'm a firm believer in a tripartite accountability model," said Graham. "Governments must fund the system adequately, doctors must provide the service adequately and defend individual rights in the context of population health, and patients must consume health care services in a responsible fashion."

If the PCR experiments eventually do get off the ground, Graham says more than 100 family physicians and 300 000 patients are expected to volunteer to participate.

After working on the project, Graham is convinced that Canadians want medicare to prosper. "After spending the last couple of years really examining other systems around the world, I am more convinced than ever that we have something special here." ?

Primary care reform: the doctor's perspective

As far as doctors are concerned, the key aspects of Ontario's reforms are:

- voluntary enrolment
- payment based on a capitation model, either as a direct payment or via a reformed fee-for-service model
- expanded delivery of on-call services
- increased emphasis on prevention services
- evening and weekend office hours
- improved use of technology, including computerized patient records, with the government paying two-thirds of the cost of new equipment and software

Primary care reform: the patient's perspective

As far as patients are concerned, the key aspects of Ontario's reforms are:

- voluntary enrolment
- expanded access to on-call services
- enhanced prevention services, such as reminders about regular tests and immunizations
- primary mental health care, including crisis intervention and referral services
- 24 hour, 7-day-a-week access to primary care services through a telephone advisory line staffed by registered nurses
- overall service coordination with a physician group, hospitals, specialists and others